The Power of One: Design Your Practice to Maximize Patient Outcomes

Kathleen Vollman
ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION

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Disclosures

- Consultant-Michigan Hospital Association Keystone Center
- Consultant/Faculty for CUSP for MVP—AHRQ funded national study
- Subject matter expert CAUTI, CLABSI, HAPU, Sepsis, Safety culture
- Consultant and speaker bureau
  - Stryker's Sage business
  - LaJolla Pharmaceutical
  - Potrero Medical
- Baxter Advisory Board

Session Objectives

- Compare and contrast narrow and expanded views of nurse's patient advocacy role and identify keys basic nursing care that prevent harm
- Understand and integrate the components of the mnemonic SAFETY into your practice
- Design your practice using the SAFETY concepts to impact one nurse sensitive indicator where sustainable outcomes have not occurred

Reboot/Reset

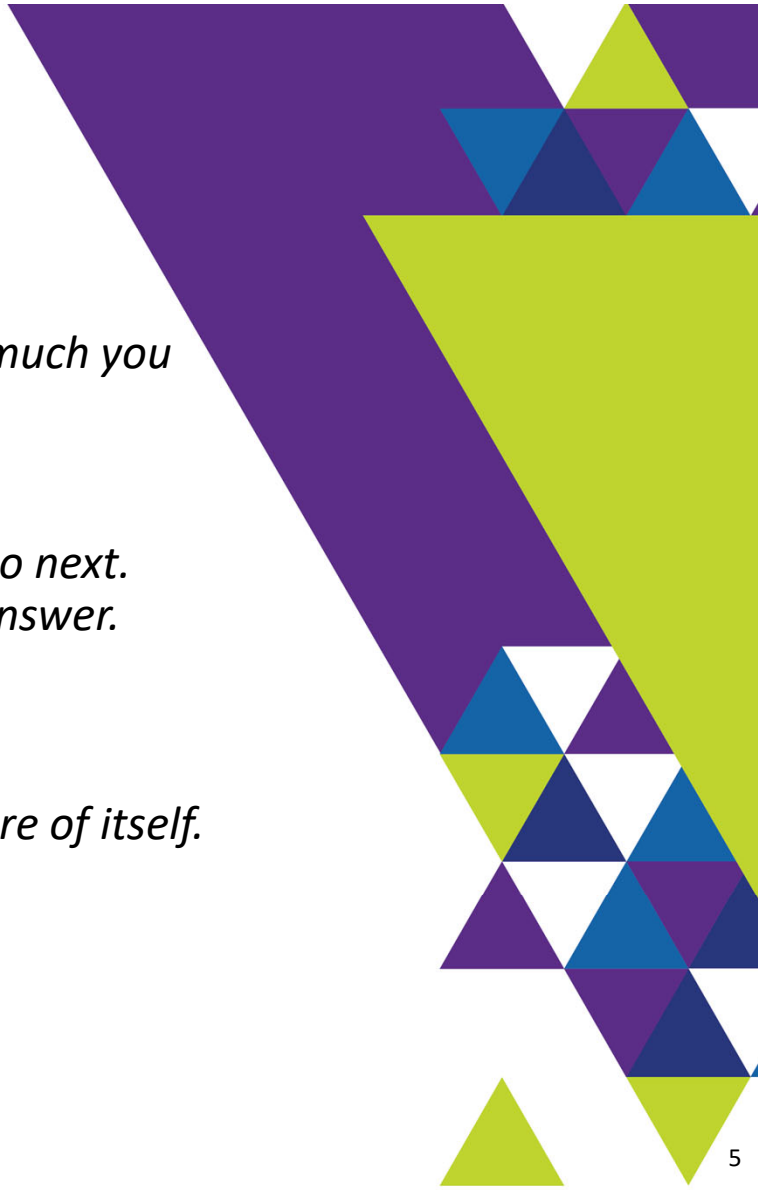
Life Coming Out of a Crisis

Life is about how much you can take and keep fighting, how much you can suffer and keep moving forward.~ Anderson Silva

Don't dwell on what went wrong. Instead, focus on what to do next. Spend your energies on moving forward toward finding the answer. ~Denis Waitley

If everyone is moving forward together, then success takes care of itself. ~Henry Ford

One day? Or day one. You decide.



Capturing the Essence of Nursing

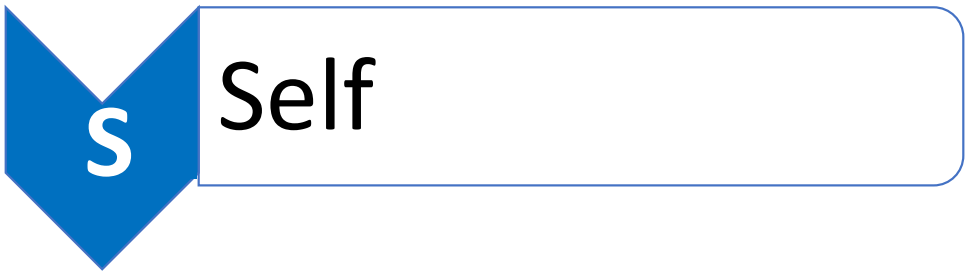
"Nurses primarily assists the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or a peaceful death) that he would perform unaided if he had the strength, will or knowledge. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible.

Henderson 1969

https://nursing-theory.org/theories-and-models/henderson-need-theory.php


ABOUT US


S
Self
A
Advocacy
F
Fundamentals
E
Evidence
T
Team
Y
Yes, I Will


S
Self

Number 1 Respected Profession

Nursing

Gallup Poll: 82% Honesty &
Ethical Rating

So Why Don't We Feel Respected?

Reclaiming Professional Respect

Work Environment

Quality of Care You Provide to Patient & Families

What Behaviors or Communications Make You Feel the Recipient of Respect?

Feeling of Respect or Not being Respected

- Respected
  - Feeling listened to
  - Feeling revered for their knowledge
  - Feeling trusted
  - Feel part of the group
  - Being acknowledged
  - Sense of belonging/contributing
  - Persons look out for each other and their support
  - Fairness
  - Free to speak
  - Opportunities to excel

- Not Being Respected
  - Disregarded
  - Not revered
  - Not trusted
  - Not supported
  - Not recognized
  - Closed conversation
  - Speaking in a tone that is demeaning
  - Ideas and opinions not considered a value priority
  - Unsafe, guarded, pressured, put down

Bournes DA, et al. Nursing Science Quarterly, 2009;22(1):47-56

Respect

Self Respect

Self Respect

Internal Dialogue

External Dialogue

The Road to Respect

I spoke.

You listened.

I felt valued and honored.

You shared your opinion.

I trusted your wisdom.

The circle of respect was complete.

We saw in each other's eyes are common humanity.

Now, moving to a zone of mutual affirmation, we felt safe to trust and learn and nurture in the give-and-take of life.

Yasmin Morais 2006

A Advocacy

Advocacy

- Advocacy can be seen as a deliberate process of speaking out on issues of concern in order to exert some influence on behalf of ideas or persons.

http://en.wikipedia.org/wiki/Advocacy accessed 03/05/2009

Advocacy Starts with Us

Broaden the Definition of Advocacy

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

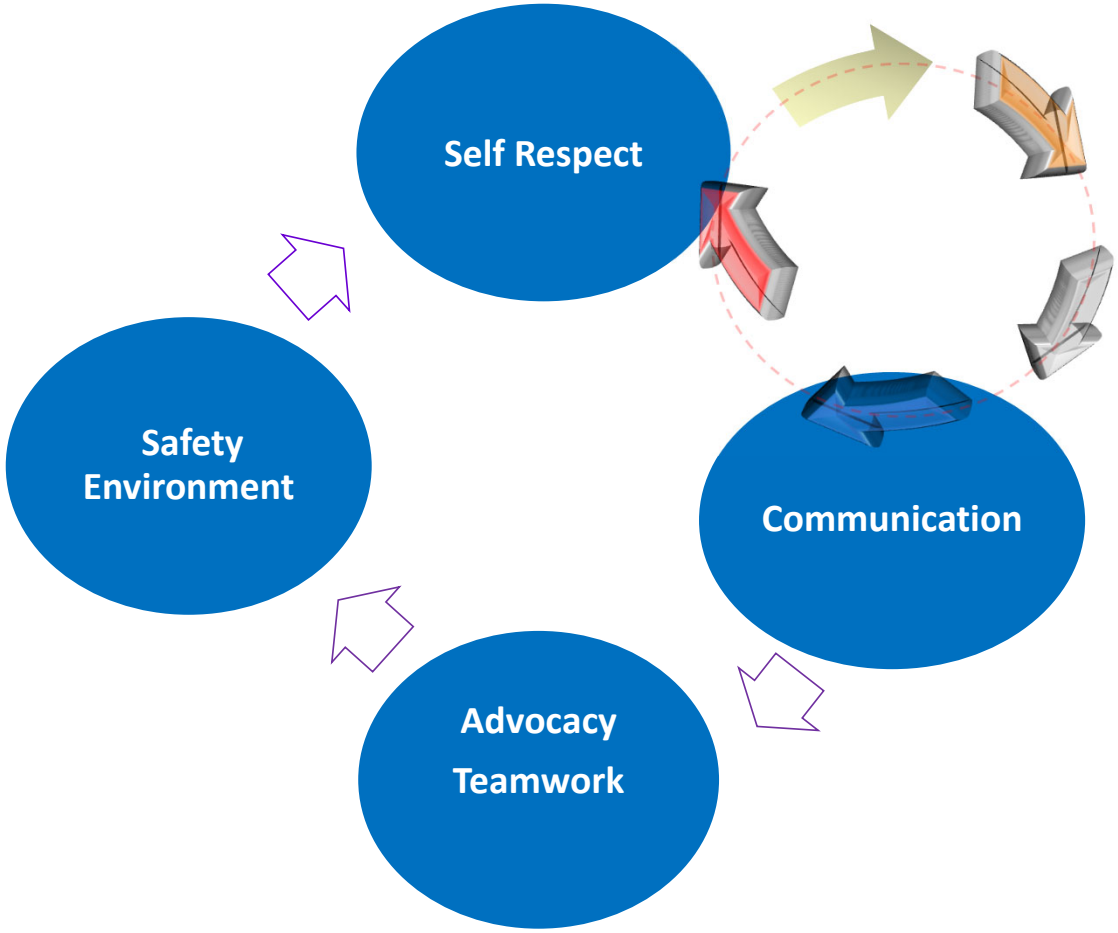
Florence Nightingale

Advocacy = Safety

Patient Advocacy/Safety Related to Clinical Practice

- Nurses knowledge of the Evidence based care
- Ability to deliver the care to the right patient at the right time, every time it is needed
- The ability to communicate patient concerns in a concise, data driven manner and take appropriate action
- Understanding that I am the voice of the patient

Why Effective Communication May Be Challenging for Nursing



The Silent Treatment: April 2011

- 85% of workers reported a safety tool warned them of a problem that may have been otherwise missed & could harm a patient
- Safety tools include: handoff protocols, checklists, COPE, automated medication dispensing machines.
- 58% said they got the warning, but failed to effectively speak up & solve the problem
- 3 “undiscussbale” issues: dangerous short cuts, incompetence & disrespect (4/5 nurses)
- 1/2 say shortcuts lead to near misses
- 1/3 say incompetence leads to near misses
- 1/2 say disrespect prevented them from getting others to listen or respect their opinion
- Only 16% confronted the disrespectful behavior

What Happens When You Speak Up!!

