

Addressing the Risk of CAUTIs with Innovative Thinking & Strategies



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Disclosures

- Consultant-Michigan Hospital Association Keystone Center
- Subject matter expert on CAUTI, CLABSI, HAPI, Safety culture for AHA
- Consultant and speaker bureau
 - △ Stryker's Sage business
 - △ LaJolla Pharmaceutical
 - △ Baxter healthcare
 - △ Potrero Medical

Objectives

- Describe the forces within the current healthcare environment that are targeting zero for device related infections.
- Identify and detail the evidence-based practices that go beyond the guidelines in preventing CAUTI's.
- Discuss possible barriers to practice changes and realistic solutions to assist the team in the implementation process.

Notes on Hospitals: 1859

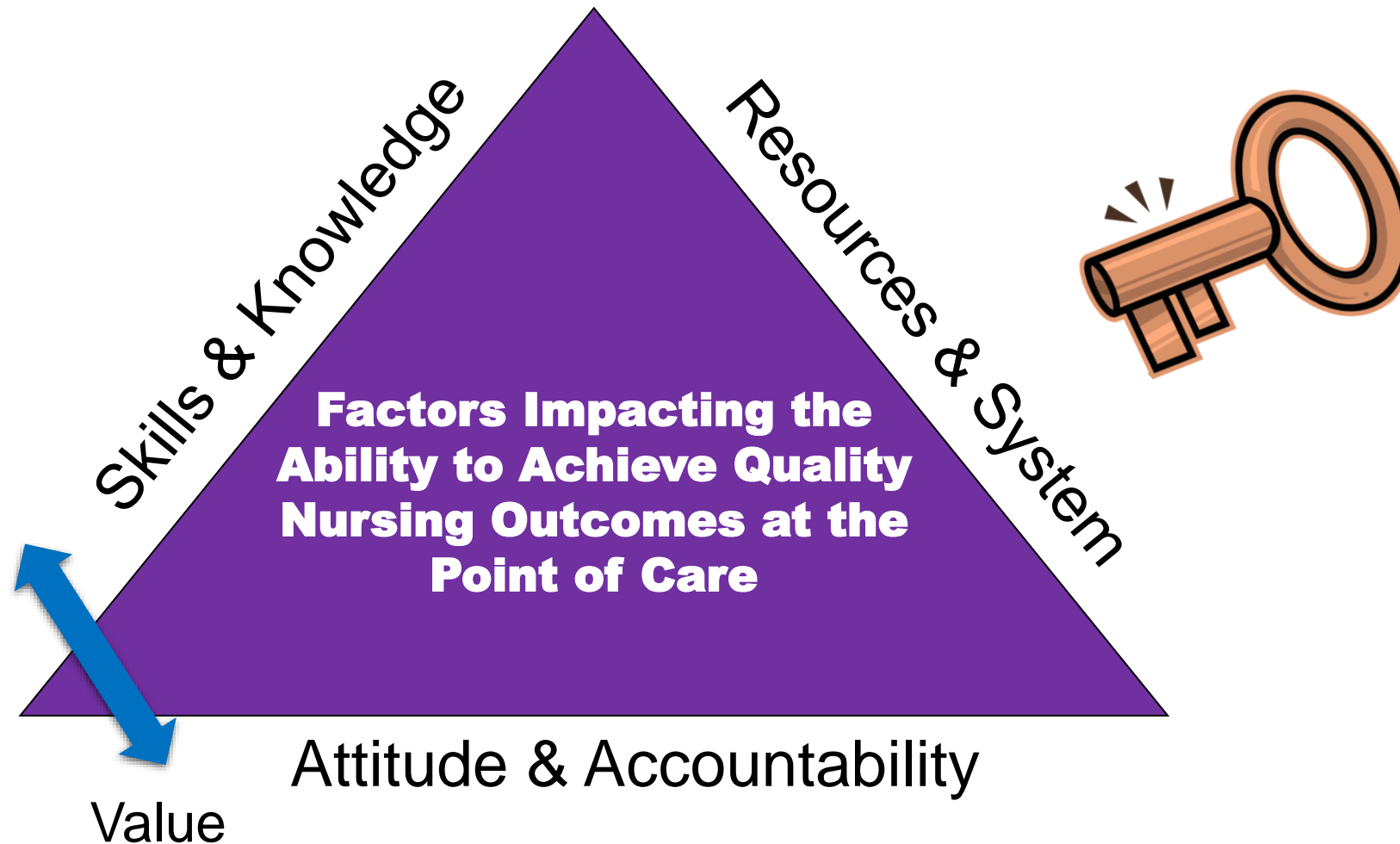
“It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.”

- Florence Nightingale

Advocacy = Safety



Achieving the Use of the Evidence



The Why: CAUTI Incidence



- ▲ One of the most common healthcare acquired infections (HAIs)- nearly up to 40% of all HAIs^{1,2}
- ▲ 70% urinary catheter associated HAIs; up to 95% in the intensive care setting²
- ▲ Approximately 20% of hospital patients have urinary catheter at some point in their stay³

1. Magill et al NEJM 2014; APIC Guide to Prevention of CAUTI, 2014;
2. Chenoweth, C. et al. *Infectious Disease Clinics of North America*, 2014 28(1), pp.105-119.
3. Saint, S et al. *Clinical Infectious Diseases*, 2008 46(2), pp.243-250



Associated CAUTI Costs

△ Catheter associated urinary tract infections (CAUTIs) are associated with increased morbidity, mortality, and costs

- △ Leads to ↑ increased morbidity, ↑ LOS 2-4 days
- △ CAUTIs are associated with an ↑ cost of \$400 million to \$500 million annually
- △ Estimated additional inpatient CAUTI costs:
 - \$4694-29,743 (Review of 6 studies)

△ Specific patient impact---

- △ Discomfort r/t to mild signs of infection
- △ Potential urethral trauma
- △ Embarrassment
- △ Pyelonephritis
- △ Urosepsis leading to potential death





Addressing CAUTIs Through Evidence Based Care Practices

CUSP & CAUTI Interventions

Adaptive /Cultural

CUSP

- Educate on the Science of Safety
- Identify Defects (Staff Safety Assessment)
- Senior Executive Partnership
- Learn from Defects
- Implement Teamwork & Communication Tools

Technical

CAUTI

Insertion

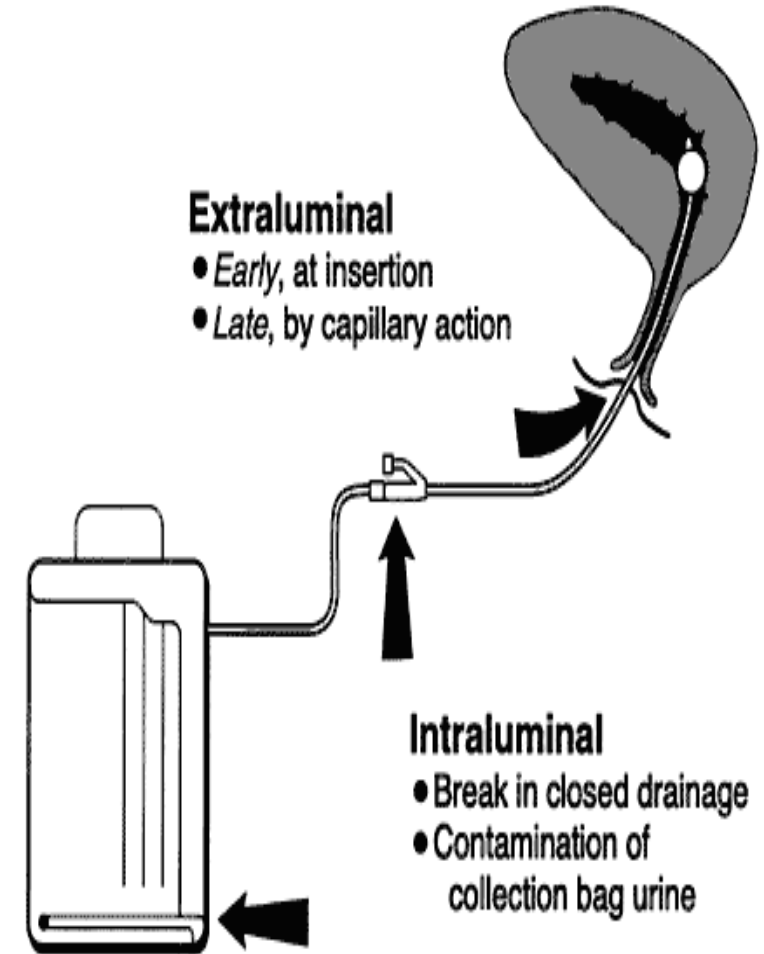
- Limiting use
- Using aseptic technique for site prep, equipment & supplies

