Karla Estrella 00:09
Welcome listeners to the NYU Langone Nursing Station podcast. This series will highlight nurses coming together to share information about daily professional practice and initiatives to improve patient outcomes. In today's episode, we will be discussing our central line associated bloodstream infection, also known as CLABSI prevention practices. For the duration of this episode, we will be referring to it as a CLABSI. This session is eligible for contact hours and in disclosure in compliance with ANCC's Commission on Accreditation. This educational activity does not include any content that relates to the products and or services of a commercial interest that would create a conflict of interest. My name is Karla Estrella. I am a Nursing Quality Specialist here at the Long Island campus and I will be co-hosting this episode.

Julie Wan 01:07
And my name is Julie Wan. I am the nurse manager of nursing quality at NYU Lincoln Brooklyn, and I will also be a co host for this episode.

Marianne Youssef 01:16
Hi, I'm Marianne Youssef, I'm the Nurse Coordinator for the Sala Institute and Hassenfeld Children's Hospital.

Stephanie DiGiovanni 01:23
Hello everyone, my name is Stephanie DiGiovanni. I'm the Director of Infection Prevention at NYU Langone Long Island.

Meaza Temesgen 01:30
Hi everyone. This is Meaza Temesgen. I'm a nursing quality specialist here at NYU Langone Brooklyn location.

Naomi Noble 01:37
Hello, my name is Naomi Noble, and I'm the Clinical Resource Nurse here in the medical ICU at Tisch Langone hospital.

Julie Wan 01:44
So welcome to all our panelists, and thank you for joining us today. So according to the Centers for Disease Control and Prevention, CLABSI is a national problem because it contributes to the increasing length of stay and potential mortality.

Karla Estrella 01:59
Speaking of CLABSI prevention, Brooklyn campus met a milestone in June for eliminating CLABSI over the course of the year. So Julie, can you share some of those best practices and what that accomplishment meant for your campus?

Julie Wan 02:13
Yes, this was really a commendable achievement for all our nurses and providers, the ancillary staff, physical therapy, housekeeping, basically everyone who has a hand in caring for our patients because it really takes teamwork to enhance patient safety. And the practice that nursing quality started a couple of years ago was to round on every single central line that we had in house and around mid 2021. We made that an interprofessional round and I think Meaza can speak more to this practice as she actually presented this at the 2023 ANCC Magnet conference.

Meaza Temesgen 02:50
Thank you, Julie. Like Julie said, you know, one of our success for our recipe is really the rounding and other components that I would speak about. The Magnet presentation, it was a one hour presentation so, I'm gonna give you a little bit of what we did within a few minutes. So, the rounding it consists of checking the charts, we have to check the CLABSI bundle, is there a flush order? Is there an indication, as those are the most important part of it. We also check the education part of it. After all that really after the chart check there is nothing like visualizing actually the actual central line. We go on the floors, and we check and we visualize them. So when I look at the line I look at make sure that looks intact, it's clean, it's dry, no bleeding, you have a date on it. So the great thing about visualizing it is the fact that I can pull the nurses or I can pull one of the managers or it could be the assistant managers, or the charge nurse might be if I see something that shouldn't be there so they can see what I'm looking so we can fix it together. So the real time discussion with the nurses is the absolute best. When we did presenting in the Magnet, what really impressed them a lot of people were taking notes was about the fact that what kind of dressing we use in our facility, as well as who are our team members. How did we expand? Why did we choose what we chose? So first thing is first, as a nursing quality specialist, of course I round but we also included other additional team members to round as well. Our title of our presentation is called 'All Eyes on the Lines' and we want to make sure it's all lives on the lines between a lot of team members. Like I say nursing quality specialist, we have venous access teams. We have hemodialysis unit RNs, we have inpatient unit RNs we have nurse managers and leaders as well. And definitely infection prevention and control armaments and we are also very lucky to have some physicians that are going with us to our rounds. Some of them are from internal medicine and we also have an infection control doctor to round with us. So why I say this is so important everyone was taking notice the fact that having an expertise when you are looking at these lines is the most effective. Because sometimes as a nursing quality specialist, I'm not really the expert as to say like, I know what I'm looking but I'm not the expert. So having the extra person like having the doctor who specializes in infection with me, or the infection prevention control, RNs who pounding on this lines, or the hemodialysis unit RNs because they deal with hemodialysis catheter a lot more than me and they change the dressing very frequently. They're experts and of course, our venous access team, who are the ones who insert the PICC line in the house, they are very knowledgeable in this area. So we use all these team members to make sure that we have different days, we do twice a week venous access, they do once or twice, we have infection control, who does it once a week. So we have all these members looking at these lines. I mentioned before the dressing we use is the CHD dressing, which is transparent. Karen and I, we thought this is the standard

