



The Emergency Nurses Association Presents *CAUTI* Slides and Transcript

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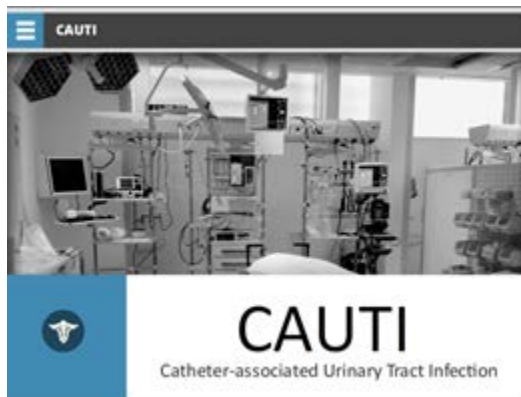
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Slides and transcript of Emergency Nurses Association presentation
<https://www.ena.org/education/education/Pages/cauti.aspx>



Attribution



Funded by the Agency for Healthcare Research and Quality (AHRQ) as part of AHRQ Safety Program: Reducing CAUTI in Hospital Patients



Objectives

The objectives of this module are as follows:

- Identify common misconceptions around about the appropriateness of urinary catheter insertion.
- Distinguish between appropriate and inappropriate uses of urinary catheters according to HICPAC, the Health Infection Control Practices Advisory Committee.
- Evaluate current practices in your institution regarding the reduction of catheter-associated urinary tract infections.
- Compare the current practices in your institution to a sample survey of ED nurses.
- Analyze a case study involving decisions around the appropriateness of a urinary catheter and the appropriateness of its removal.
- Formulate talking points to advocate appropriate urinary catheter protocols and decisions.

Introduction

CAUTIs

CAUTIs, catheter-associated urinary tract infections, account for about 35 percent of nosocomial infections. This module will review published recommendations for reducing the number of these infections and includes a discussion of the obstacles uniquely encountered by the emergency department (ED) as practice evolves to incorporate evidence-based recommendations.

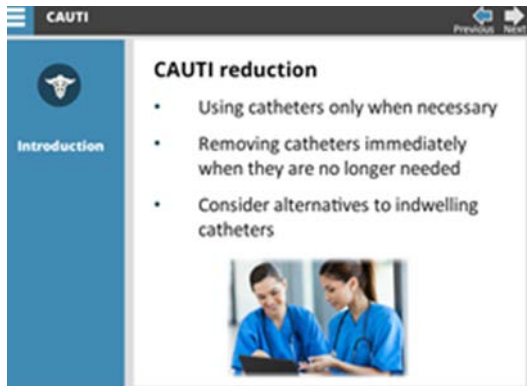
Urinary Catheter Utilization

The high incidence of catheter-associated urinary tract infections forces us to accept the urgency in addressing the problem.



A review of the literature tells us that that the incidence of catheter-associated urinary tract infections can be reduced by using catheters only when necessary, removing them immediately when they are no longer

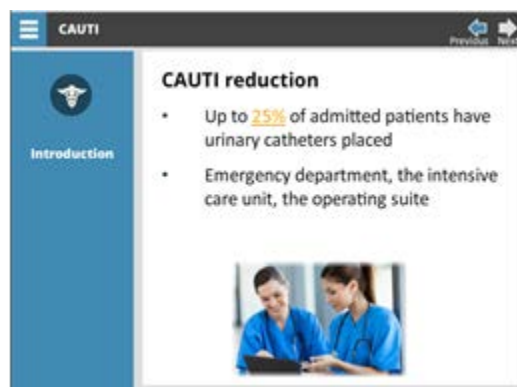
needed, and considering alternatives to indwelling catheterization. Yet the adoption of and adherence to evidence-based protocols varies greatly among institutions.



Urinary catheterization is a common procedure. Up to 25 percent of admitted patients have urinary catheters placed.

The most common areas where patients undergo urinary catheterization are the emergency department, the intensive care unit, and the operating suite.

Because catheter placement is highly prevalent in the emergency department, the emergency nurse can play a significant role in the reduction of CAUTI.

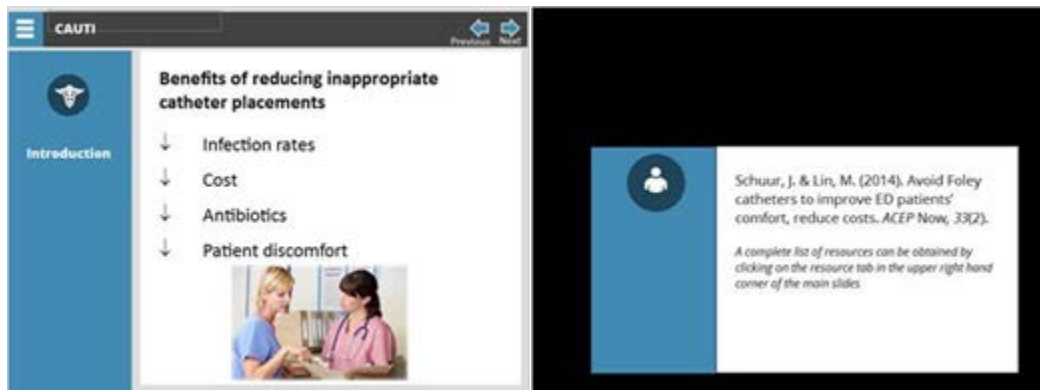


Reducing CAUTI

The benefits of reducing inappropriate placements of urinary catheters include:

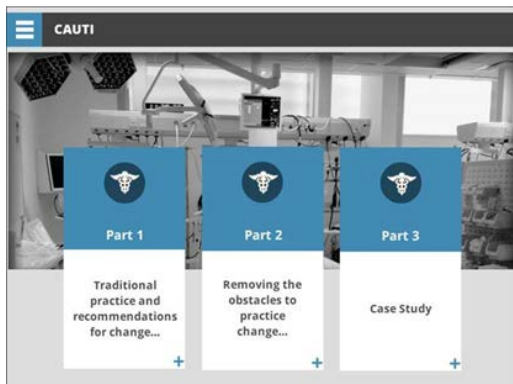
- A reduction in CAUTI rates with decreased catheter use. Avoiding unnecessary procedures will eliminate the risk of infection for those patients. It seems simple, and it is. In many cases, it is not just the UTI that is avoided, but also the more serious risk of urosepsis.
- With decreased infection rates, costs for extended hospitalizations and additional treatments are also decreased.