Maintenance

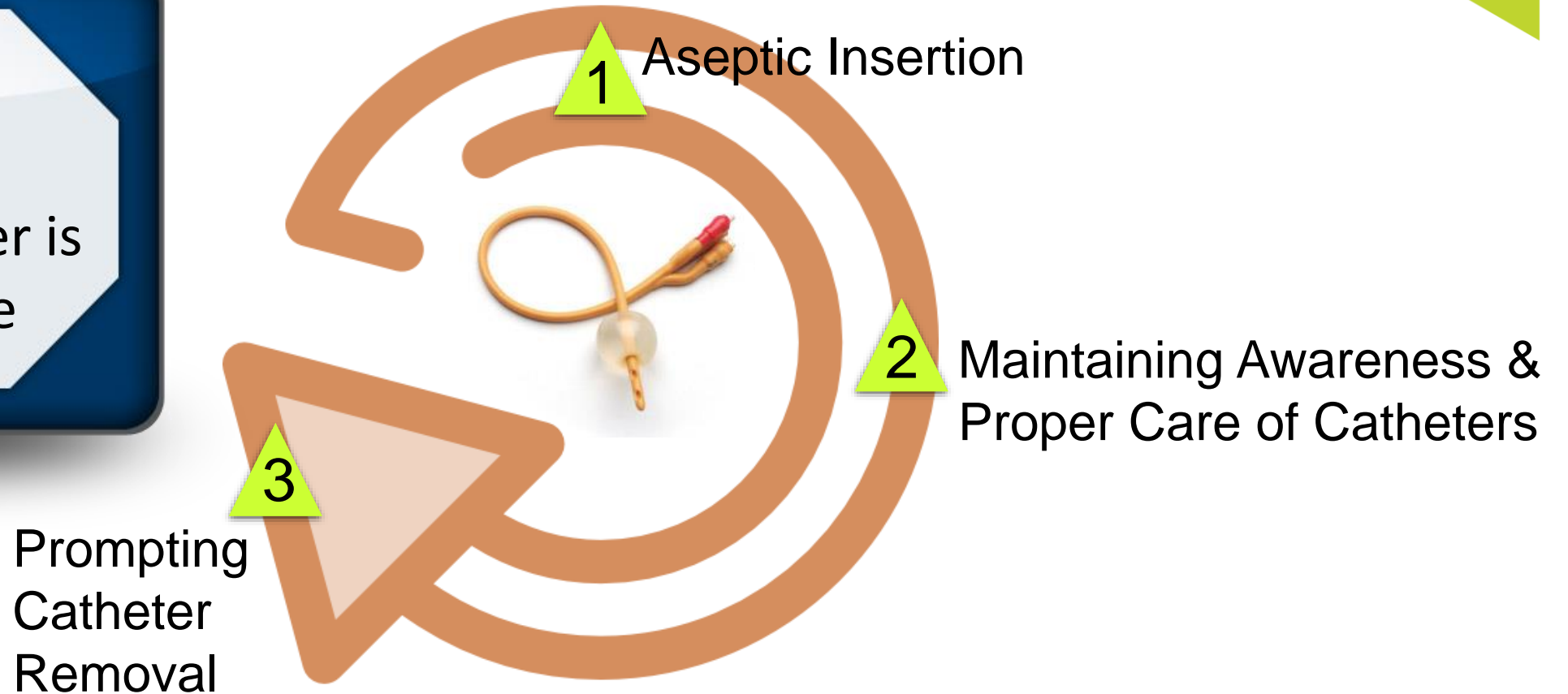
- Securing the catheter for unobstructed flow
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples

Pathogenesis of CAUTI

- ▲ Source: colonic or perineal flora on hands of personnel
- ▲ Microbes enter the bladder via extraluminal {around the external surface} (proportion = 2/3) or intraluminal {inside the catheter} (1/3)
- ▲ Daily risk of bacteriuria with catheterization is 3% to 10%; by day 30 = 100%



Disrupting the Lifecycle of the Urinary Catheter



Before Placing an Indwelling Catheter

Please Consider if These Alternatives Would be Appropriate:

- ▲ **Bedside commode, urinal, or continence garments:** to manage incontinence.
- ▲ **Bladder scanner:** to assess and confirm urinary retention, prior to placing catheter to release urine.
- ▲ **Straight catheter:** for one-time, intermittent, or chronic voiding needs.
- ▲ **External catheter:** appropriate for cooperative patients without urinary retention or obstruction.



Nurse Driven Removal Protocol: ER/ICU/OR & Floor



- ▶ Assessment of criteria for insertion
- ▶ Use of the bedside bladder ultrasound to assess urinary retention (reduce rates by 30-50%)¹
 - △ If minimal or no urine found in the bladder alternative strategies should be considered prior to catheterization
- ▶ Examine alternatives to indwelling catheters
 - △ Intermittent catheterization several times per day (post –op)
 - △ External catheters for male patients or female patients without urinary retention or bladder outlet obstruction²
- ▶ Prevalence evaluation to determine number of catheters versus the number of catheters that met criteria¹

Intermittent Catheterization Program



If retention is suspected pre or post catheter:

- ▶ If no voiding within 4-6 hours of assessment pre insertion or post removal, a bladder scan ultrasound used
- ▶ Volume < 500mL, encourage the patient to void by using techniques to stimulate bladder reflex (cold water to abdomen, stroke inner thigh, run water, flush toilet)
- ▶ Continue to assess the patient and repeat the bladder scan in 2 hours if no voiding
- ▶ If the bladder volume > 500mL, and intake is less than 3 L a day-catheterize for residual urine volume rather than place an indwelling catheter
- ▶ If volumes are greater/catheter goes back in 24hrs



iPCaRe: Evidence-Based Algorithms

Continence Care

J Wound Ostomy Continence Nurs. 2020;47(6):601-618.
Published by Lippincott Williams & Wilkins



Interventions Post Catheter Removal (iPCaRe) in the Acute Care Setting

An Evidence- and Consensus-Based Algorithm

Mikel Gray ♦ Terrie Beeson ♦ Dea Kent ♦ Dianne Mackey ♦ Laurie McNichol ♦ Donna L. Thompson ♦ Sandra Engberg



Image retrieved from <https://www.wocn.org/blog/the-latest-decision-support-tool-from-wocn/>.

Before Placing an Indwelling Catheter

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▲ **Straight catheter:** for one-time, intermittent, or chronic voiding needs.

▲ **External catheter:** appropriate for cooperative men without urinary retention or obstruction.



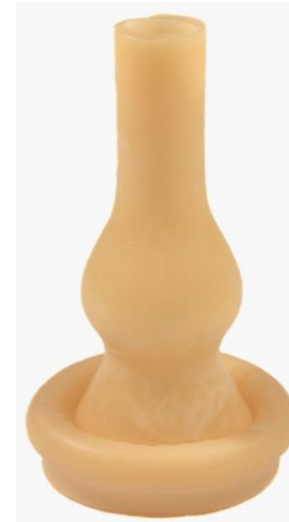
Challenges with Current Appropriate Alternatives: External Catheters for the Male Anatomy

1 out of every 200 men
is born with what's
medically known as
'micro-penis'

Buried & Micro Penis



Condom Catheter



Common Problems

Most common problems are:

- Skin irritation and maceration
- Difficult to keep the condom from falling off/retraction of the penis or decrease size
- Ischemia and penile obstruction/tightness
- Adherence: required to secure on the shaft & adhesive mechanisms are challenging

New Male Devices: Overcoming the Challenges

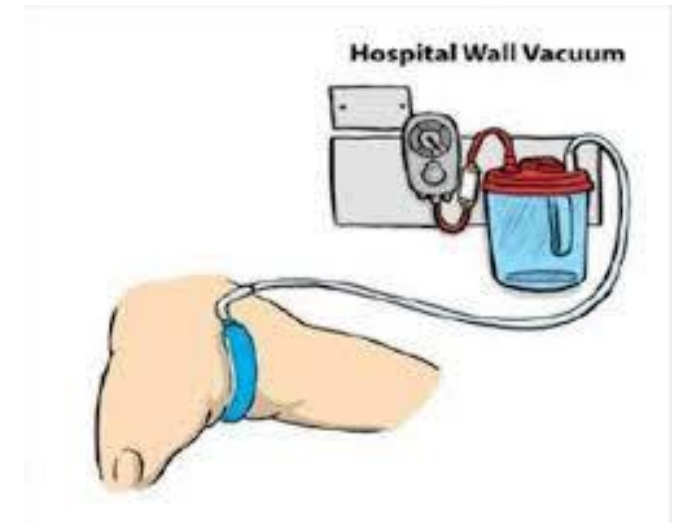
- Adjusts to different sized penises
 - △ No sizing chart required
- Prevents backflow with continuous suction
- Diverts urine away from the skin - addressing the risk factors of IAD



Alternative External Collection Devices for the Female Anatomy

How do they work?

