IT TAKES A VILLAGE...TO IMPLEMENT CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PREVENTION

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Today’s webinar is sponsored by CHAIN, Minnesota’s Collaborative HealthCare-Associated Infection Network

- CHAIN develops and helps carry out approaches for reducing and preventing healthcare-associated infections in Minnesota:
  - **CLABSI**: central line associated bloodstream infections
  - **CAUTI**: catheter associated urinary tract infections
  - **CDI, C. diff**: clostridium difficile infections
  - **SSI**: surgical site infections

- CHAIN is lead by the Association for Professionals in Infection Control and Epidemiology-Minnesota (APIC), Minnesota Department of Health, Minnesota Hospital Association, and Stratis Health.
Our story

- In the beginning…
- Dedicated time is key
- Creating a policy
- What makes a good policy?
- Our Policy & Procedures
- Policy Implementation
- Working in Silos
- A Collaborative Approach
- Lessons Learned

In the Beginning

Like all good things it started with a great idea!
In the Beginning...

- December 2008 – the idea to work on CAUTI in 2009
  - The Joint Commission National Patient Safety Goal was on the horizon

- 2009 Clinical Practice Committee took on the project
  - Reviewed the literature on urinary catheter insertion/removal

Dedicated Time is Key
Foley Kaizen Event September 2009

- Audited every inpatient on Wednesday 9/9/09 and Friday 9/11/09 to see if:
  - The patient had a Foley
  - If the patient had a Foley - did they have an order
  - Where was the Foley placed
  - Was the reason for placement documented

Foley Kaizen Event September 2009

- Identified that we were not collecting CAUTI data for units outside of our inpatient ICU.

- Created a draft list of criteria for removal - specialized for Critical Care & Emergency Center
Outcome of September 2009 Foley Event

- 28% of all inpatients had Foleys in place
- 22% of inpatients who had a Foley did not have an order for one.
- Of the Foleys without an order most were placed in the EC, several were placed in a specialty area (HVC) or were from home. This was due to ordering issues with our previous Electronic Medical Record (EMR).
- Of the Foleys that were placed rarely was a reason for insertion documented. The EC was the area most likely to document why it was placed.

Outcome of Foley Event

Staff RNs’ Responses for reasons to place a Foley catheter compared to the criteria found in the literature

- # of responses meeting criteria from the literature
- # of responses NOT meeting criteria from the literature
- # of responses are not specific enough to meet the criteria
What to do with what we had learned?

- Event information shared with the Clinical Practice Committee (CPC)
- CPC revised and approved the draft list of criteria for removal
- A second event was planned for 10/2010

Foley Kaizen Event October/November 2010

- Evaluated which units had bladder scanners
- Created draft of the Urinary Catheter (Foley) Policy
# Outcome of October/November 2010 Foley Event

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHO</th>
<th>WHEN</th>
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<tbody>
<tr>
<td>Education around event communicated to staff</td>
<td>Foley Team &amp; Michelle Hagen</td>
<td>11/2010</td>
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<tr>
<td>Trial Foley insertion sticker</td>
<td>6 N &amp; 6 S RNs</td>
<td>11/2010-2/2011</td>
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<td>Trial Foley catheter rounds as a part of Multidisciplinary Rounds</td>
<td>6 N &amp; 6 S RNs and NM</td>
<td>11/2010-2/2011</td>
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<tr>
<td>Trial Foley insertion criteria in EC</td>
<td>EC RNs (Nancy Beyer)</td>
<td>11/2010-2/2011</td>
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<tr>
<td>Foley Policy draft created</td>
<td>Foley Team</td>
<td>11/2010</td>
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<tr>
<td>Foley Policy draft approval</td>
<td>Rosie and Emily</td>
<td>1/2011</td>
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<tr>
<td>Foley insertion progress note added to Epic</td>
<td>Rosie and Pavel Cech</td>
<td>11/2010</td>
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<tr>
<td>Straight cath orderset created</td>
<td>Foley Team</td>
<td>11/2010</td>
</tr>
<tr>
<td>Straight cath orderset approval for use in Epic</td>
<td>Rosie and Muffy</td>
<td>1/2011</td>
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## Creating a policy
Identify what type of catheter the policy pertains to.
Address when ordering is necessary vs. not necessary
Address documentation requirements
Frequency of assessment of the need for a Foley catheter

Criteria for discontinuing a Foley
Liability language (re: notifying MD of any adverse outcomes)
Included information about the Surgical Care Improvement Project (SCIP) requirements for removal.

Attachments:
- Criteria for continued Foley use algorithm
- Emergency Center Foley insertion criteria
What makes a good policy?

- Create a draft in a small group first
- Lots of input from a variety of individuals
- Revisions, revisions, revisions
- It is a living document
What makes a good policy?

- Revised and Approved by:
  - Infection Control Department
  - Professional Nursing Practice Department
  - Hospitalists
  - Urologists
  - Clinical Practice Committee
Our policy

SUBJECT: Urinary Catheter ( Foley)

REFERENCE NUMBER: CZ-194255424

ORIGIN DATE: 4/2012

REVISING NUMBER:

REVISING DATES:

MOST RECENT REVIEW DATE: 4/2012

PURPOSE:
To outline the guidelines for the utilization of urinary catheters in the hospital.

RESPONSIBILITY:
Director of Professional Practice

CONTACT CONTENT EXPERTS:
Director of Nursing Practice, Urology Department, Urology and Gynecology Department, and Infection Control Department.

POLICY:
Urinary catheters will be obtained and discontinued by nursing per clinician order or per criteria established in this policy. This policy does not pertain to application or removal of catheter.

