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 |