- △ They are placed between the labia and the urethral opening
- △ The devices are attached to wall suction



Quality Improvement Project

- ▲ 18 bed adult SICU
- ▲ 10 month pre/post QI study
- ▲ Utilization of an external collection device for the female anatomy
- ▲ Daily rounds discussion
 - △ Inter-professional discussion regarding indications
 - Avoid placement
 - Early removal
- ▲ Measurement: CAUTI & SIR rates

Outcomes

Pre/Post Comparison Using Female External Device		
	Before	After
CAUTI Rate	2.55	0.7
Standardized Infection Ratio (SIR)	1.395	0.381

Indwelling Catheter Days ↓ 9%


CDC, SHEA, IDSA and NHS: Indications for Placement of Indwelling Catheter



- ▶ Perioperative use for selected surgical procedures
- ▶ **Urine output in critically ill patients**
- ▶ Management of acute urinary retention and urinary obstruction
- ▶ Assistance in pressure ulcer healing for incontinent patients
- ▶ At a patient request to improve comfort(SHEA) or for comfort during end of life care (CDC)



Examples of Indications for Urinary Catheters



	2009 HICPAC Guidelines ¹	American Nurses Association's Streamlined Evidence-Based RN Tool: CAUTI Prevention ²	Ann Arbor Criteria for Appropriate Urinary Catheter Use in Hospitalized Medical Patients ³
Example Indications	<ul style="list-style-type: none"> Acute urinary retention/obstruction Perioperative use for selected surgeries To assist with healing of open wounds in incontinent patients End-of-life care Accurate measurement of urinary output in critically ill patients 	<ul style="list-style-type: none"> Acute urinary retention/obstruction Perioperative use for selected surgeries To assist with healing of open wounds in incontinent patients End-of-life care Critically ill and need for accurate measurements of I&O (e.g., hourly monitoring) 	<ul style="list-style-type: none"> Indwelling catheters are appropriate for measuring and collecting urine only when fluid status or urine CANNOT be assessed by other means. Location in an ICU alone is NOT an appropriate indication. Criteria for 3 catheter types: indwelling, external and intermittent use catheters
Comments	<ul style="list-style-type: none"> Appropriate use in critically ill patients has varied interpretations 	<ul style="list-style-type: none"> Helpful algorithm to make decisions Based on 2009 Guidelines Use in critically ill patients still ambiguous 	<ul style="list-style-type: none"> Provides clarification to the 2009 guidelines on use for specific clinical scenarios Includes ICU Daily Checklist for indwelling catheter use

1. Gould CV, et al. *Infect Control Hosp Epidemiol.* 2010;31(4):319-326.

2. ANA: <https://www.nursingworld.org/practice-policy/work-environment/health/safety/infection-prevention/ana-cauti-prevention-tool/>

3. Meddings J, et al. *Ann Intern Med.* 2015 May 5;162(9 Suppl):S1-34.



Types Of Treatments Requiring Close UO Monitoring▶

- ▶ Bolus fluid resuscitation
- ▶ Vasopressors
- ▶ Inotropes
- ▶ High dose diuretics
- ▶ Hourly urine studies to measure life threatening laboratory abnormalities

Are you responding hourly to the patient's urine output??

Strategies for Early Removal



Example Strategy	
Physicians ^{1, 2}	<ul style="list-style-type: none">• Daily physician assessment of catheter need• Computerized order entry system to prompt physicians to remove/reorder catheter if placed in ED or in place >24 hours• Orders in place for removal in the OR and/or length of time for catheter to remain in place.
Nurses ^{1,2}	<ul style="list-style-type: none">• Nurse Driven protocol to remove all urinary catheters that do not meet criteria• Daily review by nurses for catheter indication to make recommendations for removal• Nurse-generated daily bedside reminders to encourage physicians to remove unnecessary urinary catheters• Nurse-to-nurse communication during transitions (ED, ICU): “Does this patient have a urinary catheter? Why?” If not indicated, ask for catheter to be removed before transfer.

1. Mitchell B, et al. *Infection Control & Hospital Epidemiology*, 2019 40(4), 427-431.

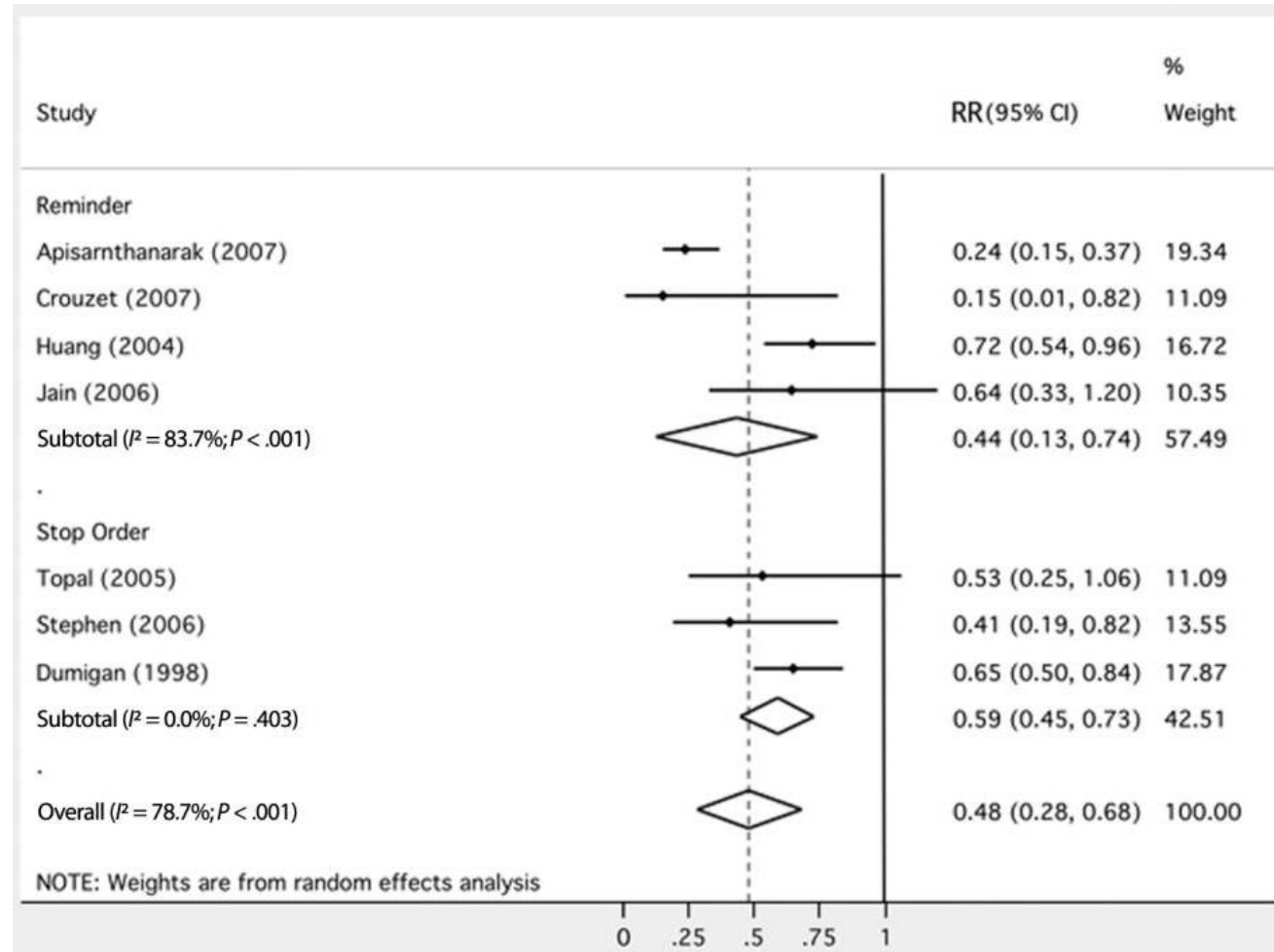
2. Tyson AF, et al *J Intensive Care Med*. 2018 Jan 1



Reminder Systems Reduce Inpatient Catheter Use and Associated CAUTIs

Reminder
56% reduction

Stop Order
41% reduction



Factors That Affect Success of Reminders, Stop Orders and Nurse Driven Protocols



- ▲ Communication patterns and unit culture relative to urinary catheter use¹
- ▲ Nurse comfort with urinary catheter removal protocols ^{1,2}
- ▲ Right urine collection alternatives ^{1,2}
- ▲ Staff knowledge and skills ^{1,2}
- ▲ Respect among nurses and physicians ^{1,2}
- ▲ Ownership by frontline staff, local leadership and quality to review, remind, and reinforce using RCA's or learn from a defect ^{1,2}
- ▲ Information technology support for data collection¹
- ▲ Feedback using data on catheter use¹
- ▲ ICU team's recognition of the hazard of urinary catheters^{1,2}





“Even if you are on the right track, you will get run over if you just sit there.”

