NYSPFP CAUTI Educational Session: No Harm Across the Board and CAUTI Reduction

Tuesday, September 30, 2014
## Today’s Agenda

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>SPEAKER(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Introductions</td>
<td>Zeynep Sumer</td>
</tr>
<tr>
<td>Progress to Date</td>
<td>NYS Partnership for Patients</td>
</tr>
<tr>
<td>Guiding Principles</td>
<td></td>
</tr>
<tr>
<td>Preventing Catheter Associated Urinary Tract Infection (CAUTI):</td>
<td>Sanjay Saint, MD, MPH</td>
</tr>
<tr>
<td>Making It Happen</td>
<td>University of Michigan Medical School</td>
</tr>
<tr>
<td></td>
<td>Ann Arbor VA Medical Center</td>
</tr>
<tr>
<td>Facilitated Questions and Answers</td>
<td>Nancy Landor</td>
</tr>
<tr>
<td></td>
<td>NYS Partnership for Patients</td>
</tr>
<tr>
<td>Concluding Remarks</td>
<td>Nancy Landor</td>
</tr>
</tbody>
</table>
Progress to Date

**CAUTI Standardized Infection Ratio by Year and Month**

- **CAUTI SIR**
- **Baseline**

6% Decrease
Progress to Date

25% Decrease
CAUTI Guiding Principles

FOR REDUCING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

1. Engage leadership support for hospital-wide CAUTI initiatives and strategies.
2. Engage staff in a sustained improvement by:
   - Creating a multifaceted team to help design CAUTI reduction and prevention strategies and interventions within specific units.
   - Implementing evidence-based interventions.
   - Conducting staff education in infection prevention.
   - Conducting regular safety events to discuss and reinforce infection prevention practices.
   - Conducting regular audits and reviews to assess the effectiveness of interventions.
   - Conducting regular staff and patient surveys to assess satisfaction with infection prevention practices.

NYS PARTNERSHIP FOR PATIENTS

September 29, 2014

INTEGRATE

- Standardize policies and practices to reduce CAUTI and associated complications, making it easy to do the right thing.
  - Establish guidelines and protocols for CAUTI prevention.
  - Implement a standardized approach to CAUTI prevention.
  - Implement a standardized approach to CAUTI monitoring.
  - Implement a standardized approach to CAUTI reporting.

BUILD AND TEST INTERVENTIONS TO REDUCE INFECTIONS

- Implement interventions to reduce CAUTI and associated complications.
  - Implement a standardized approach to CAUTI prevention.
  - Implement a standardized approach to CAUTI monitoring.
  - Implement a standardized approach to CAUTI reporting.

WEB SITE: WWW.NYSPFP.ORG

September 29, 2014
Resources Available

Catheter-associated Urinary Tract Infections

Infection Prevention Initiatives

INITIATIVE OVERVIEW MEETING MATERIALS TOOLS & RESOURCES

Check this page often for updated tools and resources from the NYSPFP CAUTI Initiative.

- Action Planning
- Communications and Campaigns
- Data Tracking and Measurement
Embed the principle of “no catheter, no infection” into all care delivery by reducing insertions and discontinuing the indwelling urinary catheter as soon as possible.

- Target interventions to reduce urinary catheter utilization and encourage early catheter discontinuation in high-utilization units, such as:
  - Emergency Department (ED):
    - Targeted education for ED staff to insert urinary catheter only when medical necessity criteria are met.
    - Implement ED-specific indwelling urinary catheter protocols for insertion criteria.
  - Operating Rooms (OR):
    - OR-specific education to standardize evaluation of medical necessity of urinary catheter for the surgical procedure.
    - Standardize indwelling catheter discontinuation timeframes post-operatively.
  - Intensive Care Unit (ICU):
- Consider alternatives to indwelling urinary catheter (e.g., condom catheter, daily weights, volume assessment).
- Implement standard urinary catheter medical necessity review upon decision to transfer to a lower level of care.
- Address the socio-adaptive aspects of committing, as an organization, to zero CAUTIs.
- Promote staff awareness of potential harm associated with using indwelling urinary catheters with posters, screensavers, catheter tray stickers, order sets embedded in the electronic medical record (EMR), and nurse-driven catheter removal protocols.
- Encourage staff to “speak up” or “stop the line” to prevent medically unnecessary indwelling catheter insertion.
- Consider Root Cause Analysis (RCA) of all identified CAUTI events.
NYSPFP Resources to Support Innovate

