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HRET HOSPITAL IMPROVEMENT INNOVATION NETWORK (HIIN)

HOWARD MEMORIAL HOSPITAL | CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

ORGANIZATION AND TEAM

HOWARD MEMORIAL HOSPITAL
Nashville, Arkansas

“Improving the health of the communities we serve”

Pictured (left to right): Kristi Wheelerhurst, Belin Pannell, Beth Scholes, Ashley Collins, MS, Crump, Gayla Beard, Linda Turner
Not Pictured: Deitra Wright, Steven May

SETTING THE STAGE

>> What happened in the hospital setting that made you want to address this topic/issue/challenge?
   • In monitoring the daily Foley days, it was noted that we were running some high numbers. This information alerted us that we were potentially missing some opportunities to enhance the care of our patients by ensuring that we discontinued Foleys at the earliest opportunity.

>> Why did you feel it was a challenge?
   • We knew going forward that it would entail a lot of education, discussions, meetings and data collection, but we knew that the care of our patients would be greatly improved.

>> Why did you make the choice to address the challenge?
   • The care and safety of our patients is always our #1 goal. We continuously are looking for ways to improve the care of our patients. This decision was not a hard decision to make. It was, most certainly, the right thing to do.

>> What did the results/outcome teach the team?
   • I would encourage anyone and everyone that may not be participating with HEN/HIIN to get on board. The education, guidance and team performance is spectacular. You are never alone. Help is just a phone call away.

>> What did the results/outcome teach the team?
   • It taught our organization that if we choose to do something we can achieve whatever we set our mind to do as long as we work as a team.

>> What did the patient teach the team?
   • When our patients and their families are educated on why we would not place a Foley when it is unnecessary, the gratitude that was expressed is all we needed. It proved to us that the patients are listening, families are paying attention and they do want to know why things are done the way they are.

>> Why did you feel it was a challenge?
   • We fully challenge anyone and everyone to get engaged and join the HEN/HIIN. It is never to late to help our patients.

>> If your intervention was implemented in all HIIN hospitals, what would you envision happening?
   • I would envision that Foleys would become a less common occurrence within hospitals. CAUTI rates would drop dramatically.

PROJECT DESIGN

>> Our community has a large elderly population. We have 4 nursing homes. That increases the chances of a large part of our admission to be elderly. Most of these patients are bed fast. If we chose to use catheters as a convenience it would greatly increase the chances for patient harm.

>> Our key players included:
   • Infection Prevention
   • Quality Director
   • PCU Manager
   • CNO
   • ER Nurse
   • Surgery Director
   • CEO
   • MD Chair

>> We managed to reduce the number of foley days from 932 to 358. This eliminated 574 chances for patient harm.

RESULTS

>> How did your hospital’s participation in the HEN/HIIN contribute to the outcome achieved?
   • I would encourage anyone and everyone that may not be participating with HEN/HIIN to get on board. The education, guidance and team performance is spectacular. You are never alone. Help is just a phone call away.

>> Why did you feel it was a challenge?
   • We applied the STOP-Appendix H form to the top of the Foley packages to alert the nurse to stop and make sure that the catheter is really being placed with an appropriate reason. Our package did not include the leg strap so we attached that to the package as well.

>> What did the patient teach the team?
   • When our patients and their families are educated on why we would not place a Foley when it is unnecessary, the gratitude that was expressed is all we needed. It proved to us that the patients are listening, families are paying attention and they do want to know why things are done the way they are.

>> What did the results/outcome teach the team?
   • “Will you/your hospital join me in agreeing “Let’s all join together and DO THE RIGHT THING for our patients?”

>> Why should other hospitals implement your intervention?
   • Very simple-join HEN/HIIN. Don’t reinvent the wheel; use ideas and interventions that have proven to be successful for other hospitals.

>> Why did you feel it was a challenge?
   • The number one reason—OUR NUMBERS PROVE THAT IT WORKED!

>> Are there any additional resources needed to spread?
   • Here is a copy of the laminated card that we used and our STOP sign. Our laminated card was 2-sided. The other side I used forisolations and what qualified in each of the three sections.

SPREAD AND SUSTAINABILITY

>> How easy is the intervention for others to implement?
   • Very simple-join HEN/HIIN. Don’t reinvent the wheel; use ideas and interventions that have proven to be successful for other hospitals.

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>> What did the results/outcome teach the team?
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> ADDRESSING THE CHALLENGE

>> If we had not addressed this our Foley numbers would have kept climbing; increasing the patient’s chances for developing a CAUTI.

>> What would and what DID happen after addressing this issue was:
   • Physicians were educated at their medical staff meeting
   • Staff were educated on ways to avoid catheter insertion
   • In-Service on aseptic techniques for insertion and removal were held
   • Nursing began offering more frequent bathroom visits to the patient
   • Laminated cards for reference on appropriate reasons for insertion were made and provided to staff

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HIIN PROGRESSION

>> What commitment would you ask each hospital to make to reduce harm in CAUTI?
   • STOP-LOOK around at your patients, their families and your work environment. What would you want someone to do. Then your commitment will speak for itself. When you start and you get used to it before long it will be a part of your everyday work environment.

>> Why did you feel it was a challenge?
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The data for our Foley days is obtained from doing daily chart reviews. We monitor where it was inserted so that we can see if one department seems more aggressive at placing Foleys than others. We review and document how long the Foley has been in to ensure that it is removed promptly. Reasons for Foley placement are monitored for appropriateness. Tracking Foley days became a part of the Infection Control nurse’s daily routine.

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