- With the rise of medication-resistant infections, the use of antibiotics is scrutinized more than ever. Every time we can avoid unnecessary antibiotic use, we reduce risks for our patients.
- Finally, catheters are uncomfortable and the resulting urinary tract infections even more so.



Main Menu

This module is divided into three parts. The first part presents traditional practice related to urinary catheter utilization and outlines recommendations for practice change. Part two addresses obstacles to practice change and provides suggestions for removing those obstacles. Part three is a case study that will give you the opportunity to assess a patient, apply the principles you've learned, and critically think through the decision-making process to providing the best care.

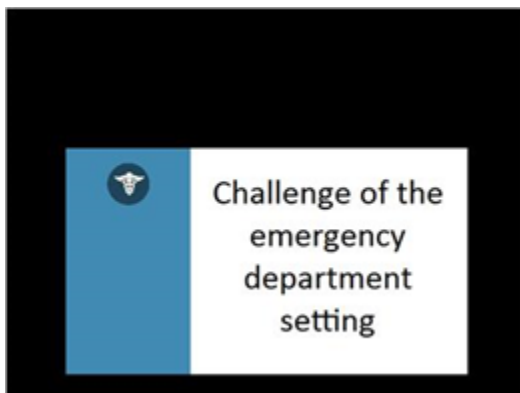
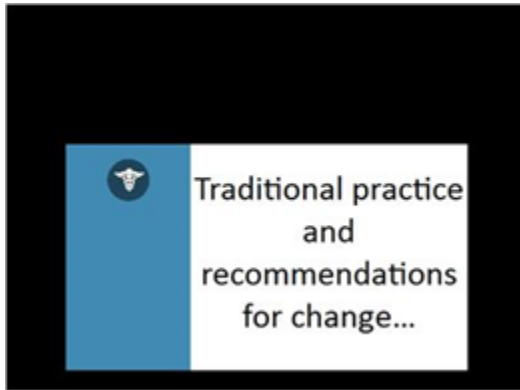


Begin by clicking on part one.

Continue by clicking on part two.

Finish your module by clicking on the case study.

Part One: Traditional Practice and Recommendations for Change

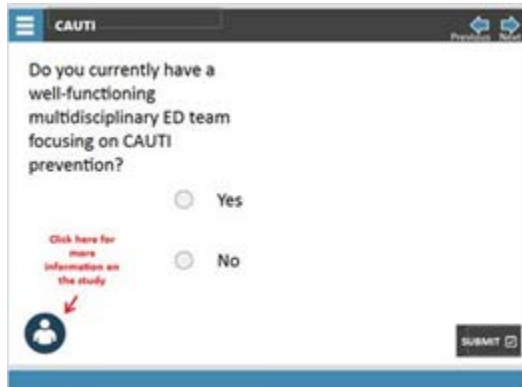


Multiteam Survey

Periodically, you will be asked a survey question to compare your current practice with that of our larger sample of emergency nurses.

Click on the icon to learn more about the survey.

Answer the survey question and click submit.




CAUTI

Do you currently have a well-functioning multidisciplinary ED team focusing on CAUTI prevention?

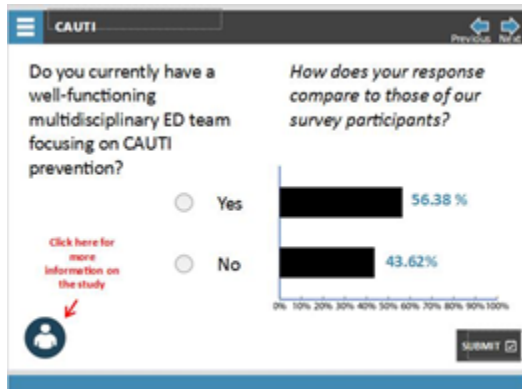
Yes

No

[Click here for more information on the study](#)



SUBMIT




CAUTI

Do you currently have a well-functioning multidisciplinary ED team focusing on CAUTI prevention?

Yes

No


[Click here for more information on the study](#)



SUBMIT

How does your response compare to those of our survey participants?

Response	Percentage
Yes	56.38%
No	43.62%



Wolf, L, Bolkholdt, M, Jones, K (2014). Urinary catheter placement practices in US emergency departments (unpublished data)

The multi-state sample included emergency nurses recruited from the membership of the Emergency Nurses Association via email.

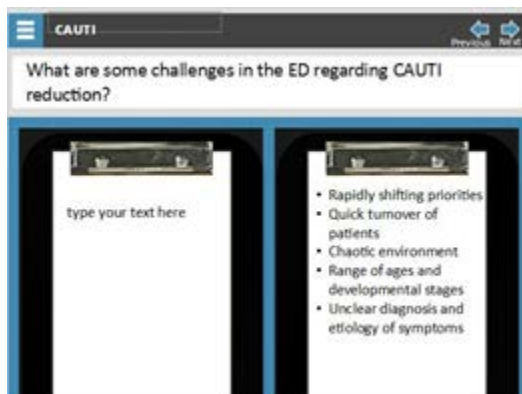
Challenges in the ED

What are some of the challenges related to CAUTI reduction in the ED setting? Enter these challenges onto the clipboard on the left of your screen. After you have finished, click submit.