- 16% of healthcare workers who raise these crucial concerns observe better patient outcomes, work harder, are were more satisfied and are more committed to staying in their jobs.

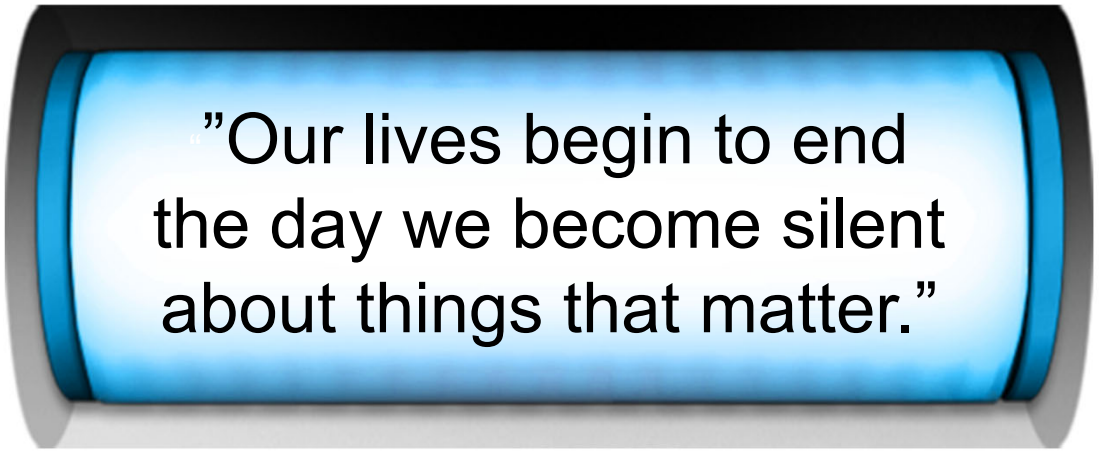
www.aacn.org/WD/Practice/Docs/PublicPolicy/**SilenceKills**.pdf
http://www.silenttreatmentstudy

OSHA: Definition of Workplace Violence

Any physical assault, threatening behavior or verbal abuse occurring in the workplace”

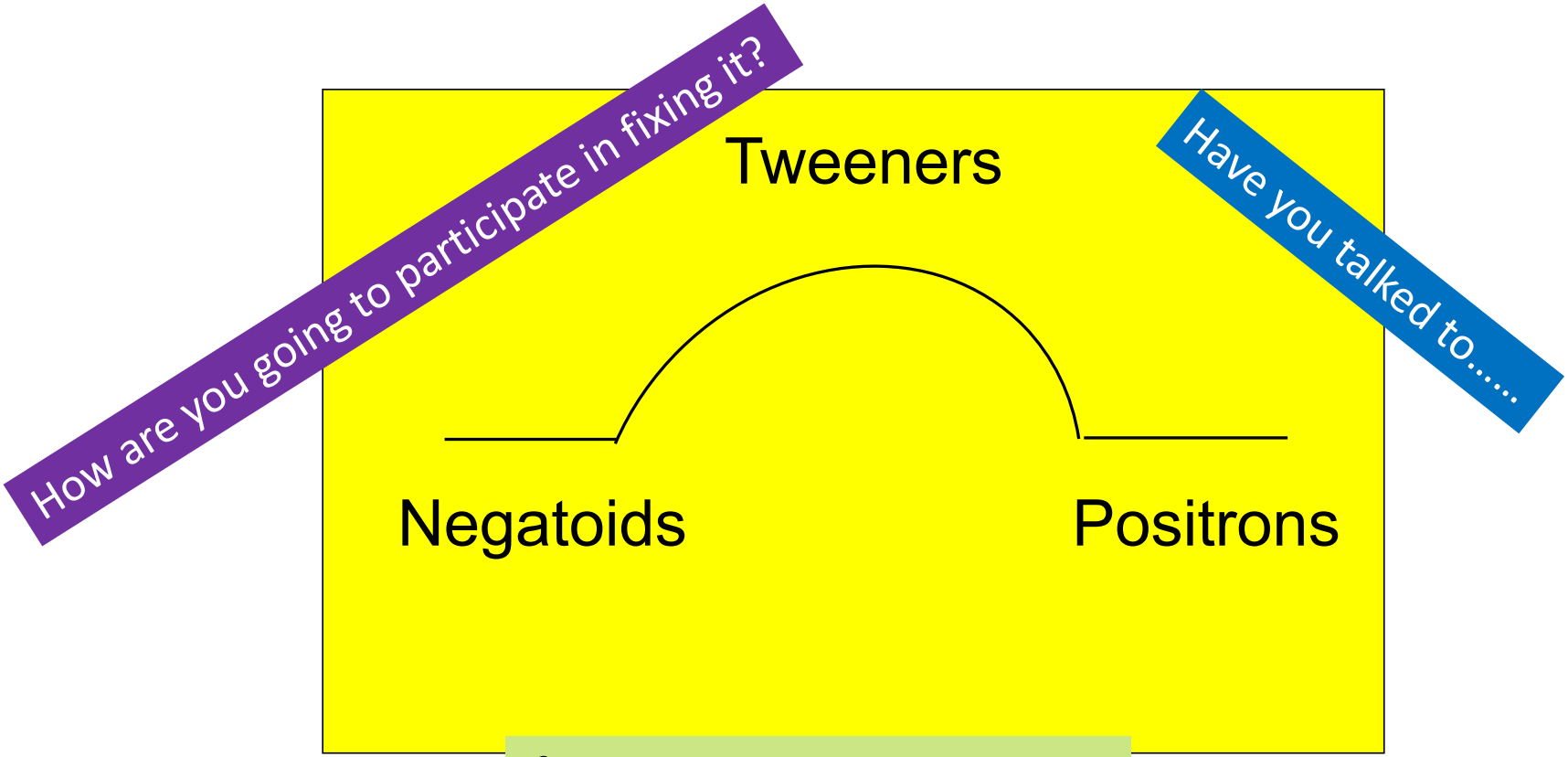
- On Average 57 nurses are assaulted each day in the US (Pressy Ganey Report 2022)[1]
- 44% experience physical violence and 67.8% experienced verbal abuse in one study during the pandemic & often went unreported[2]

https://www.medpagetoday.com/special-reports/features/100679#
Byon HD, et al. Workplace Health Saf. 2022;70(9):412-420



Martin Luther King Jr.

Understanding Your Culture & Communication Strategies



If you Permit it you Promote it

Bullying & Incivility

- Increases when nurses experience more burnout, stress and anxiety
- How to recognize
  - Breaking confidence
  - Demonstrating lack of patience
  - Describing a colleague as very old or technically inept
  - Hanging up phone before a conversation is finished
  - Making snide, abrupt remarks
  - Refusing to be available when a colleague needs assistance
  - Talking behind a colleague's back

Sherman RO My American Nurse 2023;18(2): 28-32

A good word is an easy obligation; but not to speak ill requires only our silence; which costs us nothing.

John Tillotson

Courage

"Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen."

Winston Churchill

What to Work Towards to Have a Good Culture

- Sense of purpose and pride in the work
- Provision of team backup when others need it
- Tolerance of diverse opinions
- Refusal to talk about others when they're not in the room
- A welcoming attitude towards new team members
- Accountability and responsibility for assignments engagement in their work speaking up without fear of retribution
- Respect and fairness towards others
- Open communication

“You Can Choose Comfort or You Can Choose Courage

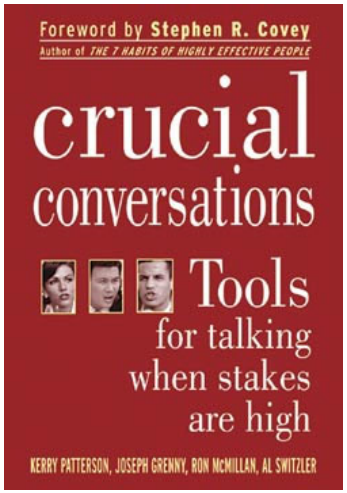
“You Can’t Have Both”

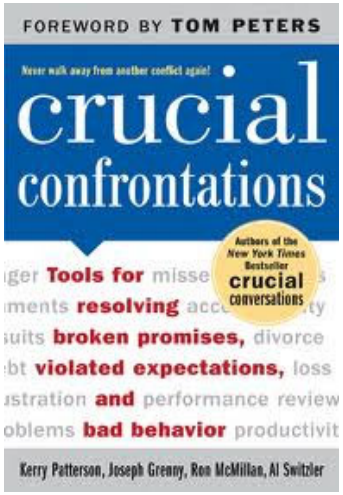
Brene Brown

What to Do Individually?

- Prevent from occurring through training on effective communication
- Deal in real time to prevent staff or patient harm
- Initiate post event reviews, action and follow-up
- Make it as transparent as possible
- Zero-tolerance policy and procedure
- Intervention strategy: code white

Communication Training





Communication Strategies

- Tools to help structure communication
  - SBAR for communication with Doctors: Situation, Background, Assessment and Recommendation
  - CUS Words: I am Concerned, I am Uncomfortable, This is not Safe

Use CUS words when assertion of your communication fails…things go wrong…concern expressed but mutual decision not reached or proposed action doesn't happen in time frame agreed upon

What to Do Individually?

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Healthy Work Culture Standards

- Skilled communication
- True collaboration
- Effective shared decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership

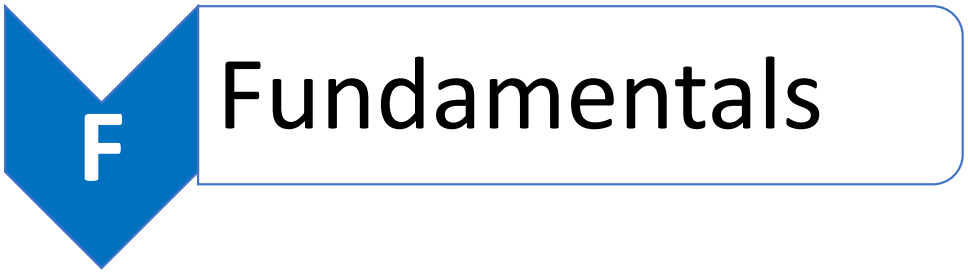
A healthy culture begins with each person & is enhanced by self work, healthy relationships & system supports

https://www.aacn.org/nursing-excellence/healthy-work-environments?tab=Moral%20Distress

Strategies for Retention

- Conduct stay interviews
- Retention committee
- Recognize staff
- Leaders being present and personal & effective communication
- Empowered work environment
- Adequate compensation
- Adequate staff
- Make changes in career ladder for attainability
- Nurse Residency

Twigg D, et. al. International J of Nursing Studies;2014;51:85-92
Duru DC, et al. *Nurs Manag (Harrow)*. 2022;29(1):17-24.


F
Fundamentals

Missed Nursing Care

- Any aspect of required patient care that is omitted (either in part or whole) or significantly delayed.
- A predictor of patient outcomes
- Measures the process of nursing care

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299.

