

California State HAI Prevention Plan Subcommittee
Thursday, October 17th, 2013
12:00pm-1:00pm
TELECONFERENCE

Attendance

Members Present

Zachary Rubin, MD, Chair; Suzanne Anders MHI; Marsha Barden, MSN; *Amy Dubois, MSN; *Elizabeth Clark, MPH, RN; *Cheryl Richardson, RN; Matt Zahn, MD. MPH

Liaison Representatives:

*Vicki Keller, RN,MSN,PHN,CIC

California Department of Public Health (CDPH)

Lynn Janssen, MS, CIC, CPHQ, Neely Kazerouni, DrPH, MPH, Jorge Palacios

*absent

Agenda Item/ Discussion
Call to Order Dr. Rubin, Chair of the subcommittee called meeting to order at 12:02 pm.
Welcome and Introductions Members introduced themselves
<u>Bagley Keene Open Meeting Act 2010</u> <ul style="list-style-type: none">Members were reminded the importance of sending agenda items to the chair, to comply with the rules for posting.
Summary Meeting Minutes (SMM) Members reviewed and approved the October 7th, 2013 SMM .

L. Janssen – Framework for subcommittee discussions? Consider asking “what are the prevention activities/goals that this subcommittee wants to set, at the facility level, which can guide how CDPH recommends prevention to hospitals”

Group - Discussion focused on improvement of central line insertion practices (CLIP) surveillance and reporting. Considering the following CLIP recommendations for the State prevention Plan:

- If hospitals continue to have elevated CLABSI rates, consider utilizing CLIP forms in all hospital locations where lines are inserted, including the OR and interventional radiology. Assess compliance with completing of CLIP forms in relationship to the total central lines inserted (at least once and on a regular basis thereafter)
- Preferentially, an observer should complete the CLIP form instead of the inserter. The inserter should not document the CLIP adherence form, if possible.
- Incorporate review of adherence to CLIP. Review maintenance of the lines also to help identify probable cause.
- Group – Recapped discussion of CLABSI and added more recommendations for the State Prevention Plan: Implement a root cause analysis or other review process when CLABSI occur.
- Adopt a central line maintenance bundle
- Monitor adherence of bundle on a regular basis, with emphasis on
 - Daily review of line necessity and prompt removal
 - Accessing the line using “scrub-the-hub” practices
 - Care of catheter site, including dressing practices

Group agreed on topic for next meeting – CDI

Timeline

- Next subcommittee meeting will be held on November 7, 2013
- Subcommittee meetings are held twice a month, on the first and third Thursday of each month.