CAUTI drilldown “conversation starters”

**INSERTION**

Where was the foley placed?

Was there difficulty with insertion?

Was there an inpatient order for the foley? If placed in the ED or another hospital, a new order must be created.

Per order, what was the medical necessity of the foley? Does this match the patient’s condition?

Does the nursing care reflect the reason for insertion? (ie order for immobility- patient cannot be moved/turned, order for hourly output- was hourly output documented?)

Was patient educated on need for foley?

**DAILY CARE AND MAINTENANCE**

Was foley care documented at least daily?

Was continued need for foley addressed daily?

If patient had foley for acute urinary retention/obstruction, was there a plan to eventually get the foley back out?

If patient had the foley for an open sacral/perineal wound, was a wound consult completed?

If the foley was removed and had to be reinserted for retention, what interventions were done before reinsertion? Urethral and bladder damage/tonicity may take 24 to 48 hours to heal after the foley has been removed.

- Bladder scans with intermittent straight caths?
- Running water or placing patient’s hand in warm water?
- Privacy? Different positioning? Increasing hydration?

**URINE CULTURE COLLECTION**

Who ordered the culture?

Why was the culture ordered? Signs and symptoms of a UTI include fever, suprapubic pain, costovertebral pain, urgency, frequency, dysuria. Cloudy or foul smelling urine is not a reason to perform urinalysis- this usually indicates catheter colonization.

How long was the foley in place before the UTI was identified?

Did the patient still need the foley for the reason given on insertion?
How long did it take to discontinue the foley after it was ordered out?

SUMMARY

What did we learn from this drilldown and how can we educate the rest of the hospital on reducing risks for CAUTI?