HRET HIIN ICU CAUTI Fishbowl

January 22, 2019
11:00 a.m. – 12:00 p.m. CT
WELCOME AND INTRODUCTIONS

Julie Kim, BS
Program Specialist, HRET
Webinar Platform Quick Reference

- Mute computer audio
- Today’s presentation
- Download slides/resources
- Register for upcoming events
- Chat with participants
<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
<th>Presenter(s)</th>
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</table>
| 11:00 – 11:05 a.m. | Welcome and Introductions  
Introduction to today’s event and agenda overview. | Julie Kim, BS  
Program Specialist, HRET |
| 11:05 – 11:45 a.m. | Framing the Discussion  
Specimen Collection Best Practices and Opportunities  
Updates from the Fish  
Catch up on the latest developments with participating Fish hospitals.  
Each hospital team will explain:  
• Opportunities discovered in specimen collection practices  
• Progress toward their AIM statements from first Fishbowl session | Julie Kim, BS  
Program Specialist, HRET  
Jackie Conrad, RN, MBA, RCC  
Barb DeBaun, RN, MSN, CIC  
Improvement Advisor, Cynosure Health  
Martha Hayward  
Patient and Family Engagement Expert, Independent Contractor (HRET) |
| 11:45 – 11:55 a.m. | Lessons Learned & Next Steps  
Provide a synthesis of generalizable lessons learned for the listening audience.  
Vision for PFE | Jackie Conrad, RN, MBA, RCC  
Barb DeBaun, RN, MSN, CIC  
Improvement Advisor, Cynosure Health  
Martha Hayward  
Patient and Family Engagement Expert, Independent Contractor (HRET) |
| 11:55 – 12:00 p.m. | Bring it Home  
Close today’s event with action items and share resources. | Julie Kim, BS  
Program Specialist, HRET |
Poll: How did you get here?

How did you hear about today’s virtual event?

a. HRET HIIN flyer
b. HRET HIIN website
c. HRET LISTSERV
d. State hospital association
e. QIN-QIO
f. Your organization/colleague
g. Other, please specify
FRAMING TODAY’S EVENT

Jackie Conrad, RN, MBA, RCC
Barb DeBaun, RN, MSN, CIC
Improvement Advisors, Cynosure Health
Welcome to the Round Up

- Prompt removal
- Use of alternatives

- Culture Stewardship
Welcome Lab and Microbiology Team Members!
Urine Testing
The Effects on Healthcare When Proper Urine Culture Management is Not Implemented

- **Clinicin**: Improper ordering
- **Nursing**: Improper collection
- **Laboratory**: False-positive results, workloads
- **Pharmacy**: Increased costs
- **ID**: Ineffective antibiotic stewardship
- **IP**: Inaccurate analysis
- **Finance**: Increased costs
- **Patient**: Adverse effects

Credit: Robert Garcia
Step 1 Opportunities to decrease inappropriate urine cultures

- Check standing and admission orders for routine urinalysis or urine culture on admission or pre-procedure.
- Are you feeling pressure to catch an infection that was present upon admission or before a catheter is inserted.

*Do you want to look good, or be good?*
Proper Collection and Handling of Urine

Source: Robert Garcia BS, MT (ASCP), CIC, FAPIC

So many opportunities to grow bugs

- Specimen collection technique
  - Is the urine transferred into a second container?
  - Is the hub scrubbed
  - Are preservatives in the container? **If not must be processed in 2H.**
  - How quickly does the specimen get into the hands of the clinical lab?
  - **Is the specimen labeled as “cath’d”?** Clean catch vs catheterized specimens are processed differently
  - When and how is the specimen stored while awaiting UA results for reflex?
  - What is the turn around time of a reflex culture?
Unlike intravascular catheters, there is no replaceable connector on indwelling urinary catheters.

**The Triad:**
- Correct site
- Proper disinfection
- Correct collection

**Advantage:**
- Direct draw
- Fewest steps
- Fewest items
- Minimizes risk of contamination

**Best Practice Triad for Urinary Catheter Specimen Collection**

**Scrub-the-Hub: 5 secs (?)**

“If a small volume of fresh urine is needed for examination (i.e. urinalysis or culture), aspirate the urine from the needleless sampling port with a sterile syringe/cannula adaptor after cleansing the port with a disinfectant.”

Make it easy to do the right thing
Educate All Collectors on Best Practice

Available at: http://www.bd.com/vacutainer/pdfs/LLAD_wall_chart_foley_catheter_collection.pdf
Opportunities identified:

- Use of a collection device
- Collecting routine specimens

Tool revised

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How did this specimen get collected?

