Boots on the Ground to Prevent Catheter-Associated Urinary Tract Infections

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Objective

To maintain a safe environment for patients at Mary Greeley Medical Center by hardwiring processes for optimal preventative care using real-time observations and feedback.

Background/Significance

Catheter-associated urinary tract infections (CAUTIs) are the most common healthcare-associated infection and account for 1 million cases per year in the United States. They are the most common cause for secondary bloodstream infections and cost $115 million to $1.82 billion annually. The CDC, AHRQ, and ANA all recommend CAUTI bundle elements including:

•daily documentation of need assessment
•an intact tamper-evident seal
•catheter securement with an appropriate device
•hand hygiene performed before and after contact with the patient and catheter components
•daily peri-urethral care performed according to hospital policy
•unobstructed urine flow
•criteria met for catheter removal

In early 2021, Mary Greeley Medical Center recognized unfavorable NDNQI and NHSN trends related to non-oncology CAUTI infections. Once recognized, it became clear that a change needed to occur. A serious safety events intensive was held with the management team and a need for real-time audits and feedback of preventative care items was identified. The Leader Safety Rounds team was developed and trained by the Patient Experience and Safety Director. The Huron Rounding software was leveraged to document rounds and to publish results and trends to leaders instantly. The Leader Safety Rounds process identified education and vendor opportunities preventing adherence to previously hardwired processes and revived focus around preventing patient harm related to CAUTIs.

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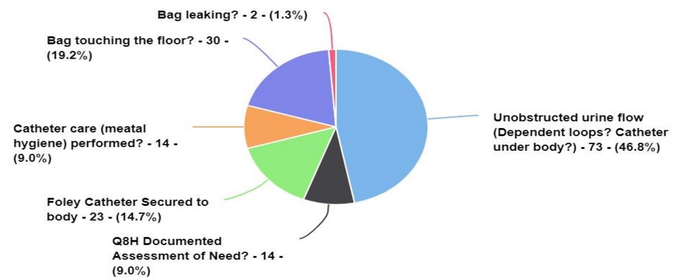
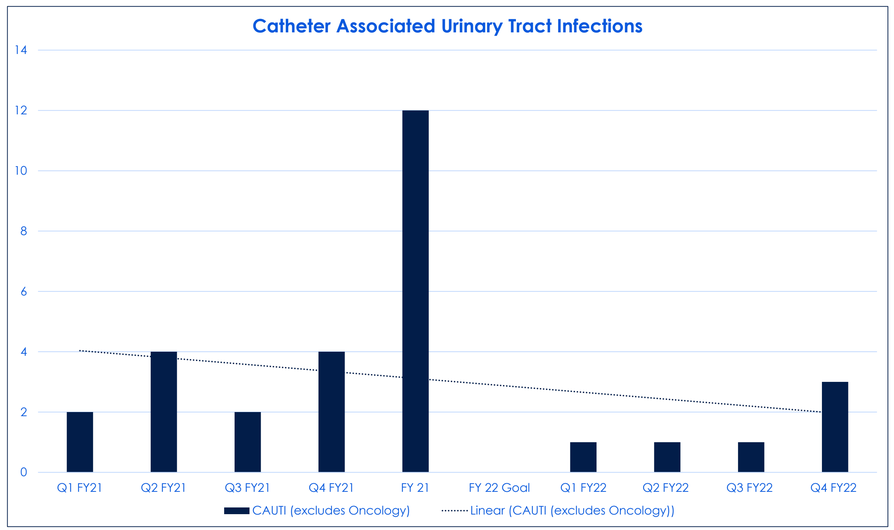
Metrics

- 2700 safety rounds completed
- Over 350 patients identified as a CAUTI risk
- 156 times the safety rounder provided feedback to a staff member and/or intervened to ensure interventions were in place to prevent CAUTIs
- Decrease from 12 CAUTIs in FY2021 to 3 CAUTIs in FY2022





Analysis

- Leader Safety Rounds completed weekly by team members assigned by department
- Individual/department feedback provided in real-time
- Safety team ensured missing interventions were put into place during round
- Department trends shared with leaders as appropriate
- Transparent data visible within Huron Accelerators portal within minutes of round used during A3s and to plan department education
- Foley champion identification and training completed as a result of findings
- Nursing management dashboards created to monitor documentation compliance for catheter cares
- Vendor evaluation of catheter kit items necessary for compliance with prevention items

References

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