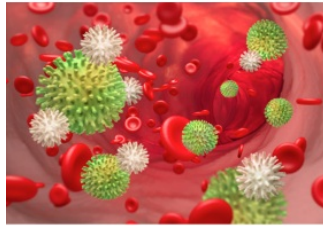


## UCI Health: Spotlight on Central-line associated bloodstream infections



Central line-associated bloodstream infections (CLABSI) result from contamination of a central line, a catheter (tube) that is inserted in a large vein in the neck, chest, or groin, used to measure pressures, and to give medication or fluids. CLABSI can occur due to breaks in infection control care practices during insertion of the central line or during the time the line is in use. Most CLABSIs can be prevented with consistent adherence to infection prevention care practices.

UCI Health has implemented key practices and processes to reduce CLABSI in their hospital. Strict adherence to these practices has resulted in the lowest CLABSI rate amongst all of the University Hospitals in California. In addition to aggressive hand hygiene, and basic CLABSI preventative practices, they introduced four new processes over the last four years that have further decreased CLABSI rates:

- Clean dressings
- CHG bathing
- Central line insertion site assessment (CLISA)–tool
- “1-2-3 Count with me” – nurses ask patients and/or visitors to count to 10 with the them as they clean the patient’s IV ports before accessing each and every time.

UCI Health experts created the CLISA tool – to standardize assessment and scoring of insertion sites across the house. This led to consistent, timely interventions to prevent infection. A few of their takeaways include:

- CLABSI reduction is an ongoing dynamic process
- Focus on gaps in basic practices/product use first
- Frontline staff should be engaged in process & outcomes
- Leadership support is necessary on multiple levels
- Keep “eyes on practice”
- Utilize EMR to drive practice
- Annual staff education – products, practice, process

Between 2008 and 2017, the standardized infection ratio (observed to expected cases) dropped house-wide at the UCI Douglas Hospital from 1.47 to 0.39

UCI Health is one of 4 hospitals out of >4,700 hospitals world wide that has implemented all 18 Actionable Patient Safety Solutions and believe it is a key element in UCI Health’s plan to become a high-reliability organization. At the heart of this plan, developed by UCI Health’s CMO, Dr. William Wilson, is UCI Health’s commitment to creating a culture of safety, which includes:

- **TeamSTEPSS program:** An evidence-based set of teamwork tools developed by the Agency for Healthcare Research and Quality aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals.
- **A Just and Accountable Culture:** A transparent culture which ensures that staff can report issues without fear of retribution.
- **Patient Safety and Quality Crosswalk:** The “Crosswalk” provides a visual illustration of the alignment between hospital accreditation standards and the CMS Conditions of Participation for Hospitals in Medicare, and all of the publicly reported hospital ranking systems.
- **Patient Safety Movement Foundation:** A partnership with a like-minded group in the goal of ZERO preventable patient deaths by 2020.

[UCI Health](#) comprises the clinical enterprise of the University of California, Irvine. Patients can access UCI Health at primary and specialty care offices across Orange County and at its main campus, UCI Medical Center in Orange, California. The 417-bed acute care hospital provides tertiary and quaternary care, ambulatory and specialty medical clinics, and behavioral health and rehabilitation services. UCI Medical Center features Orange County’s only National Cancer Institute-designated comprehensive cancer center, high-risk perinatal/neonatal program and American College of Surgeons-verified Level I adult and Level II pediatric trauma center and regional burn center. UCI Health serves a region of

nearly 4 million people in Orange County, western Riverside County and southeast Los Angeles County.

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