Your answers might have included:

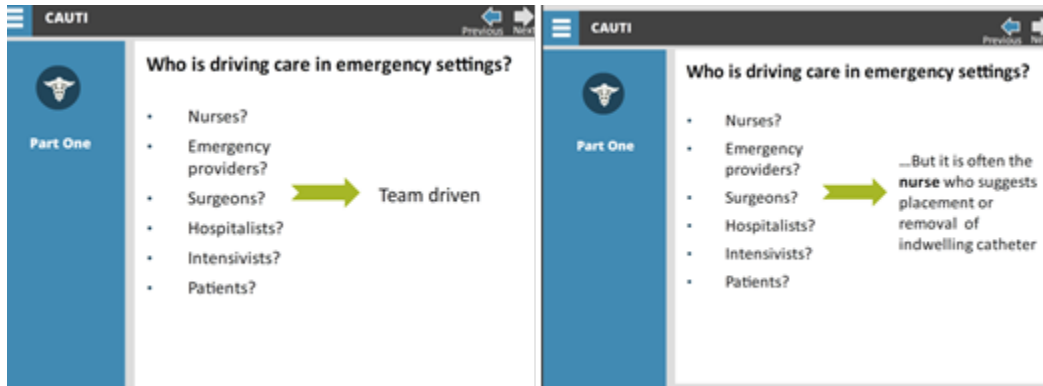
- Rapidly shifting priorities
- Quick turnover of patients
- An environment that can easily become chaotic
- Patients representing a wide range of ages and developmental stages
- And patients presenting with an unclear diagnosis and symptom etiology



Driving Patient Care

Who is driving the care in the ED? Is it nurses? Emergency providers? Surgeons? Hospitalists? Intensivists? Patients?

Emergency care is team driven, but it is often the nurse who suggests the need for an indwelling urinary catheter, or who can suggest alternatives.



Nursing Study

A recent nursing study explored individual and environmental factors that positively and negatively affect clinical decision-making regarding urinary catheter placement and maintenance.

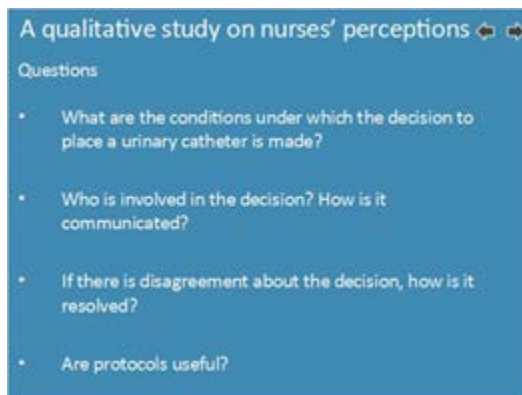
Click on the icon for the article's citation



Employing a qualitative exploratory design, the researchers conducted focus groups with 23 English-speaking emergency nurses recruited from attendance at a regional conference.

In the Mizerek and Wolf study, nurses were asked questions including:

- What are the conditions under which the decision to place a urinary catheter is made?
- Who is involved in this decision; how is the decision communicated?
- If there is disagreement about the decision, how is it resolved?
- Are protocols useful?



The study identified several themes, including ownership, education and competencies, communication, barriers, and facilitators.



In this module, we have selected several responses from the focus group and will periodically display them on the screen, as shown here. First you will see the theme, followed by a quote from one of the focus group members.

Note: Quotes represent responses from our focus group members regarding catheter placement and decision-making in the ED.

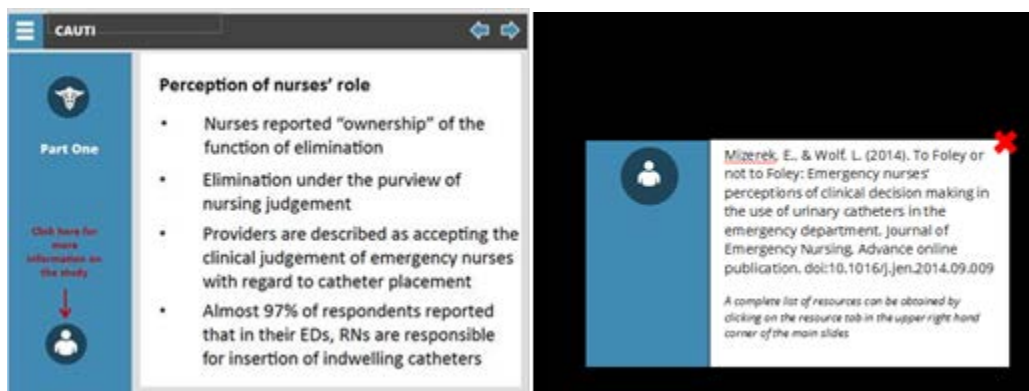


Perceived Role of Nurses

In the qualitative study conducted by Mizerek and Wolf, nurses reported “ownership” of the function of elimination. Nurses stated that care related to elimination fell under the purview of nursing judgment, even when a provider order was obtained after the fact. Providers are described as accepting the clinical judgment of emergency nurses with regard to catheter placement.

Almost 97 percent of nurses surveyed reported that, in their EDs, RNs are responsible for insertion of indwelling catheters.

Click on the icon to learn more about this study.



Perceived Role of ED Nurse

At the initial patient encounter, and as the patient moves along the continuum of care, the emergency nurse makes clinical decisions that affect patient safety and the efficacy, efficiency, and cost-effectiveness of care.

These decisions involve problem identification, acuity assignment, acquisition of resources, and patient advocacy.

When looking at this from a CAUTI perspective, some relevant questions are:

Problem identification

- What is the chief complaint?
- Is it related to the urinary tract?
- Is it related to volume (dehydration, hypovolemic shock, fluid overload, hypertension, congestive heart failure)?

Acuity assignment

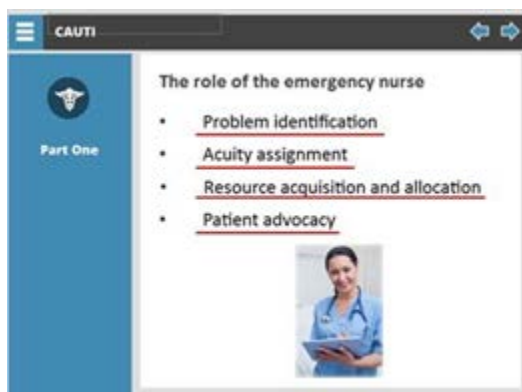
- What is the urgency to be seen?
- What is the urgency for diagnostic testing (blood and urine laboratory values)?
- What is the need for ongoing monitoring (intake and output, response to fluid resuscitation)?

