**On the CUSP: Stop CAUTI in the ED**

**ED Mini-Presentation to Accompany June 2, 2015 ED Coaching Call**

Sarah: Hello everyone. Thank you for listening today. My name is Sarah Dalton. I am a Program Specialist with the Health Research and Educational Trust. Welcome to the fourth mini-presentation in the CAUTI Cohort 9 Educational Webinar Series. Today's topic is aseptic catheter insertion practices in the ED. We encourage you to watch this short presentation with your team.

At the end of the presentation, there are a few tips for success to discuss with the group. This presentation is intended to accompany the June 2 ED coaching call hosted by the New Jersey Hospital Association. Today's presenter is Ms. Milisa Manojlovich. Milisa received an Associate Degree in Nursing in 1985, Master's Degree in 1989 and PhD in 2003.

She has been on the faculty at the University of Michigan School of Medicine since 2004 where she is currently an Associate Professor. Milisa's [inaudible 00:00:59] program of research focuses on how communication between physicians and nurses affect outcomes for hospitalized patients. She also conducts research with Doctors [inaudible 00:01:10] and Sarah Grimes to find ways to reduce hospital-acquired conditions such as CAUTI.

Milisa maintains CCRN certification by practicing at the bedside at the Critical Care Medicine Unit of the University of Michigan Health Systems 2 days a month. I'd now like to turn it over to Milisa.

Milisa: Thank you, Sarah. I appreciate that introduction. Hello, everybody. I'm just so delighted to be with you today talking about aseptic catheter insertion practices in the ED. We are focusing on engagement today. I've got a few learning objectives for you in this short little presentation. You should be able to discuss barriers to the ED staff and how can we improve engagement? We're also going to be able to describe strategies to engage your ED staff in aseptic insertion technique.

The ED is a really very busy, very crazy, sometimes out-of-the-world experience. It can be really hard to engage staff in something that seems simple like aseptic insertion but we'll be talking about how to do that. Hopefully, you'll get some tips that you can take back and use in your own facilities. We know that the guidelines for preventing CAUTI have always recommended aseptic insertion techniques.

When you talk to health care providers who insert catheters, they all say they use aseptic technique. However, in multiple observation studies, at least half of the time there are significant breaks in aseptic technique. People don't always say or they don't always do what they say, although everyone means well.

The health care providers may not have the skills to maintain aseptic technique, given the work environment constraints. When you think about how you learned to insert a catheter way back in the day, it was probably in a very controlled environment. You probably had an instructor right there and nearby. You may have first learned on a mannequin. It was all very structured. Everything was laid out for you nicely. You could take your time.

Then boom, you're in the job. You're at the bedside. You're in the ED. All of a sudden, that [inaudible 00:03:25] is that you're supposed to actually be inserting the catheters in. There is no resemblance whatsoever to how you learned how to do it. Even physicians learn how to insert catheters. Where do they learn? Most of them as med students in OR where the patient is already asleep, draped in sterile gowns. Everything is already sterile.

That makes it very or at least much easier to insert catheters in that environment as well. That's one problem to aseptic insertion is lack of knowledge meaning that lack of knowledge of how to insert catheters in the chaotic environments in which we work.

Another reason may be that health care providers may observe their peers inserting catheters and notice that aseptic technique is not used. When you think about you learn to do it 1 way in school. Then you go into the work world. You see what your peers do. It's like, "My peers aren't doing what they were taught at school. Why should I?" What are some strategies that you can use to overcome?

First of all, as always, we first have to make sure that there's an appropriate indication for catheterization. There was actually a study done I think back in 2007 that showed that when catheters were inserted for inappropriate reasons, many more cases of CAUTI developed. We should just be clear about that at the top. Let us make sure that your patient has an appropriate indication for catheterization.

What you can do is you can review catheter insertion technique during annual competency testing. We have what is called a blitz where we have to go to annual testing on BLS, on other [inaudible 00:05:08] updates, et cetera. Aseptic insertion technique could be part of that annual competency testing. If you're in a facility that has techs or non-licensed personnel insert catheters, you can require that there be oversight for catheter insertion by a licensed provider.

