

Organizational Self Assessment

Question	Tools
<p>Does the organization have the tools to champion change?</p>	<p>CUSP Barrier Identification and Mitigation Tool - See Appendix N</p> <p>Overview of Factors Affecting the Success of Improvement Initiatives (corresponding to Table 4-1 of CLABSI Monograph <i>Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, page 73)</p> <p>CUSP Engage the Senior Executive Tools</p> <p>CUSP Back to the Basics Document - See The CLABSI Elimination Toolkit – Appendix 9</p> <p>AHRQ Surveys on Patient Safety Culture</p> <p>Michigan Keystone intensive care unit (ICU) project: Six-step Comprehensive United Based Safety Program (CUSP) process to assess and improve the safety culture</p> <ul style="list-style-type: none"> ○ CUSP How to Conduct a Culture Check-up - See Appendix G ○ NCABSI Team Check-Up - See Appendix I <p>Accountability of Health Care Personnel in Preventing CLABSIs</p> <p>Johns Hopkins Quality Safety Research Group – Nurse Empowerment (PPT Slides)</p> <p>Sustainability Rating Scale (from The Joint Commission’s Multidrug-Resistant Organism (MDRO) Toolkit, <i>What Every Health Care Executive Should Know: The Cost of Antibiotic Resistance</i>)</p> <p>Project Prioritization Matrix (from MDRO Toolkit)</p> <p>Develop a Culture of Safety - IHI Website</p>

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<p>Does the organization have the tools for an active, well resourced surveillance program?</p>	<p>2013 CDC Central Line-Associated Bloodstream Infection (CLABSI) Event Definition</p> <p>WHO Assessing and tracking patient harm – A methodological guide for data-poor hospitals</p> <p>Pooled Cumulative Incidence Densities for CLABSI in Adult ICU Patients, WHO Data 1995–2010 (corresponding to Table 6-2. of CLABSI Monograph, page 105)</p> <p>CLABSI Rates per 1,000 Central Line–Days in Limited-Resource Countries (2002–2011) (corresponding to Appendix B of CLABSI Monograph, pages 115–118)</p> <p>Egyptian Surveillance forms</p> <ul style="list-style-type: none"> ○ Surveillance Form 1 ○ Surveillance Form 2 <p>SICU Monthly Survey</p> <p>Outcome and Process Performance Measures (adapted from CLABSI Monograph)</p> <p>Examples of National and International HAI Surveillance Systems (corresponding to Table 5-1 of CLABSI Monograph <i>Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, pages 87–89)</p> <p>Benefits, Essential Components, and Limitations of Electronic Surveillance Systems (corresponding to Table 5-2 of CLABSI Monograph, page 91)</p> <p>Steps in Evaluating Electronic Surveillance Systems for Potential Incorporation into a Facility</p>

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Does the organization have access to current guidelines for the prevention of CLABSIs?	<p>Examples of International Clinical Practice Guidelines That Include CLABSI Prevention Strategies (corresponding to Table 2-1 of CLABSI Monograph <i>Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, pages 13–15)</p> <p>Examples of Clinical Practice Guidelines or Practice Standards Developed by Organizations or Professional Societies Regarding Aspects of CLABSI Prevention or Diagnosis (corresponding to Table 2-2 of CLABSI Monograph, pages 15–21)</p> <p>Position Papers Related to CVCs, CLABSIs, and Their Prevention (corresponding to Table 2-3 of CLABSI Monograph, pages 21–22)</p> <p>Society for Healthcare Epidemiology of America/Infectious Diseases Society of America Compendium of Strategies to Prevent Healthcare Associated Infections</p> <ul style="list-style-type: none"> o Chapter on CLABSIs
Does the organization use improvement in CLABSI rates to bolster licensure of accreditation?	<p>Review of Joint Commission and Joint Commission International Requirements That Address the Prevention and Control of CLABSI</p>
Does the organization educate clinicians about the incidence, prevalence, reasons for and avoidance of CLABSI?	<p>HAI Causes in US by DHHS (corresponding to Sidebar I-1 of CLABSI Monograph, page vi)</p> <p>Prevalence of HCAI in Developed Countries (corresponding to Figure I-1 of <i>CLABSI-Monograph Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, page viii)</p> <p>Prevalence of HCAI in Developing Countries (corresponding to Figure I-2 of <i>CLABSI-Monograph</i>, page ix)</p> <p>Intrinsic and Extrinsic Risk Factors for CLABSI (corresponding to Table 1-2 of CLABSI Monograph, page 4)</p> <p>Intrinsic Risk Factors for CLABSIs and Susceptible Populations (adapted from CLABSI Monograph)</p> <p>Routes for Central Venous Catheter Contamination with Microorganisms (corresponding to Figure 1-1 of CLABSI-Monograph, page 5)</p> <p>CUSP Vascular Access Device Training Slides and Quiz</p> <p>Potential Educational Delivery Methods and Reduced CLABSI Rates (adapted from CLABSI Monograph)</p>