Need for resources

- What teams need to be activated (specialists, code team, trauma team, brain injury team)?
- What protocols need to be instituted (sepsis, stroke, myocardial infarction)?

Patient advocacy

- What are the expressed needs of the patient and how do they balance with the needs of treatment?



Protocols Survey

Answer the following survey question as it relates to your institution, then click submit.

CAUTI

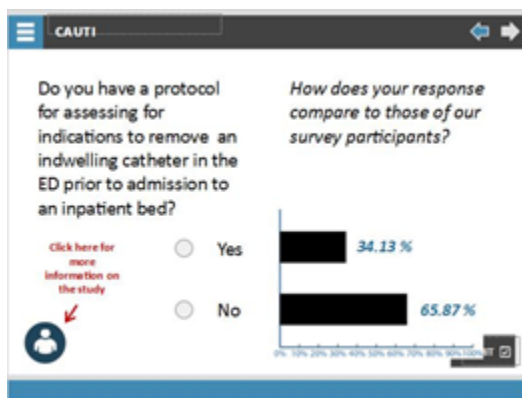
Do you have a protocol for assessing for indications to remove an indwelling catheter in the ED prior to admission to an inpatient bed?

[Click here for more information on the study](#)

Yes

No

SUBMIT



The multi-state sample included emergency nurses recruited from the membership of the Emergency Nurses Association via email

Catheter Removal Survey

Answer the following survey question as it relates to your institution, then click submit.

CAUTI

In the past quarter, for how many patients with indwelling urinary catheters was the catheter removed before transfer to inpatient units if no longer needed?

Never/Rarely

Under 1/2 the time

1/2 the time

Over 1/2 the time

Almost always/Always

[Click here for more information on the study](#)

SUBMIT

How does your practice align with that of other emergency nurses and departments?

The interesting fact to note here is not that patients are being admitted to inpatient units with urinary catheters. Rather, nurse respondents reported that they knew the patient no longer needed a urinary catheter, but removal was not considered. They weren't making the connection that they could be the initiator of this practice change by advocating for removal of unnecessary urinary catheters.

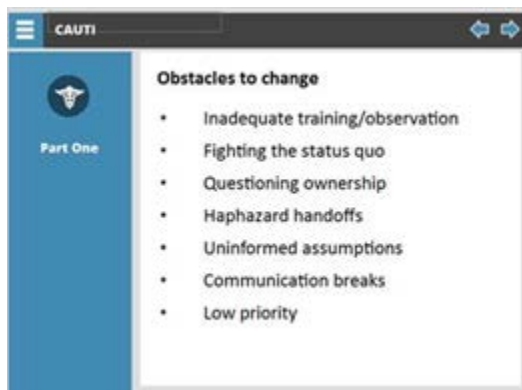


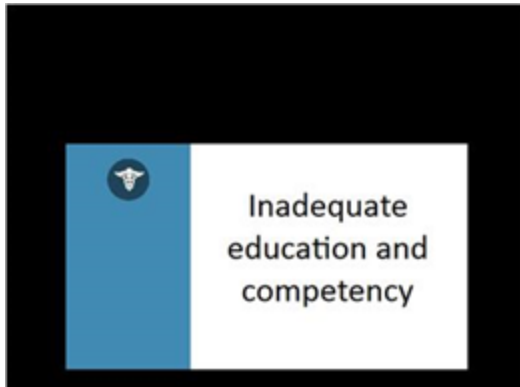
Obstacles to Change

Nurses are aware of the next step in the process of reducing CAUTIs, yet our survey results indicate that real practice change gets held up. What are the obstacles to practice change? Nurses surveyed reported the following:

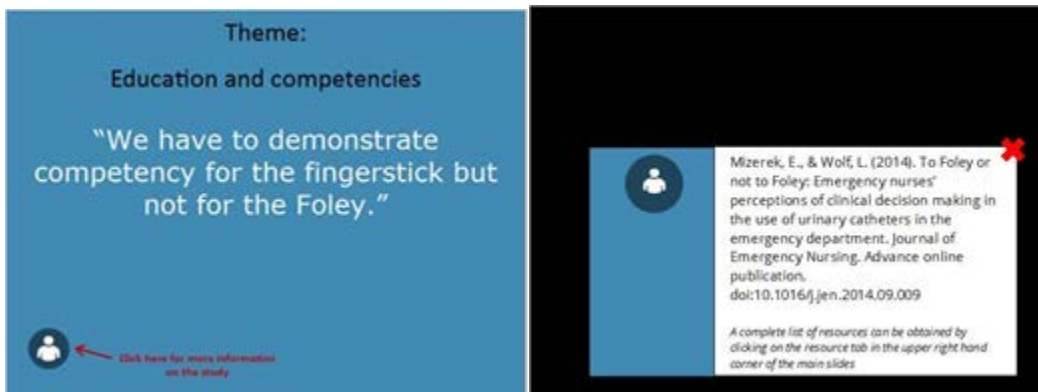
- Inadequate training and observation.
- Fighting the status quo. It's what we have always done.
- Questions around ownership: Whose problem is it?
- Handoffs that lack uniformity and consistency allow important information to be missed.
- Uninformed assumptions and a breakdown of communication.

Finally, in the chaotic environment of the ED, CAUTI takes low priority. After all, the patient will be gone from the ED in a short while and nurses don't directly observe any complications.

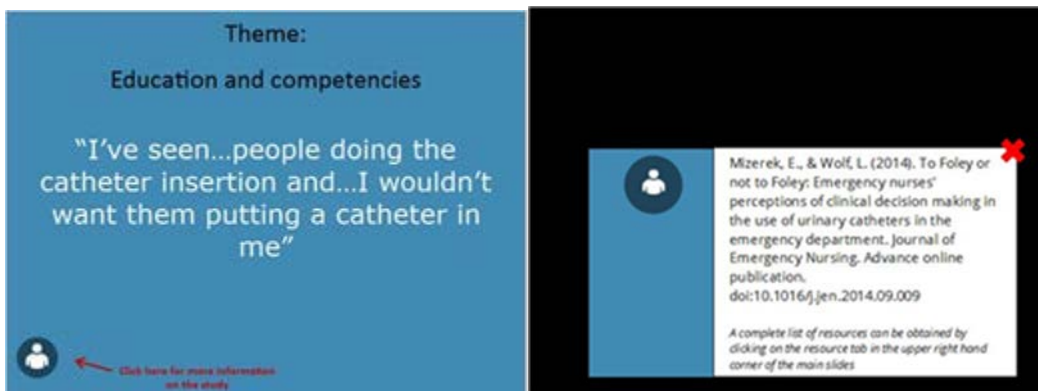




This quote represents focus group member responses to questions about education and competency in CAUTI reduction and catheter insertion.



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This quote represents focus group member responses to questions about education and competency in CAUTI reduction and catheter insertion.

Theme:

Education and competencies

"...there are technique issues even with a lot of the seasoned staff."

[Click here for more information on the study](#)

Mizerek, E., & Wolf, L. (2014). To Foley or not to Foley: Emergency nurses' perceptions of clinical decision making in the use of urinary catheters in the emergency department. *Journal of Emergency Nursing, Advance online publication*. doi:10.1016/j.jen.2014.09.009

A complete list of resources can be obtained by clicking on the resource tab in the upper right hand corner of the main slides

Aseptic Technique Survey

Answer the following survey question as it relates to your institution, then click submit.

CAUTI

Urinary catheters are inserted using aseptic technique and sterile equipment

Never
 Rarely
 Sometimes
 Often
 Always

[Click here for more information on the study](#)

SUBMIT

CAUTI

Urinary catheters are inserted using aseptic technique and sterile equipment

How does your response compare to those of our survey participants?

Response	Percentage
Never	0.63 %
Rarely	1.89 %
Sometimes	5.03 %
Often	23.9 %
Always	68.55 %

[Click here for more information on the study](#)

The multi-state sample included emergency nurses recruited from the membership of the Emergency Nurses Association via email

Two-Person Survey

Answer the following survey question as it relates to your institution, then click submit.

CAUTI

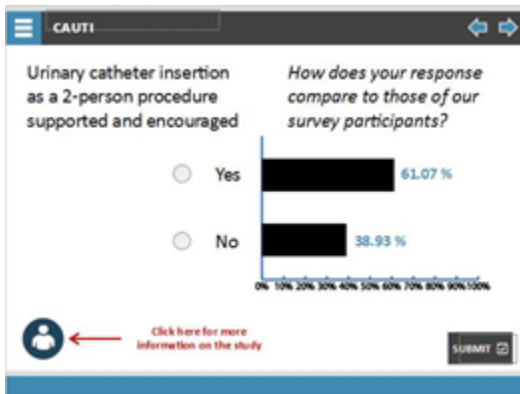
Urinary catheter insertion as a 2-person procedure supported and encouraged

Yes

No

Click here for more information on the study

SUBMIT



The multi-state sample included emergency nurses recruited from the membership of the Emergency Nurses Association via email

This quote represents focus group member responses to questions about education and competency in CAUTI reduction and catheter insertion.

Theme:

Education and competencies

"...just check it off"

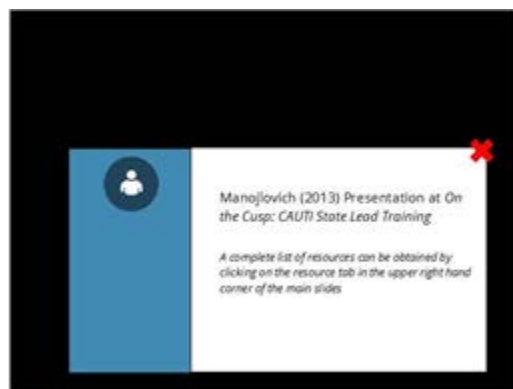
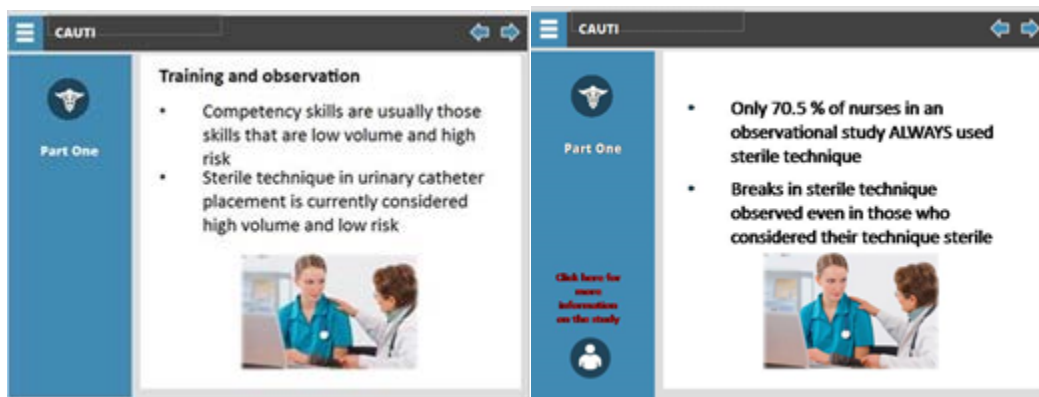
Mizerek, E., & Wolf, L. (2014). To Foley or not to Foley: Emergency nurses' perceptions of clinical decision making in the use of urinary catheters in the emergency department. *Journal of Emergency Nursing*. Advance online publication. doi:10.1016/j.jen.2014.09.009

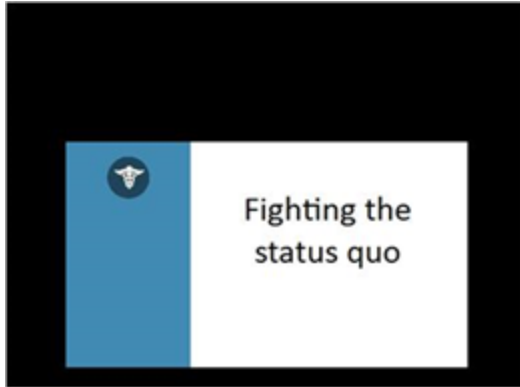
A complete list of resources can be obtained by clicking on the resource tab in the upper right hand corner of the main slides