It can be an important little tool to develop a policy on catheter insertion techniques are in place, so that new nurses or new techs can go to the policy and read about it up-front, refresh their memory or understand how it's done in your facility. Then you can use a variety of checklists. Checklists are a great way because inserting the catheter does follow a set series of procedures or a set of steps. Using a variety of checklists can also help overcome that lack of knowledge.

Lack of importance is another reason or can be another barrier to successful insertion of ... Oh boy, listen to me. It can be another barrier to aseptic insertion of catheters. Activities that are strictly within the nursing domain may not perceived as being very important or of much value compared to activities that cross disciplinary boundaries.

What I mean by that is that nurses, when we do our work, we do it behind closed curtains. It's hidden away from the public eye, of course, understandably, to maintain patient autonomy and privacy. However, when we do that, no one gets to see the great job that we do or the work that is done. We ourselves don't toot our own horns being the modest health care providers that we are.

It seems to lose its importance. However, when a doctor goes to insert a central line, when an [arc 00:06:49] line goes in or the room is filled with people, there's light, there's camera, there's action, it all gets a lot of attention. Wow. What they're doing seems to be very, very important compared to what nurses do behind closed curtains. It doesn't seem very important.

In addition, there's a lot of importance around catheter insertion if it's perceived as a set of tasks. It's just another task for me to do. It's just something else to be checked off on my list of tasks. If we don't think about catheter insertion as a component of evidence-based practice, then, again, it loses some meaning and some importance.

What can we do to overcome this lack of importance? I think we have to think of aseptic insertion as a component of evidence-based practice no matter what the discipline is. It does follow the evidence. There is evidence to suggest that aseptic insertion is the way to go. We've already talked about having an appropriate indication.

There's evidence around these principles. If we think about it as part of my practice and that I need evidence to practice at the top of my license, this is the way to make it more important.

Developing a culture where evidence-based practice is recognized and rewarded is another important strategy. In a culture where evidence-based practice is recognized and rewarded, then everyone is more in-line and in agreement with performing practices that are aligned with the evidence.

If we think about our nursing practice, as this is a component of my nursing practice, my nursing practice consists of many components. It's not just a task to be done. Again, that raises the level of importance to this and makes it more likely to be something that we're going to pay attention to.

Another barrier to aseptic insertion is lack of feedback. Patients move from the ED to other units. There's really no systematic process to let the ED staff know of patient outcomes. You don't really know what happened to the patient. Many times, you don't even know what the diagnosis is. Off they go to the floor, the ICU or wherever. You really have no way of knowing what happened to them.

A way to or a strategy to overcome this lack of feedback to let staff know what's happening is to post the CAUTI rates for all of the units so that comparisons can be seen or at the very least, post the CAUTI rates in the ED for those units where the bulk of the patients go. If you see those monthly CAUTI rates, it gives you some feedback on how what you did in the ED is affecting patients who have gone elsewhere. Those are some barriers.

A final one here is lack of resources. When you think about what are resources, and time is a resource, obviously money, space, equipment, these are all resources. When there's constraints on those resources, then when those constraints on those resources, they can all contribute to situations where aseptic insertion technique is not used.

Also, we have human resources. When you have a variation in staff, this also contributes to a lack of resources. When you have high turnover, getting the staff up-to-date, when you have under-staffing and people are running around trying to do 2 or 3 peoples' jobs at the same time, all of these variations in staffing resources contribute to this general sense of, "We just don't have enough time or people to do what we need to do."

Obviously, we can't overcome any of these resources but we can minimize their impact. For example, having adequate supplies such as over-the-bed tables so that people are not setting up or trying to set up sterile fields on dirty linen hampers or on open garbage cans. As we noticed in some of our studies, having hand sanitizers available and also having them in consistent locations, this is helpful.

Obviously, having enough sterile gloves. Having the best type of kit to stock for your patient population. Ask yourself, "Would individual supplies be better than having a kit?" For example, in our ED in a study that we did, we noticed that 30% of the catheters were temp-sensing Foleys. Temp-sensing Foleys are not in your "standard kit."