- **Tools and Resources**
  - **INITIATIVE OVERVIEW**
  - **MEETING MATERIALS**
  - **TOOLS & RESOURCES**

  Check this page often for updated tools and resources from the NYSPFP CAUTI Initiative.

  - **Action Planning**
    - **Action Planning Worksheets for Best Practice Recommendations:**
      The following worksheet and pilot strategies can help guide the implementation of process improvements as hospitals work to reduce CAUTIs.

      - CAUTI Team Planning Worksheet
      - CAUTI Pilot Strategy: Optimizing Catheter Use in the Emergency Department
      - CAUTI Pilot Strategy: Rapid Improvement Tests for Optimizing Catheter Discontinuation

- **Webinars**
  - **Socioadaptive Elements**
    - **Webconference recording**
      [https://nyspfp.webex.com/nyspfp/lsr.php?RCID=680cc62ca5ade02e7bd5a129d1884463](https://nyspfp.webex.com/nyspfp/lsr.php?RCID=680cc62ca5ade02e7bd5a129d1884463)
Encourage staff awareness and support for increased hospital-wide attention to reducing patient harm caused by indwelling urinary catheters.

- Engage Leadership support for hospital-wide CAUTI reduction efforts.
- Engage staff in continuous improvement by:
  - Creating a multi-disciplinary team to help design CAUTI reduction protocols and promote awareness within their specific unit or disciplines. Consider including:
    - Wound Care Specialist
    - Infection Preventionist
    - Physical Therapy
  - Recruit physician, nurse, and infection prevention champions, particularly in high-use areas such as the ED, peri-operative units, and ICUs.
  - Have the team develop a list of appropriate indications for indwelling urinary catheterization, starting with those specified in the 2009 HICPAC Guidelines.
  - Implement continuous hospital-wide education on importance of CAUTI reduction and potential harm from indwelling catheters, including CAUTI, development of urethral strictures, secondary bacteremia or sepsis, and patient discomfort.
- Provide data to units in as close to real-time as possible, including CAUTI rates, adherence to urinary catheter insertion protocols, and catheter utilization ratios.
- Implement a format for team members to provide continuous feedback.
- Engage patients and caregivers to reduce risks associated with indwelling urinary catheters (or incontinence) through education about the benefits of not inserting a catheter, and indwelling urinary catheter maintenance.
  - Enlist patient and family help with toileting as appropriate.
  - Provide patient and caregiver education verbally and in writing; consider using “teach back” techniques to ensure instructions are understood.
  - Encourage questions from staff, patients, and families.
NYSPFP Resources to Support Engage

- Appropriate indications
  - Educational Materials on Alternatives to Foley Catheters
    - [https://www.nyspfp.org/Materials/NYSPFP_Handout_CAUTI_110413.pdf](https://www.nyspfp.org/Materials/NYSPFP_Handout_CAUTI_110413.pdf)
  - Educational webinars with sample success stories and Scripts for staff to use with patients and family to explain urinary catheter usage and discontinuation
Integrate

Build and test interventions to reduce all patient harm with a focus on reducing the rate of indwelling urinary catheter insertion and early discontinuation of catheters when no longer medically necessary.