for all. We realize during our Magnet presentation, a lot of people were interested to see what kind of dressing are we talking about, we actually at some point, we have to Google it and to show to them what it looks like. The CHD dressing is transparent; that means if there is any bleeding, or if there's anything you will be able to see through it. So it's really, really important and it's effective and we continue to use and to do so. The other success after the rounding is how do we communicate this information that we find to other team members? As you know, we get a lot of new doctors, new nurses, new nurse managers, it doesn't matter. So there's always a new person on the floor so we wanted to make sure that everyone is aware. We disseminate this information during morning hurdles. We also do a summary of the lines, the findings, what was missed. And we also include what was great about it, because we want to make sure we're encouraging so we send all this information at summary, we email to our senior leaders, we discussed this in our morning huddles, we definitely discuss this in our face to face while we're looking at the lines. I also do a lot of secure charts with the doctors before I even go to the floors to make sure that if there is an indication, if there's any questions for me, and I also get a lot of support from the doctors surrounded with me. So in short, this is really the recipe for success; visualizing it, checking the chart, making sure that we have team members who look at the lines from different parts of expertise in this field, and also disseminating the information in real time and every day. This is, in short, our recipe for success.

Karla Estrella 07:42
Wow, what an amazing accomplishment. 'All Eyes on the Lines', definitely an interdisciplinary approach. Teamwork is definitely the best way to fight any infections as it takes the team to keep our patients safe. Speaking of initiatives, recently nursing won an award called on the CLABSI playbook. Stephanie, are you able to share more information about the enterprise playbook for CLABSI?

Stephanie DiGiovanni 08:12
Sure, Carla. Thank you. Agreed, that was a wonderful summary of Brooklyn's great efforts and initiatives that they are doing over there in Brooklyn. as Meaza described, you know, it's really important to have a team approach when preventing infections for our patients and 'All Eyes on the Lines' is a great slogan we use here in Long Island as well. But the enterprise did roll out in realizing they needed a team approach with clearly defined roles, the CLABSI playbook, which is a wonderful document that provides team members with clearly defined interventions, roles and responsibilities for central line insertion and maintenance. It really promotes adherence to best practices and compliance with assign duties, making sure everybody knows what their responsibility is with that central line. And actually, after the rollout of the playbook, NYU Langone health as a system experienced its first CLABSI, free month, and the rates of infections have remained low. So a really successful initiative that was rolled out across campuses, multidisciplinary approach was really effective.

Karla Estrella 09:16
Thank you for sharing that. Stephanie. One of the frequently asked questions from our clinical nurses is, what is the difference between a tunnel and a non tunneled central line? And how long can they stay?

Meaza Temesgen 09:32
So recently, like I think a few months back, we have an accurate presentation by the venous access team. And I thought I knew but I learned a great deal. To be simplified and just to explain it, the tunneled and the non-tunneled one, the tunnel one goes under the skin. If you look at it, you will see that it goes under the skin, while the non-tunneled one is kind of like it's on top of the skin like so the insertion site you see it inside the skin but the catheter is soft, it's outside of the skin. So the tunneled one, you can actually visualize it under the skin and you can actually trace your finger on it, if you will, or you can look at it. And you can see that there's something inside the skin, the tunneled one is cuffed and non-cuffed one. So the non-tunneled one is just like that, it is temporary. Usually it's just used for less than three weeks and they will just take it out. The tunneled one can stay more than three weeks, so it depends on how long the patient needs it. The non-tunneled one also have something called the cuffed and the non-cuffed one and the easiest way I can describe it is the cuffed one does not have wings and the non-cuffed one have a little bit of wings. If you look around the patient's skin, it is really like sutured with a little wing. That's why they call it, wing. And then the non-cuffed one has no wings. Those are the differences. The catheters itself, we have the jugular vein, you have the subclavian vein, we have the femoral vein. The femoral vein is very difficult area to put it in. It is also very hard to keep it very clean, because sometimes you know, it's very close to the private areas. So it's usually not recommended. Usually the doctors do it as a last resort. Other than that, by visualizing by looking at it, you can keep it and you can clean. If you just Google non-tunneled versus tunneled one and the cuffed and non-cuffed there are great images on Google. You can actually take a look and you will be able to see exactly what I'm talking about. I hope this explains it.