Hospital Variation in Missed Nursing Care

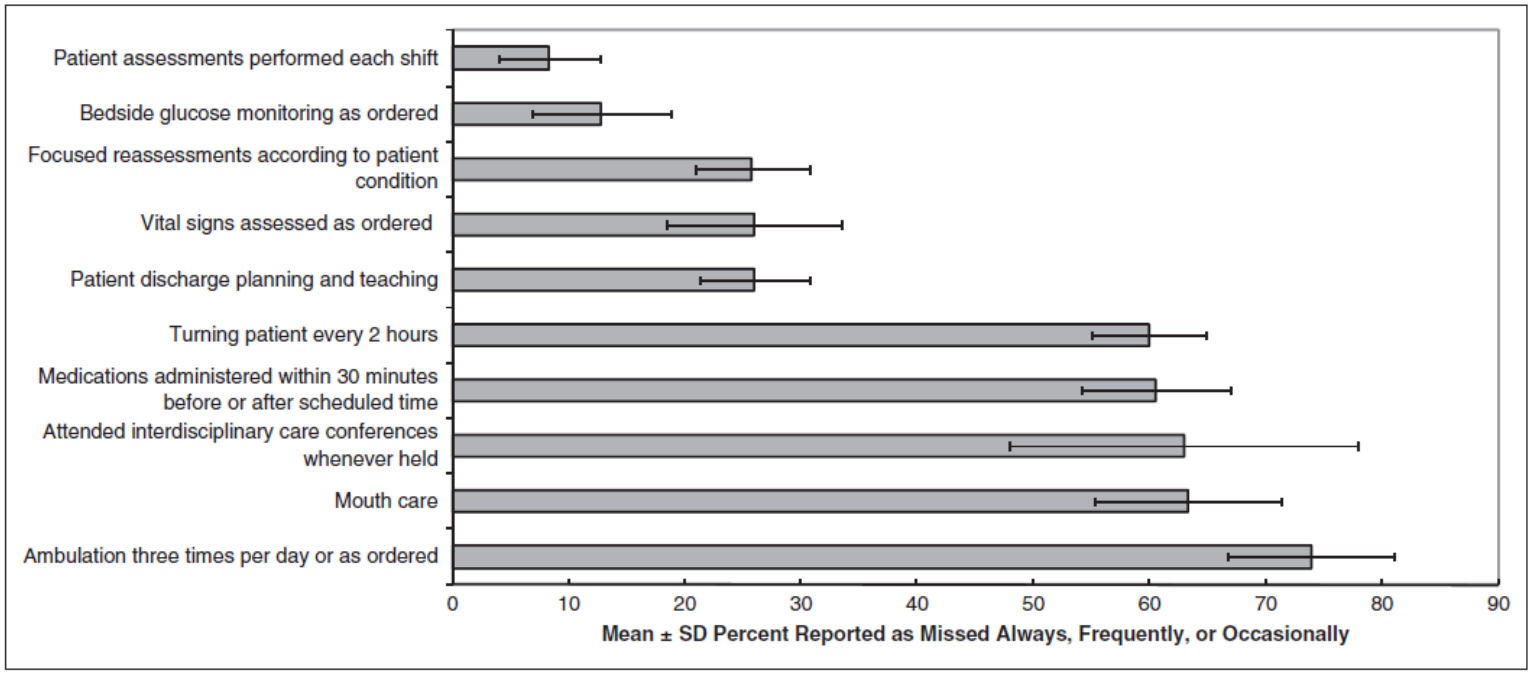


Figure 2. Elements of care most and least frequently missed. The solid bars represent the means across all 10 hospitals, and the range lines indicate the standard deviations.

Kalish, R. et al. (2012) Am Jour Med Quality, 26(4), 291-299

Patient Perceptions of Missed Nursing Care

Table 2. Elements of Nursing Care by Ability of Patient to Report and Extent Missed*

	Fully Reportable	Partially Reportable	Not Reportable
			■ Patient assessment ■ Surveillance ■ IV site care
Frequently Missed	■ Mouth care ■ Listening ■ Being kept informed	■ Ambulation ■ Discharge planning ■ Patient education	
Sometimes Missed	■ Response to call lights ■ Response to alarms ■ Meal assistance ■ Pain medication and follow-up	■ Medication administration ■ Repositioning	
Rarely Missed	■ Bathing	■ Vital signs ■ Hand washing	

* IV, intravenous.

Kalisch, B et al. (2012). TJC Jour Qual Patient Safety,38(4), 161-167

Rationing Care-How we Prioritize

- Highest priority activities for nurses
  - Those which are likely to have an immediate negative impact
    - Administering meds
    - Medical directed treatments
    - Procedures-wound dressings, labs
- Lower priority activities for nurses
  - Those which show no immediate negative harm
    - Ambulation
    - Oral hygiene
    - Emotional support
    - Teaching

Rationing contributes to functional and cognitive decline

Bail K, et al. International Journal of Nursing Studies. 2016;63:146-161

Protect The Patient From Bad Things Happening on Your Watch

Implement
Interventional Patient Hygiene

INTERVENTIONAL PATIENT HYGIENE

Hand Hygiene

- Hygiene…the science and practice of the establishment and maintenance of health
- Interventional Patient Hygiene….nursing action plan directly focused on fortifying the patients host defense through proactive use of evidence-based hygiene care strategies

Catheter Care

Bathing & Assessment

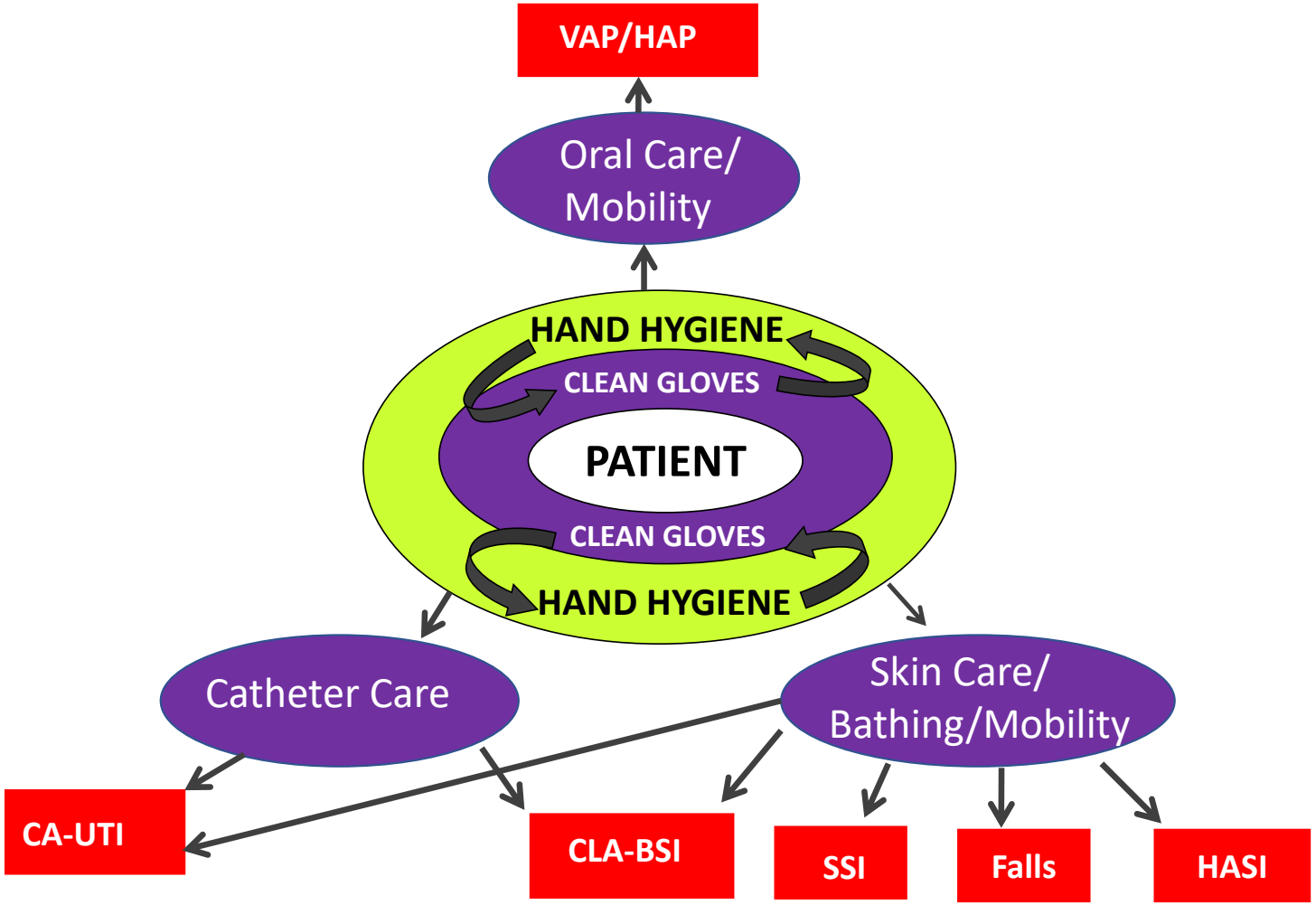
Comprehensive Oral Care Plan

Incontinence Associated Dermatitis Prevention Program

Pressure Ulcer Prevention

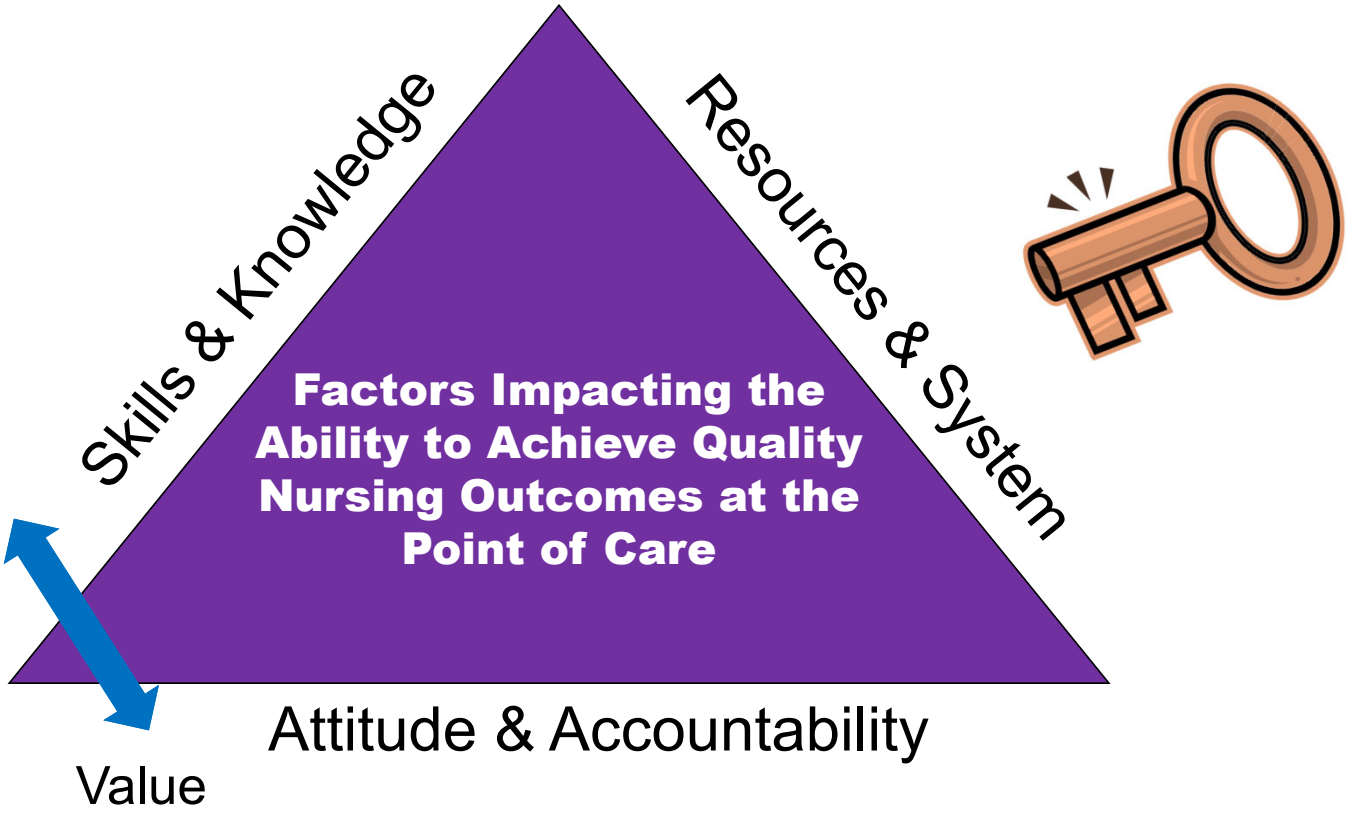
Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

