Form Approved
OMB No. 0920-0666
Exp. Date:12/31/2026
www.cdc.gov/nhsn

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)

Sex at Birth: ☐ F ☐ M ☐ Unknown Gender Identity (specify):_____

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)

*Were all 5 maximal sterile barriers used? ☐ Y ☐ N

*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

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*Central line catheter type:

- ☐ Non-tunneled (other than dialysis)
- ☐ Tunneled (other than dialysis)
- ☐ Dialysis non-tunneled
- ☐ Dialysis tunneled
- ☐ PICC
- ☐ Umbilical
- ☐ Other (specify): _____
  ("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