inotropes falling out. 'We trialled the CHG-impregnated dressing on the main ICU. The staff could see what was going on and got used to it. In most of the ICU patients, it became the norm. The number of infections went down and we advised NICE on the benefits of using it based on practical experience.'

The majority of the members of the expert group believed guidance on the use of CHG-impregnated dressings should be extended to cover all CVADs, including those in patients being treated in the community. 'CHG at the point of the insertion site should, in specific circumstances, be used in the community, because the risk of infection in the community with some patient groups is probably just as high from a microbiology point of view as in an acute care setting,' expressed a participant. Some, however, considered that it would be advantageous, but not absolutely necessary.

Determining the cost-effectiveness of CHG-impregnated dressings was also part of the debate. 'Collection of data is key to being able to evaluate the cost-effectiveness of CHG dressings,' said a member of the panel. A recent paper (Thokala et al, 2016) suggested that cost savings could be achieved if infection levels were at a certain level.

An attendee said it was not just about the cost, but also about what the dressing feels like for the patient. Her staff wore the dressings for a week and then went back to the patients to exchange feedback. 'Patient experience and patient safety were more important than cost,' she explained, 'but that was a few years ago so it may have changed now.'

When discussing the use of negative, positive or neutral needle-free device connectors, most participants said they would use positive, with some members of the expert group having recently switched from neutral to positive. One of them mentioned the reason for this change was to reduce occlusion incidences. Another highlighted the use of passive disinfection devices: 'They provide a closed system, which protects the needle-free device between uses, whereas 'scrub the hub' is only as good as the individual who cleans the hub.' An audit (Cameron-Watson, 2016) described the effects on compliance and incidence of VAD-related bacteraemia following the introduction of a passive disinfection device. The results showed VAD-related bacteraemia rates reduced by 69%.

A participant explained that, in terms of infection risk, certain devices are more liable to cause ingress of microorganisms through these connectors. 'Recent findings suggest that the risk of infection with needle-free connectors is not necessarily related to the type of device but to individual devices, which may be more difficult to clean between use,' he said. 'The disinfection of the hub is key,' expressed another member of the panel.

National consensus document

The need for a potential national consensus document on data collection and reporting for VAD-related infections was also part of the debate. Some participants wondered how different it would have to be from the Matching Michigan programme, and whether it could take some aspects of that programme. Others questioned the ability to collect the data in the wards when people do not have an electronic system and are still reliant on a paper system, and many pointed out the issue of taking ownership of the data collection, whether it be done by microbiologists, infection control teams or vascular access teams.

'It's not going to happen, unless it's a national target. We are not going to get trusts to buy into this without it being driven,' said a member of the panel. Another attendee added: 'To do it continuously would become a headache and take resources away. It should be something done regularly but for a short period of time; that would be feasible.'

There was variation in the Matching Michigan project as to how well hospitals were able to comply with the infection control procedures and monitoring, and so whether they achieved sustained improvements in infection rates (Dixon-Woods et al, 2012; Dixon-Woods et al, 2013). 'There is no one way of doing it. In some it's infection control, in others it's the ICU staff, and in others it's ward champions. So, it is very variable,' said a participant, who pointed out that a lot of it seems to depend on the attitude of the chief executive of the trust: 'If he is not interested, it doesn't happen.'

Conclusion

Over a 3-hour discussion, the members of the panel agreed on few of the 15 topics listed under the round-table agenda. They could not determine a definition for CRBSI and CLABSI, with some of them suggesting 'VAD-related infections' as a better definition. There was no agreement on how to tackle the challenges related to data collection (what to collect, where to collect it, who should collect it), or on how to address the problem of missing a lot of data due to lines being removed without further investigation. There was, however, a general consensus that some form of a standardised documentation or recording process for VAD-related bacteraemia would be of benefit moving forward, and an agreement that a national target on data collection is required. **BJN**

KEY POINTS

- The members of the panel could not agree on a definition for catheter-related bloodstream infections (CRBSIs) and central line-associated bloodstream infections (CLABSIs)
- A lack of consistency in measuring and reporting CRBSIs and CLABSIs was evident among the panel, especially when describing data collection procedures outside of the intensive care unit (ICU)
- Most attendees pointed out it was difficult to agree on what data to collect, where to collect it, and who should collect it
- When discussing the use of negative, positive or neutral needle-free device connectors, most participants said they would use positive, with some members of the group having recently switched from neutral to positive
- There was a general consensus that some form of a standardised documentation or recording process for VAD-related bacteraemia would be of benefit moving forward

Association for Professionals in Infection Control and Epidemiology. Guide to the elimination of catheter-related bloodstream infections. 2009. tinyurl.com/yah79jd4 (accessed 24 August 2017)

Cameron-Watson C. Port protectors in clinical practice: an audit. Br J Nurs. 2016; 25(8): S25–S31. http://doi.org/10.12968/bjon.2016.25.8.S25

Dixon-Woods M, Leslie M, Bion J, Tarrant C. What counts? An ethnographic study of infection data reported to a patient safety program. The Milbank Quarterly. 2012; 90(3): 548–591

Dixon-Woods M, Leslie M, Tarrant C, Bion J. Explaining Matching Michigan: an ethnographic study of a patient safety program. J Implementation Science. 2013. 8: 70

National Institute for Health and Care Excellence. The 3M Tegaderm CHG IV securement dressing for central venous and arterial catheter insertion sites. Medical technologies guidance [MTG25]. 2015; tinyurl.com/yb284y4h (accessed 24 August 2017)

NHS England. Next steps on the NHS five year forward view. 2017 tinyurl.com/mfl4td7 (accessed 24 August 2017)

Thokala P, Arrowsmith M, Poku E et al. Economic impact of Tegaderm chlorhexidine gluconate (CHG) dressings in critically ill patients. J Infect Prev. 2016; 17(5): 216–223. http://doi.org/10.1177/1757177416657162