CAUTI Event Report Tool: Data for Event Analysis

This event report tool is designed to be used as a guide through the initial investigation for a defect analysis where the primary goal is to learn what happened and what factors may have contributed to the catheter-associated urinary tract infection (CAUTI). It is not a stand-alone tool. Users are encouraged to review the defect analysis process outlined in the Agency for Healthcare Research and Quality’s (AHRQ’s) Comprehensive Unit-based Safety Program (CUSP) model. Specifically consult the [Identify Defects Through Sensemaking](https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/identify/index.html) module and the [Learn From Defects Tool](https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/toolkit/learndefects.html) for a description and instructions on how to perform a full defects analysis on a healthcare-associated infection such as CAUTI.

This tool is also a template, which means it can and should be adapted to each organization. Please manage this documentation according to your hospital’s patient confidentiality policy.

The questions listed below are to assist teams in getting started, not limit what is examined. This list of questions is a compilation of initial questions commonly asked during a CAUTI defect analysis/root cause analysis process and does not represent an exhaustive list of all questions that may need to be addressed. Indeed, the questions listed here may very well drive additional questions to understand active and latent issues more thoroughly. The goal is to learn as much as possible about potential latent and active errors contributing to the development of CAUTI in an individual patient. In addition, the data gathered from multiple CAUTI event investigations can and should be aggregated to look for trends and common denominators within a facility or unit, which furthers understanding to reduce risks. Lastly, do not wait too far out to complete the event report tool as it may be difficult to fill in the details.

Demographics

*(Please manage this documentation according to your hospital’s patient confidentiality policy)*

1. Patient’s medical record number:

2. Patient’s date of birth:

3. Patient’s gender:  Male  Female  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Hospital admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day of week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Diagnoses:

6. Patient locations from catheter insertion through time urinary catheter removed (include dates, locations/room numbers, and staffing ratios):

Location of insertion:  Emergency Department  Ambulatory  Surgery  Direct Admission  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Room #\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_  
Was your nurse–patient staff ratio out of range from the usual numbers?  YES  NO

Room #\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_  
 Was your nurse–patient staff ratio out of range from the usual numbers?  YES  NO

Room #\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_  
Was your nurse–patient staff ratio out of range from the usual numbers?  YES  NO

Room #\_\_\_\_\_\_\_ from \_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_  
Was your nurse–patient staff ratio out of range from the usual numbers?  YES  NO

Room #\_\_\_\_\_\_\_From \_\_\_\_\_\_\_\_ to\_\_\_\_\_\_\_\_\_  
Was your nurse–patient staff ratio out of range from the usual numbers?  YES  NO

Notes:

CAUTI Information

7. Infection date (date of onset of symptoms or culture date):

8. Criteria met for infection:

9. Why was a urine culture sent? (Select reasons from list of evidence-based rationales below.)

1. Patient has one or more of the following clinical signs/symptoms (check all that apply):

Fever without other obvious source

Suprapubic pain with no other recognizable cause

Flank pain (costovertebral angle pain) with no other recognizable cause

Urgency without indwelling urinary catheter in place

Frequency without indwelling urinary catheter in place

Dysuria without indwelling urinary catheter in place

Acute hematuria

Delirium

Rigors

Pelvic discomfort

1. Part of an evaluation of sepsis **without** a clear source.
2. Part of an evaluation of patients with isolated fever or altered mental status ONLY IF other foci of infections are not identified on history, on examination, or from other lab testing.
3. Patients who may present with atypical symptoms of urinary tract infection ONLY IF other foci of infection are not identified on history, on examination, or from other lab testing.
4. For bacteriuria screening in asymptomatic patients with the following underlying comorbidities or conditions (check all that apply):

Prior to urologic procedures

Pregnant woman

Neutropenia

1. Other (please describe):

Comments:

10. Microorganism(s) cultured: What are the usual modes of transmission for this organism?

(This question is not designed to try to figure out where this patient’s organism came from, but to stimulate discussion about possible sources of the infecting organism and its chain of infection. This has implications for prevention strategies. For example, if it is a colonic organism, you may want to look at patient hygiene, management of diarrhea, and environmental cleaning in an occupied bed, or if a multidrug-resistant organism, you may want to examine antibiotic ordering patterns.)