Karla Estrella 11:31
Thank you, Meaza. Your tips do certainly help me visualize the difference between the two and the timeline itself definitely helps differentiate the two as well. So speaking of timeline, in general, when is it appropriate to remove a central line?

Stephanie DiGiovanni 11:49
Generally speaking, you know, our organization has really well defined indications for central lines and that's shared, you know, with all the staff who are inserting whether it's our venous access team, or in our ICUs. The biggest opportunity we have is ensuring that the daily needs assessment is being done every day, collectively with the care team to ensure that that central line is still appropriate. We know as patients as their stay continues their clinical courses change and usually we hope for the better, right? So as those patients progress and are moving out of the ICU down two floors, it's really important to consider removing the central line when it's no longer necessary. Then, if they are on the floor with central lines, having that discussion every day in rounds, is this still necessary? I think that's our biggest opportunity, just making sure that

central lines are removed as soon as they're no longer needed. I think everybody understands the thoughtfulness of placing a central line whether or not it's necessary or not. But I think our biggest opportunity is ensuring that they come out as soon as possible.

Meaza Temesgen 12:55
I really want to second that and what she said. It's very, very important to take it out. If it's no longer needed, take it out. So, the only way you can take it out if it's no longer needed is if you have that discussion every single day, do you still need it? Why are we using it? Do we still need it? As long as you have those conversations, you're having this dialogue with the clinicians and with the nurses, you know, you'll be able to take it out and reduce CLABSI.

Julie Wan 13:19
Thank you both for sharing that. Now let's shift into talking a little bit more about maintaining and caring for our central lines. Why do we need to change the needleless axis valve and how often do we change them?

Marianne Youssef 13:33
Changing the needleless axis valve is dependent really on what's infusing through the line. For example, with continuous fluid, the needleless axis valve gets changed every four days. While IV solutions such as blood products, or TPN, they get changed every 24 hours, and something like propofol or intra lipids is every 12 hours. There's also some age related variations to like for neonates, the time interval for changing the back check valves with certain solutions might be a little longer. I think when any clinician is in doubt, they should always refer to the central venous access device policy on Ellucid. It's a great resource and it outlines all of these factors in detail.

Naomi Noble 14:19
I also want to add, which everybody here has alluded to, coming from critical care, we definitely get our fair share of central line dressings and central lines that are complicated to care for given the patient's comorbidity and other issues that take play that make these dressings very difficult to maintain. Some frequent things that come up with clinicians here is an HD catheter dressing. While definitely it is the responsibility of the HD nurse to come when they do dialysis and the dressing is due to be changed to change it. It really is a shared responsibility. So if a nurse sees that the dressing needs to be changed, having that communication with the dialysis nurse, clearly defining who's going to be changing it, maybe if you need help changing the dressing, maybe if you can be utilized in some way to assist. It's always so, so important. I feel I can't emphasize this enough coming from critical care to really foster good communication and close the loop so that everybody's on the same team. All eyes are truly on the line. If we have a questionable dressing, it's escalated not just to the dialysis nurse not just to the primary nurse, but to the team, maybe infectious disease, maybe your clinical resource nurse so that we can help troubleshoot out of the norm atypical scenarios.

Stephanie DiGiovanni 15:38
If I could piggyback on what Naomi just mentioned, I agree with are extremely important that the entire team is responsible for the central line. You know, there's been misconceptions, specifically with haemodialysis lines, where maybe the primary RN says no, the dialysis nurse takes care of the dressing. I don't have to take care of the dressing. But we all know that that's not true, right? Everybody's responsible. I like the mention of escalating not just to the nurse or the haemodialysis nurse, but to the entire team. So everybody is aware that there may be a problem with this dressing, we're addressing it. But everybody's aware of where that patient is in their clinical course. We've utilized here handoff between the haemodialysis nurse and the RN on the days that the patient is receiving dialysis to have that communication, even reminders about CHG bathing, you know, hey, was the bath done? So I think it's really important to have effective communication.

Julie Wan 16:29
I really like what Stephanie just said about that clear communication to every team member. Like you said, it's got to be at all levels so that everyone is on the same page and knows what's happening with the patient and that central line. Has anyone ever encountered a patient who was allergic to CHD? What did you do when you did have that encounter?

Naomi Noble 16:49
Yes, in the critical care setting, and in all settings, you will come across a patient with CHD allergy. And we do have on Ellucid a specific standard on how to care for patients that have CHD allergies. But in brief summary, you would use betadine to clean the area and you can cover the central line with its primacor or sorbaview dressing as well. Any kind of tegaderm dressing would work. And you would put instead of a bio patch or CHD. To cover the site underneath the dressing you would use an algebra X, I'll just just look similar to bio patch, but it's silver instead of blue and the silver side goes down touching the skin. The dressing as long as it's dry and intact. It stays for seven days. That's how we would maintain a CHD allergy.

Meaza Temesgen 17:38
I just want to add, here in Brooklyn we actually had a patient about last week who had a CHD allergy. I did not see agitex used in adults here in Brooklyn campus, but I know we use it in NICU. But what we used for this particular patient was instead of doing the CHD dressing, we use the gauze dressing. The difference is that gauze dressing has to be changed in 24 hours as opposed to, you know, if it is CHD dressing it could have been stayed over there. As long as it's intact and not bleeding, it could have stayed for seven days. So what we did was we changed it every 24 hours and of course we abstain from leaving also the patient a CHD bath and the patient was well and was discharged

Karla Estrella 18:20
For bleeding purposes, is there anything that we can add to prevent that bleeding.

Naomi Noble 18:27
If there's bleeding, which a lot of times can happen, think of your patients comorbid history. So a lot of times we have these issues patients that are coagulopathic, are liver patients, and just knowing your patient population, their risk of developing CLABSI helps. In particular, these liver patients, a lot of times they are very high risk of developing a CLABSI and needing this line for a prolonged period of time and they're also at risk for bleeding. So sometimes even in coagulopathic patients, not with a PICC line but the other central lines temporary central lines, having the providers add another stitch can help maintain the bleeding or get the bleeding to stop and then we have different products that can be used if it's still a problem. One of the products is Avitene. Avitene is a powdered solution. It's available in central supply and Tisch hospital. Avitene comes in a separate container. It's not part of the central line dressing kits, you do have to remember to open it onto your sterile field. The whole dressing would be done obviously thoroughly and it's some powder that you can apply to the bleeding site. You apply a little bit of pressure until it forms a little bit of a clot and then you would apply the CHD dressing over it. But the most important thing to keep in mind when any sort of deviation from the standard of care occurs is to try to think why is this occurring and escalate to the team, to IPC, to, again, your clinical resource nurse. Whoever has some expertise in the area so that we can figure out what is the best way to manage the line. Since we're not able to maintain the typical standard of practice of a completely clean, dry and intact site that needs to be changed every seven days, it might require the dressing to be changed more frequently. But again, you don't want to keep changing the dressing and reopening the area to possible rebleeding. You do want to give it a little bit of time to clot off that site and you also want to remember that while you do want that site to clot off a little bit so it doesn't continue to bleed, remember that any area with dried blood on it can harbor microbial, so that's also a risk for infection. So again, having this discussion and escalating it, when you do have bleeding at the insertion site is the first best step to do. I know that in the medical ICU, we've incorporated this into our daily rounds. When the providers round on our patients, we do include any sort of discussion about how old the line is what the dressing looks like. And if there's any deviation from the standards of care, so that we can escalate it to the appropriate people.

