KANSAS HEALTHCARE COLLABORATIVE

KANSAS On the *CUSP*

Frequently Asked Questions

General FAQs

1. What data are collected?

a) Number of infections per month, based on CDC definitions
b) Number of catheter days per month, based on CDC definitions
c) Completion of the Monthly Team Checkup Tool at least once per month
d) Survey of the safety culture, based on the AHRQ Hospital Survey of Patient Safety Culture (HSOPS), taken once at baseline and a second time 18 months thereafter
e) Exposure assessment, once just prior to project launch

2. Is the national On the CUSP project team intending to collect data, or will each state collect data and submit results?

Each participating hospital will be responsible for data collection and entry into the MHA CareCounts database on a monthly basis. Some states have the ability to collect data or are submitting to NHSN already. In those cases, the requirements will be different than if they were submitting all data through CareCounts.

3. In what format will the data be collected?

a) All of the data elements will be entered into a web-based database at www.mhacarecounts.org.
b) The exposure tool will be completed in SurveyMonkey.

4. Is there a need for a business associate agreement for data collection?

HRET works with each state to determine the necessity for a business associate agreement/data release.

5. How many people will need to travel to the face-to-face, state-sponsored meetings?

A minimum of 2 or 3 members from each hospital unit team should attend the state-level, face-to-face workshops, as one of the goals is to support team development and interaction. It is recommended that at least one physician, one nurse, and one infection control practitioner attend from each team.

Central Line FAQs

1. What constitutes a central line for these efforts?

Please see the below Table of included and not included devices.

Type of Device	Is it a central line for the purposes of the CLABSI Project?
Percutaneously inserted internal jugular vein catheter	YES
Percutaneously inserted subclavian vein catheter	YES
Percutaneously inserted femoral vein catheter	YES
Percutaneously inserted femoral artery catheter	YES
Axillary arterial catheters	YES
Introducer sheath (includes sheaths for pacing wires or pacing catheters, cordis, etc.)	YES
Pulmonary artery catheters (Swan-Ganz)	YES
Percutaneously inserted dialysis catheters	YES
Tunneled dialysis catheters	YES
Implanted central line catheters (i.e. mediports)	YES
Peripherally inserted central lines (PICCs)	YES
Tunneled infusion central lines (all sites)	YES
Peripheral arterial lines (radials, ulnars, dorsalis pedis, brachials)	NO
Implanted pacers/defibrillators	NO

If it has a lumen for infusing, withdrawing or monitoring, and the tip terminates in or near the heart, it is a central line.

2. Is there a reason to rotate central line sites and if so, on what schedule?

No, current evidence does not support routine "rotation" or rewiring of lines on any kind of schedule. Central lines may be rewired or moved to a new site based on other clinical reasons including suspected infection.

3. If I'm worried a central line might be infected, should I rewire it or remove it?

Central lines only need to be removed for documented infection. If a patient appears to have an infection (fever, increasing white blood cell count, etc.) and sources other than the line seem unlikely, the line should be rewired and cultured and blood culture should be taken. The line should be removed if it is culture positive. *Clinical judgment is important here*. You may wish to remove a line that is not yet proven infected if the

patient is ill enough or you are concerned enough that the line is the source. CDC guidelines indicate that there is no present evidence to suggest that routine rewiring is beneficial in the absence of infection or suspicion of infection.

4. What constitutes an infection?

There are several criteria including:

a) The catheter is positive (>15 colonies) for the same organism found as outlined in (b) or (c).
b) The patient has positive blood cultures with recognized pathogens (non-skin contaminant organisms) and these pathogens are not related to another site of infection (such as pneumonia) OR:
c) The patient has one of the following fever, chills or hypotension, without other identifiable site of infection and two or more blood cultures (drawn on separate occasions not more than 48 hrs apart) that are positive for a common skin contaminant such as Staph epidermidis.