INTERVENTIONAL PATIENT HYGIENE(IPH)



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

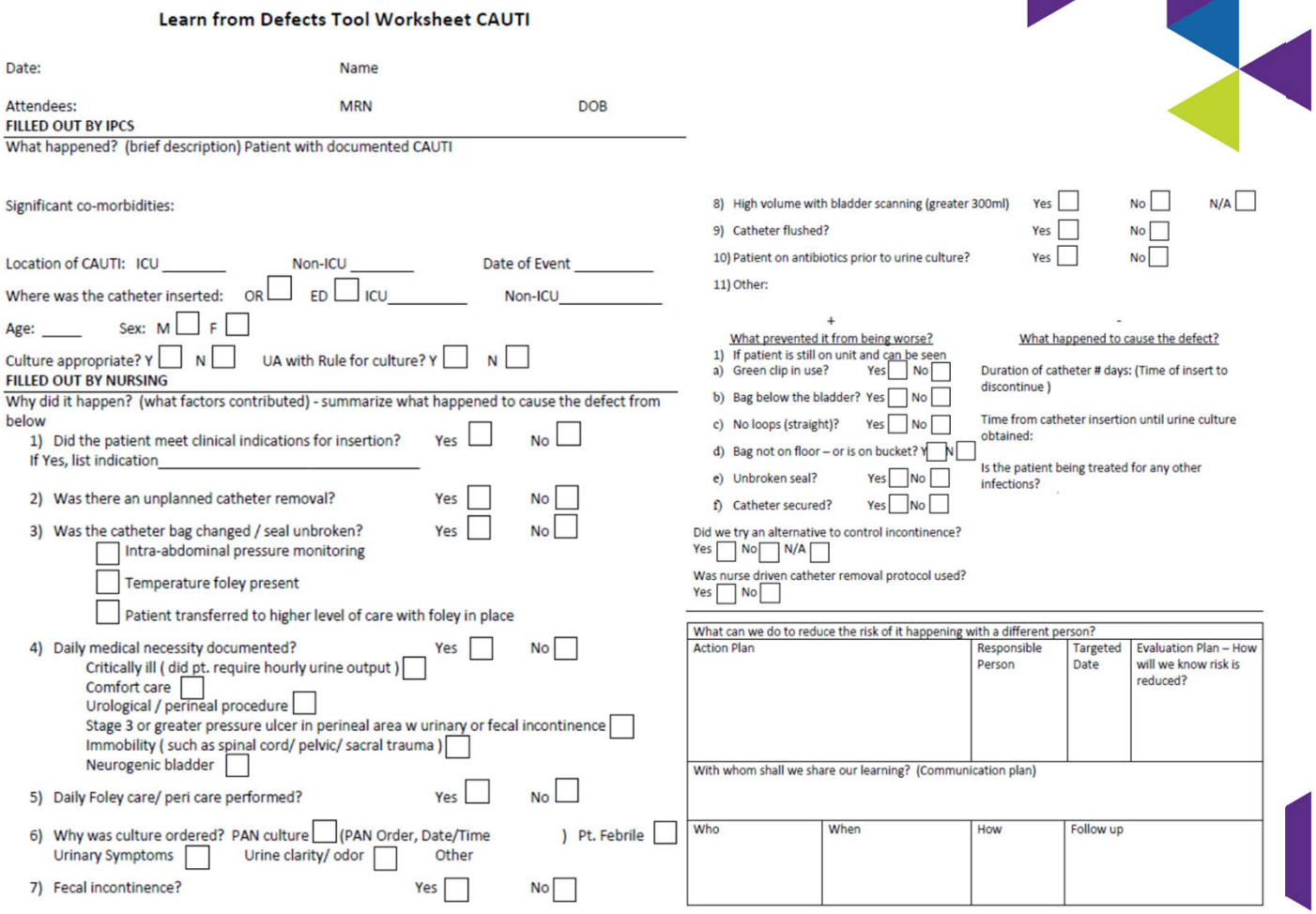
Achieving the Use of the Evidence



Vollman KM. Intensive Crit Care Nurs, 2013;22(4): 152-154

Strategies to Link Harm with Patient Advocacy Role

- Do No Harm Rounding
- Immediate learn from a deficit
- Incorporate action plans and data into daily huddle



Learn from Defects Tool Worksheet CAUTI

Date: Name

Attendees: MRN DOB

FILLED OUT BY IPCS

What happened? (brief description) Patient with documented CAUTI

Significant co-morbidities:

Location of CAUTI: ICU _____ Non-ICU _____ Date of Event _____

Where was the catheter inserted: OR ☐ ED ☐ ICU_____ Non-ICU_____

Age: ____ Sex: M ☐ F ☐

Culture appropriate? Y ☐ N ☐ UA with Rule for culture? Y ☐ N ☐

FILLED OUT BY NURSING

Why did it happen? (what factors contributed) - summarize what happened to cause the defect from below

1) Did the patient meet clinical indications for insertion? Yes ☐ No ☐
   If Yes, list indication_____
2) Was there an unplanned catheter removal? Yes ☐ No ☐
3) Was the catheter bag changed / seal unbroken? Yes ☐ No ☐
   - ☐ Intra-abdominal pressure monitoring
   - ☐ Temperature foley present
   - ☐ Patient transferred to higher level of care with foley in place
4) Daily medical necessity documented? Yes ☐ No ☐
   - Critically ill (did pt. require hourly urine output) ☐
   - Comfort care ☐
   - Urological / perineal procedure ☐
   - Stage 3 or greater pressure ulcer in perineal area w urinary or fecal incontinence ☐
   - Immobility (such as spinal cord/ pelvic/ sacral trauma) ☐
   - Neurogenic bladder ☐
5) Daily Foley care/ peri care performed? Yes ☐ No ☐
6) Why was culture ordered? PAN culture ☐ (PAN Order, Date/Time) Pt. Febrile ☐
   Urinary Symptoms ☐ Urine clarity/ odor ☐ Other
7) Fecal incontinence? Yes ☐ No ☐
8) High volume with bladder scanning (greater 300ml) Yes ☐ No ☐ N/A ☐
9) Catheter flushed? Yes ☐ No ☐
10) Patient on antibiotics prior to urine culture? Yes ☐ No ☐
11) Other:

+ What prevented it from being worse?	- What happened to cause the defect?
1) If patient is still on unit and can be seen	
a) Green clip in use? Yes ☐ No ☐	Duration of catheter # days: (Time of insert to discontinue)
b) Bag below the bladder? Yes ☐ No ☐	
c) No loops (straight)? Yes ☐ No ☐	Time from catheter insertion until urine culture obtained:
d) Bag not on floor – or is on bucket? Y ☐ N ☐	
e) Unbroken seal? Yes ☐ No ☐	Is the patient being treated for any other infections?
f) Catheter secured? Yes ☐ No ☐	

Did we try an alternative to control incontinence? Yes ☐ No ☐ N/A ☐

Was nurse driven catheter removal protocol used? Yes ☐ No ☐

What can we do to reduce the risk of it happening with a different person?

Action Plan	Responsible Person	Targeted Date	Evaluation Plan – How will we know risk is reduced?

With whom shall we share our learning? (Communication plan)

Who	When	How	Follow up

Fundamental Care to Reduce Risk of CAUTI

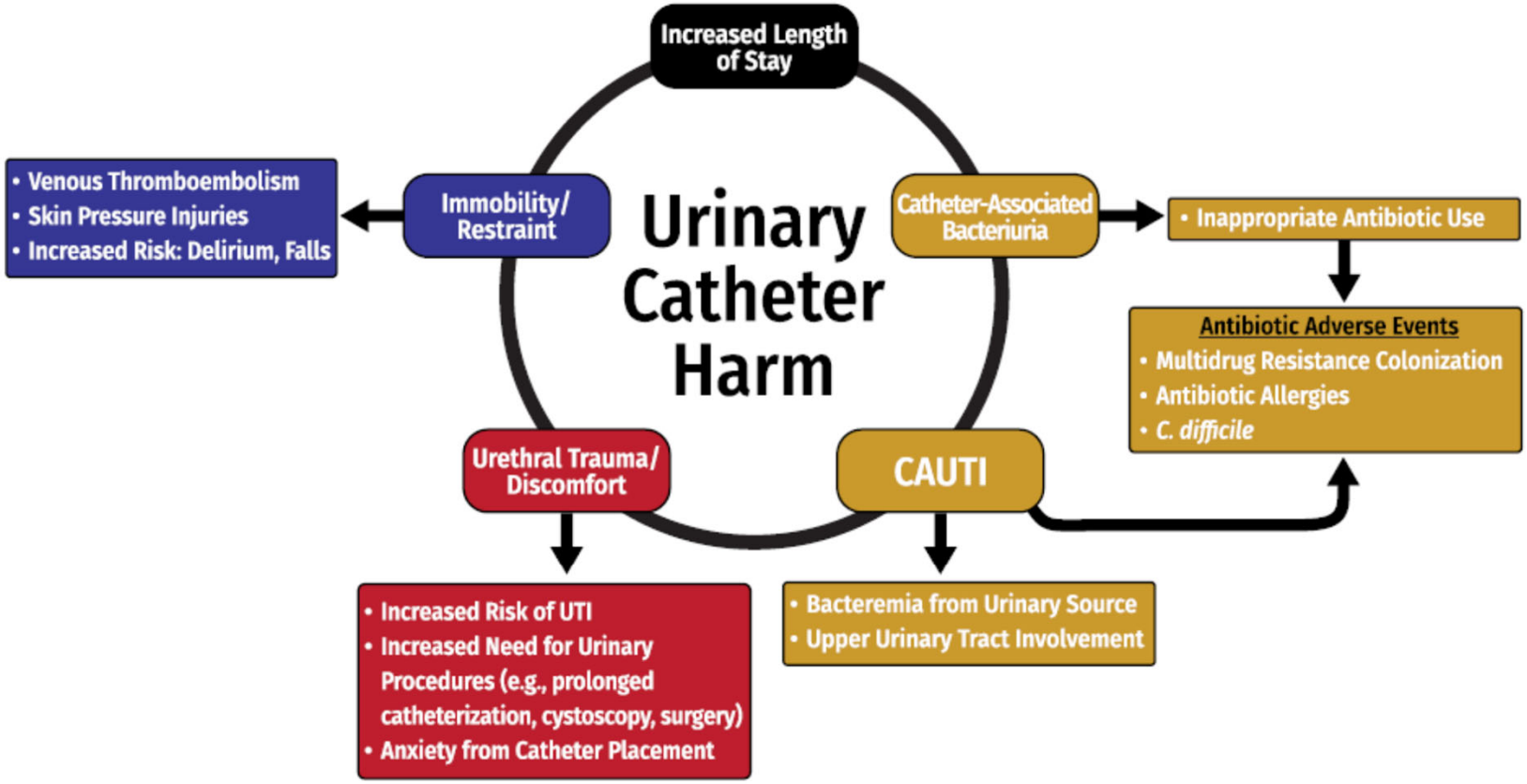
The Why: CAUTI Incidence

- One of the most common healthcare acquired infections (HAIs)- nearly up to 44% of all HAIs[1,2]
- 70% urinary catheter associated HAIs; up to 95% in the intensive care setting[2]
- Approximately 20% of hospital patients have urinary catheter at some point in their stay[3]
  - 50% do not have appropriate indication [4]
- Specific patient impact[5]
  - Discomfort r/t to mild signs of infection
  - Potential urethral trauma
  - Embarrassment
  - Pyelonephritis
  - Urosepsis leading to potential death

2024 CMS Threshold SIR 0.65

- For Every 1000 in-hospital CAUTI cases, there are 36 excess deaths[4]
- Catheter-Associated Urinary Tract Infections (CAUTI)[4]
  - 6 studies
  - Cost range: $603 to $1,189, ICUs $1764[4]

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
4. Patel PK, et al. *Infect Control Hosp Epidemiol.* 2023;44(8):1209-1231.
5. Agency for Healthcare Research and Quality (2017). Retrieved from https://www.ahrq.gov/hai/pfp/haccost2017-results.html.