- Work with CLABSI, Pressure Ulcer, Fall Prevention, and Surgical Site Infection quality improvement teams to prevent overlap or gaps in care.
- Ensure interdepartmental planning and communication, particularly in shared processes and hand-offs between:
  - ED and nursing units
  - ED and surgical suite
  - Surgical suite and nursing units
  - Critical care and all units
- Test and evaluate interdisciplinary cross-education and communication tools. Modify tools and protocols based on monitoring and staff feedback. Examples of tools include:
  - Whiteboards

- Posters
- Rounding documentation
- Hand-off documentation
- Daily goals sheets
- Implement EMR protocols to reduce insertion of indwelling urinary catheters. Example protocols and checklists include:
  - Order sets and care plan that includes CAUTI Insertion and Prevention Bundle.
  - Standardized medical indications for indwelling urinary catheter.
  - Nurse-driven discontinuation protocols—driven by daily assessment of medical necessity.
  - Hard stop discontinuation orders for appropriate specialties (i.e., surgical patients).
NYSPFP Resources to Support Integrate

- Posters

**NYSPFP No Harm Across the Board Posters:**
The NYSPFP No Harm Across the Board laminated posters can be used at the unit or departmental level for frontline staff to track and document the number of days since the last harm event, as well as provide some strategies for reducing harm. The poster below is available for professional printing. It is 12”x18” (Full Bleed).

- **CAUTI Poster**

**NO HARM ACROSS THE BOARD**

Days Since Last **CAUTI**

Catheter-Associated Urinary Tract Infection (CAUTI) Prevention:

- Catheters are invasive; avoid unnecessary catheters, and only insert catheters in the presence of an appropriate indication.
- Insert catheters using aseptic technique.
- Perform hand hygiene.
- Maintain catheters based on guidelines:
  - Tamper-evident seal is intact;
  - Collection bag is not on the floor;
  - Collection bag is below bladder level; and
  - Collection bag is secured to the leg.
- Ensure patients with catheters have labeled urine collection containers at the bedside.
- Review catheter necessity daily and remove promptly.
NYSPFP Resources to Support Integrate

- Webinars with example protocols from hospitals with nurse driven protocols

Catheter-associated Urinary Tract Infections

Infection Prevention Initiatives

- Initiative Overview
- Meeting Materials
- Tools & Resources

Below please find information and materials from conferences, webinars, and other learning sessions related to the NYSPFP CAUTI Initiative.

- **2014**
    - Agenda
    - Meeting Materials:
      - Slides
      - Cost Calculator
      - CatherOut.org Script
    - Webconference Recording
    - Transcript
Standardize policies and practices to reduce CAUTI and associated complications; make it easy to do the right thing.

- Modify EMR to contain standard order sets that include insertion criteria, daily review of medical necessity (ideally during each shift), and protocols for discontinuing indwelling catheters.

- Standardize education and communication using approved tools, such as whiteboards, posters, rounding, and hand-off documentation.

- Ensure policies and procedures are in place that reinforce the insertion and maintenance bundles, including (but not limited to): ongoing education, clinical skills review, monitoring, etc.

- Monitor compliance with policy and protocols. Gather data and provide feedback to the entire staff on:

- Compliance with CAUTI Insertion and Prevention maintenance bundles.

- CAUTI rates tracked by service line and unit.

- Indwelling urinary catheter insertion rates and catheter utilization ratios in the ED.

- Adherence to appropriate medical necessity indications for insertion of urinary catheter.

- Schedule systematic reviews of the established CAUTI Prevention Program that incorporate data analysis, results of RCA, and staff feedback.
NYSPFP Resources to Support Hardwire

Catheter-associated Urinary Tract Infections

Infection Prevention Initiatives

INITIATIVE OVERVIEW MEETING MATERIALS TOOLS & RESOURCES

Check this page often for updated tools and resources from the NYSPFP CAUTI Initiative.

Action Planning
Communications and Campaigns
Data Tracking and Measurement

The following are tools that can be helpful for internal data tracking, and can be used to identify high utilization units, to monitor appropriate indications for catheter use, and to evaluate the impact of various interventions.

