The problem:

- A need for documented evidence that central venous access devices (CVADs) had been observed and were being monitored was identified.
- Identified that ICU team were called out to support wards with CVAD care and advice on a regular basis.
- A team approach was needed to look at addressing these issues as this would need to be a Trustwide project involving both inpatient and community teams as well as the quality improvement team.

What we did:

- Survey of staff confidence and competence in CVAD care across the Trust, (108 staff responded).
- Literature search for central line scoring tools carried out with very few results.
- Identified a suitable scoring tool that was adapted for use in our Trust.
  - Introduced the scoring tool using a PDSA cycle one ward at a time.
  - Produced standardised care posters for use across all Trust sites.
  - Increased the number of education days about CVADs.
  - CVAD passports developed for community patients.

What has happened?

- Increased attendance at Trust CVAD education sessions.
- Trustwide launch of the CLIPS tool supported by a month long campaign that included ward visits and online information.
- Number of "distressed" incidence involving CVADs post launch of initiative dropped from 2/3 a month to 0 for the first time in 2 years.
- Documentation review of CVAD insertions has led to new insertion checklist to comply with NSSIIPs.

What now?

- Ward based CVAD champions have been identified in order to help support in-patient areas and maintain compliance with recording CLIP scores.
- New prescription charts will have space allocated for CLIP score and flushes administered via CVADs.
- Review of CVADs care bundle in ICU to comply with QIPICu2 recommendations.