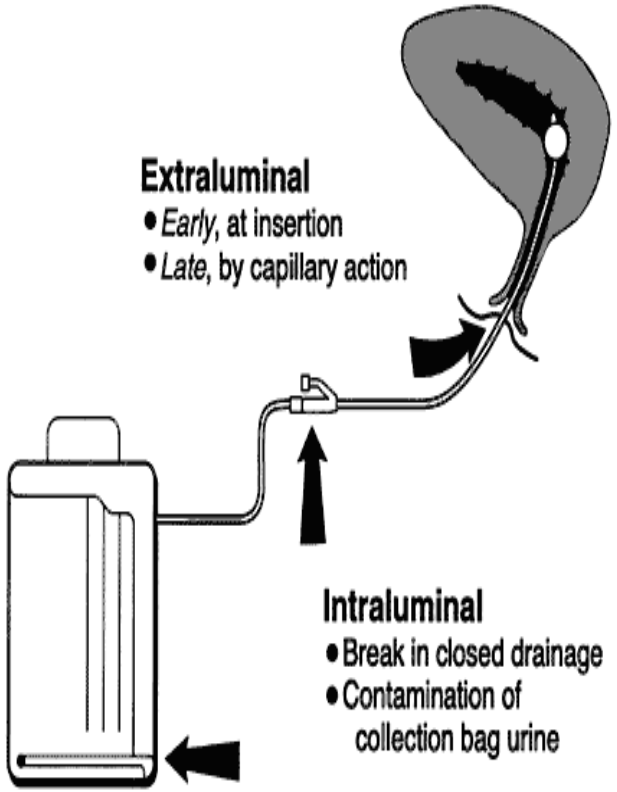


Isn’t this a patient safety issue, not just CAUTI?

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

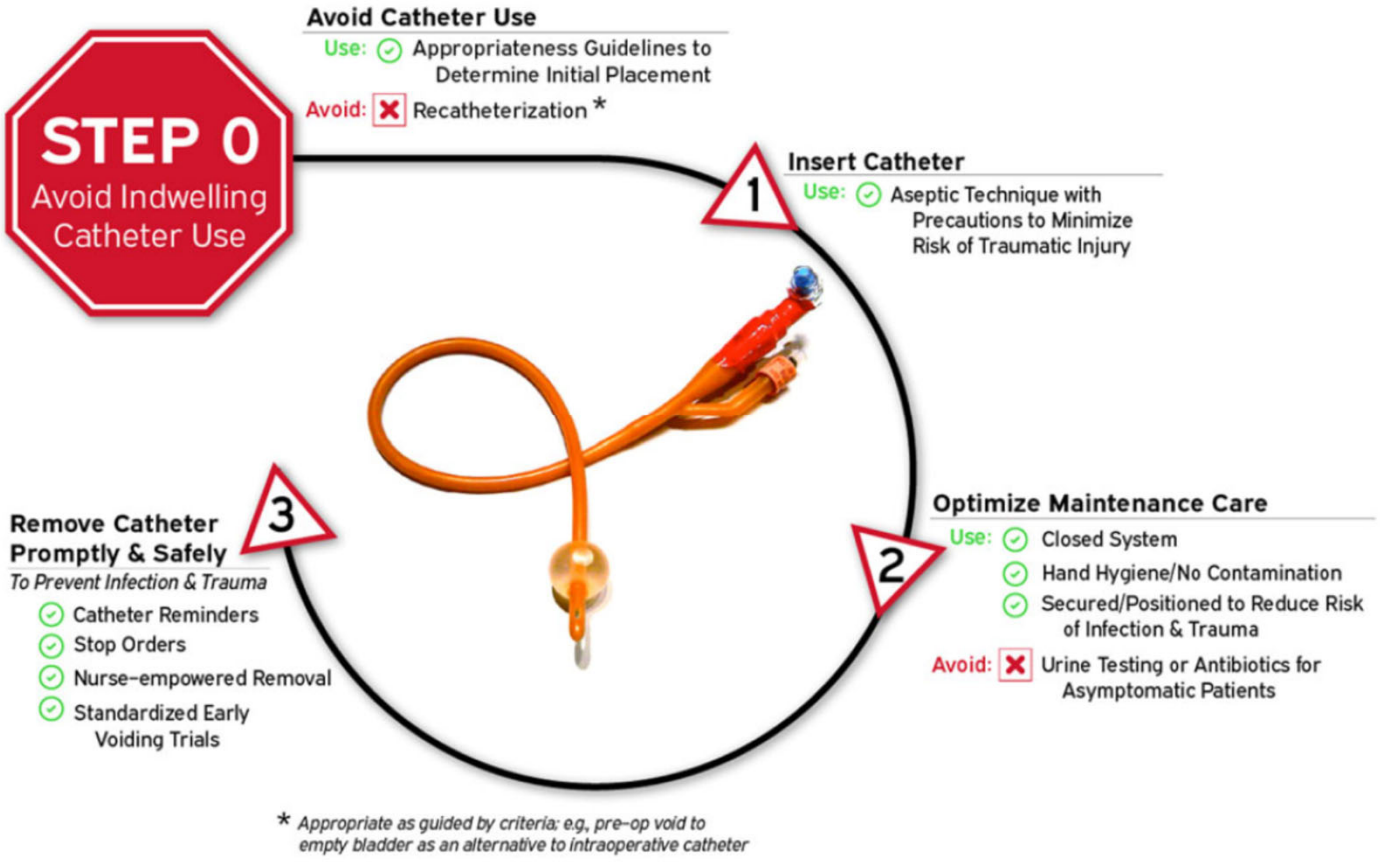
Pathogenesis of CAUTI

- 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%



APIC Guide to Preventing CAUTI: 2014

Disrupting the Lifecycle of the Urinary Catheter



Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

Essential Practices for CAUTI Prevention: Organizing Framework

- Infrastructure & resources
- Education & training
- Insertion
- Management
- Additional approaches
- Approaches that should not be use

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

SHEA/ISDA/APIC:
Indications for Placement of Indwelling Catheter

- Perioperative use for selected surgical procedures;
  - urologic surgery or surgery near structures of GI
  - prolonged surgery (if only reason should be removed in OR)
  - large volume infusions or diuretics during surgery
- Hourly assessment of UO in ICU patient when used clinically to modify therapies;
  - Volume resuscitation, diuresis & vasopressor
- Management of acute urinary retention and urinary obstruction
  - Postvoid residual bladder volume > 500 cm^3 by scanner if no symptoms
  - >300 cm^3 if bladder fullness, persistent urge, leaking
- Assistance in pressure ulcer healing for incontinent patients when alternative supplies to protect wound or manage incontinence is not feasible
- Part of palliative/comfort care regimen if address specific goal of patient, reducing pain or frequent movement to change bed

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

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 Protocol: Prevent Insertion or Assist with Early Removal

- 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 obstruction[2]

1. Saint S, et al. Clin Infect Dis. 2008;46(2):243-250,
2. *Saint S, et al. J am Geriatr Sco. 2006;54(7)1055-1061
3. Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

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-repeat intermittent catheter
- If volumes are greater/catheter goes back in 24hrs

STOP CAUTI Sample Policy and Procedure
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/hcpr/cauti/documents/Sample%20Policy%20and%20Procedures.pdf
University of Virginia Health System nurse driven intermittent cath program

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

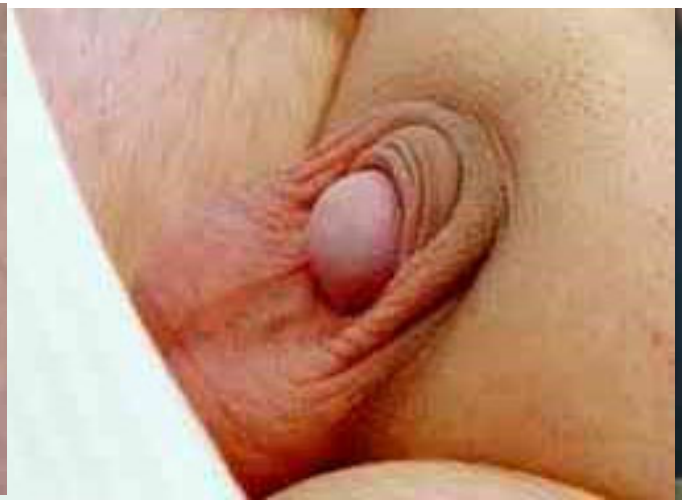
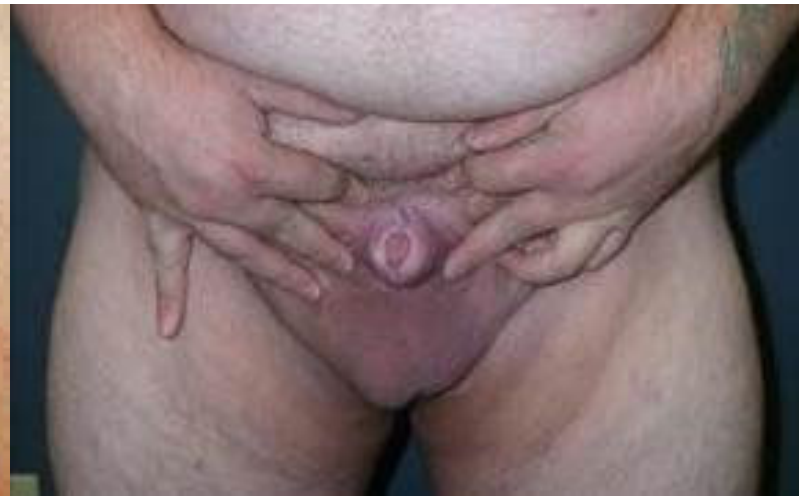
An Evidence- and Consensus-Based Algorithm