Meaza Temesgen 21:06
We have almost the same thing, but we just call it StatSeal. Our StatSeal is to control bleeding, and it is available in our supply room. So the StatSeal we have there is a powder form and we also have like a disk, a little bit of disk. Like she said it's going to be using a septic technique, it will take it out and then you put on either the powder, or you can put on the disk and the nurse have these available to them. The most important thing to know is sometimes it's okay and as normal, if you see bleeding within 24 hours. After discussion, like is there any reason why this patient is kept bleeding after you escalating all that? Sometimes also, the answer is as simple as the fact that this is post op and some patients they just bleed so they need the StatSeal. So the StatSeal, the most important thing is the application. Once you apply it is very, very important to maintain pressure for a full two minutes. This is something we talk about every single time because we have noticed that some nurses, they did not know that they put just a little bit of pressure and they thought they can just stop but you have to really put pressure on it for a full two minutes and no peeking is allowed. Once you do that, it's also very, very important

not only not to keep changing the dressing, but it's important to maintain it just like that for the first 24 hours so that way the StatSeal really can absorb all the bleeding and can stop the bleeding.

Karla Estrella 22:27
Thank you Naomi and Meaza, I agree. Definitely going back to the basics and identifying why it's bleeding in the first place is a good way to prevent infection instead of just changing the dressing every time. Going back to some of our maintenance elements, one of the misconception with alcohol caps also known as the curos caps is, do we still need to scrub the hub even though we just changed the caps?

Marianne Youssef 22:58
Going back to Naomi was saying in terms of if there's any deviation from practice, it exposes us to infections and potential complications. So there is a misconception that if there is a needleless access valve that's covered with an alcohol cab, it doesn't require scrubbing and that's false. Alcohol impregnated caps provide what's called passive disinfection, meaning they provide a degree of disinfection to the area that it's in direct contact with. Given the shape of the needleless access valve, there's a lot of little grooves and gaps that can still harbor bacteria, that the curos cap or the alcohol impregnated cap won't be able to disinfect. Therefore, we have to imply active disinfection which allows to remove the debris through active scrubbing. So scrubbing for a minimum of 10 seconds allows for that any of that debris that settled in those grooves to actually be removed as well.

Karla Estrella 23:59
Thank you, Marianne. I agree there are a lot of areas especially on the valves that can be missed from the impregnated caps that scrubbing definitely prevents some of that infection as well. Speaking of the other high risk strategy to help with our high risk patients, does anyone know some ways to use the AquaGuard for patients?

Naomi Noble 24:22
So the AquaGuard can be useful in patients where there's a lot of opportunity for secretions or basically dampening around the site. In the ICU that can frequently happen near a tracheostomy site, or a patient that is generally having a lot of drooling or a lot of oral secretions, when sites close to the neck like an IgA or subclavian. Similarly, you can have the problem with any sort of femoral lines that are close to the meatus and from sweat, just from the folding of the groin as well as perhaps urine if the patient doesn't have a foley. So again, we definitely want to do everything that we can do to optimize the site before we even place the central line and have that discussion with the team, what's the best location for the central line that would reduce any possible risk of CLABSI? Part of that discussion is preparing the patient. If it's indicated that an IgA would be the best spot, that the patient has a beard, the best thing for the nurse would do would be to speak to the family member explain that you would need to shave part of the beard to reduce any risk of infection and prepare that site shaved down the area so that there's no hair, make sure it's the optimal site that you're not going to have an issue with a lot of secretions, we try to avoid the femoral site anyway. But certainly, you're gonna run into problems

with not only hair, but also with more secretions, even just sweat and if the patient's adenitis, they'll tend to leak there as well. When all that is done, and you're still having issues. One strategy according to the standard to help maintain the dressing site is to use AquaGuard, which is just a larger dressing that you can place over it to maintain the area and keep that area as dry as possible.