The nurses have to run and get a kit as well as a temp-sensing Foley. This can set up situations where there may be lack of a septic insertion technique in trying to set all of this up in as sterile an environment as possible.

We also need to make sure that there adequate facilities for hand hygiene. People need to wash their hands with soap and water as well as using alcohol hand rub. There are some strategies that you might want to think about to overcome these lack of resources.

When we think about aseptic insertion, you can think about a whole series of checklists that you can use or even think of what are really those components that really absolutely have to be maintained? There are only 5. I've got them for you here on this slide. You need a sterile field. You need to perform hand hygiene immediately before and after insertion. You need to use sterile gloves, drapes and sponges.

You need to use appropriate antiseptic or sterile solution for the cleaning as well as a single-use packet of lubricant jelly for the catheter tip. If the catheter is accidentally contaminated, you have to discard it and get a new sterile catheter and try again. These are all that you need to have aseptic insertion technique. Nothing else really matters, as long as these components are maintained.

Some tips for success then. A non-punitive culture, visible and supportive leadership. What I mean by that is having a leadership who's actually there in the unit with you watching you as you work, not over your shoulder watching you but just seeing what you're doing, seeing some of the challenges that you're experiencing, watching your workflow. How are they doing it? Where are the supplies? How far do they have to go to get the supplies?

Look at the supplies themselves. Oh my goodness, look at the stock. Are we using all of this stock? Stock sitting on the stock cart is money that is not being put to good use. Do we have too many of this kind of supply? Look at here's the hand rub, the alcohol hand rub in this location outside of this room but over here it's in a separate, different location outside of this room.

Your leadership can see people running around, can see people maybe stopping, reversing themselves, going back maybe because something doesn't quite work right, all of these things. Leadership once they see can then use to incorporate into strategies that they can then take forward to other leaders to say, "There's something not quite right in the ED. What can we do to help our staff so that they can do their jobs better?"

Another tip for success is to identify system-wide barriers to aseptic insertion. Obviously lack of adequate supplies is a system-wide barrier. Lack of space for a sterile field set-up, lack of manpower, these are all barriers to aseptic insertion as well as to other components of practice. There is a sense that if you're having trouble with aseptic insertion technique, you may be having trouble with other areas of your practice.

This all requires leadership attention and maybe part of a larger system-wide issue. Trying to allocate resources to overcome as many barriers as possible is another tip for success, although this too can be difficult. I mentioned having too many supplies on the supply cart. That's a resource, financial resources, sitting there not being used.

Taking more of a lean, a Toyota lean, approach, having less money put into the resources on the cart and putting more money into the resources such as adequate supplies or adequate space may be helpful but, again, you need that leadership there to actually see what's happening in the ED so that they can help the staff make those determinations.

Oh, more tips for success. It's important I think to think about transitioning to an evidence-based practice approach for patient care delivery. There are many evidence-based practice models available to choose from. They all provide guidelines for listing staff support and buy-in.

When I talked about having your visible and supportive leadership, it wasn't just to do the grand tour through the unit and then go back to the office suite but to actually talk with staff, engage with staff, also listen to staff and to take from the staff lessons that they can move forward and come up with a strategic plan.

Enabling collaborative and decentralized decision-making, this is all part of the same things that I'm talking about. By having the people who are at the point of care involved with the decision-making, it helps to engage them further. It also helps to make sure that the leadership is seeing and hearing right from those who are providing the care.

Obviously, this involved then allowing nurses to make decisions that affect their practice. These are also tips for success to overcome the barriers that we started off this little mini-presentation with. I hope that there's lessons here that you can use and take back to your facilities. I will make sure that I'm available to answer any questions that you may have. Now I'm going to turn it back over to Sarah.

Sarah: Thank you so much, Milisa. Thank you for taking the time to do this mini-presentation today. Please remember to fill out an evaluation of this presentation at the link shown on this slide. We hope that you'll join us for the upcoming June 2 [inaudible 00:17:02] coaching call at 2:00PM Eastern time where, as Milisa mentioned, she will be available to answer any questions that you have related to the content of this presentation. Thank you again for listening.