11. Did the patient occupying the room prior to this patient being diagnosed with CAUTI have an infection with the same organism(s)?

YES  NO

Any there any patients in the intensive care unit (ICU) infected with this same organism(s) currently?

YES  NO

12. Was this patient’s urine culture obtained appropriately? (by evidence-based hospital policy)

YES  NO

Was the specimen transported to the lab per hospital policy?

YES  NO

Note: If not known for this patient, inquire of staff how urine cultures are obtained and transported to lab generally. Inquire specifically if obtained via specimen collection port or from urimeter/bag. Ask what happens if specimen cannot be immediately transported to the lab. Practices may vary between units.

Urinary Catheter Information

13. Date urinary catheter inserted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date urinary catheter removed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total number of days urinary catheter was in (dwell time): \_\_\_\_\_\_\_\_\_

Number of days between insertion and CAUTI symptoms (or CAUTI criteria in unresponsive/sedated patient): \_\_\_\_\_\_\_\_\_\_

14. Type of provider inserting urinary catheter:

RN  LPN  CNA  Attending physician  Resident

Advanced practice provider

Other (please describe):

15. Did the person who inserted this urinary catheter have documented competency to insert it?  
 YES  NO  Information not available

If so, did competency assessment require a return demonstration?  
 YES  NO  Information not available

16. Patient’s location when the indwelling urinary catheter was inserted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. What type of urinary catheter was inserted? (Indwelling, coude, three-way, etc.)\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What size of urinary catheter was inserted? \_\_\_\_\_\_\_\_\_\_\_French

Was the seal between catheter and tubing intact?  YES  NO

18. Are hospital indications for indwelling urinary catheter insertion consistent with current evidence-based guidelines?  YES  NO

19. What were indications for insertion? (use hospital policy)

Acute urinary retention (e.g., due to medication [anesthesia, opioids, paralytics], nerve injury)

Acute bladder outlet obstruction (e.g., due to severe prostate enlargement, blood clots, urethral compression)

Need for accurate measurements of urinary output in the critically ill

To assist in healing of open sacral or perineal wounds in incontinent patients

To improve comfort for end of life, if needed

Patient requires strict prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fracture)

Selected perioperative needs:

* Urologic surgery or other surgery on contiguous (adjacent) structures of the genitourinary tract
* Anticipated prolonged duration of surgery (Note: catheters placed for this reason should be removed in the post-anesthesia care unit.)
* Large volume infusions or diuretics anticipated during surgery
* Need for intraoperative monitoring of urinary output

If not included above, what were documented indications?

20. Were indications for insertion for this patient valid, per evidence-based hospital policy and rationale?  YES  NO

21. Was there a physician order for the indwelling urinary catheter prior to insertion?  
 YES  NO

22. Were alternatives to a urinary catheter documented?  YES  NO

23. What catheter alternatives were available on inserting unit for this patient? (e.g., condom catheter for males, external female catheter, etc.)

Note: Even if this patient’s urinary catheter insertion was clinically indicated, assessing units for availability of catheter alternatives is a good practice during these examinations since a lack of availability may be detected. This may vary by unit also.

24. If a bladder scanning protocol was available, was it followed prior to urinary catheter insertion/reinsertion if indicated for this case?  YES  NO  N/A

If not, why?

25. Were issues encountered during catheter insertion? (difficult insertion, breach of sterile technique, more than one insertion kit used, etc.)  YES  NO

If yes, describe:

26. Is there a standard sterile insertion tray available for use that contains a closed drainage system?  YES  NO If YES, was it used?  YES  NO

Note: Never assume one was used even if available. Some providers may not use the kit if they perceive it to be too time consuming or think there is cost savings to not using it. If not used, understanding why will assist in developing interventions to promote use of standardized kits.