Will Rogers



The Culture of Culturing



Asymptomatic bacteriuria” (ASB) is the condition of having a specified count of bacteria in an appropriately collected urine sample obtained from a person without clinical signs and symptoms of urinary tract infection.



1. Overuse of antibiotics that can potentially cause complications in the individual patient, including *C. difficile*
2. ↑increase in resistant pathogens impact the individual, organization & community patterns of resistance. ¹
3. Falsely inflates an organization’s CAUTI rate as bacteremia is unnecessarily treated²
4. 23% to 50% antibiotic days for UTI are from ASB ²

Survey of Doctors and Nurses for Indications to Urine Culture



Order Indication	Physicians	Nurses
Appearance	23%	61%
Odor	42%	74%
Dysuria	54%	35%
Pan culture	38%	45%
UA > 100 WBCs/hpf	58%	43%

Recommendations on Urine Culture Management



🔗 Establish a **preculture strategy** that directs efforts at how cultures are ordered rather than solely addressing issues after a UA or UC test is finalized:

- △ Modify the electronic medical record to include appropriate and inappropriate indications for UAs/UCs that address patient symptomology
- △ Eliminate automatic orders in care plans where appropriate
- △ Provide education for all clinicians who order UCs with emphasis on appropriate indications for UCs and UTI symptoms in catheterized and non-catheterized patients
- △ Carefully evaluate patients with fever and order UCs as appropriate
- △ Reflex urine testing should be considered only if used in conjunction with careful clinical evaluation for signs and symptoms of UT



Modify Your EMR Ordering Process

▲ Incorporated mandatory selection of standardized indications in EMR for ordering a UC in catheterized patients:

- △ Suprapubic pain/tenderness
- △ Acute gross hematuria
- △ Costovertebral angle tenderness
- △ New fever/rigors with clinical assessment negative for more likely etiology
- △ Acute alteration of mental status with clinical assessment negative for more likely etiology
- △ Alteration in medical condition with clinical assessment negative for more likely etiology in patient whom fever may not be a reliable sign
- △ Increased spasticity or autonomic dysreflexia in patients with altered neurologic sensation

Lowers urine cultures and CAUTI rates

Example:

St. Joseph Mercy Hospital Urine Culturing Tool

*SHOULD THIS PATIENT BE EVALUATED FOR A URINARY TRACT INFECTION?

Does the patient have any of the following without alternate explanation?

1. Urgency, frequency, dysuria
2. Suprapubic pain/tenderness
3. Flank pain or tenderness
4. New onset delirium
5. Fever >38 C/Rigors
6. Acute hematuria
7. Increased spasticity or autonomic dysreflexia in a spinal cord injury patient
8. ≥ 2 SIRS criteria (T > 38 C or < 35 C, HR > 90, RR > 20 or PaCO₂ < 32 mmHg, WBC > 12 K/mm³ or < 4 K/mm³ or > 10% bands) OR shock with concerns for sepsis

YES

NO

Send U/A & urine culture

Document indication for sending urine culture

Start empiric therapy
(see reverse side)

Do NOT send urine culture

*Symptom based screening is not reliable in the following cases: pregnancy, prior to urologic procedures, patients with complex urinary anatomy (i.e., nephrostomy tubes, urinary tract stents, h/o urinary diversion surgery in the past, or renal transplant), patients admitted to the ICU, or neutropenia. Use your clinical judgment for this population.

Version date: 9/19/2012

EMPIRIC THERAPY BASED ON CLASSIFICATION OF URINARY TRACT INFECTION (UTI)

Empiric choices should take into account recent previous cultures

If urine culture is negative & patient was on antibiotics at the time of the culture & patient has symptoms (1-8 on the reverse side) it may be appropriate to treat

PATIENT CATEGORY	PREFERRED	2 ND LINE	DURATION
ASYMPTOMATIC BACTERIURIA Defined as having NONE of symptoms 1-8 on the reverse side	Do not treat except in pregnancy, prior to urologic procedures, or neutropenia Candiduria: Change catheter. Do not treat except prior to urologic procedures or in neutropenia		
UNCOMPLICATED LOWER TRACT UTI	TMP/SMX or Nitrofurantoin	Ciprofloxacin or Cephalexin	TMP/SMX x 3 days Nitrofurantoin x 5 days (contraindicated if CrCl < 60 mL/min) Ciprofloxacin x 3 days Cephalexin x 7 days
COMPLICATED LOWER TRACT UTI Male, urinary catheter present or removal within the last 48 hrs., GU instrumentation, anatomic abnormality or obstruction, significant co-morbidities	Ceftriaxone or TMP/SMX or Cefepime (if risk for resistant gram negatives) or Piperacillin-tazobactam (if risk for resistant gram negatives and enterococcus)	Ciprofloxacin	7 days if prompt resolution 5 days if quinolone used 14 days if delayed response to therapy or bacteremia
SEPSIS WITH UTI, PYELONEPHRITIS, PERINEPHRIC ABSCESS	Ceftriaxone or Cefepime (if critically ill, septic or recently hospitalized) or Piperacillin-tazobactam (if critically ill, septic or recently hospitalized and concern for enterococcus)	Severe PCN allergy Vancomycin PLUS Aztreonam	Sepsis: 10-14 days Sepsis with gram negative bacteremia: IV antibiotics or step down to oral quinolone if susceptible Sepsis without bacteremia: Change to oral therapy when stable Uncomplicated pyelonephritis (i.e., healthy young female): Ciprofloxacin x 7 days TMP/SMX x 14 days Beta-lactams x 10-14 days Perinephric abscess: prolonged duration - consult ID and urology

Follow culture results and de-escalate therapy based on final results and sensitivities.

FOR EACH ANTIBIOTIC: DOCUMENT INDICATION AND PLANNED DURATION FOR ALL PATIENTS

Collection & Transport to Reduce Contamination



- ▲ If a catheter placed > 2 weeks, change the catheter before collecting a specimen¹
- ▲ Clamp tubing 12 inch below sample port allowing urine to fill the tube. Scrub the hub with antiseptic aspiration from the sampling port. Follow by unclamping of the tube.²
- ▲ If specimen can't be transported and plated on culture medium within 2 hrs. of collection, then specimen should be refrigerated. ³
- ▲ To overcome logistic barriers: most use urine collection tubes with preservatives.³

1. www.apic.org/implementationguides April 2014,
2. Lo E, et al. Infect Contr & Hosp Epidemiol. 2014;35(5):464-479,
3. Garcia, R & Spitzer ED. American J of Infect. Control. 2017;45(10):1143-1153

Collection & Transport to Reduce Contamination



- ▲ If a catheter placed > 2 weeks, change the catheter before collecting a specimen¹

Contaminated urine cultures lead to additional diagnostic evaluation and inappropriate antibiotic administration > 40%

Klausing BT, et al. American Journal of Infection Control. 2016;44:1166-1167

medium within 2 hrs. of collection, then specimen should be refrigerated.³

- ▲ To overcome logistic barriers: most use urine collection tubes with preservatives.³

1. www.apic.org/implementationguides April 2014,
2. Lo E, et al. Infect Contr & Hosp Epidemiol. 2014;35(5):464-479,
3. Garcia, R & Spitzer ED. American J of Infect. Control. 2017;45(10):1143-1153

On Transfer

What devices can be removed before the patient is transferred to a different level of care?