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Does the organization have an effective hand hygiene program?	<p>World Health Organization's "My 5 Moments for Hand Hygiene" (corresponding to Figure 3-1 of CLABSI Monograph, page 43)</p> <p>WHO Guidelines on Hand Hygiene in Health Care</p> <ul style="list-style-type: none"> ○ Handwashing Technique with Soap and Water (See Figure II.2, p.156) ○ Hand Hygiene Technique with Alcohol-Based Hand Rub (See Figure II.1, p.155) <p>Complimentary Hand Hygiene Educational Resources</p> <p>2011 CDC Hand Hygiene Guidelines to Minimize CLABSI Risk</p>
Does the organization make multiple types of catheters available?	<p>Comparison of the Major Types of Central Venous Catheters (CVCs) (corresponding to Table 1-1 of CLABSI-Monograph <i>Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, page 3)</p> <p>Pediatric Vascular Access Devices</p> <p>CDC – FAQ About Catheters</p> <p>Visual Depiction of Each Type of CVC</p> <p>Antimicrobial- or Antiseptic-Impregnated Catheters Utilization Algorithm</p> <p>Article: "Device Selection: A Critical Strategy in the Reduction of Catheter-Related Complications," with chart on Vascular Access Device Selection. Reprinted from <i>Nutrition</i> vol. 12, no. 2, M Ryder, Device Selection: A Critical Strategy in the Reduction of Catheter-Related Complications, pp. 143–145, Copyright 1996, with permission from Elsevier Science Inc.</p>
Does the organization have standardized insertion procedures?	<p>Aseptic versus Clean Technique</p> <p>CUSP Line Cart Inventory</p> <p>CVC Insertion Checklist Sample Documents:</p> <ul style="list-style-type: none"> ○ Virginia Mason Medical Center – Central Line Bundle Insertion Checklist ○ Virginia Mason Medical Center – Surgical Safety Checklist ○ Johns Hopkins Hospital Insertion Checklist ○ Beth Israel Medical Center – Central Line Checklist ○ BJC Vascular Catheter Insertion Checklist ○ Scotland - CVC insertion checklist <p>Central Line Insertion Checklist—Template Word Document</p>

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	<p>CVC Insertion Bundles</p> <p>CDC Dialysis Bloodstream Infection Prevention Collaborative audit tools, protocols, and checklists</p> <ul style="list-style-type: none"> • CDC's dialysis checklists portfolio • CDC's dialysis audit tools portfolio <p>Open Versus Closed Intravenous Systems (corresponding to Sidebar 3-1 of CLABSI Monograph, page 49)</p> <p>CDC Hemodialysis Scrub the Hub Protocol</p> <p>NHSN Central Line Insertion Practices (CLIP)</p>
Does the organization have standardized maintenance procedures?	<p>CVC Maintenance Bundles</p> <p>Daily Central Line Maintenance Checklist - Template Word Document</p> <p>CUSP Central Line Maintenance Audit Form</p> <p>CUSP Event Report Template</p> <p>CUSP Care of Patient with Peripheral Line</p> <p>CUSP Care of Patient with PICC Line</p> <p>CUSP Care of Patient with Short Term CVC</p> <p>CUSP Care of Patient with Tunneled CVC of Implanted Port</p> <p>CUSP Care of Patient with Hemodialysis Catheter</p> <p>CUSP Care of Patient with Hemepheresis Catheter</p> <p>CUSP Blood Drawing from a Hemodialysis and Hemepheresis Catheter</p> <p>CUSP Care of Patient Receiving PPN/CPN</p> <p>CUSP Accessing/Deaccessing Implanted CV Access Port</p>
Does the organization have an active evaluation program for CLABSI?	<p>2013 CDC Central Line-Associated Bloodstream Infection (CLABSI) Event Definition</p> <p>CLABSI Fact Sheet (Source: Quality and Safety Research Group, Johns Hopkins University)</p> <p>Examples of National and International HAI Surveillance Systems (corresponding to Table 5-1 of CLABSI Monograph <i>Preventing Central Line–Associated Bloodstream Infections: A Global Challenge, A Global Perspective</i>, pages 87–89)</p> <p>WHO Assessing and tracking patient harm – A methodological guide for data-poor hospitals</p> <p>Pooled Cumulative Incidence Densities for CLABSI in Adult ICU Patients, WHO Data 1995–2010 (corresponding to Table 6-2. of CLABSI Monograph, page 105)</p>

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	<p>CLABSI Rates per 1,000 Central Line–Days in Limited-Resource Countries (2002–2011) (corresponding to Appendix B of CLABSI Monograph, pages 115–118)</p> <p>Benefits, Essential Components, and Limitations of Electronic Surveillance</p> <p>Steps in Evaluating Electronic Surveillance Systems for Potential Incorporation into a Facility</p> <p>Egyptian Surveillance forms</p> <ul style="list-style-type: none"> ○ Surveillance Form 1 ○ Surveillance Form 2 <p>SICU Monthly Survey</p> <p>Outcome and Process Performance Measures (adapted from CLABSI Monograph)</p>
Does the organization have the tools for involving patients and families in avoiding CLABSIs?	<p>American Thoracic Society Patient Education Material – Central Venous Catheter</p> <p>CDC Central Line-associated Bloodstream Infections: Resources for Patients and Healthcare Providers</p> <p>CDC Frequently Asked Questions about Catheters</p> <p>CDC-SHEA Patient Guides: FAQ's about catheter associated blood stream infections</p> <p>A Brochure from The Joint Commission's Speak Up™ Campaign</p>