Catheter Bundle Practices

*(Observations of common practices through rounds may be indicated as some of the following information may not be available for this specific patient.)*

27. Is the catheter bundle protocol based on the most up-to-date evidence?  YES  NO

28. Was the catheter anchored to the bag properly per hospital policy?  YES  NO

If NO, why not?

29. Was the patient assessed daily for an ongoing need for the catheter?  YES  NO

If NO, why not?

30. Were criteria met for keeping the catheter in place daily prior to catheter removal? (Refer to Question 20 for criteria.)  YES  NO

If NO, why not?

31. Was the catheter removed as soon as it was no longer clinically indicated?  YES  NO

If NO, why not?

32. Is there a nurse-driven protocol for early catheter removal?  YES  NO

If yes, do the nurses feel comfortable using the protocol without being reprimanded?  YES  NO

33. Was the urinary catheter drainage system opened at any point during the duration of catheterization? (e.g., tamper-evident seal intact, no documentation or staff reports of breach in system)  YES  NO

34. Is the presence of a urinary catheter and date of insertion included on all transfer/shift report checklists/protocols?  YES  NO

35. If tracked, what are hand hygiene compliance rates in each unit where this patient received care for the month in which the CAUTI occurred? (also include non-nursing units, such as radiology, surgical services, emergency department, physical therapy, etc.)

36. If this patient received services from non-nursing units such as radiology or the cardiac catheterization lab, etc., do those departments have policies in place for transport and handling of patients with urinary catheters?  
 YES  NO  Patient did not receive services from non-nursing units such as radiology, catheterization lab, etc.

If yes, are they compliant with them?  YES  NO  N/A

37. Does each patient have an individual, clean container in which to empty the urinary catheter collection bag?  YES  NO

Is it dedicated to urine only and clearly labeled as such (i.e., this container serves only to empty urine, not to empty other body fluids such as nasogastric drainage, surgical drains, etc.)?  
 YES  NO

Other Potential Contributing Factors for CAUTI

38. Were there any changes or problems with the urinary catheter equipment or related supplies at any point during the time this patient had a urinary catheter? (e.g., backorders necessitating a product substitution; introduction of a new indwelling urinary insertion kit; change in securement device; backorder/issues with urinary catheter alternatives such as condom catheters)  YES  NO

If YES, please explain:

39. If documented, did the patient and/or family receive education on the urinary catheter and what they could do to prevent infection?  YES  NO

If YES, what sort of education? (e.g., verbal and in person, a written flier/brochure, etc.)

40. What are environmental cleaning routines for terminal room cleans? For occupied rooms? Who cleans the bed and direct patient contact surfaces such as side rails, call button, TV controls, etc., in an occupied bed? How is that cleaning done?

How is cleaning evaluated?

If available, what are the results of environmental cleaning monitoring in this ICU?

41. Was the patient bathed daily?  YES  NO

How and when was meatal care performed?

Were bath basins used for bathing?  YES  NO

If YES, how were they cleaned and disinfected after each use? (If they were disposable basins, were they thrown away after use?)

Was tap water used for bathing?  YES  NO

How were the bath basins dried before storing?

How were the bath basins stored?

42. From Question 6, was there any potential impact on the development of CAUTI from staffing ratios on the units during the time this patient had a urinary catheter? (e.g., catheter was inserted or left in due to lack of staff for hourly or every 2 hours voiding rounds, staff not available to toilet patients immediately upon need)  YES  NO

Details:

43. **From the information collected and team discussion, was this this CAUTI potentially avoidable? Why or why not?**

(This is a question for team discussion and debate, based on what has been learned through gathering the information above. No definitive answer is required. Discussion needs to include opportunities for improvement not only in the direct aspects of care but also in more latent, upstream areas such as staffing, competency evaluation, patient hygiene, environmental hygiene, diarrhea management, etc. From this point, an evaluation of the proximate probable cause(s) of the CAUTI and development of an action plan to address any identified system gaps is identified, following the AHRQ CUSP Defect Analysis process.)

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