Core Recommendations

- ▶ Insert catheters only for appropriate indications (1B)
- ▶ Leave catheters in only as long as needed (1B)
- ▶ Ensure that only properly trained persons insert and maintain catheters (1B)
- ▶ Insert catheters using aseptic technique and sterile equipment (1C)
- ▶ Consider use of alternatives (II)
- ▶ Maintain a close drainage system (1B)
- ▶ Secure the system (1B)
- ▶ Maintain unobstructed urine flow (1B)
- ▶ Key the collecting bag below the level of the bladder at all times (1B)
- ▶ Unresolved:
 - Antiseptic or sterile saline for meatal cleaning before insertion

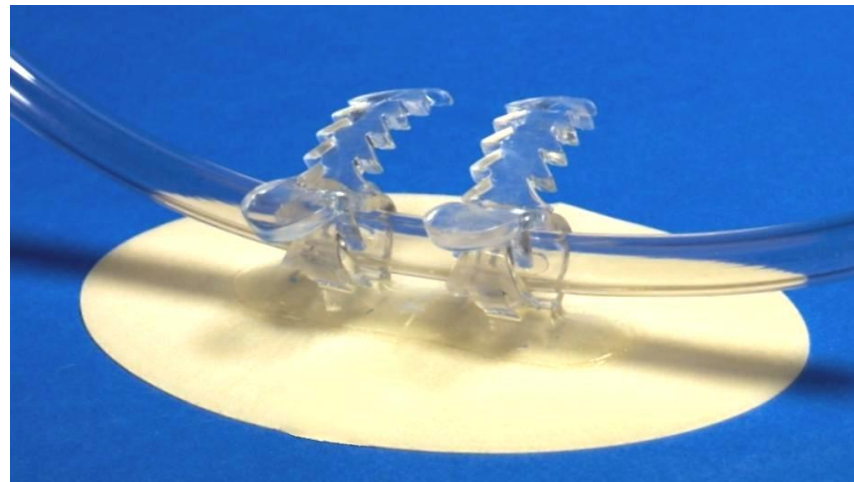
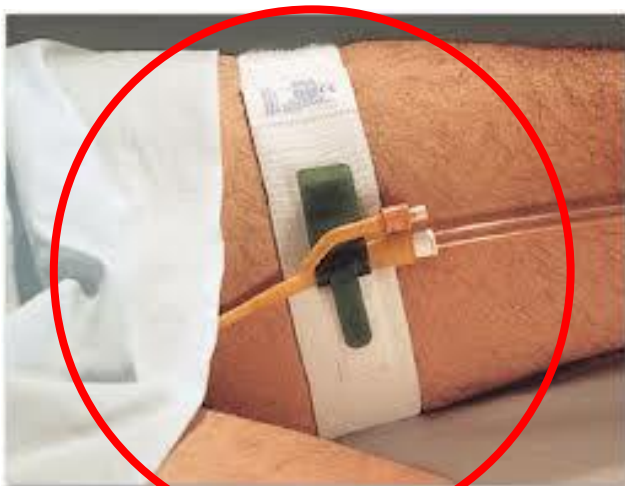
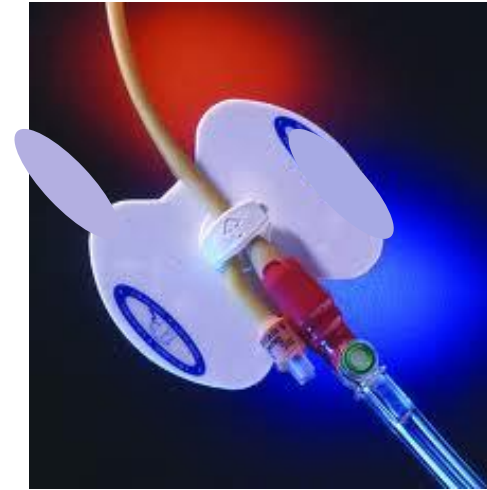
Simplified Insertion Checklist for Urinary Catheter

Components of Checklist	Compliant	
	Yes	Yes, after correction
Hand hygiene before and after procedure		
Sterile gloves, drapes, sponges, aseptic sterile solution for cleaning, and single use packet lubricant used		
Aseptic insertion technique (no contamination during placement)		
Proper securement of urinary catheter post-procedure		
Closed drainage system and bag below patient post-procedure		

Core Recommendations


- ▶ Insert catheters only for appropriate indications (1B)
- ▶ Leave catheters in only as long as needed (1B)
- ▶ Ensure that only properly trained persons insert and maintain catheters (1B)
- ▶ Insert catheters using aseptic technique and sterile equipment (1C)
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- ▶ Maintain a close drainage system (1B)
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- ▶ Maintain unobstructed urine flow (1B)
- ▶ Key the collecting bag below the level of the bladder at all times (1B)
- ▶ Unresolved:
 - Antiseptic or sterile saline for meatal cleaning before insertion

Securement Devices



Core Recommendations

- ▶ Insert catheters only for appropriate indications (1B)
- ▶ Leave catheters in only as long as needed (1B)
- ▶ Ensure that only properly trained persons insert and maintain catheters (1B)
- ▶ Insert catheters using aseptic technique and sterile equipment (1C)
- ▶ Consider use of alternatives (II)
- ▶ Maintain a close drainage system (1B)
- ▶ Secure the system (1B)
- ▶ Maintain unobstructed urine flow (1B)
- ▶ Key the collecting bag below the level of the bladder at all times (1B)
- ▶ Unresolved:
 - Antiseptic or sterile saline for meatal cleaning before insertion

A black and white photograph of two young children, likely toddlers, standing outdoors in a yard. Both children are crying with their mouths wide open. A speech bubble originates from the child on the left, containing the text "Why are there so many bugs in here?". The background shows a brick wall and some foliage.

Why are
there so
many bugs in
here?

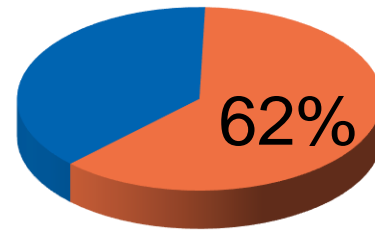
How We Bathe May Impact
CAUTI's

Bath Basins

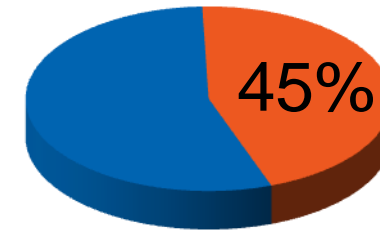
Potential Source of Infection

Large multi-center study evaluates presence of multi-drug resistant organisms

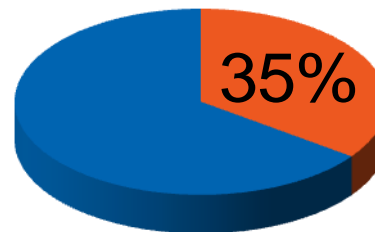
Total hospitals: 88
Total basins: 1,103



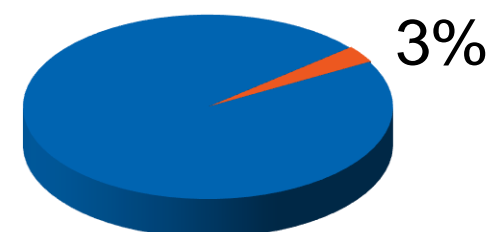
Contaminated
686 basins/88 Hospital



Gram negative bacilli
495 basins/86 hospitals



Colonized w/ VRE
385 basins/80 hospitals



MRSA
36 basins/28 hospitals

Mechanisms of Contamination

▲ Skin flora¹

▲ Multiple-use basins^{2,3,4}

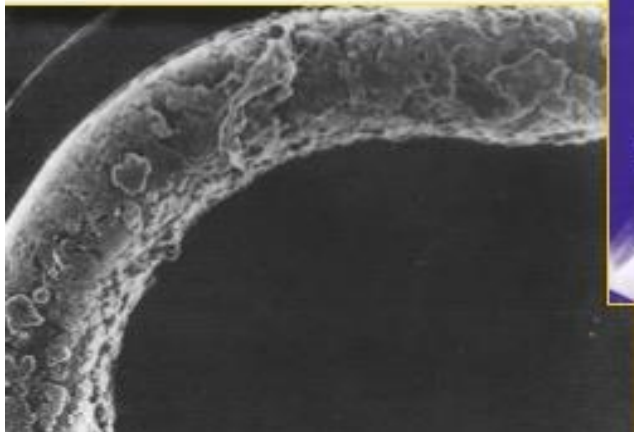
- Incontinence cleansing
- Emesis
- Product storage

