

## Root Cause Analysis Form for BSI with Central Venous Catheter Patient

Patient Name:	Reported Month/Year:	NHSN Criteria Met: <input type="checkbox"/> Yes <input type="checkbox"/> No
DOB:	LTC/SNF Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where:
Organism(s):		
Date CVC Inserted:	Was CVC inserted > 48 hrs before infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Inserted by:	Hospital where inserted:	
If infection occurred less than 48 hours from the time of insertion of new CVC, follow up with the facility where it was inserted as this could indicate that the BSI is related to the insertion practices.		
<b>Event Details</b>		
<b>Think about the 72 hours prior to start of infection when answering the following questions</b>		
Were there any observed breaches of proper hand hygiene or infection control by anyone involved in this patient's care at the dialysis unit?	<input type="checkbox"/> Yes If yes, corrective action plan	<input type="checkbox"/> No
Was the dressing integrity assessed and documented and dressing changed during dialysis treatment?	<input type="checkbox"/> Yes If yes, look for documented s/s of infection	<input type="checkbox"/> No If no, corrective action plan
Was an alcohol-based chlorhexidine (>0.5%) solution or povidone iodine or 70% alcohol used during the dressing change?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If no, corrective action plan
Was the hub scrubbed for 15 seconds with 70% alcohol or chlorhexidine with alcohol every time the catheter was accessed or disconnected?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If no, corrective action plan
Was this catheter manipulated or used by any other staff besides the dialysis staff, i.e. did anyone at a hospital or long term care facility access the catheter?	<input type="checkbox"/> Yes If yes, notify MD and speak with other facility. CVC should <i>only be used for dialysis</i> .	<input type="checkbox"/> No
Was the dialysis unit adequately staffed on the suspected date of infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If no, did staff take time to complete proper CVC care?
Are you able to identify any other possible sources of contamination?	<input type="checkbox"/> Yes If yes, address issues	<input type="checkbox"/> No
Were there any mechanical problems with the CVC?	<input type="checkbox"/> Yes If yes, was proper procedure followed to address problems?	<input type="checkbox"/> No
Are there any patient factors that you believe may have contributed to this infection?	<input type="checkbox"/> Yes If yes, educate patient/family member	<input type="checkbox"/> No
Comments:		