Training and Observation

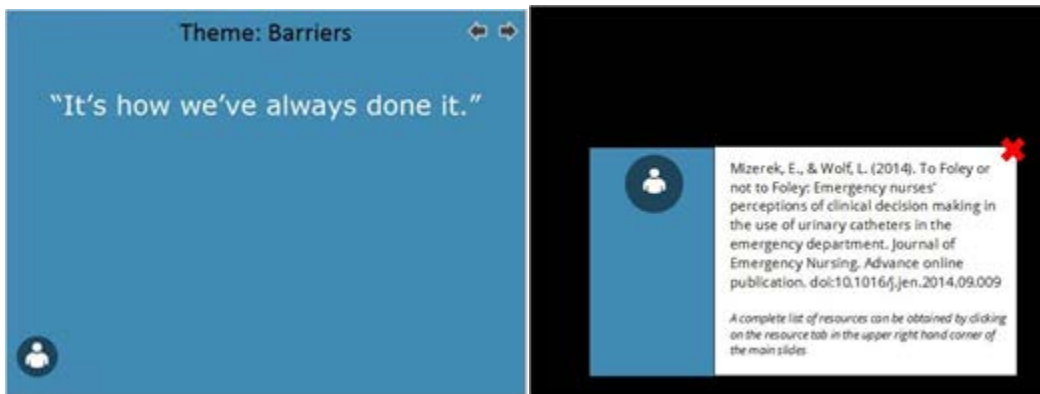
Sterile technique in urinary catheter placement is part of pre-licensure nursing education. It is not a competency that is periodically reevaluated in every institution. Traditionally, competencies selected for demonstration have been those considered low-volume/high-risk: skills either not exercised frequently, which may decline due to lack of practice, or those associated with a higher risk of complications or difficulty. Sterile technique in urinary catheter placement has been regarded as neither. It is done frequently and is not considered high risk. However, because of the likelihood of infection, it might be time to consider it a high-risk procedure, in which providers would have to periodically demonstrate their competency, rather than something done as a quick annual check off without being evaluated in a clinical setting.

It was stated earlier that CAUTIs represent about 35 percent of nosocomial infections. Why is there such a high rate of infection? In an unpublished study (Manojlovich, 2013), only 70.5 percent of nurses surveyed reported using sterile technique “always.” Also, observations revealed breaks in sterility even by those individuals who considered their technique sterile and knew they were being monitored. Two-person catheter insertion promotes the practice of sterile technique, as the second person can assist with positioning and observe for breaks in sterility.





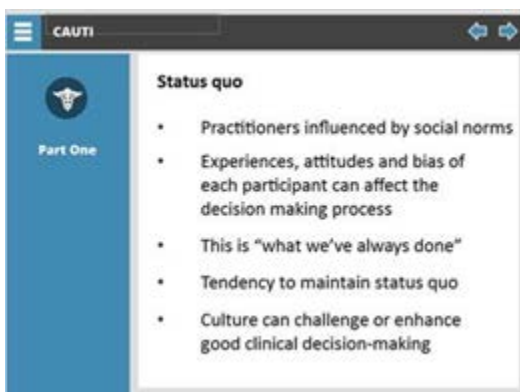
This quote represents a response by a focus group member regarding barriers to CAUTI reduction.

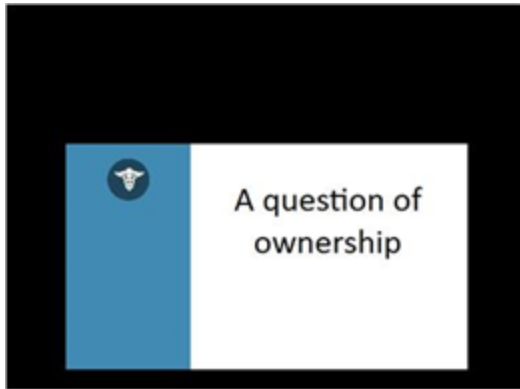


Status Quo

In addition to training and observation issues, another obstacle is complacency regarding the status quo. Health care practitioners as a group can be highly influenced by social norms, and the experiences, attitudes, and biases of participants can affect the decision-making process.

“This is what we have always done” becomes the battle cry of those individuals resistant to change. The overall culture of an emergency department, including the tendency to maintain the status quo, can challenge good clinical decision-making. However, if the culture embraces change and evidence-based practice, the outcome can be good clinical decision-making.





Ownership

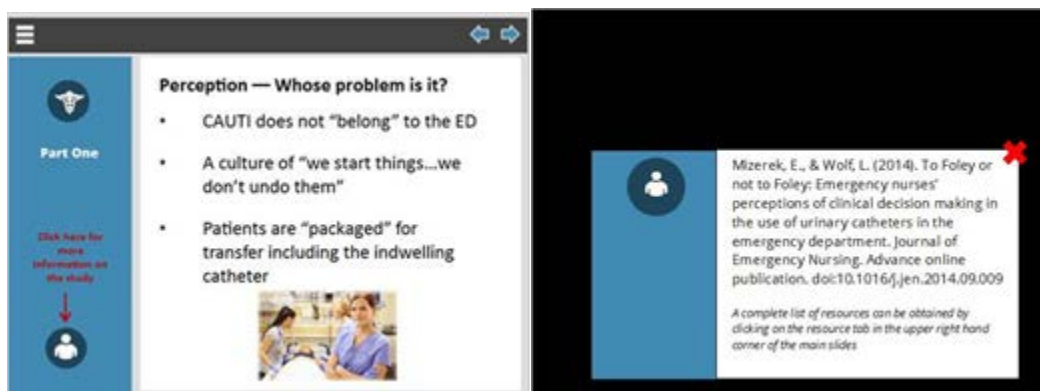
A question of ownership can be an obstacle in the move from recommendations to practice change.