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

iPCaRe
Interventions Post Catheter Removal

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

Buried & Micro Penis

Condom Catheter

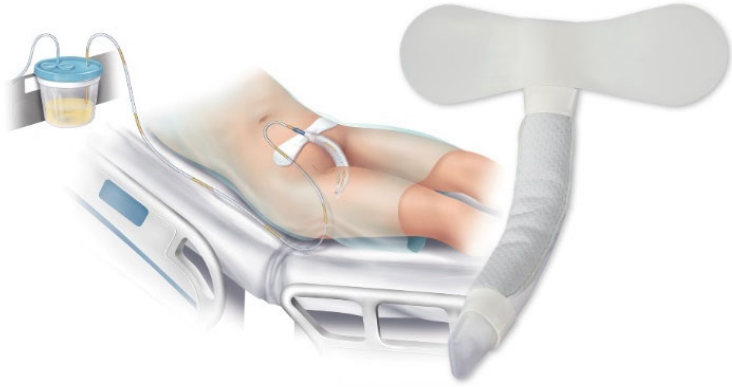
- Most common problems are:
  - Skin irritation and maceration
  - Difficult to keep the condom from falling off/retraction of the penis or decrease size
  - Ischemia and penile obstruction/tightness
  - Adherence: required to secure on the shaft & adhesive mechanisms are challenging

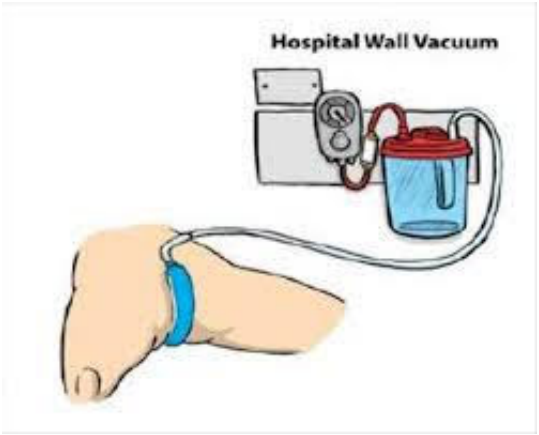
New Male Devices: Overcoming the Challenges

- 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





SHEA/ISDA/APIC:
Indications for Placement of Indwelling Catheter

- Perioperative use for selected surgical procedures;
  - urologic surgery or surgery near structures of GI
  - prolonged surgery (if only reason should be removed in OR)
  - large volume infusions or diuretics during surgery
- Hourly assessment of UO in ICU patient when used clinically to modify therapies;
  - Volume resuscitation, diuresis & vasopressor
- Management of acute urinary retention and urinary obstruction
  - Postvoid residual bladder volume > 500 cm^3 by scanner if no symptoms
  - >300 cm^3 if bladder fullness, persistent urge, leaking
- Assistance in pressure ulcer healing for incontinent patients when alternative supplies to protect wound or manage incontinence is not feasible
- Part of palliative/comfort care regimen if address specific goal of patient, reducing pain or frequent movement to change bed

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

Types Of Treatments Requiring Close UO Monitoring

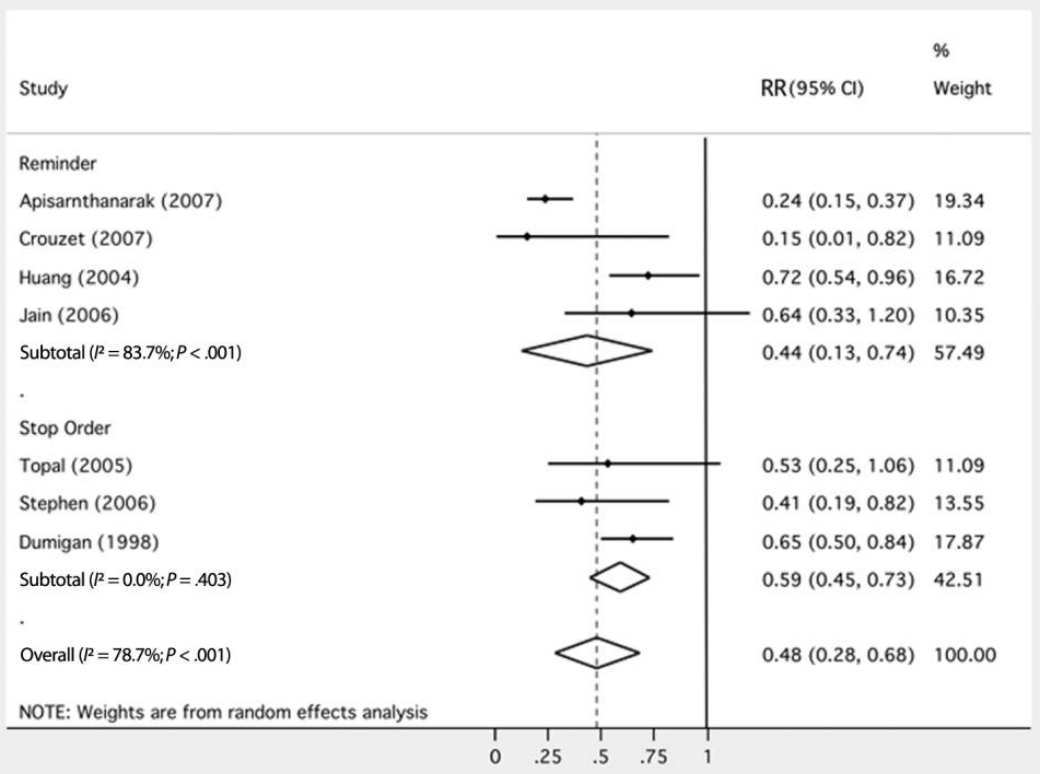
- Bolus fluid resuscitation
- Vasopressors
- Inotropes
- High dose diuretics
- Hourly urine studies to measure life threatening laboratory abnormalities

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

Reminder Systems Reduce Inpatient Catheter Use and Associated CAUTIs

Reminder
56% reduction

Stop Order
41% reduction



Meddings J et al. Clin Infect Dis, 2010;51:550-560

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

- Communication patterns and unit culture relative to urinary catheter use[1]
- 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 collection[1]
- Feedback using data on catheter use[1]
- ICU team's recognition of the hazard of urinary catheters[1,2]

1. Meddings J, et al. BMJ Qual Saf. 2014 Apr;23:277-89.
2. Quinn M, et al Jt Comm J Qual Patient Saf. 2019 Dec 23.

Essential Recommendations

- Insertion:
  - Insert urinary catheters only one necessary for patient care and leave in only as long as indications remain
  - Consider other methods for bladder management: intermittent catheterization, male or female external devices
  - Use appropriate technique for catheter insertion
  - Consider working in pairs to help perform patient positioning and monitor for potential contamination
  - Hand hygiene
  - Insert following aseptic technique and sterile equipment
  - Use sterile gloves, drape and sponges, a sterile antiseptic solution and a sterile single use pack of lubricant Jelly for insertion
  - Use the catheter with the smallest feasible diameter

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231

Essential Maintenance Recommendations

- Properly secure indwelling catheter
- maintain a sterile, continuously closed drainage system
- Replace the catheter in the collection system using aseptic technique when breaks in technique, disconnection or leakage occur
- Maintain unobstructed urine flow
- Routine hygiene: cleaning the medial area with antiseptic solutions and unresolved issue, emerging literature supports CHG use prior to catheter insertion
- For examination of fresh urine, collect a small sample by aspirating urine from a needleless sample port with sterile syringe after cleansing the port with disinfectant
  - If a catheter placed > 7 day, change the catheter before collecting a specimen[1]
- Timely transport to the lab if not feasible use a collection device with a preservative

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231

The Culture of Culturing: New Essential Practice

- Standardize your urine culturing by adapting an institutional protocol for appropriate indications for urine cultures in patients with or without an indwelling catheter
- Considering incorporating indications in EMR

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231

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 treated[2]
4. 23% to 50% antibiotic days for UTI are from ASB [2]

1. Health Research & Educational Trust (2017). : 2017. Chicago, IL: Health Research & Educational Trust. Accessed at www.hret-hiin.org
2. Garcia, R & Spitzer ED. American J of Infect. Control. 2017;45(10):1143-1153.

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%

Advani SD, et al. Open Forum Infect Dis. 2019 Aug 1;6(8).

Recommandations 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

Garcia, R & Spitzer ED. American J of Infect. Control. 2017;45(10):1143-1153.

Modify Your EMR Ordering Process

Appropriate uses of urine culture include the following

- Presence of symptoms suggestive of a urinary tract infection (UTI):
  - Flank pain or costovertebral angle tenderness
  - Acute hematuria
  - New pelvic discomfort
- New onset or worsening sepsis without evidence of another source on history, physical examination, or laboratory testing
- Fever or altered mental status without evidence of another source on history, physical examination, or laboratory testing
- In spinal-cord-injury patients and other highly complex patients symptoms may include increased spasticity, autonomic dysreflexia, and/or sense of unease

Lowers urine cultures and CAUTI rates

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231

Inappropriate Indications for Cultures

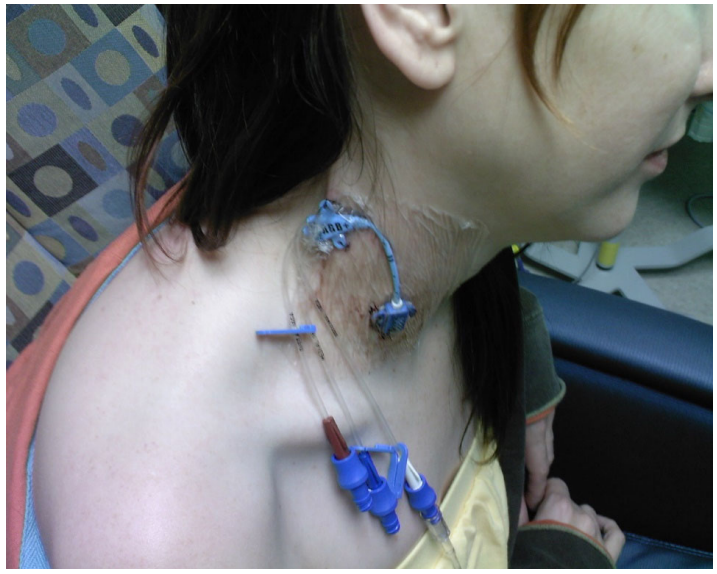
Inappropriate uses of urine cultures include the following:

