sentara nurse

Crushing the CLABSI Crisis: A 72% Decrease in 1 Year

Brenda Earley, BSN, RN and Lael King, BS

Contact: bbearley@sentara.com

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

SENTARA®

Background

In 2013, Sentara Norfolk General Hospital a 525 bed, level 1 Trauma Center identified an increase in Central Line Associated Bloodstream Infections (CLABSI) trending toward double the 2012 infection rate. Between January and April 2013, we had already had 20 CLABSI's.

An interprofessional team consisting of :

- Senior Leadership
- Infection Prevention
- Quality Improvement
- Nursing
- Physicians
- Product consultants

developed and implemented evidence-based best practices around preventing CLABSI's. Modifications included changing products identified by bedside staff, re-education and reinforcement of bundle components, hand hygiene, avoidance of femoral catheter placement, and daily assessment of catheter necessity resulting in a 72% decrease in CLABSI infection rates within one year.

Objectives

- Decrease CLABSI's
- Improve interprofessional collaboration between Nursing, Infection Prevention, and Physicians
- Identify commonalities seen in our infections
- Create a best practice for system wide implementation

Challenges Identified

- Educating staff on multiple changes in a short period
- Physician resistance
- Embedding best practice within the culture
- Time constraints with daily rounding

Process

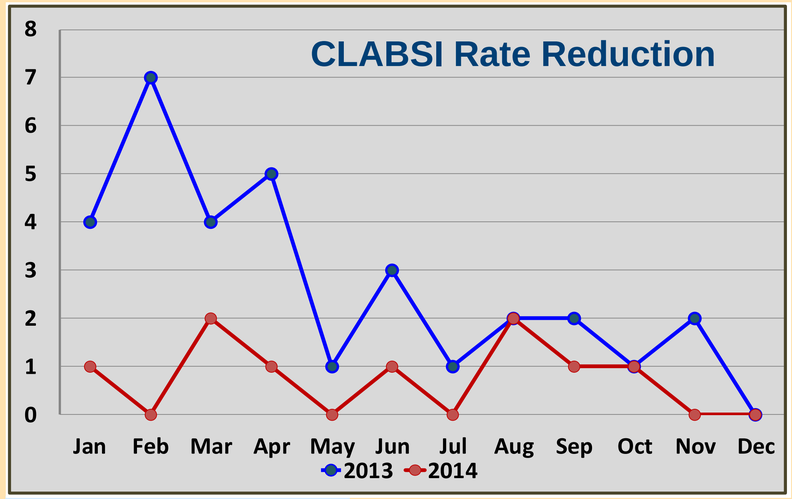
1. Created an anonymous survey for staff to identify infection causes
2. Looked within Sentara System to identify current best practices
3. Presented results to Senior Leadership for input and action
4. Implemented a Healthcare Acquired Infection Team (HAI) co-led by Nursing Leadership and Infection Prevention
5. Redesigned auditing and rounding process
6. Involved Administration from onset
7. Changed culture, policies, practice and products

Changes Implemented:

Outcomes

- In 2014 SNGH had a 72% reduction
  (32 CLABSI's in 2013 to 9 CLABSI's in 2014)
- Our 6 Intensive Care Units had a 94% reduction rate
  (17 CLABSI's in 2013 to 1 CLABSI in 2014)
- Improved patient safety
- Enhanced interprofessional relationships
- Resolved physicians resistance
- Adopted a new best practice within our Sentara System
- Instituted standardized auditing and rounding providing staff with real time education and feedback

Results



Lessons Learned

- Solicit input from frontline staff
- Identify problems earlier
- Prioritize early involvement of Administration
- Conduct real time rounding and feedback

Future Direction

Based on the success of this project, moving forward and sustainability are key. Continuous education and frequent auditing is required to maintain our goal. Interprofessional collaboration is imperative for continued success.

Acknowledgements

Susan Kaplan PhD, RN; Paul D Chidester MD, FACP and the Members of our HAI Team

August 2015