Form Approved
OMB No. 0920-0666
Exp. Date: 01/31/2021
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Central Line Insertion Practices Adherence Monitoring

*required for saving

Facility ID: ____________________ Event #: ______________________________

*Patient ID: ____________________ Social Security #: __ __ __ - __ __ - __ __ __ __

Secondary ID: ____________________ Medicare #: ______________________

Patient Name, Last: ____________________ First: __________________ Middle: _________________

*Gender: ☐ F ☐ M ☐ Other *Date of Birth: ___ /___ /______ (mm/dd/yyyy)

Ethnicity (specify): ___________________________ Race (specify): ______________________________

*Event Type: CLIP *Location: _______________________ *Date of Insertion: ___ /___ /_____ (mm/dd/yyyy)

*Person recording insertion practice data: ☐ Inserter ☐ Observer

Central line inserter ID: _________ Name, Last: ___________________ First: _____________________

*Occupation of inserter:

☐ Fellow ☐ Medical student ☐ Other student ☐ Other medical staff
☐ Physician assistant ☐ Attending physician ☐ Intern/resident ☐ Registered nurse
☐ Advanced practice nurse ☐ Other (specify): _____________________

*Was inserter a member of PICC/IV Team? ☐ Y ☐ N

*Reason for insertion:

☐ New indication for central line (e.g., hemodynamic monitoring, fluid/medication administration, etc.)
☐ Replace malfunctioning central line
☐ Suspected central line-associated infection
☐ Other (specify): _______________________

If Suspected central line-associated infection, was the central line exchanged over a guidewire? ☐ Y ☐ N

*Inserter performed hand hygiene prior to central line insertion: ☐ Y ☐ N (if not observed directly, ask inserter)

*Maximal sterile barriers used: Mask ☐ Y ☐ N Sterile gown ☐ Y ☐ N
Large sterile drape ☐ Y ☐ N Sterile gloves ☐ Y ☐ N Cap ☐ Y ☐ N

*Skin preparation (check all that apply) ☐ Chlorhexidine gluconate ☐ Povidone iodine ☐ Alcohol
☐ Other (specify): ____________________

If skin prep choice was <u>not</u> chlorhexidine, was there a contraindication to chlorhexidine? ☐ Y ☐ N ☐ U

If there was a contraindication to chlorhexidine, indicate the type of contraindication:

☐ Patient is less than 2 months of age - chlorhexidine is to be used with caution in patients less than 2 months of age
☐ Patient has a documented/known allergy/reaction to CHG based products that would preclude its use
☐ 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? ☐ Y ☐ N (if not observed directly, ask inserter)

*Insertion site: ☐ Femoral ☐ Jugular ☐ Lower extremity ☐ Scalp ☐ Subclavian ☐ Umbilical ☐ Upper extremity

Antimicrobial coated catheter used: ☐ Y ☐ N

Assurance of Confidentiality: 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)).

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 D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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*Central line catheter type:

☐ Non-tunneled (other than dialysis) ☐ PICC
☐ Tunneled (other than dialysis) ☐ Umbilical
☐ Dialysis non-tunneled ☐ Other (specify): ________________________________
☐ Dialysis tunneled (“Other” should not specify brand names or number of lumens; most lines can be categorized accurately by selecting from options provided.)

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

Custom Fields

Label		Label	
________________________	____/____/_____	________________________	____/____/_____
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Comments

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