- Tracking Tool: Review for Urinary Catheter Necessity at the Time of Insertion in the Emergency Department
- Tracking Tool: Review of Urinary Catheter Necessity at Transition Trigger Points (ongoing)
- Point Prevalence Study for Urinary Catheters
CAUTI Guiding Principles

FOR REDUCING CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

- **Innovate**: Develop new methods to prevent CAUTI, such as preoperative screening and surgical site preparation.
- **Integrate**: Implement evidence-based practices across the continuum of care, including patient education and hand hygiene.
- **Engage**: Foster a culture of patient and staff engagement, including feedback and reporting mechanisms.
- **Hardware**: Utilize devices and technology to monitor and prevent CAUTI, such as automated catheterization systems.

1. **Guiding Principle 1**: coached preoperative screening and surgical site preparation
2. **Guiding Principle 2**: Implement evidence-based practices across the continuum of care, including patient education and hand hygiene
3. **Guiding Principle 3**: Foster a culture of patient and staff engagement, including feedback and reporting mechanisms
4. **Guiding Principle 4**: Utilize devices and technology to monitor and prevent CAUTI, such as automated catheterization systems

**NYS PARTNERSHIP FOR PATIENTS**

**CAUTI Guiding Principles**

September 29, 2014
Summary of Resources

- Webinars
- Posters
- Data collection/Tracking tools
- Educational websites e.g. http://www.catheterout.org
Preventing Catheter-Associated Urinary Tract Infection (CAUTI): Making It Happen

Sanjay Saint, M.D., M.P.H.
Preventing Catheter-Associated Urinary Tract Infection (CAUTI): Making It Happen

Sanjay Saint, MD, MPH
George Dock Professor of Medicine
Ann Arbor VA Medical Center
University of Michigan Medical School

30 September 2014
NYSPFP
Catheter-Associated Urinary Tract Infection (CAUTI)

- UTI is a common cause of hospital-acquired infection
- Most due to urinary catheters
- Up to 20% of inpatients are catheterized
- Leads to increased morbidity and healthcare costs
“Many noninfectious catheter-associated complications are at least as common as clinically significant urinary tract infections.”
Addressing CAUTI Prevention within the Broader Patient Safety Context

Partnership for Patients

- Venous thromboembolism
- Falls
- Pressure ulcers
- Immobility
- Trauma
- Urinary Catheter Harm
- Increased Length of Stay
- Patient discomfort
How can we reduce catheter use and prevent CAUTI?
Disrupting the Lifecycle of the Urinary Catheter

1. Preventing Unnecessary and Improper Placement

2. Maintaining Awareness & Proper Care of Catheters

3. Prompting Catheter Removal

4. Preventing Catheter Replacement

(Meddings. Clin Infect Dis 2011)
The Most Common Venue for Foley Placement?

Emergency Department
## 2009 HICPAC Urinary Catheter Indications

### A. Examples of **Appropriate** Indications for Indwelling Urethral Catheters

<table>
<thead>
<tr>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has acute urinary retention or obstruction</td>
</tr>
<tr>
<td>Need for accurate measurements of urinary output in critically ill patients</td>
</tr>
<tr>
<td>Perioperative use for selected procedures:</td>
</tr>
<tr>
<td>• urologic surgery or other surgery on contiguous structures of genitourinary tract</td>
</tr>
<tr>
<td>• anticipated prolonged surgery duration (removed in post-anesthesia unit)</td>
</tr>
<tr>
<td>• anticipated to receive large-volume infusions or diuretics in surgery</td>
</tr>
<tr>
<td>• operative patients with urinary incontinence</td>
</tr>
<tr>
<td>• need for intraoperative monitoring of urinary output</td>
</tr>
<tr>
<td>To assist in healing of open sacral or perineal wounds in incontinent patients</td>
</tr>
<tr>
<td>Requires prolonged immobilization (e.g., potentially unstable spine)</td>
</tr>
<tr>
<td>To improve comfort for end of life care if needed</td>
</tr>
</tbody>
</table>