5. Do you need to use a line cart or will other things do as well?

No, you don't need to have a specific "line cart," but the principle of keeping all necessary supplies together in one place and readily available still applies. Any storage container or system will work (box, bag, etc).

6. Are multi-lumen catheters more likely to lead to infection? Are triples worse than doubles?

Multiple lumens are worse compared to singles. The number of lumens should be minimized when possible. Consideration should be given daily to whether a catheter is needed at all.

7. Are large bore catheters better or worse (i.e. cordis or dialysis catheters)?

These catheters have different purposes and one is not better or worse than the other.

8. What is the best cleanser to wash your hands? Purell (alcohol based) versus soap?

Either is fine except when the patient has known C. difficile infection since alcohol-based agents like Purell don't work against C. difficile. Soap and water should be used under those circumstances.

9. Do I have to use chlorhexidine? Will other antiseptics work?

Chlorhexidine (2% in 70% isopropyl alcohol) is the preferred agent (data shows it works better) unless there is a documented allergy to chlorhexidine. For allergic patients, povidine iodine solutions may be used.

10. How large a field needs to be cleaned with chlorhexidine for line placement?

You should clean a generous enough area so that if you need to attempt more than one approach, additional attempts remain in the prepped area.

11. Do I need to "bathe" the patient in chlorhexidine?

No, they must be draped in a sterile fashion from head to toe, but only the insertion site (see # 9) needs to be prepped with chlorhexidine. You may choose to do chlorhexidine baths as part of care, but not for specific line insertions/rewires.

12. What is the best method or device for securing the central line to the skin? Does suture type or technique matter?

Performing an "air tie" reduces skin necrosis but there is no preferred method for suturing or securing the line to the skin. Silk or other sterile surgical suture will work fine. Sterile stapling devices also are fine.

13. What type of dressing for maintenance is best?

Clear dressings are preferred, but no one brand is required.

14. How often does a dressing need to be changed?

When it is dirty, loose, damp, or has been lifted up to inspect the site.

15. Do impregnated catheters (silver, chlorhexidine, etc.) reduce risk for CLABSI?

They may, but their use is not required.

16. Is the subclavian site preferred over the internal jugular (IJ)?

While the subclavian is considered a cleaner site, the difference is small. Since the IJ site has less mechanical risk in terms of creating a pneumothorax etc., the balance of risk is such that either site is fine.

17. What about femoral lines?

Femoral vein sites have a much higher risk of infection and should be avoided unless absolutely necessary.

18. Does full body drape mean down to the toes?

Yes, from head to toes. This helps to ensure no sterile equipment gets contaminated.

19. Does everyone in the room have to gown, mask and glove for the line, or only the person actually placing the line?

Everyone. As a general rule, if you can reach the bed from where you are standing, you should be fully gowned and gloved.

20. May I use the central line to draw blood cultures?

Only if they are drawn at the time of insertion into a new site, and only one set should be drawn from the new line. **Rewired lines or existing lines should not be used to draw blood cultures**.

21. What about emergent lines?

Emergency lines such as those placed during codes, trauma or other emergent situations don't need to follow the insertion rules because the nature of the situation demands speedy placement to save a life. However, they should be removed and replaced in a new site as soon as possible and should not stay in place >24 hours.

22. What constitutes an emergent line?

A situation that is immediately life threatening to the patient. Examples include cardio-respiratory arrest, near arrest events and trauma. This does not include convenience or expediency only on part of the staff placing the line.

23. Do we include central lines from the ED and/or Operating rooms?

Yes, all central lines a patient may arrive with to the ICU, regardless of where they were put in or by whom, count as an ICU CLABSI once the patient has been in the ICU for 48 hours. If it becomes infected in the first 48 hrs in the ICU then it is not counted as a CLABSI in the ICU. This also extends 48 hrs beyond discharge from the ICU if the line is still present. That is, if the patient goes to a step down unit or the floor with a line and develops a line infection in the first 48 hrs on the step down unit or floor, the infection counts as an ICU CLABSI.