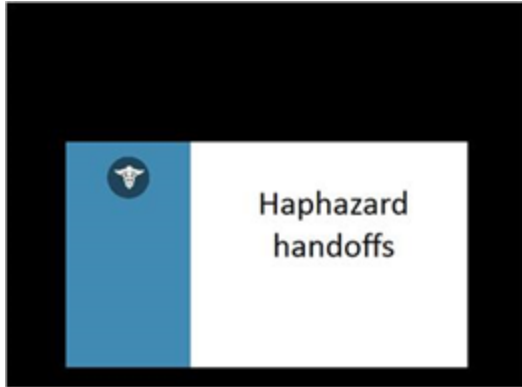
Emergency nurses in this sample indicated that CAUTI is not an issue that “belongs” to the emergency department. They reported that things were started in the emergency department, not undone: patients were readied or “packaged” for inpatient units, and the indwelling catheter was often considered part of the package.

Because of this perception, emergency nurses in this sample did not feel as much ownership of the possible adverse outcome, although they reported that they held ownership of the decision to place the catheter initially.

Since an infection won’t develop until the patient has left the ED, the emergency nurse does not see the patient outcome associated with the decision to catheterize.

So whose problem is urinary catheterization anyway? Emergency nurses? Inpatient nurses? Providers? Assumptions around catheter use and the issues they create become the problem of the institution, not of individual nurses or patients. Accepting shared responsibility and individual accountability is a big step toward addressing the problem.

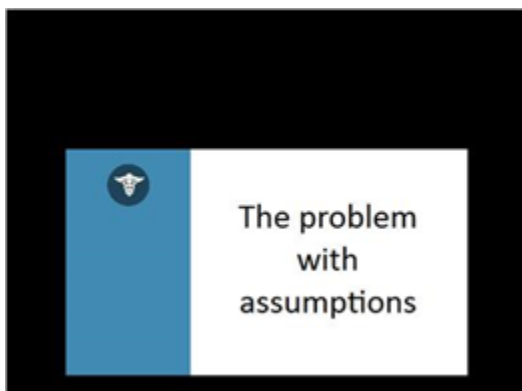
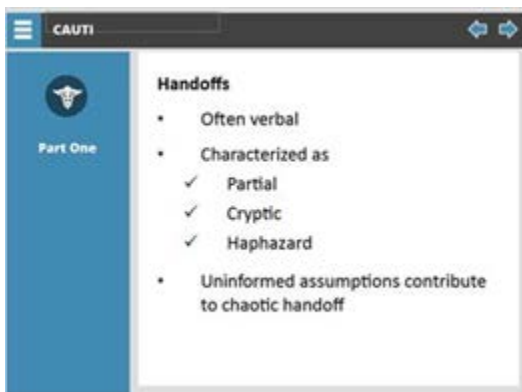




Cryptic Handoffs

In the ED, verbal handoffs, whether between nurses or between nurses and other clinicians, have been characterized as “partial,” “cryptic,” and “remarkably haphazard.”

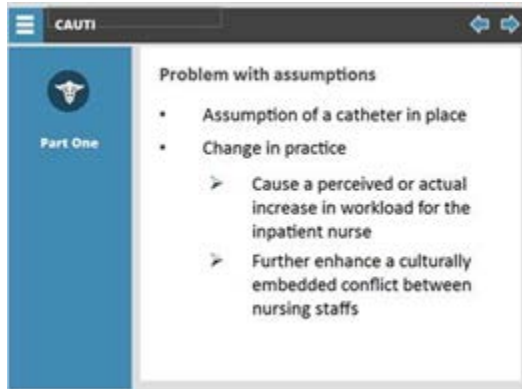
Uninformed assumptions of both the emergency nurse and the inpatient nurse contribute to a chaotic handoff.



Problematic Expectations

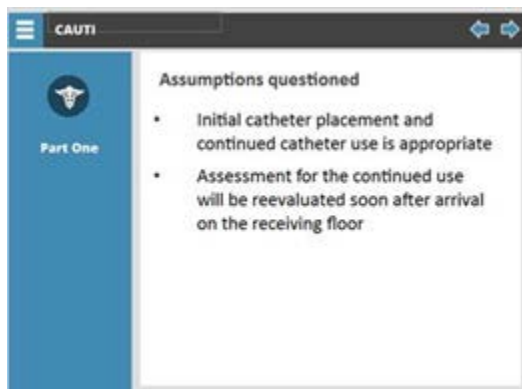
Because it is customary for many patients to come from the ED with an indwelling catheter in place, the inpatient nurse might come to expect it. If the emergency nurse were to start sending patients without

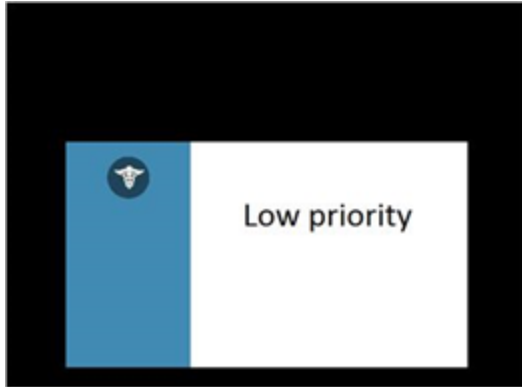
indwelling catheters, it could be viewed as an oversight. Such a change in practice, even though it might be best for the patient, could cause a perceived or actual increase in workload for the inpatient nurse. In some cases, this might intensify a preexisting culture of conflict between the two nursing staffs.



Assumptions Questioned

If a patient comes to the unit with a catheter in place, the inpatient nurse might assume that it was an appropriate placement and that the emergency nurse would have removed it if it were no longer needed. By the same token, the emergency nurse might assume that there is a continued need for a catheter, and that this need would be reevaluated on the floor. In reality, it may be several hours before the inpatient nurse would evaluate the need to remove the catheter. The inpatient and emergency nurses need to communicate clearly regarding the criteria for placement of an indwelling urinary catheter in addition to indications for its continued use.