Alternatives to Consider

1) Accurate daily weights
2) Urinal/commode/bedpan
3) Condom catheters
4) Intermittent catheterization with bladder scanning
Avoiding Indwelling Catheter Insertion in the ED

2 studies have intervened in the ED to reduce insertion:

1) Gokula et al. ER staff education and use of a urinary catheter indication sheet improves appropriate use of Foley catheters. Am J Infect Control. 2007:
   – 75% fewer indwelling catheters inserted after the intervention

2) Fakih et al. Effect of establishing guidelines on appropriate urinary catheter placement. Acad Emerg Med. 2010:
   – Physicians ordered 40% fewer insertions after the intervention
But if the patient really, really needs a Foley...

Ensure proper aseptic technique is used during insertion
Disrupting the Lifecycle of the Urinary Catheter

1. Preventing Unnecessary and Improper Placement

2. Maintaining Awareness & Proper Care of Catheters

3. Prompting Catheter Removal

4. Preventing Catheter Replacement

(Meddings. Clin Infect Dis 2011)
Proper Maintenance

• Keep the urinary system closed

• Make sure flow is unobstructed:
  – No kinking or coiling
  – Drainage bag should be lower than the bladder
  – Regularly empty the bag
Disrupting the Lifecycle of the Urinary Catheter

1. Preventing Unnecessary and Improper Placement
2. Maintaining Awareness & Proper Care of Catheters
3. Prompting Catheter Removal
4. Preventing Catheter Replacement

(Meddings. Clin Infect Dis 2011)
Timely Removal of Indwelling Catheters

- 30 studies have evaluated urinary catheter reminders and stop-orders
  - Significant reduction in catheter-associated urinary tract infection (53%)
  - No evidence of harm (ie, re-insertion)
  - Will also address the non-infectious harms of the Foley

What about the ICU?
<table>
<thead>
<tr>
<th>Patient has acute urinary retention or obstruction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Need for accurate measurements of urinary output in critically ill patients</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perioperative use for selected procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• urologic surgery or other surgery on contiguous structures of genitourinary tract</td>
</tr>
<tr>
<td>• anticipated prolonged surgery duration (removed in post-anesthesia unit)</td>
</tr>
<tr>
<td>• anticipated to receive large-volume infusions or diuretics in surgery</td>
</tr>
<tr>
<td>• operative patients with urinary incontinence</td>
</tr>
<tr>
<td>• need for intraoperative monitoring of urinary output</td>
</tr>
</tbody>
</table>

| To assist in healing of open sacral or perineal wounds in incontinent patients |

| Requires prolonged immobilization (e.g., potentially unstable spine) |

| To improve comfort for end of life care if needed |

Just because a patient is in the ICU does NOT mean that the patient needs a Foley…

The Key Question is this:

Are hourly assessments of urine output required?
ICUs have very high urinary catheter use

Utilization may be reduced hospital-wide if patients transferred out of the ICU are evaluated for catheter necessity at time of transfer

(Slide courtesy of M. Fakih)
Trigger Point: OR To Floor

- Operating Rooms have very high urinary catheter use
- Utilization may be reduced hospital-wide if patients transferred out of the PACU are evaluated for catheter necessity at time of transfer
Disrupting the Lifecycle of the Urinary Catheter

1. Preventing Unnecessary and Improper Placement

2. Maintaining Awareness & Proper Care of Catheters

3. Prompting Catheter Removal

4. Preventing Catheter Replacement

(Meddings. Clin Infect Dis 2011)
Discontinue urinary catheter when it no longer meets appropriateness criteria

Patient voids within 6 hours and no symptoms

- Observe

Patient voids within 6 hours but has symptoms of abdominal fullness or discomfort

- Bladder scan, if volume <300 ml, observe. Repeat postvoid bladder scan if symptoms persist and contact physician

Patient unable to void within 6 hours

- Bladder scan, if volume >300 ml, intermittent catheterization. Repeat postvoid bladder scan if symptoms persist and contact physician