Stephanie DiGiovanni 26:19
Just for the listeners awareness, we do have a high risk strategy plan that is available on Ellucid and basically it goes above the standard of care. For these patients who are identified as high risks as Naomi mentioned, patients who have secretions or femoral lines, and there's other high risk factors that are considered there and they offer a strategy for those patients. So I would encourage everyone to familiarize yourself with that high risk strategy plan as well. Another best practice that is utilized is CHG bathing of course, as we've mentioned. But MRSA and MSSA screening and decolonization is a big program in NYU. Each hospital has a different approach, but the premise is the same. Here in Long Island, we screen patients who are adult patients who are being admitted to the ICU for MRSA and MSSA so that's just one measure that we take to prevent infections and our high risk patients like those in the ICUs. But generally speaking, we have a robust screening process as well across the campuses.

Karla Estrella 27:20
So being our ICU patients are one of our most vulnerable population when it comes to hospital acquired infections, what are the best practices in ICU?

Naomi Noble 27:32
I think that the ICU presents its challenges because there are multiple factors that are contributing to making the patient possibly a higher risk for CLABSI, partly their comorbidities, their other acute illnesses that are going on and then the side effects from those illnesses. The patient has increasing weeping edema, the patient has been on antibiotics for a long time, the patient's immune compromised, the patient's coagulopathic and is bleeding. So the patient requires a line to be in for a prolonged period of time, and requires more than one line. So there are many factors that you have to consider, especially in the ICU population, when you consider reducing preventing patient harm. I think the best thing for clinicians to keep in mind is that there is a protocol and there is a standard of care that was created for all the patients, because that's the best evidence that we have to prevent infection and as long as we try to keep our practice to the standard of care that is required, then we can expect a certain outcome. What happens in the ICU, though, is oftentimes we may need to deviate from that standard of care. Either the line needs to be in for a little bit longer, there is some bleeding at the site, or we can't necessarily choose an optimal site for a line. That is why communication is your next best strategy. You have to escalate to the people that will know how to best troubleshoot. We have all kinds of nursing experience on different units, different kinds of clinical expertise, and different nurses that are involved in different practice councils. But your clinical resource nurse or your IPC of your unit will know how to best guide you. If the line needs to be maintained and the patient is requiring a loan for a prolonged period of time, bring it up in rounds. Perhaps the patient can have a PICC line and doesn't need the IJ or let's say the line was placed emergently in the

groin, the team could consider switching it out to a more optimal site and do it under sterile conditions as opposed to emergent conditions. So always referring back to your clinical judgment and remembering that what are we doing to prevent patient harm? Are we meeting all expectations using the strategies that are in the Ellucid protocol that we have? what can we do when our line is bleeding? What can we do when there is moisture around the site? We definitely have systems in place to help us manage those scenarios. But still getting back to the fundamentals of why is the line needed? Is this the optimal site? Is this under the best condition possible that I need to maintain this site so that the patient doesn't develop a CLABSI? And then consider all things, what are my patient's goals of care? And the interventions that are going to be needed? Does it require a central line? And if so, how long? And does it require this type of central line? All these questions really need to be addressed, we can't just go tunnel vision and focus on just how to maintain a complicated line, we really have to broaden our perspective and utilize all resources that we have escalated appropriately and come up with the best solution for each of our patients.

Julie Wan 30:59
Thank you, Naomi. I think one of the common themes I'm hearing from today's episode, is really driving that conversation about indication and, and essentially what's the plan to remove this central line for the patient. Something we do want to ask also is, whenever a patient needs TPN, or total parenteral nutrition, why is it important to have a dedicated port for that?

Marianne Youssef 31:25
So, solutions that have crystalloids or electrolytes in them, they pose a higher risk for incompatibility with other medications. So it's important to make sure that our medications can be well infused together. So we always prefer to have a dedicated TPN port to prevent any medication incompatibilities. And there are some instances where there is no other port available. In these instances, we encourage the pausing of TPN and you want to flush the line with the appropriate amount of fluid before and after administration of medication. Again, this is only if there is no other port available. And as nurses with any medications or IV solutions that we're administering, it's important to check that they're compatible together. So when you're checking in your MAR, there's something called Lexicomp. If you pull up Lexicomp, there's a program in it equaled Trissel's and you can input all of your medications in it, to see if they can be infused together and if there's any adverse reactions that occur if they are. In the pediatric population, we have something called the pediatric compatibility chart, which we also make sure nurses have to check prior to any medication and administration. If there are medications that don't coinfuse together or have a higher risk of causing line crystallization, for example, a lot of the TPN if you coinfuse them can cause that. Here at Hassenfeld Children's Hospital during morning rounds, we'll bring that up during rounding just so that the whole team is aware that if these medications are coinfused together, there's a higher risk of line crystallization.

