Project Management Tool

CLABSI Reduction/PDS Check In

Date:

Facility name:

To ensure progress is occurring post-implementation of **Prevantics®** Device Swab with CLABSI reduction, below are questions to be addressed during the bi-weekly/monthly clinical cadence calls.

At the initiation of the trial a mutually agreed upon CLABSI reduction of __% (number, rate, SIR) over 6 months:

1. Have there been any CLABSI(s) identified this month?
    - How has this impacted the incidence rate?
    - How does this compare to previous months/or the same time period last year?

2. What is the compliance rate with the PDI provided audit tool?
    - How is compliance with the other CLABSI bundle components (hand hygiene, insertions, dressing changes, CHG patch, tubing, caps, line necessity, CHG bathing, nasal decolonization, if applicable)?

3. Do staff feel confident with when and where to use Prevantics®Device Swab?
    - If a feedback form is being used, have any concerns been identified re: PDS use?
    - Are there any additional educational or training needs?
    - Have you identified any barriers to use?

4. Touched on above, has line utilization been stable since beginning of trial?
    - Any issues with device utilization that we should be aware of?

5. Has the data collection process remained consistent since the start of the trial? (This will be important to consider if/when facilities begin to address HOB and Fungemia).

6. If there were any CLABSIs identified, was a root cause analysis performed for gaps in process and policy compliance? Any issues identified? What interventions in place to prevent future events?

7. Are there any overarching quality improvement initiatives implemented since the start of the trial that could impact the CLABSI bundle or outcomes? (this should be 'no' but important to confirm since practices can change over 6 months)

8. Reiterate CLABSI reduction goal and PDI's various educational and staff training support modalities.

PDI Clinical Signature _____Date_____
PDI Health Systems Signature_____ Date_____
Facility Clinical Champion Signature_____Date_____