▲ Bacterial biofilm from tap water¹⁻⁴



1. Larson EL, et al. *J Clin Microbiol*. 1986;23(3):604-608
2. Johnson D, et al. *Am J Crit Care*, 2009;18(1):31-38, 41
3. Marchaim D, et al. *Am J Infect Control*. 2012;40(6):562-564.
4. Shannon RJ, et al. *J Health Care Safety Compliance Infect Control*. 1999;3:180-1

Biofilms are Ubiquitous



Water Source

Hospital Tap Water

- ▲ Bacterial biofilm
- ▲ Most overlooked source for pathogens²
- ▲ 29 studies demonstrate an association with HAIs and outbreaks²
- ▲ Transmission:¹⁻³
 - △ Drinking
 - △ Bathing
 - △ Rinsing items
 - △ Contaminated environmental surfaces
- ▲ Immunocompromised patients at greatest risk¹



1. Anaissie EJ, et al. *Arch Intern Med*. 2002;162(13):1483-1492.,
2. Cervia JS, et al. *Arch Intern Med*, 2007;167:92-93,
3. Trautmann M, et al. *Am J of Infect Control*, 2005;33(5):S41-S49,

Understanding Water

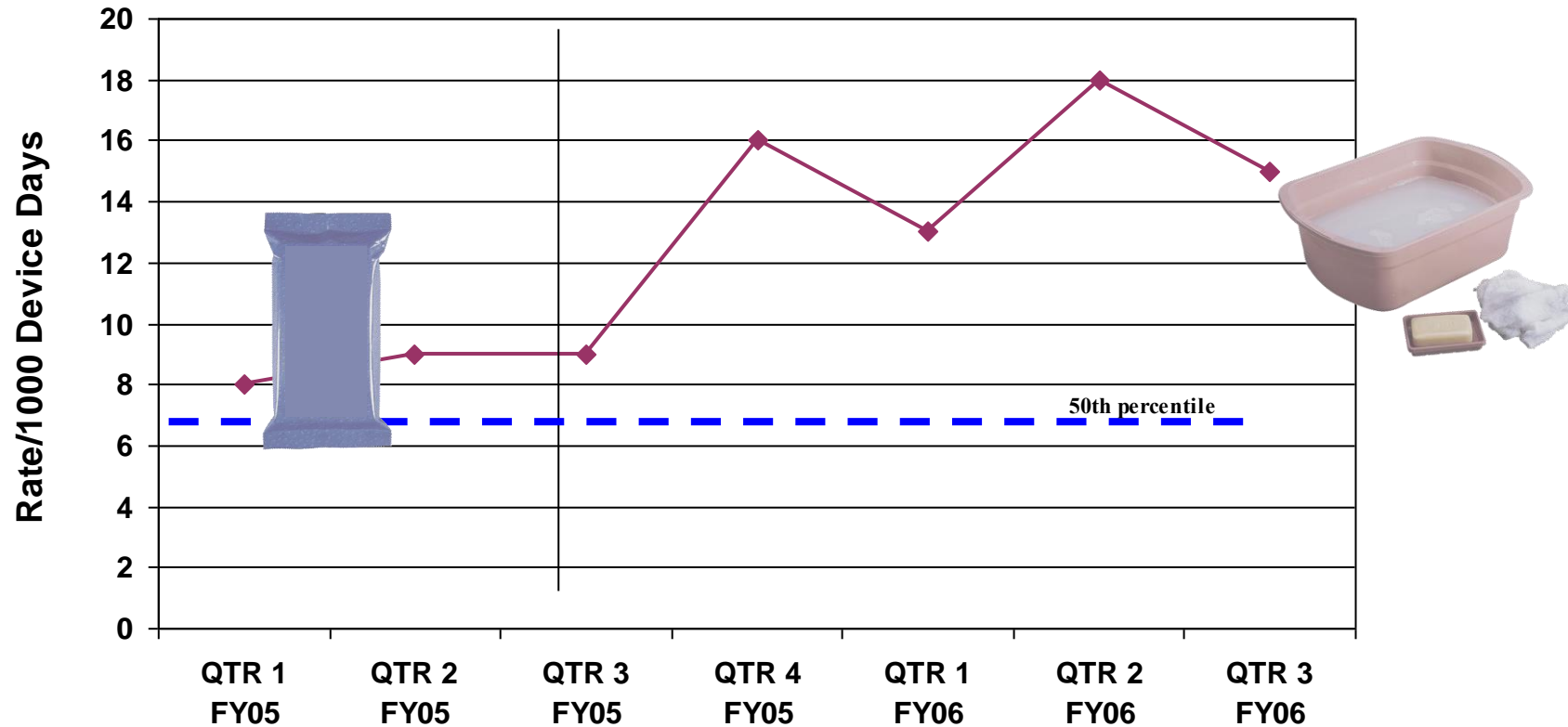
- ▲ All water except for sterile water and filtered water is contaminated with microbes (e.g., potable water, tap water, showers, and ice)¹
- ▲ In healthy persons, contact or ingestion of such water rarely leads to infection¹
- ▲ However, contact or ingestion of such water may cause infection in immunocompromised persons or when applied to non-intact skin¹
- ▲ Transmission of these pathogens from a water reservoir may occur by direct and indirect contact, ingestion and aspiration of contaminated water, or inhalation of aerosols²

1. Presented at MSIPC October 6th, 2016, Lansing MI by Dorine Berriel-Cass

2. *Decker BK, et al. Opin Infect Dis 2013; 26:345–51.

Impact on UTI with Basin Bathing

UTI Rate- Removal of Prepackaged Bath Product QTR 3 FY05



The Effect of Bathing with Basin and Water and UTI Rate, LOS and Costs



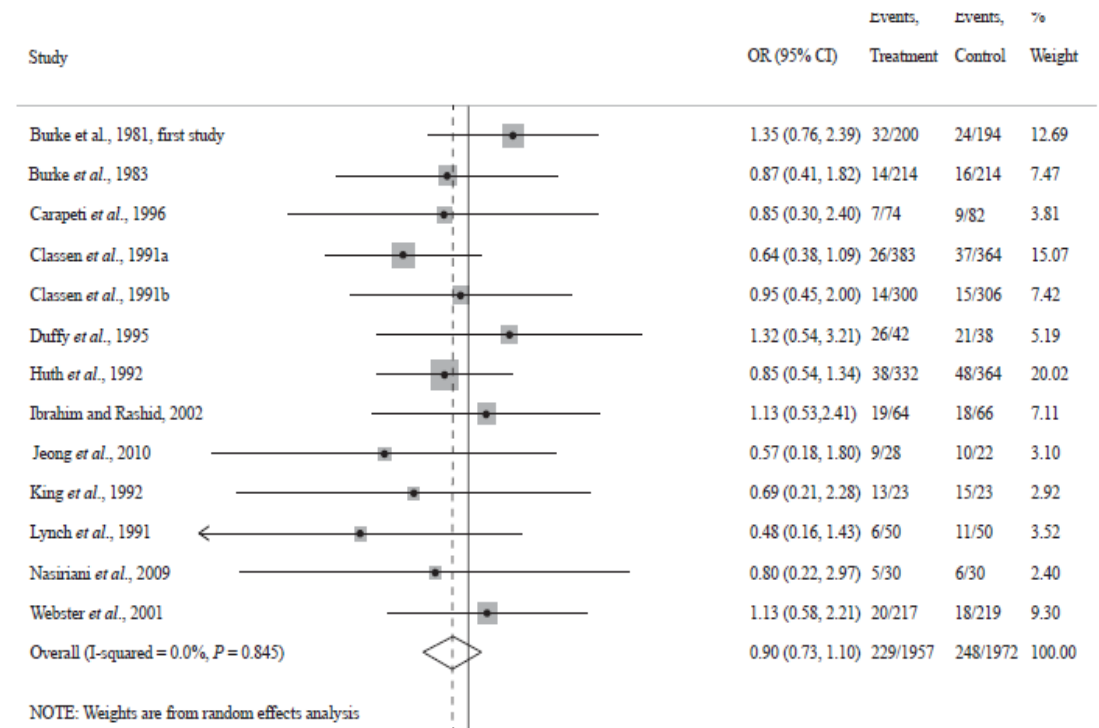
Unit Census: 14				
Phases	Product Cost	No. of UTI	Median⁴ LOS 17 Days	Median⁴ Cost (4857.00)
I- Pre-Packaged Bathing Washcloths (9 months)	\$10,530 ¹ (\$3.00)	25	175	\$117,175
II- Basin/Water (9 months)	\$3,510 ² (\$1.00)	48	336	\$224,916
III- Additional Product Cost, UTI, LOS, COSTS	\$7,020	23 ³	151	\$107,741

¹Based on 3 packages of 8 towels each ²Based on product cost of towels, soap, and basin³
Difference between phase I pre-package/phase II basin water⁴



Cleansing of Patients with Indwelling Catheter

- Antiseptic cleaning of the meatal area before and during catheter use may reduce the risk of CAUTIs.
- Indwelling catheter care should occur with the daily bath (basinless bathing), as a separate procedure using clean technique
- There is no evidence to support 2x a day indwelling catheter care
- If a large liquid stool occurs, bathe the patient with basinless bathing
- Apply barrier cloth to area of skin requiring protection



Comparison of antibacterial agent for routine care vs soap and water trended towards significance

For Successful Banning of Basins for Patient Care

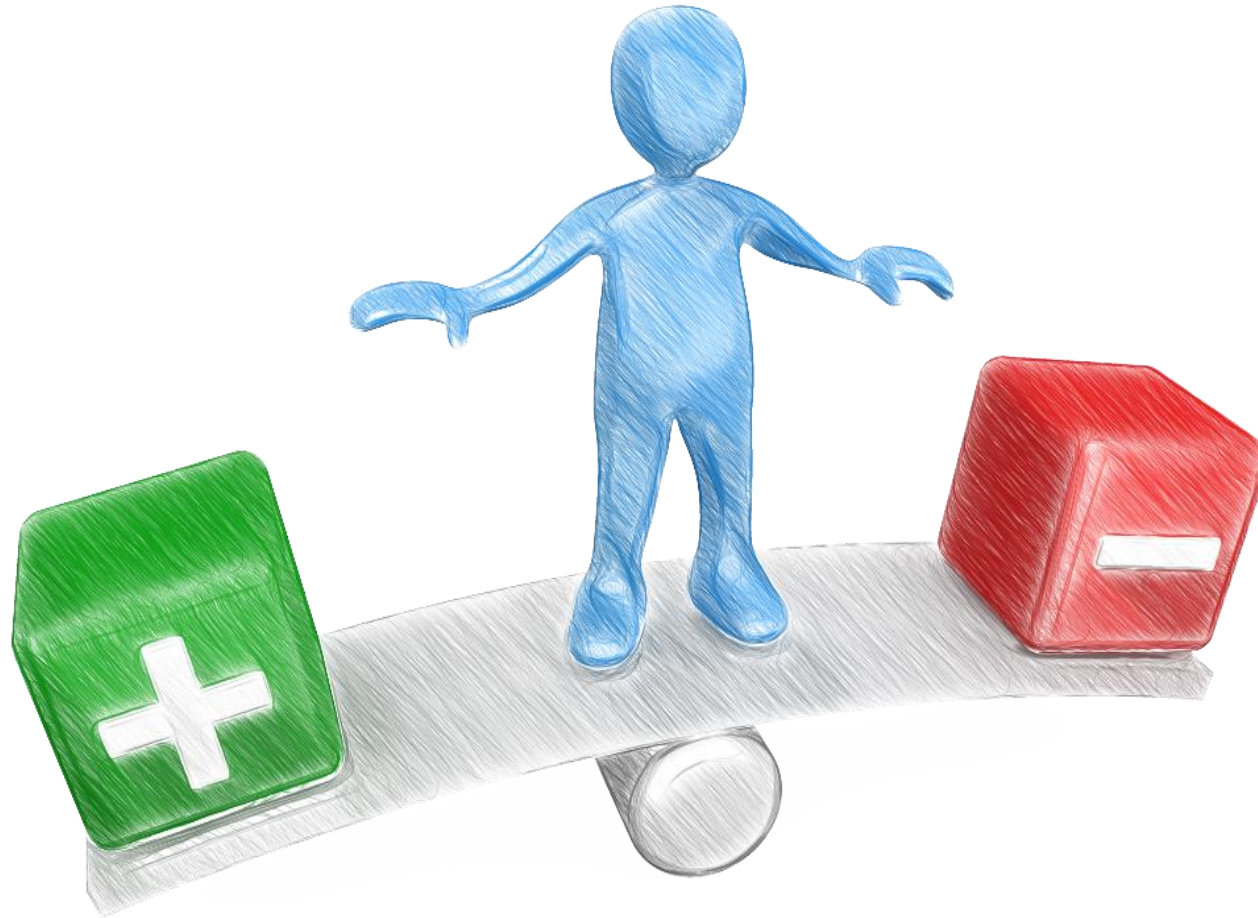
▲ We need to provide alternatives for the other functions:

Current	New
Emesis	Emebags being installed in every adult and ped pt. room, ACU, PACU
Storage of patient items	Clear plastic “baggies” Trial of “Concierge List” to decrease waste of unused/unneeded products
Foot soaks	Shampoo caps, prepackaged
Shampoo patient’s hair	Shampoo caps par’d on all units
24 hour urine, ice	Store some basins in lab to be dispensed with each 24 hour jug.
Bath cloths with no insulation, cold halfway through bath.	Bath cloths with insulation to stay warm longer

Things to Consider



Cost-Benefit Ratio



CAUTI vs. IAD & Pressure Ulcer

Moisture Injury: Incontinence Associated Dermatitis

- ▲ Inflammatory response to the injury of the water-protein-lipid matrix of the skin^{1,2}
 - Caused from prolonged exposure to urinary and fecal incontinence
- ▲ Top down injury²
- ▲ Physical signs on the perineum & buttocks
 - △ Erythema, swelling, oozing, vesiculation, crusting and scaling^{1,2}



IAD: Multisite Epidemiological Study



5,342 patients in 189 acute care facilities in 36 states

Prevalence study

- To measure the prevalence of IAD, describe clinical characteristics of IAD, and analyze the relationship between IAD and prevalence of sacral/coccygeal pressure ulcers

Results: 2492 patients incontinent (46.6%)

- 57% both FI and UI, 27% FI, 15% UI
- 21.3% IAD rate overall/14% also had fungal rash
- 45.7% in incontinent patients
 - 52.3% mild
 - 27.9% moderate
 - 9.2% severe
- 73% was facility-acquired
- ICU a 36% rate
- IAD alone and in combination with immobility statistically associated with FAPI

WOC

- ▶ Incontinence associated dermatitis (IAD)
- ▶ Bathing strategies to maximize the barrier function of the skin³
- ▶ Do no harm: process variation reduction



Infection Preventionist

- ▶ Nurse catheter removal program⁴
- ▶ Basin less bathing to address the risk factors with basins and tap water^{1,2}
- ▶ Do no harm: process variation reduction



1. Marchaim D, et al. *Am J Infect Control*. 2012;40(6):562-564,
2. Trautmann M, et al. *Am J of Infect Control*, 2005;33(5):S41-S49,
3. McGuckin M, et al. *AJIC*, 2008;36:59-62,
4. Parry MF. et al. *AM J Of Infect Control*. 2013;41:1178-81

Engage the Patient & Family

- ▲ Educate patients and families about the steps that are being taken to minimize the risk of CAUTI.
- ▲ Education: purpose, current indications for use, expected duration of the catheter, why it is important to remove as soon as possible & catheter alternatives
- ▲ Catheter removal goal on whiteboard & include in rounds

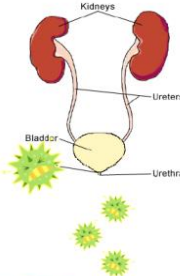


Tools Used with Intervention

🔄 Lecture for nurses

🔄 Pocket cards, posters

REMOVE THAT URINARY CATHETER!



Urinary Catheters Increase:

- Likelihood of Infection
- Patient Discomfort
- Antibiotic Use
- Length of Stay
- Cost

** Patients with urinary catheters tend to stay in bed, making them more immobile, and increasing their risk of skin breakdown*



Urinary Catheters ARE Indicated for:

- ☑ Acute urinary retention or obstruction
- ☑ Perioperative use in selected surgeries
- ☑ Assist healing of perineal and sacral wounds in incontinent patients
- ☑ Hospice / comfort care/ palliative care
- ☑ Required immobilization for trauma or surgery
- ☑ Chronic indwelling urinary catheter on admission

❌ Foley Catheters are NOT indicated for:

- ☑ Urine output monitoring OUTSIDE intensive care
- ☑ Incontinence (place on toileting routine, change frequently)
- ☑ Prolonged postoperative use
- ☑ Patients transferred from intensive care to general units
- ☑ Morbid obesity
- ☑ Immobility (turn patient q 2 hours, up in chair)
- ☑ Confusion or dementia

Questions?
Contact [Insert Info]



DOES YOUR PATIENT REALLY NEED A URINARY CATHETER?