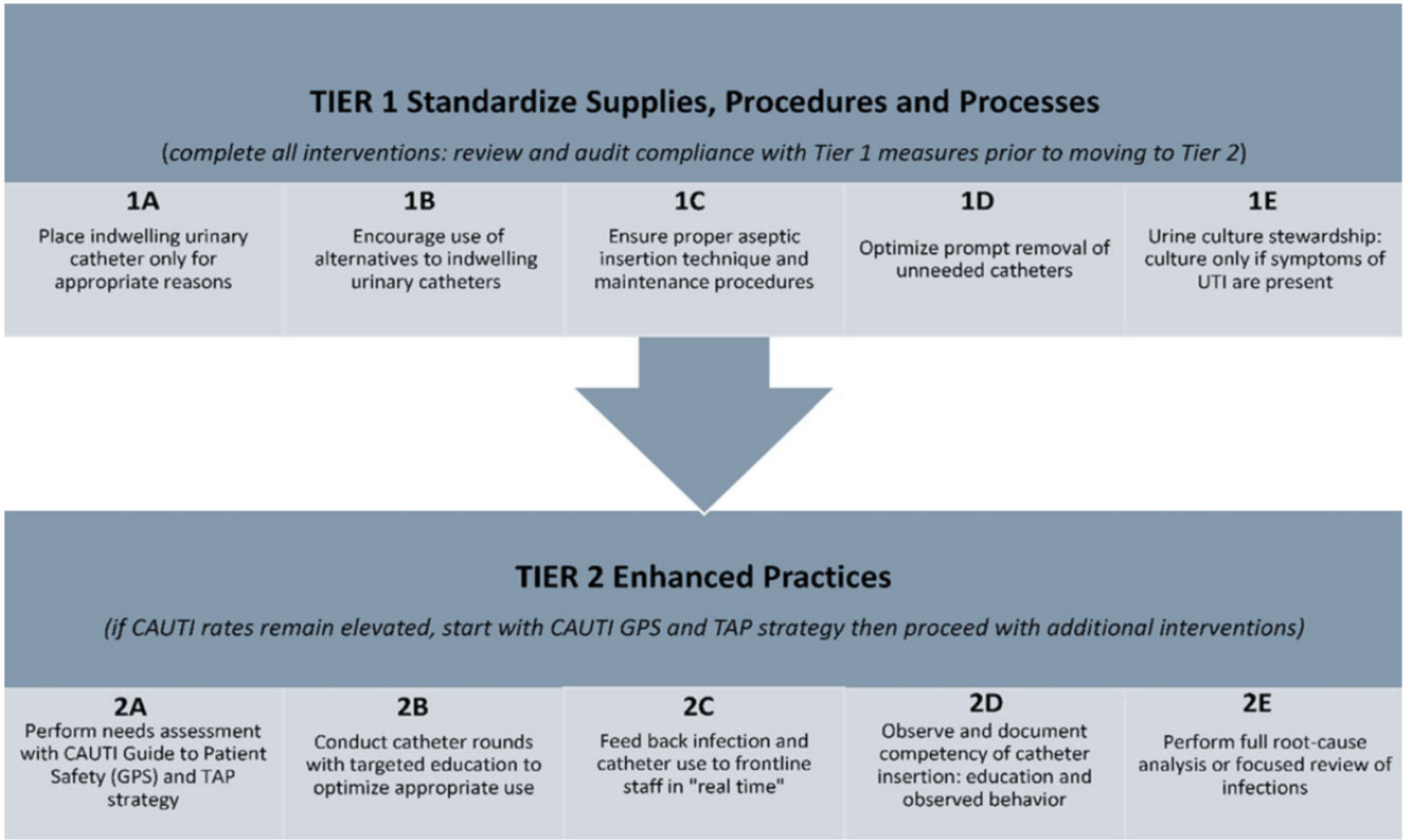
- Odorous, cloudy, or discolored urine in the absence of other localizing signs and symptoms
- Reflex urine cultures based on urinalysis results, such as pyuria, in the absence of other indications (absence of pyuria suggests diagnosis other than CAUTI)
- Urine culture to document response to therapy unless symptoms fail to resolve.

Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231

On Transfer

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





Patel PK, et al. *Infect Control Hosp Epidemiol*. 2023;44(8):1209-1231.

E Evidence

Time Lag—Research into Practice

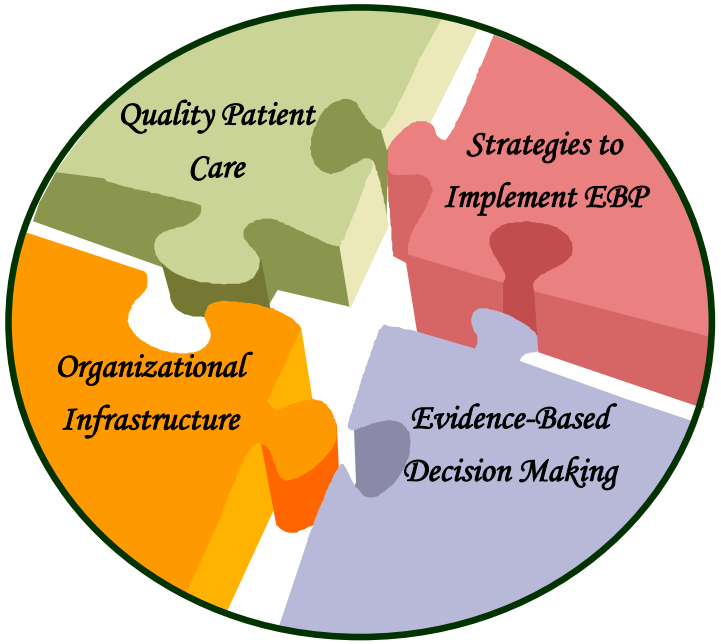
17 Years

Balas, E. A., & Boren, S. A. (2000). Managing clinical knowledge for health care improvement. Yearbook of medical informatics, 9(01), 65-70.
Grant, J., Green, L., & Mason, B. (2003). Basic research and health: a reassessment of the scientific basis for the support of biomedical science. Research Evaluation, 12(3), 217-224.
Wratschko, K. (2009). Strategic orientation and alliance portfolio configuration. Springer Fachmedien.

Examples of Dated Practices

- Recording vital signs every four hours at night on stable patients, despite their need for on disrupted sleep for recovery
- Removing urinary catheters only upon a physician's order to do so although the removal of catheters according to a nurse driven protocol is more efficient may prevent CAUTI's
- Not performing delirium screening on patients in the ICU. This failure cost 4 to 6 18 billion annually because delirium affects up to 80% of ICU patients.
- Valuing the role of family members: Knowing that the recognition of family involvement may lead to more efficient and effective care, as family members may significantly influence how a patient presents symptoms to healthcare providers.

Yoder JC, et al. JAMA Intern Med. 2013;173:1554-1555
Magers TL, Evidence Based Practice in Nursing and Healthcare: A guide to Best Practice. 2014;70-73
Peitz GJ, et al. Crit Care Med, 2013;41(suppl 10):S46-56
Lewin SA, Skea ZC, Entwistle V, et al. Cochrane Database Syst Rev 2001: CD003267.



Evidence-Based Practice

What is Good About EBP!!!

- Firm foundation to do the right thing
- Improved patient outcomes
- Basis for interventions
- Basis for evaluation
- Ability to talk in a similar language with other disciplines
- Methods allow correct and more expedient movement of evidence into practice


Activity without purpose is
the drain of your resources

We Make a Difference in Quality & Safety

- Increase nurse staffing was associated with; lower hospital related mortality, lower cardiac arrest, lower hospital acquired pneumonia in the surgical population, lower episodes of failure to rescue, lower UTIs, lower G.I. bleed/shock, lower falls & rates in hospital acquired pressure ulcers
- The risk of hospital deaths would increase by 31% or roughly 20,000 avoidable deaths each year if all hospitals had 8 patients per nurse instead of 4 (JAMA 2002)
- When nurses case managed children with asthma there were fewer absences from school
- 11% improvement in failure to rescue (HealthGrades 2009 Report)

We Make a Difference in Quality & Safety

- Home care/discharge planning/APRN's; lower length of stay, lower healthcare costs, fewer hysterectomies
- Patients in CCU with better nurse work environment experienced a 11% lower odds of 30-day mortality (Kelly DM Crit Care Med 2014)
- Patient satisfaction directly correlated to registered nurse satisfaction (HCAHPS)
- 10% ↑ in the # of RNs ↓ lung collapsed by 1.5%, pressure ulcers 2%, Falls 3%, UTI < 1% (Urich Med Care 2003, 41(1):142-152)
- Nurse's effect explained 7.9% of variance in patients' clinical condition during their hospital stay (Yakusheva O, et al, HSR, 2014)

Patient Safety Strategies Strongly Encouraged for Adoption with Moderate to High Evidence

- Preoperative and anesthesia checklists to prevent perioperative events
- Bundles with a checklist to prevent CLA-BSI
- Interventions to reduce use of urinary catheters; stop orders, reminders or removal protocols
- Bundle to prevent ventilator associated pneumonia
- Hand hygiene
- Multiple component initiative to prevent pressure ulcers
- Prophylaxis intervention for venous thromboembolism
- Using real-time ultrasonography for placement of central catheters

Alspach JG. Crit Care Nurse, 2013;33(3):9-12

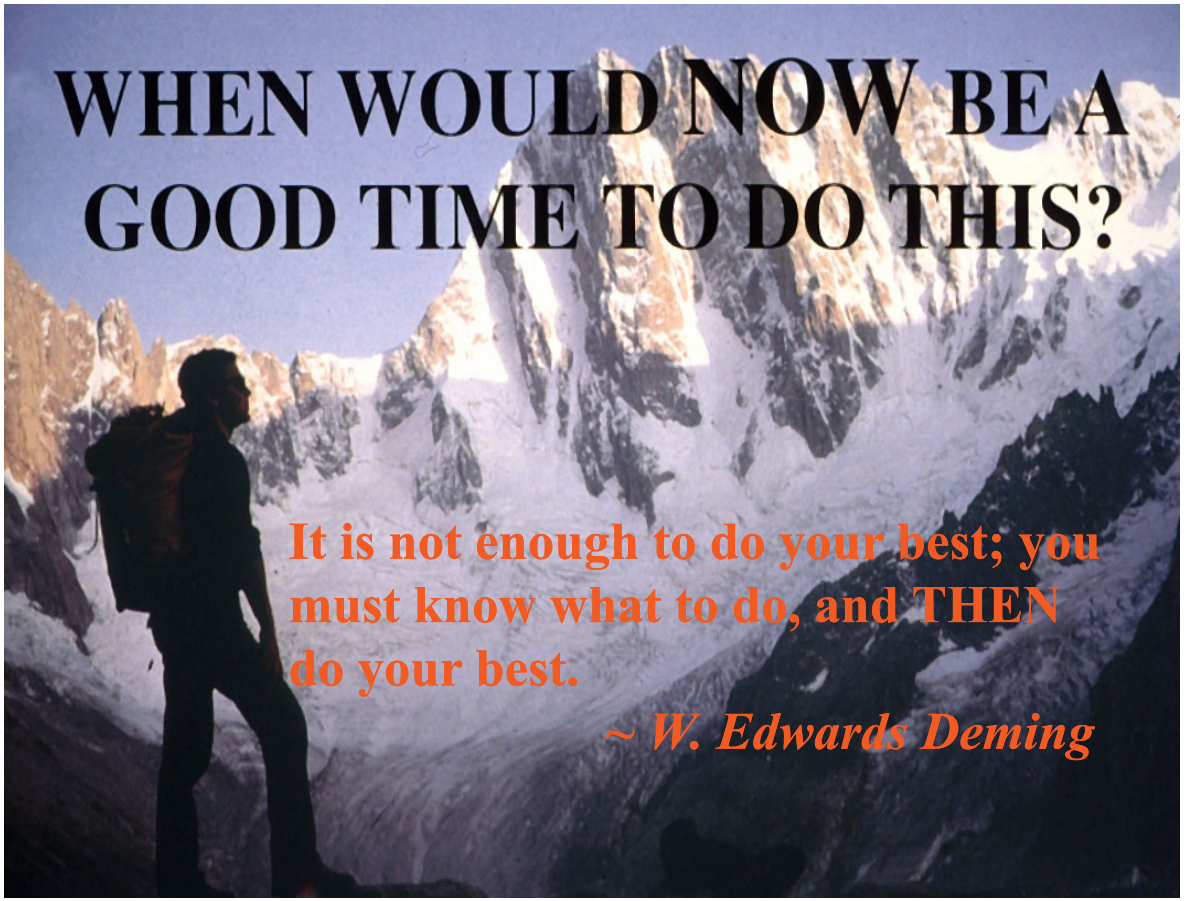
Patient Safety Strategies Encouraged for Adoption with Moderate to High Evidence

- Interventions to reduce patient falls
- Using clinical pharmacist to reduce adverse drug events
- Documenting patient preference for life-sustaining treatment
- Obtaining informed consent prior to medical procedures
- Team training
- Medication reconciliation
- Using surgical outcome report cards
- Rapid response systems
- Computerized provider order entry
- Using simulation training and patient safety efforts

Alspach JG. Crit Care Nurse, 2013;33(3):9-12

Quality is never an accident. It represents the wise choice of many alternatives.”