Karla Estrella 33:07
Thank you, Marianne for sharing the whys it's so important to definitely dedicate a specific port when it comes to administering TPN. Here in Long Island campus, we're very fortunate to collaborate with pharmacy. Every time they bring up a TPN bag up to the floor with the filter they actually also include one needleless access valve with the bag so that the nurses can have them readily available once they start hanging in your bag. We're just going to shift gears a little bit and talk about the pediatric populations when it comes to central lines maintenance. When patients go home, it's very important that they continue that care. Marianne, can you share a little bit more of that initiative there in your campus?

Marianne Youssef 33:59
Sure. So we have several initiatives going on in our campuses with our pediatric population. A few weeks ago, I went to a work related function and one of the speakers that was presenting said something really important that I think applies to the pediatric population and they said, If one child is sick, that means their whole family is sick. We understand the importance of working with the families in order to produce best outcomes. So one of the projects that we are working on and have been working on is that when we took a look at our CLABSI rates, and data, we saw that there was a higher prevalence of CLABSI in our non-English speaking patients so we knew there was an opportunity to do better for these patients. So we began doing something called language other than English rounds. This is where we visit any non-English speaking patient and their family and discuss the care and maintenance of the central lines in their preferred language. We provide them with opportunity to ask questions and we provide them with written material in their preferred language as well and we really established that partnership with the patient and the family in CLABSI prevention. Another initiative that we worked on, was really developed and carried out by my colleague Patrick Yam in response to a CLABSI that occurred in the outpatient setting. So he worked very hard with the leaders of the outpatient pediatric setting to address barriers that the patients and the families encounter at home when they do have a central line. So he made these kits that can be distributed to them that contain all equipment that will be needed in the care and maintenance of the central line at home. This kit also includes educational booklet, which is available in multiple language and the booklet further provides education on the care and maintenance on the line as well as how to use certain supplies. So for example, how the family would use the CHT wipes or the AquaGuard. These kits are distributed also in the inpatient setting for newly placed lines on patients that are going to go home and be caring for these lines.

Karla Estrella 36:11
Thank you, Marianne, for sharing that. Before we conclude this episode, what's one message you would give to a nurse who are taking care of a central line? I would say clean hands prevent infection.

Meaza Temesgen 36:24
No one can go wrong with that one. I think clean hands is the best. But I would say when in doubt, just ask questions. If the indication doesn't make sense just keep asking, why do we have this lines?

Naomi Noble 36:37
Communication trumps everything. No one person has all the answers and we're all still learning and every patient is different. So all eyes on the line, and if any deviation from your perfect clinical textbook book, which is a lot of cases, escalate.

Marianne Youssef 36:55
I would say, be your own champion. We do have a lot of champions for CLABSI prevention and whenever you do call on that person on your unit to be for that extra help or you need assistance, take that opportunity to learn and develop your own knowledge so that you can ultimately be a champion for your patient and an advocate for your patient.

Stephanie DiGiovanni 37:18
I have to agree with everyone's comments. I think effective communication is extremely important and asking questions, when in doubt, is really also very important.

Julie Wan 37:29
I agree with everyone as well and I think for me having that rounding and having those eyes on the lines more frequently is what's going to help drive some of this communication.

Karla Estrella 37:40
Thank you so much for joining us today and being a valuable resource to our nursing staff. We hope that our listeners found this discussion helpful and useful to their practice. You can find links to the resources in our website, we'll be adding the high risk strategy and our CVID policy as well. On our website for any questions or comments, please email #nursingstationpodcast. Also as a reminder, this session is eligible for 0.5 contact hours. A survey will be posted after listening to this episode.