“Clean” catch?

Urinary catheter?
Source of specimen matters
Meanwhile, back at the ranch

Lots of variation.
Lab is getting involved
Reflex Urine Testing Resources

Appropriate Urine Culture Article

Dive into this topic on February 12th!
Next Fishbowl – Reflex Urine Culture Testing

- Review your policy or criteria for running a urine culture from a UA.
- Where are UA specimens kept while awaiting results?
- What is the reliability of accuracy of specimen labeling as clean catch vs catheterized?
- Can a UA be ordered without reflex to culture?
Updates from the Hospitals

- USA Health University, AL
- Concord Hospital, NH
- Franciscan Health Crown Point, IN
Updates

- Specimen Collection and Transportation Tracer Findings.
- Change ideas tested or implemented
- Engagement strategy—patients, lab, nurses, physicians

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USA Health University Hospital (MSCU) – Alabama

- **ICU Stats**
  - Bed size: 8
  - Type of unit: Medical Surgical Cardiac Unit
  - University Hospital is a Level I Trauma Center, Regional Burn Center, and a Stroke Center.

- **CAUTI Fishbowl Journey**
  - Weekly point prevalence for Urinary Catheters and Central lines which includes observation of documentation and clinical compliance with the organization’s maintenance bundle policies
  - Follow-up with Infection Control director about lab reflex process
  - Follow-up with Teresa Barnett, microbiology lead regarding lab tubes with preservatives

**Team Members:**
Kimberly Tucker, Nurse Manager of MSCU
Rosanna Johnson, Unit Supervisor
Sarah Gates, Nurse Educator
Teresa Aikens, Nurse Manager for Infection Prevention/Control
Chelsie Wilkinson, RN MSCU
Karen Miller, PCA
Teresa Barnett, Microbiology Lead
Franciscan Health Crown Point– Indiana

- **ICU Stats**
  - Bed size-21
  - Type of unit- Combined Medical/Surgical ICU

- **CAUTI Fishbowl Journey**
  - Working towards automatic UA with reflex to culture order corporate initiative
  - Evaluating process and evidence for per protocol UA with reflex to culture upon insertion of Foley
  - Dive into specimen collection and handling
    - Preservative in Culture tube
    - Analysis done real time, no batching
    - Possible room to improve documentation of how specimen is collected
  - Antibiotic Stewardship-overall decrease in antibiotic use, attempting to gather data on specific antibiotic use for asymptomatic bacteriuria
  - Lab Director included as new member of the team!

Team Members:
Travis Thatcher-Curtis, Director of Nursing Operations
Richard Tants, Laboratory Director
Chris Shakula, Infection Preventionist
April Nikoloski, Critical Care CNS
Concord Hospital – New Hampshire

- **ICU Stats**
  - 18 beds
  - General ICU
  - Small CT surgery program, trauma center

- **CAUTI Fishbowl Journey**
  - The culture of “Pan” Culturing
  - Utilization – 2 Question Approach

Team Members:
- Jody Case, Director of Critical Care
- Erica Petralia, Critical Care Educator
- Delia Shepard, Critical Care Nurse
- Bobbie-Jo Rean, Critical Care ARNP
- Christine Villeneuve, Infection Prevention
- Star Brown, QA Nurse
- Kathy Wieliczko, Patient Relations Coordinator
Concord’s Big Board
Lessons Learned

Jackie Conrad, RN, MBA, RCC
Barb DeBaun, RN, MSN, CIC
Improvement Advisors, Cynosure Health
Guidelines for evaluation of new fever in critically ill adult patients: 2008 update from the American College of Critical Care Medicine and the Infectious Diseases Society of America

Neomi P. O’Grady, MD; Philip S. Barie, MD, MBA, FACC; John G. Bartlett, MD; Thomas Bieck, MD, FACC; Karen Carroll, RN; Andre C. Kall, MD; Peter Linden, MD; Dennis G. Muki, MD; David Nierman, MD, FACC; William Pascullie, MD; Henry Masur, MD, FACC

Objective: To update the practice parameters for the evaluation of adult patients who develop a new fever in the intensive care unit, for the purpose of guiding clinical practice.

Participants: A task force of 11 experts in the disciplines related to critical care medicine and infectious diseases was convened from the membership of the Society of Critical Care Medicine and the Infectious Diseases Society of America. Specialties represented included critical care medicine, surgery, internal medicine, infectious diseases, neurology, and laboratory medicine/microbiology.

Evidence: The task force members provided personal experience and determined the published literature (MEDLINE articles, textbooks, etc.) from which consensus was obtained. Published literature was reviewed and classified into one of four categories, according to study design and scientific value.