*If concerns arise during any part of the above assessment, please contact the physician*

(Prepared by Mohamad Fakih, MD, MPH - St. John Hospital & Medical Center, Detroit, MI)
“The hospital is the most complex human organization ever devised…”

Peter Drucker
What if you need further help in preventing CAUTI?
Additional Approaches

1) Tier 1 & Tier 2

2) CAUTI GPS

3) Applying Mindfulness to CAUTI
## Tier 1 Protocol: Use of Indwelling Urinary Catheter Kit

<table>
<thead>
<tr>
<th>Assess daily the necessity of the indwelling catheter</th>
<th>Encourage use of alternatives to indwelling catheter</th>
<th>Use standard indwelling urinary catheter kit with pre-sealed junction</th>
<th>Ensure proper aseptic insertion technique</th>
<th>Follow maintenance and removal template for care and removal of the catheter</th>
<th>Measure CAUTI rates monthly</th>
</tr>
</thead>
</table>

*Monitor CAUTI rates closely. Proceed to Tier 2 if either of the following conditions are met over a period of 6 months:*

1. ICU ≥ 9 CAUTIs/10,000 patient days  
2. Non-ICU, Acute Care ≥ 3 CAUTIs/10,000 pt days & 2 CAUTIs/1,000 catheter days


| Assess and document competency of healthcare workers performing insertion | Consider Root Cause Analysis or Focused Review of CAUTI or catheter use to identify improvement opportunities | Measure monthly for 6 months; re-evaluate. If rate has dropped below indicated levels proceed back to Tier 1 | Sources: HICPAC CDC Guidelines on CAUTI Prevention, www.catheterout.org | (Department of Veterans Affairs, VISN 11) |
Additional Approaches

1) Tier 1 & Tier 2

2) CAUTI GPS

3) Applying Mindfulness to CAUTI
Self-Assessment Tool for Hospitals and Units

CAUTI Guide to Patient Safety (“CAUTI GPS”)

• A 1-page (11-item) trouble-shooting guide

• Help identify the key reasons why hospitals may not be successful in preventing CAUTI

• Once the barriers are identified, can then propose and implement solutions
## CAUTI Questionnaire (Version 1.00)

### Question 1:
Do you currently have a well-functioning team (or work group) focusing on CAUTI prevention?
- [ ] Yes
- [ ] No

### Question 2:
Do you have a project manager with dedicated time to coordinate your CAUTI prevention activities?
- [ ] Yes
- [ ] No

### Question 3:
Do you have an effective nurse champion for your CAUTI prevention activities?
- [ ] Yes
- [ ] No

### Question 4:
Do bedside nurses assess, at least daily, whether their catheterized patients still need a urinary catheter?
- [ ] Yes
- [ ] No

### Question 5:
Do bedside nurses take initiative to ensure the indwelling urinary catheter is removed when the catheter is no longer needed (e.g., by contacting the physician or removing the catheter per protocol)?
- [ ] Yes
- [ ] No

### Question 6:
Do you have an effective physician champion for your CAUTI prevention activities?
- [ ] Yes
- [ ] No

### Question 7:
Have physicians fully embraced CAUTI prevention activities?
- [ ] Yes
- [ ] No

### Question 8:
Is senior leadership supportive of CAUTI prevention activities?
- [ ] Yes
- [ ] No

### Question 9:
Do you currently collect CAUTI-related data (e.g., urinary catheter prevalence, urinary catheter appropriateness, and infection rates) in the unit(s) in which you are intervening?
- [ ] Yes
- [ ] No

### Question 10:
Do you routinely feedback CAUTI-related data to frontline staff (e.g., urinary catheter prevalence, urinary catheter appropriateness, and infection rates)?
- [ ] Yes
- [ ] No