DEFINITION:
Foley urinary catheter is a flexible tube that is passed through the urethra during urinary catheterization and into the bladder to drain urine.

PROCESS:
1. Before introducing a Foley catheter, the expectation in the area will test the patient with a sterile drape and hands until the patient is physically or medically stable to do the test.

2. A physician order is required to insert a Foley catheter. If a patient arrives from another area of the hospital or from another hospital with a Foley catheter in place, the nurse should determine whether the physician order is specific to the patient or if the patient does not meet the criteria described above for the Foley catheter or if the patient does not meet the criteria, the Foley catheter should be discontinued.

3. Emergency insertion criteria.

Our policy

- Relief of urinary retention or obstruction
- Management of urinary incontinence in female by frusen patients
- Use of Foley for urinary retention, post cardiac arrest (no remote nephropathy)
- Significant anatomic defect
- Urgent post void residual
- Chemically treated and is well
- Crush injury
- Certain if present needing severe upper and lower urinary tract injuries
- Renal injury
- Renal injury
- Management of urinary retention with the patient unable to perform catheterization
- Practice for patients being catheterized by medical personnel
- Urological bladder failure or multiple criteria, rapid rejection
- Insertion of Foley catheter will be documented in the electronic medical record (EMR) (Epic).

4. The use of a Foley catheter will be reassessed on day of the status.

5. If a Foley catheter may be discontinued per the criteria specified in this policy with a clinician order rate otherwise specified by the clinician.

6. Foley catheters will be discontinued if there is no patient meets the following criteria:
   a. Urological intervention with diagnosis of catheter
   b. Transient renal failure
   c. Acute uremia
   d. Acute renal failure
   e. Acute renal failure
   f. Management of urinary retention with the patient unable to perform catheterization
   g. Urological bladder failure or multiple criteria, rapid rejection

7. Foley catheters will be removed if a patient meets the following criteria:
   a. Sudden onset of a new lesion
   b. Presence of a catheterization
   c. Diagnosis of cancer
   d. Diagnosis of renal failure
   e. Diagnosis of diabetic nephropathy
   f. Diagnosis of chronic kidney disease
   g. Diagnosis of chronic kidney disease
   h. Diagnosis of chronic kidney disease
   i. Diagnosis of chronic kidney disease
   j. Diagnosis of chronic kidney disease
   k. Diagnosis of chronic kidney disease
   l. Diagnosis of chronic kidney disease
   m. Diagnosis of chronic kidney disease
   n. Diagnosis of chronic kidney disease
   o. Diagnosis of chronic kidney disease
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   q. Diagnosis of chronic kidney disease
   r. Diagnosis of chronic kidney disease
   s. Diagnosis of chronic kidney disease
   t. Diagnosis of chronic kidney disease
   u. Diagnosis of chronic kidney disease
   v. Diagnosis of chronic kidney disease
   w. Diagnosis of chronic kidney disease
   x. Diagnosis of chronic kidney disease
   y. Diagnosis of chronic kidney disease
   z. Diagnosis of chronic kidney disease

8. Foley catheters will be removed if patient meets the following criteria:
   a. Sudden onset of a new lesion
   b. Presence of a catheterization
   c. Diagnosis of cancer
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   z. Diagnosis of chronic kidney disease
Our policy

Algorithms
Algorithms

Procedures
Policy Implementation

- Housewide Foley Audit March 2012 for baseline data prior to implementation
  - Current Foley Practices
  - Reasons for catheter use
Policy Implementation

- Electronic Medical Record changes

- Mandatory Education for all nurses
  - Video regarding Foley infection prevention practices
  - Review of new policy

- Housewide Foley Audit December 2012 for post-implementation data
  - Current Foley Practices
  - Including reason for Foley
Policy Implementation

- Imbedding education in new employee education
  - Foley infection prevention practices
  - Review of new policy
  - Review of criteria

Working in Silos
Working in Silos

Infection Prevention

Clinical Nursing Specialists & Clinical Nurse Educators

Clinical Practice Committee

Directors and Nursing Managers

A Collaborative Approach

It really does take a village
A Collaborative Approach

- Collaborative formed in 2012 to streamline work
  - Rosaleen Bloom, Oncology CNS
  - Aminata Cham, Med/Surg CNS
  - Jeanne Hierstein, Maternal/Special Care Nursery Nurse Educator
  - Sarah Pangarakis, Critical Care CNS
  - Linell Santella, Director of Infection Control

A Collaborative Approach

- Addressed Gap Analysis for CAUTI & CLABSI
- Ongoing education/audits for nursing staff
- Implement Root Cause Analysis process for every CAUTI
- Identifying documentation gaps
Lessons Learned

- Be flexible/open to new ideas
- Identify key stakeholders from the start
- Electronic Medical Record (EMR) support
- Identify what should be in a procedure vs. a policy vs. a protocol?
Our Next Steps

- Analyze data from 12/2012 audit
- Roll out bladder scanners house wide
- Implement bladder scanning protocol
- Crossword puzzles for Nurses and Nursing Assistants
- Revise policy with streamlined Emergency Center Insertion Criteria and add bladder scanning protocol
Our next steps

- Implement Root Cause Analysis process for every CAUTI
- Ongoing education for nursing
- Implement Nursing Assistant education
- Focus on insertion technique for all nurses/techs inpatient and in the surgery center

Educational Tools

- [http://www.youtube.com/watch?v=CpF6gU6bL08](http://www.youtube.com/watch?v=CpF6gU6bL08)
Selected References


Questions
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