

# Central Line Insertion Practices Adherence Monitoring

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\*required for saving

Facility ID: _____	Event #: _____
*Patient ID: _____	Social Security #: _____ - _____ - _____
Secondary ID: _____	Medicare #: _____
Patient Name, Last: _____	First: _____ Middle: _____
*Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other	*Date of Birth: ___ / ___ / _____ (mm/dd/yyyy)
Sex at Birth: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Unknown	Gender Identity (specify): _____
Ethnicity (specify): _____	Race (specify): _____
*Event Type: CLIP *Location: _____ *Date of Insertion: ___ / ___ / _____ (mm/dd/yyyy)	
*Person recording insertion practice data: <input type="checkbox"/> Inserter <input type="checkbox"/> Observer	
Central line inserter ID: _____ Name, Last: _____ First: _____	
*Occupation of inserter:	
<input type="checkbox"/> Fellow	<input type="checkbox"/> Medical student
<input type="checkbox"/> Physician assistant	<input type="checkbox"/> Attending physician
<input type="checkbox"/> Advanced practice nurse	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Other student	<input type="checkbox"/> Intern/resident
<input type="checkbox"/> Other medical staff	<input type="checkbox"/> Registered nurse
*Was inserter a member of PICC/IV Team? <input type="checkbox"/> Y <input type="checkbox"/> N	
*Reason for insertion:	
<input type="checkbox"/> New indication for central line (e.g., hemodynamic monitoring, fluid/medication administration, etc.)	
<input type="checkbox"/> Replace malfunctioning central line	
<input type="checkbox"/> Suspected central line-associated infection	
<input type="checkbox"/> Other (specify): _____	
If Suspected central line-associated infection, was the central line exchanged over a guidewire? <input type="checkbox"/> Y <input type="checkbox"/> N	
*Inserter performed hand hygiene prior to central line insertion: <input type="checkbox"/> Y <input type="checkbox"/> N (if not observed directly, ask inserter)	
*Were all 5 maximal sterile barriers used? <input type="checkbox"/> Y <input type="checkbox"/> N	
*Maximal sterile barriers used: Mask <input type="checkbox"/> Y <input type="checkbox"/> N Sterile gown <input type="checkbox"/> Y <input type="checkbox"/> N	
Large sterile drape <input type="checkbox"/> Y <input type="checkbox"/> N Sterile gloves <input type="checkbox"/> Y <input type="checkbox"/> N Cap <input type="checkbox"/> Y <input type="checkbox"/> N	
*Skin preparation (check all that apply) <input type="checkbox"/> Chlorhexidine gluconate <input type="checkbox"/> Povidone iodine <input type="checkbox"/> Alcohol	
<input type="checkbox"/> Other (specify): _____	
If skin prep choice was <u>not</u> chlorhexidine, was there a contraindication to chlorhexidine? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	
If there was a contraindication to chlorhexidine, indicate the type of contraindication:	
<input type="checkbox"/> Patient is less than 2 months of age - chlorhexidine is to be used with caution in patients less than 2 months of age	
<input type="checkbox"/> Patient has a documented/known allergy/reaction to CHG based products that would preclude its use	
<input type="checkbox"/> Facility restrictions or safety concerns for CHG use in premature infants precludes its use	
*Was skin prep agent completely dry at time of first skin puncture? <input type="checkbox"/> Y <input type="checkbox"/> N (if not observed directly, ask inserter)	
*Insertion site: <input type="checkbox"/> Femoral <input type="checkbox"/> Jugular <input type="checkbox"/> Lower extremity <input type="checkbox"/> Scalp <input type="checkbox"/> Subclavian <input type="checkbox"/> Umbilical <input type="checkbox"/> Upper extremity	
Antimicrobial coated catheter used: <input type="checkbox"/> Y <input type="checkbox"/> N	
<p><b>Assurance of Confidentiality:</b> The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).</p> <p>Public reporting burden of this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).          CDC 57.125 (Front)</p>	

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\*Central line catheter type:

- |  |   |
|--|---|
| <input type="checkbox"/> Non-tunneled (other than dialysis)<br><input type="checkbox"/> Tunneled (other than dialysis)<br><input type="checkbox"/> Dialysis non-tunneled<br><input type="checkbox"/> Dialysis tunneled | <input type="checkbox"/> PICC<br><input type="checkbox"/> Umbilical<br><input type="checkbox"/> Other (specify): _____<br><small>("Other" should not specify brand names or number of lumens; most lines can be categorized accurately by selecting from options provided.)</small> |
|--|---|

\*Did this insertion attempt result in a successful central line placement?     Y     N

**Custom Fields**

Label	Label
_____ / ____ / _____	_____ / ____ / _____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Comments**