

# CLABSI Root Cause Analysis Form

## CLABSI Root Cause Analysis (RCA) Data Collection Form

As part of our commitment to eliminate central line associated blood stream infections (CLABSI), we review each case to help to prevent the next infection. Please help collect the following information to assist with reviewing this case.

Patient Name: \_\_\_\_\_

HD patient? \_\_\_\_\_

MRN: \_\_\_\_\_

Did patient die: \_\_\_\_\_

IV Therapies Received: \_\_\_\_\_

Date of Infection: \_\_\_\_\_

Nursing Agency: \_\_\_\_\_

Organism (s): \_\_\_\_\_

Start of Care Date: \_\_\_\_\_

Hospital Admitted To: \_\_\_\_\_

History of Present Illness: \_\_\_\_\_

### **Details of CLABSI**

Days on service (Day after hospital discharge or day of outpatient IV placement is Day 1): \_\_\_\_\_

Date of Last Contact with Nursing: \_\_\_\_\_

Significant Events: \_\_\_\_\_

### **Central Line Details**

<b>Insert date</b>	<b>Type</b>	<b>Insertion Site</b>	<b>If Port, Date Last Accessed</b>	<b>If Port, Date Last Deaccessed</b>	<b>Number of Lumens</b>	<b>Removal Date</b>

a. Where was the line(s) placed (e.g., hospital, interventional radiology, etc.)? \_\_\_\_\_

**\*\*\* This part TO BE COMPLETED BEFORE MEETING**

Question	Yes/No
Was this a sutured line(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No -> If no, what was securement method: _____
Was the tubing secured?	<input type="checkbox"/> Yes <input type="checkbox"/> No -> If no, what was securement method: _____
Were there any line issues (clot, re-wire, exchange, manipulation, dislodgement, bleeding)?	<input type="checkbox"/> Yes <input type="checkbox"/> No -> If yes, date of problem: _____
Were there any equipment (tubing/needless port etc.) issues? (e.g. leak, unplanned break in line, dressing not changed per policy)	<input type="checkbox"/> Yes <input type="checkbox"/> No -> If yes, date of problem: _____

### Central Line Care

Question	Yes/No
Was the dressing change timing appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> No -> If no, date of last dressing change: _____
Type of dressing? (i.e Tegaderm, Primapore, Opsite, Gauze/Tape, other)	<input type="checkbox"/> Sorbaview <input type="checkbox"/> Tegaderm <input type="checkbox"/> Primapore <input type="checkbox"/> Opsite <input type="checkbox"/> Gauze/Tape <input type="checkbox"/> Other: _____
Type of skin prep/antiseptic used for dressing? (ie Chloraprep, tincture of iodine, Iodine, other)	<input type="checkbox"/> Chloraprep <input type="checkbox"/> Tincture of iodine <input type="checkbox"/> Iodine <input type="checkbox"/> Other: _____
Who performed the dressing changes?	<input type="checkbox"/> Nurse from affiliated agency <input type="checkbox"/> Nurse from unaffiliated agency <input type="checkbox"/> Patient <input type="checkbox"/> Caregiver <input type="checkbox"/> Outpatient infusion center staff <input type="checkbox"/> Other: _____
Was dressing documented as dry and intact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was chlorhexidine used in the dressing?	<input type="checkbox"/> Yes, chlorhexidine-impregnated dressing <input type="checkbox"/> Yes, chlorhexidine-impregnated sponge <input type="checkbox"/> No

**\*\*This part of the document TO BE COMPLETED DURING MINI-RCA MEETING BY THE GROUP**

**RCA Summary and Plan**

System Level Factors for this Infection\*

\*It can be useful to dig deeper for each factor why asking Why? Why? Why?

<b>Factors</b>	<b>Fill in information</b>
PATIENT/FAMILY CHARACTERISTICS	_____
TASK FACTORS/TOOLS/EQUIPMENT <ul style="list-style-type: none"> <li>• (e.g. protocol, availability of tools, equipment)</li> </ul>	_____
NURSE FACTORS	_____
TEAM FACTORS <ul style="list-style-type: none"> <li>• (e.g. communication, speaking up)</li> </ul>	_____
KNOWLEDGE & SKILL FACTORS	_____
TECHNOLOGY FACTORS <ul style="list-style-type: none"> <li>• (e.g. software, hardware, medical devices)</li> </ul>	_____
LOCAL ENVIRONMENT FACTORS <ul style="list-style-type: none"> <li>• (e.g. staffing, lighting, culture)</li> </ul>	_____
INSTITUTIONAL FACTORS	_____
OTHER FACTORS	_____

a. Action plan? \_\_\_\_\_

**Start, Stop, Continue Planning\***

**\*Translate the above ideas into 2 ideas for each of the questions below.**

<b>Action</b>	<b>Answers</b>
<b>START:</b> What are 2 things we can commit to START doing?	1. _____ 2. _____
<b>STOP:</b> What are 2 things we can commit STOP doing?	1. _____ 2. _____
<b>CONTINUE:</b> What are 2 things we can commit to CONTINUE doing	1. _____ 2. _____

Attendees: \_\_\_\_\_

Date Completed: \_\_\_\_\_