### Question 11:
Have you experienced any of the following barriers?
- a. Substantial nursing resistance
  - [ ] Yes
  - [ ] No
- b. Substantial physician resistance
  - [ ] Yes
  - [ ] No
- c. Patient and family requests for an indwelling urinary catheter
  - [ ] Yes
  - [ ] No
- d. Indwelling urinary catheters commonly being inserted in the emergency department without an appropriate indication
  - [ ] Yes
  - [ ] No

[Submit]  [Clear form]
Additional Approaches

1) Tier 1 & Tier 2

2) CAUTI GPS

3) Applying Mindfulness to CAUTI
A Dilemma

• Much of what we do in healthcare – especially in the hospital – is reflexive
  – If a patient is hypoxemic: we give oxygen
  – Low BP: IV fluids
  – Positive blood cultures: antibiotics
  – Frequency, urgency, and dysuria: dx UTI
A Dilemma

• These rote responses are usually helpful

• However, this reflex-like approach can lead to problems
  – Pt sick enough to be admitted from the ED: Foley catheter
  – Asymptomatic catheterized patient has a “dirty” urine: antibiotics
One Possible Solution: “Medical Mindfulness”
One Possible Solution: “Medical Mindfulness”

• Being in the moment and considering decisions carefully before jumping to reflexive action

• Daniel Kahneman:
  – Intuition (System 1): fast, automatic, effortless; difficult to alter
  – Reasoning (System 2): slower, effortful, & flexible

• In medicine, we are constantly toggling back-and-forth between the reflexive and the complex

• How can we apply this to everyday practice?
Applying Mindfulness to Bedside Nursing: Catheter-Associated Urinary Tract Infection
(Kiyoshi-Teo et al. Infect Cont Hosp Epid 2013)

• Taking a 5-second “pause” before…
  – Inserting an indwelling catheter
  – Emptying the drainage bag or transporting the patient

• Asking…
  – Is it absolutely necessary to use an indwelling catheter in this patient? Can I use an alternative?
  – Am I using proper technique? Do I need to ask for help? Can the catheter be removed today?
Wrap Up

• CAUTI and indwelling catheter use are important patient safety issues

• Proven approaches to reduce catheter use: prevent CAUTI and other patient safety problems

• Additional approaches if still unhappy with your CAUTI rates: Tiered approach, GPS, mindfulness

• Thank you for your work on behalf of your patients
Thank you!

www.catheterout.org
Hospital Questions and Discussion

Questions
Nearly 2 million Americans develop a healthcare-associated infection each year, and some 100,000 of them die as a result. Such infections are generally preventable by means of evidence-based, quality-improvement interventions, but too many hospital staff members resist these efforts. The technical know-how exists to prevent infection, but the human, adaptive problem often remains untreated and unresolved. This book is designed to meet that challenge.

In easy-to-read, user-friendly language, Preventing Hospital Infections leads readers through a step-by-step description of a quality improvement intervention as it might unfold in a model hospital, pinpointing the likely obstacles and offering practical strategies for how to overcome them. The text draws on the extensive personal clinical experience of the authors, including examples, anecdotes, and down-to-earth, practical guidance.

"A major contribution toward removing the number one impediment to stopping hospital infections: Putting proven prevention methods into practice."

Donald M. Berwick, MD, President Emeritus and Senior Fellow, Institute for Healthcare Improvement

"This book provides an important new approach to preventing hospital infections, one that can be applied to other hospital safety initiatives as well. The book itself is insightful, practical, and, of all things, a good read."

Professor Didier Pittet, MD, MS, CB, Director, Infection Control Programme & WHO Collaborating Centre on Patient Safety, University of Geneva Hospitals and Faculty of Medicine, Geneva, Switzerland

"This timely and important book offers an innovative, down-to-earth, and accessible approach to one of the biggest threats to the hospitalized patient—the problem of hospital infection."

Abraham Verghese, MD, MACP, FRCPE(Edin), Linda R. Meier and Joan F. Lane Provostial Professor, Vice Chair for the Theory and Practice of Medicine, Department of Medicine, Stanford University