



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"/> Other student	<input type="checkbox"/> Other medical staff
<input type="checkbox"/> Physician assistant	<input type="checkbox"/> Attending physician	<input type="checkbox"/> Intern/resident	<input type="checkbox"/> Registered nurse
<input type="checkbox"/> Advanced practice nurse <input type="checkbox"/> Other (specify): _____			
*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			

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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	
_____	___/___/___	_____	___/___/___
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments