

## CLIP: Operationalization Debate 5 29 '08

**CLIP Subcommittee: An additional requirement that applies to all General Acute Care facilities:**

Although the CLIP data set does not include the daily assessment of line necessity, the CLIP Subcommittee strongly recommends that 1) hospitals be required to develop a process to complete a daily assessment of line necessity and have a 2) mechanism to demonstrate that process to CDPH surveyors. Daily assessment of line necessity in ALL ICUs 3) by a licensed care giver is strongly associated with reducing line infections and the Subcommittee believes this process measure should be addressed. While inspection of the line insertion site is a routine part of daily nursing care, evaluation of line necessity is an important process measure that reduces risk for infection because it prompts the removal of lines sooner rather than later.

### AFL 08-10: Additional reporting requirement

All 1) hospitals are required to develop and implement a process to ensure daily assessment of central line necessity for all patients with central lines on units under surveillance and to 2) be able to present results of that process to CDPH surveyors. Daily assessment of line necessity by a licensed care giver 3) (defined as a person with the authority to order insertion or discontinuation of a central line) is strongly associated with reduction of infection risk because it prompts the removal of lines sooner rather than later. This activity is separate from inspection of the line insertion site which is a routine part of daily nursing care.

#### Issues:

Phrases in Question	Questions	Perspectives
Hospitals required to develop a process to complete a daily assessment vs. develop and implement a process	Could implementation be potentially optional with the original wording?	
Have a mechanism to demonstrate the process vs. be able to present results	How is this operationalized, i.e., what criteria should L&C look for validate compliance?	Assuming a form of documentation, this is not proscriptive of where the documentation needs to be.
Licensed care giver: undefined vs. person w/ authority to order insertion or discontinuation of a line	Who is responsible for decision to decide if line should be continued or not? If an RN makes determination, what can he/she do?  How is it proven that the person documenting actually did what they were charged with doing?	Per scope of practice, RNs are allowed to assess but not to diagnosis. If the line needs to be pulled, the order must come from an MD. What if the initial assessment is incorrect? If the physician is validating, why is he/she not acknowledging? Can this be inserted as a prompt into the intervention note?  If handled as a verbal order (ex: during ICU rounds), TJC working to decrease verbal orders from MDs. What about central lines monitored in a non-ICU setting?