Willa Foster


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

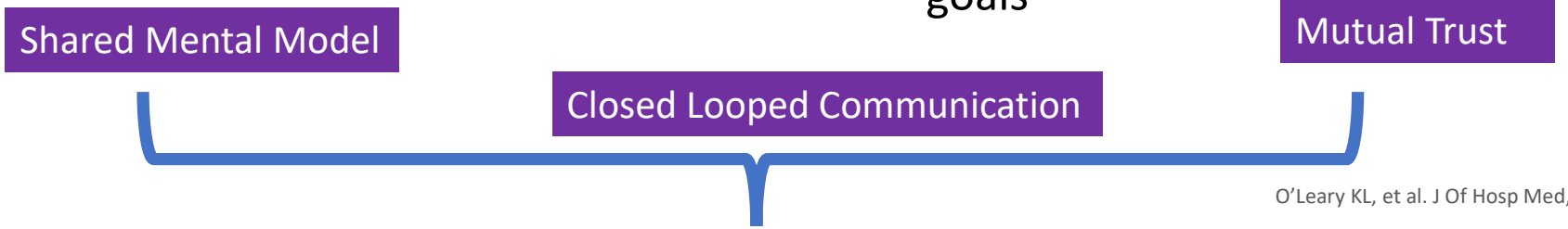
T Team

There is no “I” in TEAM…but there is a “ME”

Path to High Performing Teams

- Team Leadership
- Mutual performance monitoring
- Backup behavior
- Adaptability
- Team orientation

- The leader directs & coordinates team activities
- Team members monitor each other performance
- Team members anticipate & respond to one another's needs
- Team adjust strategies based on new information
- Prioritize team goals over individual goals

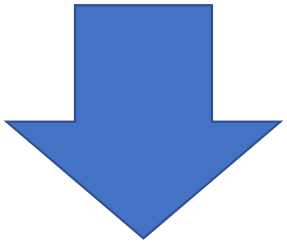


O'Leary KL, et al. J Of Hosp Med, 2012;7(1):48-54

Tools and Strategies to Improve Communication and Teamwork

- Structured Handoff
- Huddles
- Daily rounds/goals
- Pre-procedure briefing
- Checklists

Hospitals With High Teamwork Ratings



- Higher patient satisfaction
- Higher nurse retention rates
- Lower hospital costs

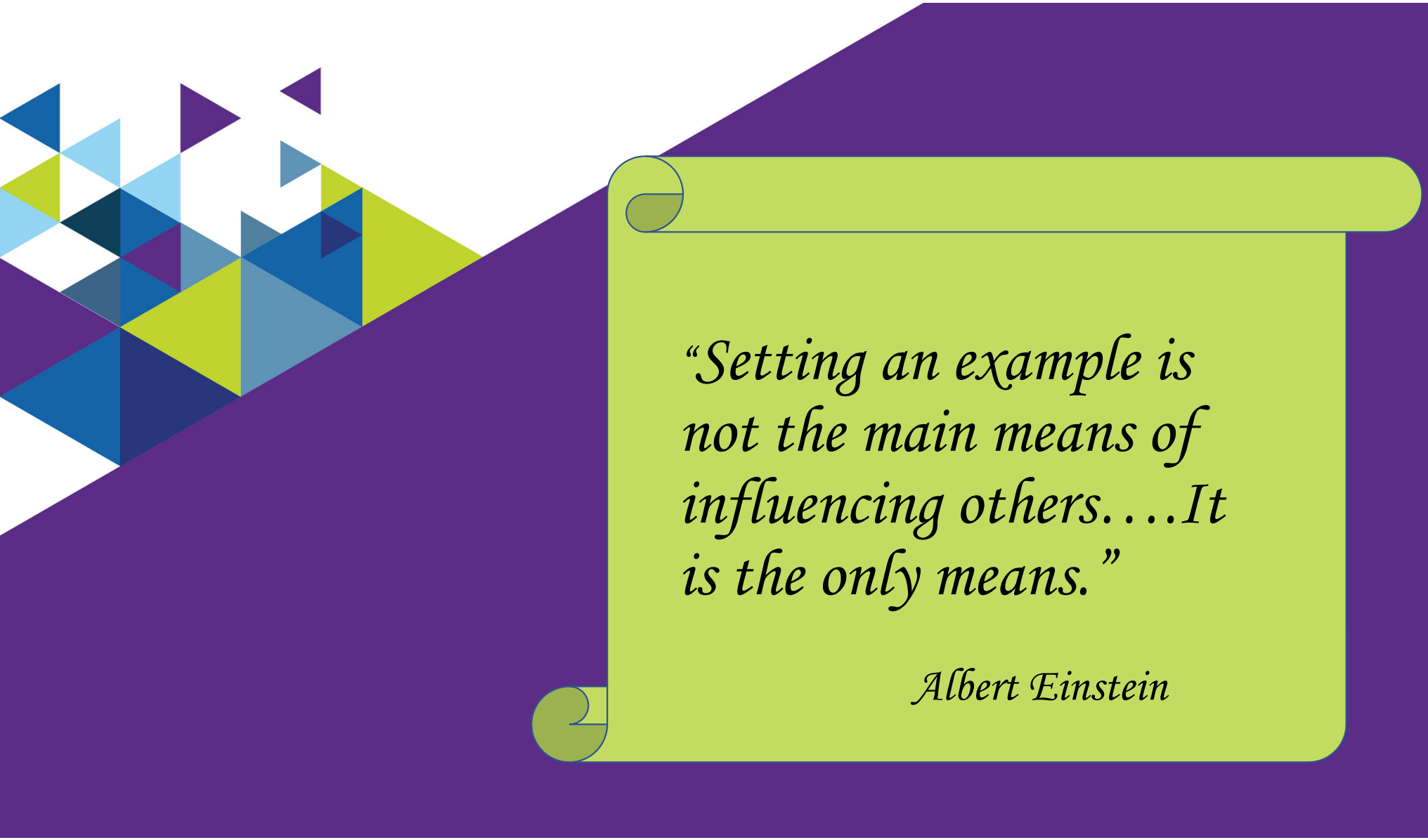
O'Leary KL, et al. J Of Hosp Med, 2012;7(1):48-54

Tools Don’t Create Safety

People Do!!!

The Silent Treatment, April 2011


The Most Powerful Force of Human
Behavior is Social Influence


"Setting an example is not the main means of influencing others….It is the only means."
Albert Einstein

Yes, I Will

Yes, I Will

Focus on Achieving Nurse Sensitive Outcomes &
Commit to a Culture of Safety & Accountability

Yes, I Will

Be the Power of One

“ I am only one, but still I am one.

I cannot do everything, but still I can do something.

I will not refuse to do the something I can do.”

Helen Keller

Yes, I Will

"You gain strength, courage and confidence by every experience in which you really stop to look fear in the face. You must do the thing which you think you cannot do."

Eleanor Roosevelt

Yes, I Will

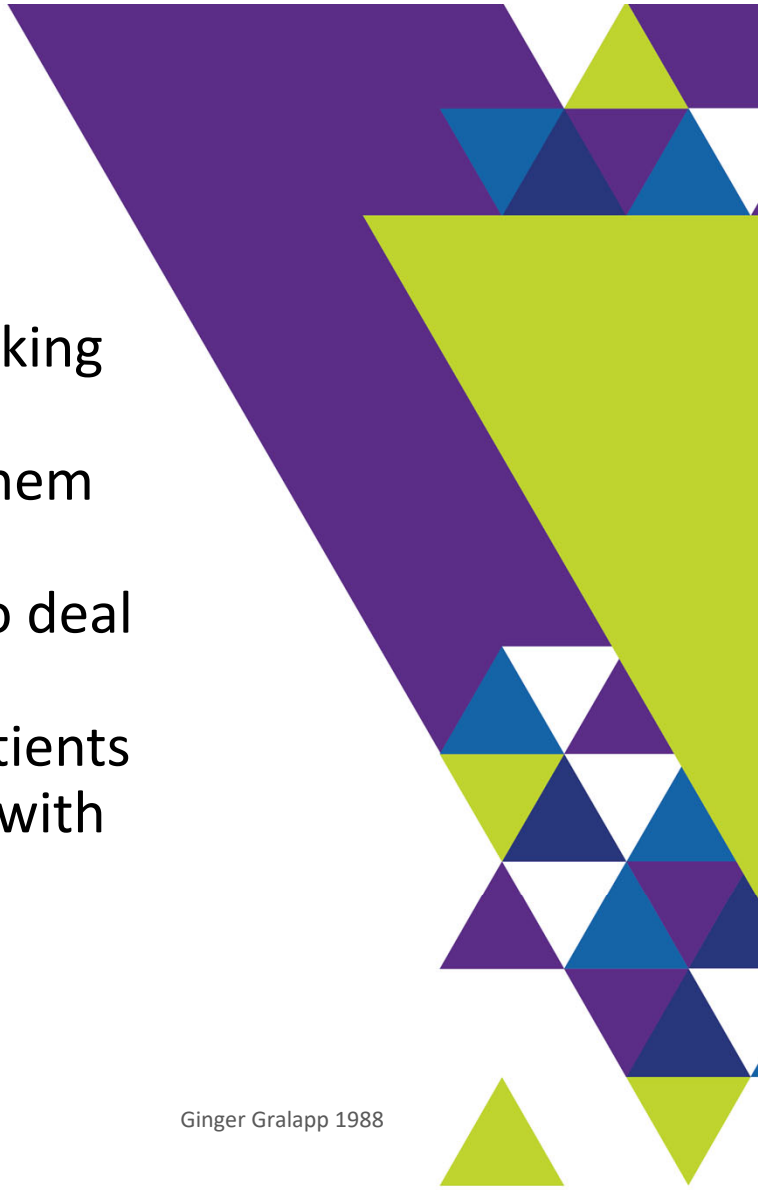
"Change and growth take place when a person has risked himself & dares to become involved with experimenting with his own life."

Herbert Otto

Yes, I Will

The Front Line

We as tattered nurses stand on the front line, taking care of others dealing with the body and mind. Attempting to heal patient's wounds and help them go on with life..lending and ear when in need, listening to their pain & strife. Teaching some to deal with illness, telling them what the future holds…good, bad, indifferent we nurses help patients be bold. We're always on the front line dealing with a never-ending fight….



Ginger Gralapp 1988

The Front Line (cont'd)

health, healing and wellness…sometimes we nurses need to take flight. For we need time to heal emotionally within ourselves…outlets to cope and learn we can't always put our feelings on the shelf. Somewhere there must be a middle ground where we can all go and rest, and soon we'll return to the front line whereas nurses we can be our best.

Ginger Gralapp 1988

Kathleen Vollman
ADVANCING NURSING THROUGH KNOWLEDGE & INNOVATION

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