ORIENTATION AND TEAM

MEMORIAL HOSPITAL – MAINE HEALTH
North Conway, New Hampshire

SETTING THE STAGE

- In 2008 we started looking at urinary catheter usage, not necessarily related to CAUTI but the over utilization.
- The vast majority were being placed without a qualified reason and possible for nursing convenience.
- It was a challenge to educate the ED staff to reduce the number of urinary catheters placed.
- With the volume of urinary catheters we knew we were potentially increasing our risk of CAUTI.

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RESULTS

- How did your hospital's participation in the HEN/HiIN contribute to the outcome achieved?
  - Support from NH Foundation for Healthy Communities and HRET and HiIN.
    - Attendance at statewide CAUTI presentation 2016
    - Alternative to use of indwelling urinary catheters
    - Reducing indwelling urinary catheter use in ED and O.R.
    - Reporting structure
    - Educational support
- What did the results/outcome teach the team?
  - Able to make significant change in relatively short time period
  - Involvement of nursing and providers
- What did the patient teach the team?
  - Patients welcome the ability to remain independent with toileting
  - Appreciate timely removal of urinary catheter

RESULTS

MEMORIAL HOSPITAL CAUTI RATE

- What would have happened if you didn’t address the challenge?
  - Potential for increased incidence of CAUTI
- What evidence based intervention (or interventions) was/were selected to address the challenge?
  - Education
  - Policy revision
  - Acute urinary retention or obstruction
  - Precise measurement of urinary output
  - Select surgical procedures
  - Open sacral or perineal wounds in an incontinent patient
  - Prolonged immobilization, i.e., spinal injury
  - Terminal care as a comfort measure

LESSONS LEARNED

- What is the call to action for others with a similar challenge?
  - Data speaks volumes
  - Significant guilt over each CAUTI/HAI
  - Cost with increased length of stay and treatment
- If your intervention was implemented in all HiIN hospitals, what would you envision happening?
  - Celebrate small victories, any reduction is important

PROJECT DESIGN

- The projects initial focus was on the prevalence of urinary catheters not exclusively CAUTI.
  - Show data of incidence of urinary catheters placed in ED without good reason.
  - Change CPOE order sets to include removal date.
  - OB: post-operative cesarean section: Nursing Order Foley to gravity, discontinue Foley first post-op day
  - Daily monitoring of urinary catheters in place (see NHSN CLABSI and CAUTI denominator sheet).
  - Urinary catheter insertion and maintenance competency check list (see Competency Check List).
  - Reduce indwelling catheter use in OR cases with short surgical intervention times.
- Internal Patient Safety Initiatives and as part of Clinical Standards Committee.

SPREAD AND SUSTAINABILITY

- How easy is the intervention for others to implement?
  - once in place, it is easily sustainable
- Why should other hospitals implement your intervention?
  - There is intense pressure to meet these requirements:
    - Ethical considerations for the patient
    - Negative impact of immobility created by urinary catheter
    - Patient discomfort
    - Potential trauma
    - Increased fall risk
    - Risk of CAUTI
    - Evidence based practice supports it.
    - Financial considerations demand it.
    - Our policies expect it.
- Are there any additional resources needed to spread?
  - Senior leadership support
  - Board responsibility for quality outcomes
  - Provider support

HIINPROOFMENT

- What commitment would you ask each hospital to make to reduce harm in CAUTI?
  - Involve patient in decision making or risks and benefits.
- *Will you/your hospital join me in 40% reduction annually or 12 months of no CAUTI?*