Table 2. Identified deficiencies and actions taken to increase compliance with evidence-based practices.

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| Identified deficiencies  | Actions taken  |
| Inconsistencies in chlorhexidine bathing  | * Developed checklist for return demonstrations to ensure completion of 100% of required components
* Created attestation inclusive of the indications and proper procedure for chlorhexidine bathing
* Developed health literate patient education tool to emphasize importance
* Developed patient education video to embed in the interactive patient care platform
 |
| Inconsistencies in utilizing chlorhexidine swabs for the disinfection of needleless access sites | * Surveyed staff on barriers to use of chlorhexidine swabs for disinfection
* Provided return demonstration of appropriate product use utilizing ‘Scrub the Hub’ rounds
 |
| Labeling of lines and intravenous fluid bags not performed to policy standard  | * Developed and disseminated educational flyer outlining key policy components
* Developed and trialed compilation of supplies including labels in a single container to investigate increased compliance with CLABSI bundle elements
 |
| Confusion over responsibility for dialysis lines  | * Collaborated with Kidney Dialysis Unit to standardize practice for shared ownership of changing dialysis catheter dressings
* Provided real-time education with Infection Prevention rounds on the unit
 |
| Lack of awareness of policy for discontinuing central lines  | * Developed and disseminated educational flyer outlining key policy components
 |
| Inability to identify specific types of lines  | * Development of a didactic education presentation providing an overview of common types of lines
 |
| Unnecessary accessing of ports  | * Collaboration with Emergency Department and procedural areas to enhance awareness and encourage peripheral IV usage
 |
| General confusion related to policy and best practice in units with low lines days  | * Creation and dissemination of a 1-page flyer outlining all essential components of line care
* Developed educational and resource material guiding use of new chlorhexidine impregnated central line dressings and considerations for monitoring
* Collaborated with facility educator to develop 1-page flyer outlining central line flushing for patency and policy for central venous access device clotting
 |
| Confusion around the variety of hemostasis agents and associated dressing care  | * Creation and dissemination of a 1-page flyer outlining dressing care with each agent
 |
| Confusion around utilization and care of central line stabilization devices   | * Collaborated with vendor to present educational in-services at monthly meeting with all facility educators as well as on select units
 |
| Inconsistency in documentation within the electronic medical record created failures in triggering of specific nursing tasks   | * Collaborated with informatics colleagues to reinforce components of nursing documentation which trigger nursing tasks that prompt evidence-based practices like daily chlorhexidine baths and review of line necessity
 |
| Providers choosing to continue central line use despite meeting necessity criteria for discontinuation  | * Solicited support from Chief Medical Officer to reinforce importance of available options and CLABSI prevention
 |
| Prolonged use of femoral lines   | * Solicited support of Epidemiologist to reinforce the importance of addressing central line necessity in multidisciplinary rounds
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