Consensus Process: The task force met twice in person, several times by teleconference, and held multiple e-mail discussions during a 2-yr period to identify the pertinent literature and arrive at consensus recommendations. Consideration was given to the relationship between the weight of scientific evidence and the strength of the recommendation. Draft documents were composed and debated by the task force until consensus was reached by nominal group process.

Conclusions: The panel concluded that, because fever can have many infectious and noninfectious etiologies, a new fever in a patient in the intensive care unit should trigger a careful clinical assessment rather than automatic orders for laboratory and radiologic tests. A cost-conscious approach to obtaining cultures and imaging studies should be undertaken if indicated after a clinical evaluation. The goal of such an approach is to determine, in a directed manner, whether infection is present so that additional testing can be avoided and therapeutic decisions can be made. (Crit Care Med 2006; 36:1330–1349)

Key Words: fever; intensive care unit; critical illness; blood cultures; catheter infection; pneumonia; cellulitis; sinalis; surgical site infection; nosocomial infection; temperature measurement; urinary tract infection
Patient and Family Engagement for CAUTI Prevention

- Coming Up….February 12th
- Featuring Catholic Medical Center, NH
Vision for PFE

Hospitals and other health care providers achieving quality and safety goals by fully engaging patients and their families, determining what matters most to them in every situation, and partnering with them to make improvements to all aspects of care.
PFE Metrics

Point of Care
- Planning checklist for scheduled admissions (Metric 1)
- Shift change huddles / bedside reporting with patients and families (Metric 2)

Policy & Protocol
- PFE leader or function area exists in the hospital (Metric 3)
- PFEC or Representative on hospital committee (Metric 4)

Governance
- Patient and family on hospital governing and/or leadership board (Metric 5)

Front Line Staff
Leadership
Board/C-Suite
What you can do to engage pts in CAUTI

• Include patients and their family in care decisions
• Involve patients and their family in safety rounds
• Share patient stories in meetings
• Ask patients or family members to share their stories
• Provide CAUTI prevention education to patients
• Share what you are doing to help prevent infections
• Ask patients and family to help educate staff
• Include days of use on white board
Bring it Home

Julie Kim, BS
Program Specialist, HRET
Articles of interest – session 1

Appropriate Urine Culture Article

Non-infectious Complications of Catheters Article
Resources

Change Package

Top 10 Checklist

CAUTI Prevention Bundle
## ANA Evidence-Based CAUTI Tool

### Streamlined Evidence-Based RN Tool: Catheter-Associated Urinary Tract Infection (CAUTI) Prevention

**ANA-Guideline CAUTI Prevention: Setting Limits, Preventing Harm, and Saving Dollars**

**Key Practice Strategies Identified (CPH):**
1. Practice Catheter Use
2. Timely Removal of Catheter

**Infection Prevention and CAUTI, Maintenance and Post-Natal Care**


**IUD (2009) Criteria for Indicating Cathereterizable Urethra:**
- Anatomical and Functional Evaluation
- Absence of renal dysfunction
- Absence of lower urinary tract abnormalities
- Absence of prostatic hyperplasia
- Absence of symptoms of lower urinary tract infections
- Absence of recent bladder catheterization
- Absence of recent instrumentation
- Absence of recent instrumentation

**Insertion Checklist to Prevent CAUTI in the ANA Hospitalized Patient: Important Evidence-Based Steps**

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<thead>
<tr>
<th>Step</th>
<th>Yes</th>
<th>No</th>
<th>Reminder</th>
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<tbody>
<tr>
<td>1. Evaluate if CVC is appropriate per the OGG Guidelines (OGCE 2009).</td>
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<td>2. Select smallest appropriate IUD 14 Fr, 14 Fr or 12Fr is usually appropriate unless contraindicated.</td>
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<td>3. Obtain written patient permission to facilitate appropriate catheterization technique.</td>
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<td>4. Perform hand hygiene.</td>
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**After CAUTI evaluation:**
- Insert or reinsert catheter if appropriate, based on patient's needs and preferences.
- Consider alternatives such as intermittent catheterization or suprapubic catheterization if available.
- Maintain continuous surveillance and education to prevent CAUTI.

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### Resources

- American Hospital Association
- Resources
- ANA Evidence-Based CAUTI Tool
Upcoming ICU CAUTI Fishbowl Series Events

- February 12, 2019 – Reflex Cultures
  - Register [here](#)
- March 12, 2019 – PAN Cultures
  - Register [here](#)

- All from 11 a.m.- 12 p.m. CT
THANK YOU!