INDICATIONS FOR URINARY CATHETER USE INCLUDE:

- Acute urinary retention or obstruction
- Perioperative use in selected surgeries
- Assist healing of perineal and sacral wounds in incontinent patients
- Hospice/ comfort care/ palliative care
- Required immobilization for trauma or surgery
- Chronic indwelling urinary catheter on admission

ANY QUESTIONS, PLEASE CALL [INSERT CONTACT INFO]

REMOVE UNNECESSARY URINARY CATHETERS!

URINARY CATHETER PROJECT

Goals:

- To decrease catheter-associated urinary tract infections (CAUTI)
- To improve patient safety
- To teach nurses the indications for urinary catheter use
- To reduce the unnecessary use of urinary catheters in the inpatient setting

Background:

- 600,000 patients develop hospital-acquired UTIs per year.
- 80% of these are urinary catheter-associated.
- Approximately half of the patients with a urinary catheter do not have a valid indication for placement.
- Each day the urinary catheter remains, the risk of the CAUTI increases 5%.

Prevention of CAUTI:
Follow criteria indicated for a urinary catheter:

1. Acute urinary retention or obstruction
2. Perioperative use in selected surgeries
3. Assist healing of perineal and sacral wounds in incontinent patients
4. Hospice / comfort care/ palliative care
5. Required immobilization for trauma or surgery
6. Chronic indwelling urinary catheter on admission

Promptly Remove Unnecessary Urinary Catheters!

Questions? Call [Contact Info]

Hospital Logo Placed Here

REMOVE THAT URINARY CATHETER!

Foley catheters can cause:

- ↑ Infections
- ↑ Length of Stay
- ↑ Cost
- ↑ Patient Discomfort
- ↑ Antibiotic Use

Urinary Catheters confine patients to bed, making them more immobile and thus increasing their risk for skin breakdown.

PREVENTION IS KEY.

OBTAIN ORDERS TO DISCONTINUE UNNECESSARY URINARY CATHETER!

Front

REMOVE THAT URINARY CATHETER!

Foley Catheters are indicated for:

- Acute urinary retention or obstruction
- Perioperative use in selected surgeries
- Assist healing of perineal and sacral wounds in incontinent patients
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- Confusion or dementia
- Patient request

Back

Catheter-Associated Urinary Tract Infections (CAUTI)

Top Ten Checklist



Insert indwelling urinary catheters only for clinically appropriate reasons. Involve clinicians in all units where catheters are commonly inserted, including ED, ICU and surgical procedure units.



Promote use of alternatives to indwelling catheters such as external catheters, bladder scanners, intermittent catheterization, optimal incontinence products, prompted toileting and use of urinals, bedside commodes and daily weights as alternative methods to collect and measure.



Ensure proper aseptic insertion and maintenance technique involving hand hygiene, soap and water perineal care, strict adherence to aseptic catheter insertion steps, catheter securing, no kinks, bag lower than bladder and avoid breaks in closed system. Do not routinely change catheters. Educate all staff and family that care for or transport catheterized patients.



Optimize prompt removal of urinary catheters that are not clinically indicated. Conduct daily review of catheter necessity, with consideration of nurse empowerment to remove by default if no longer clinically indicated.



Culture only when symptomatic. Do not culture because of odor, color, cloudiness or simply prolonged catheter use.



Perform root cause analysis on all CAUTIs to identify root causes and contributing factors. Evaluate and discuss with interprofessional team to identify systems issues and practice gaps related to unnecessary or improper catheter use.



Provide transparent feedback to providers and staff regarding hospital-wide and unit-specific infection and catheter utilization data.



Observe, document competency and provide real-time feedback of catheter insertion and maintenance on a routine basis.



Conduct regular catheter rounds with targeted education to reduce inappropriate use and clarify interpretations of appropriateness criteria.



Encourage and expect staff, patients and families to speak up and consider hand hygiene as an "always event," as well as to inquire about the daily necessity of indwelling urinary catheters.

A person with a backpack is silhouetted against a vast, snow-covered mountain range under a clear blue sky. The person is standing on a rocky outcrop, looking towards a prominent, jagged mountain peak in the distance. The scene is high-altitude and serene.

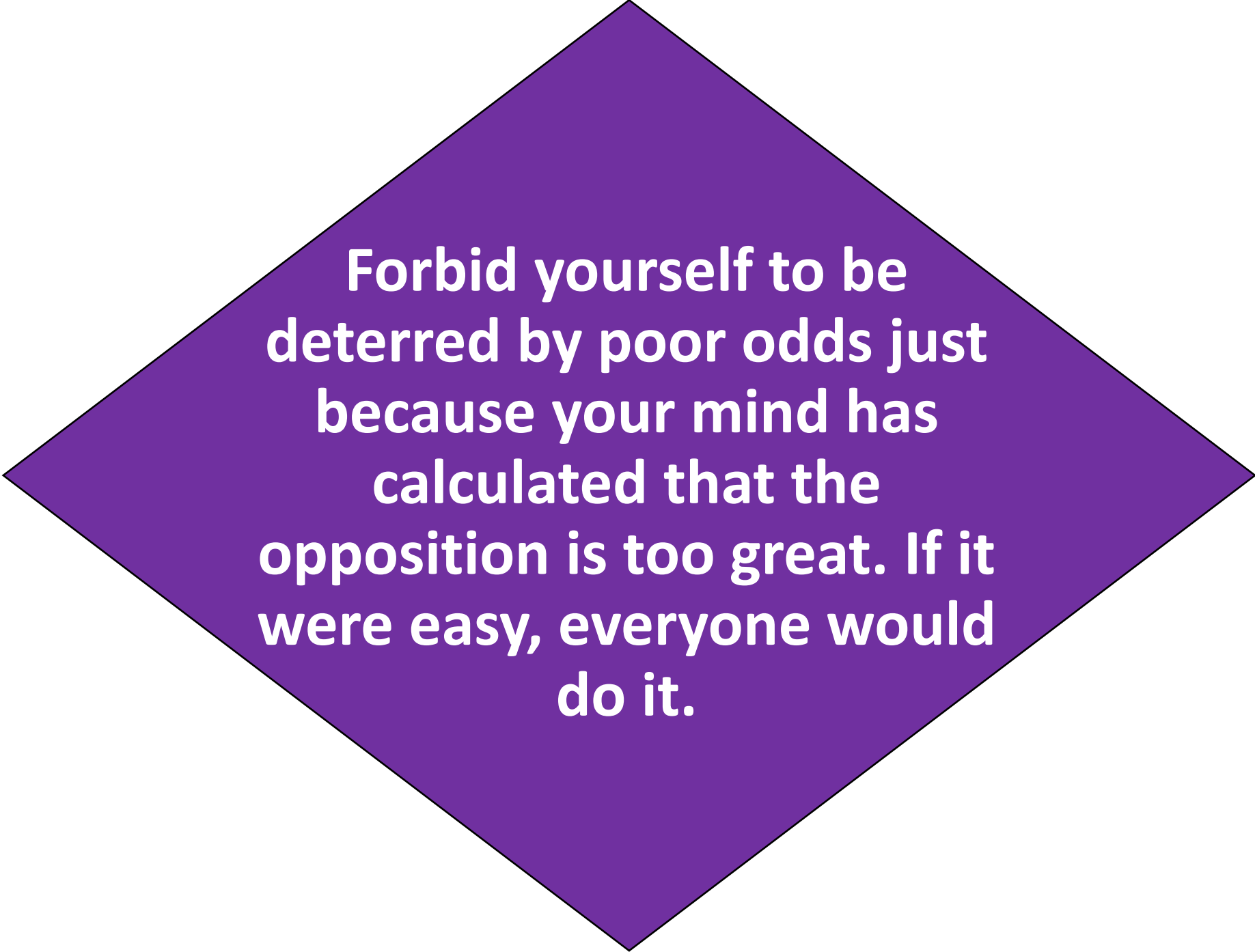
WHEN WOULD NOW BE A GOOD TIME TO DO THIS?

It is not enough to do your best;
you must know what to do, and
THEN do your best.

~ *W. Edwards Deming*

Advocacy Starts with Us





**Forbid yourself to be
deterred by poor odds just
because your mind has
calculated that the
opposition is too great. If it
were easy, everyone would
do it.**

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