The CLABSI Reduction Plan

Davis 8 Oncology and Bone Marrow Transplant
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Background

Central-line-associated bloodstream infections (CLABSI) are associated with an increased risk of mortality and prolonged hospitalization. The UC Davis Health Oncology and Bone Marrow Transplant unit has 9,822 central line days per year out of a total of 11,584 patient days per year. Immunocompromised patient populations are at greater risk for infection and have longer device days, creating a barrier to successful CLABSI prevention efforts.

Purpose

The purpose of this investigation is to decrease the incidence of CLABSI rates with the implementation of the CLABSI bootcamp. Specifically, this investigation occurred during the FY21 Q 2 on the Davis 8 Oncology and Bone Marrow Transplant Unit.

Methods

The Davis 8 Unit Based Practice Council developed a CLABSI education bootcamp addressing the methods to effective infection prevention for oncology patients with a central line catheter in place. The education bootcamp consisted of four learning stations. There were 2 sessions a day, both 2 hours in length. The bootcamp was held for a period of 5 straight days. It was mandatory that all Davis 8 registered nurses sign up and attend.

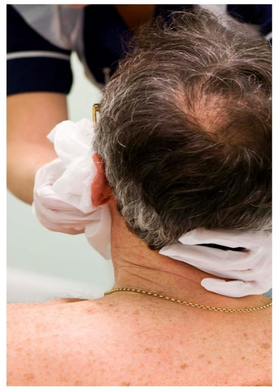
Implementation

Station 1

2 Person Dressing Changes

Station 2

Chlorohexidine Treatments and Messaging



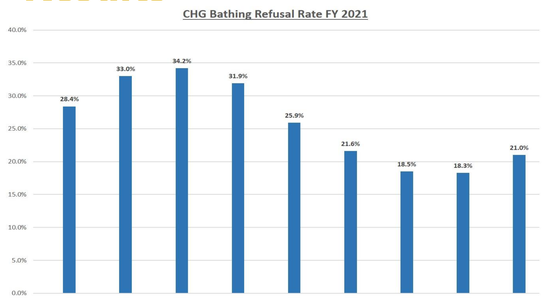
Station 3

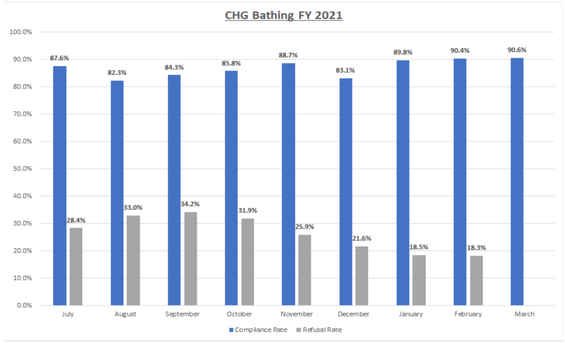
2 Person Blood Culture Collections

Station 4

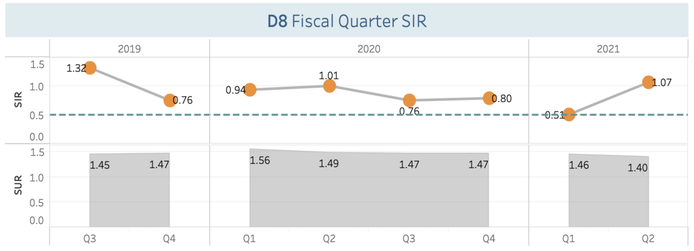
Environmental Surveillance

Results





Bootcamp Held October 2020



Conclusions

A total of 86 Davis 8 registered nurses attended the mandatory 2-hour CLABSI Education Bootcamp. Post-Bootcamp CLABSI rates were anticipated to be less than pre-implementation rates. In conclusion, there was an increase in CHG treatment compliance and a reduction in patient refusal of CHG treatment post bootcamp. However, more studies needed to be collected in order to the determine the overall effectiveness of the bootcamp.

Further Study

There is a need for further evaluation to determine the effectiveness of the CLABSI Education Bootcamp. Audits to assess nursing compliance and patient participation in infection prevention measures were started in Quarter 2 of FY21. A CLABSI task force was created around the same time – a multidisciplinary team specific to Davis 8, including members from the Infectious Disease physician group. The group will monitor audits and CLABSI rates closely and continue interventions to help reduce the occurrence in this specific population.

References

- UCDMC Tableau Dashboard
- UCDMC PCS Quality & Safety Dashboard
- Canva Free Media Photos

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