# Community Acquired CLABSI Questionnaire for Patients and Families (Patton et. al)

***This form should be completed by patients and their caregivers after developing a CLABSI.***

1. Were there any problems with the IV line, like contamination, breakage, not drawing, difficult to flush, getting displaced, or needing TPA or cathflo? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Was everyone involved in caring for the line washing or sanitizing their hands?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Did everyone scrub the hub of the IV line each time prior to using it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Was the tubing disconnected for any reason? If so, did you use anything to protect the tubing? \_\_\_\_\_\_\_\_

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1. How frequently did you or anyone else use the line for lab draws, medications, hydration, or nutrition?

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1. Was the cap changed? If so, why and by who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. When was the dressing last changed? Why was it changed (dirty, not sticking, it was time, etc.)? Who changed the dressing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Was the line kept away from any contamination (diapers, ostomies, wounds, G-tubes, tracheostomies, soiling, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Is the patient’s environment clean? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Are you getting what you need to care for the IV line? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. When did you last receive instruction in caring for the IV line? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Why do you think the CLABSI occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Patton LJ, Cardwell DL, Falder-Saeed K. Standardize, engage, and collaborate: an initiative to reduce community acquired central line blood stream infections across the continuum of care. J Pediatr Nurs. 2019;49:37-42.*