Quality Improvements

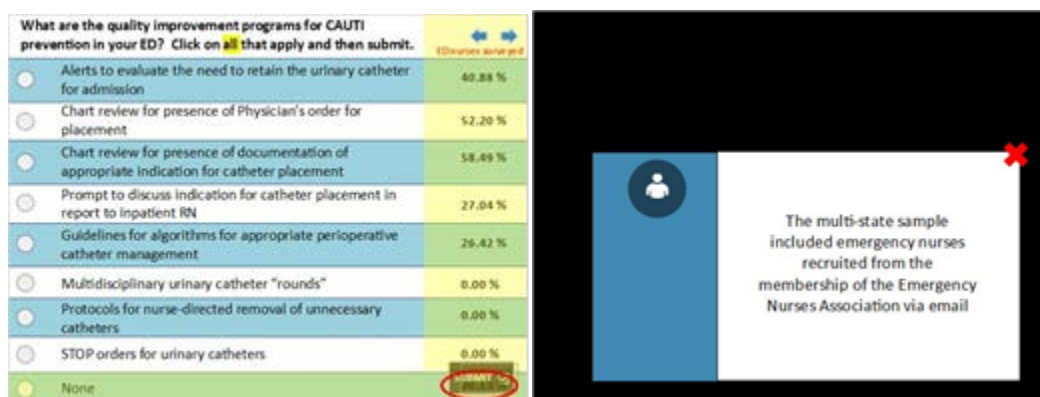
Click on each quality improvement program for CAUTI prevention that are in place in your ED, then click submit.

What are the quality improvement programs for CAUTI prevention in your ED? Click on **all** that apply and then submit.

- Alerts to evaluate the need to retain the urinary catheter for admission
- Chart review for presence of Physician's order for placement
- Chart review for presence of documentation of appropriate indication for catheter placement
- Prompt to discuss indication for catheter placement in report to inpatient RN
- Guidelines for algorithms for appropriate perioperative catheter management
- Multidisciplinary urinary catheter "rounds"
- Protocols for nurse-directed removal of unnecessary catheters
- STOP orders for urinary catheters
- None

SUBMIT

Finally, CAUTI reduction can be relegated as low priority. There are still health care facilities that have no CAUTI reduction initiatives or guidelines. With the onset of clinical manifestations of CAUTI beginning after the patient has left the ED, the priority can become even lower.



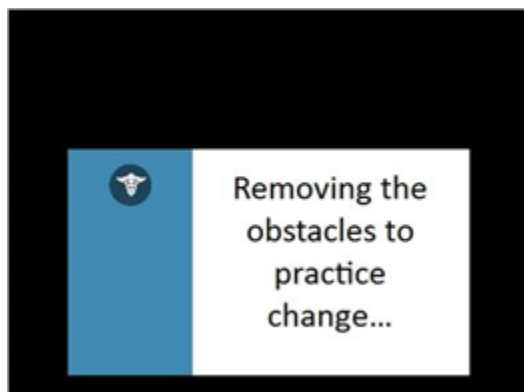
Recommendations

CAUTI reduction initiatives include—

- Chart review
 - Is an order entered for the catheter?
 - Is there an appropriate indication for insertion?
 - Is there documentation of continued need upon admission?
- Perioperative algorithm
 - Is there an algorithm in use for perioperative placement?
 - Is the staff aware of and educated about the algorithm?
 - Is it used consistently?
- Nurse-directed removal
 - Is there a protocol for the nurse to evaluate ongoing need and remove the catheter if the criteria are met?
 - Is the protocol followed consistently?
- Catheter “rounds” and STOP orders
 - These are more relevant in the inpatient environment, but is there a protocol in place that ensures every patient in the ED with an indwelling urinary catheter is evaluated for the appropriateness of the initial placement and whether there is an ongoing need?

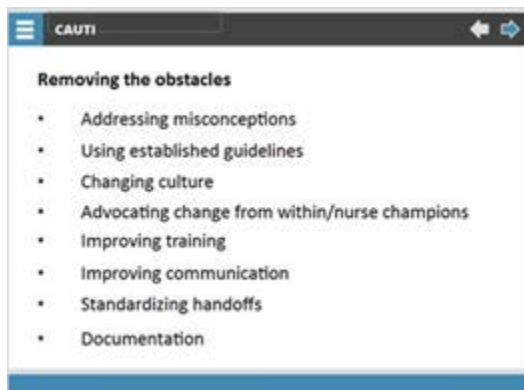


Part Two: Removing the Obstacles to Practice Change



Obstacles

Removing the obstacles to real practice change includes addressing misconceptions, using established guidelines, changing culture, advocating from within, improving training and communication, standardizing handoffs, and documenting protocols.





Misconceptions Addressed

Traditional reasons for catheter placement may seem logical, but many are not.

- A catheter facilitates intake and output (I &O) measurement. In the critically ill patient, a urinary catheter may indeed be indicated. But accurate I & O measurement can be accomplished in many patients with less invasive measurement methods.
- We traditionally thought that a catheter was helpful in preventing falls because patients didn't have to get up to the bathroom. However, the catheter doesn't eliminate the urge to urinate, and tubing can actually contribute to tripping and falling in the patient who may be confused and tries to get up.
- We thought that catheterization would protect the skin in the incontinent patient. While a catheter may prove useful in advanced-stage pressure ulcers, there are many other products that can create a barrier to protect intact skin. Additionally, the presence of a catheter can cause pressure and may damage fragile tissue.
- Finally, we thought having patients catheterized would save time, but clearly, with extended lengths of stay, infection complications, and other risks, this intervention ultimately consumes both time and resources.

CAUTI

Catheter misconceptions:

- Facilitates I & O measurement
- Protects patient from falls
- Protects skin in the incontinent patient
- Saves time for the bedside nurse

Facilitates I & O measurement

I & O measurements can be accomplished with less invasive measurement methods

- Bedpan
- Urinal
- Diaper

CAUTI

Protects patient from falls

Urge to urinate still present and a confused patient may try to get up

Protects skin in the incontinent patient

Use other possible barriers

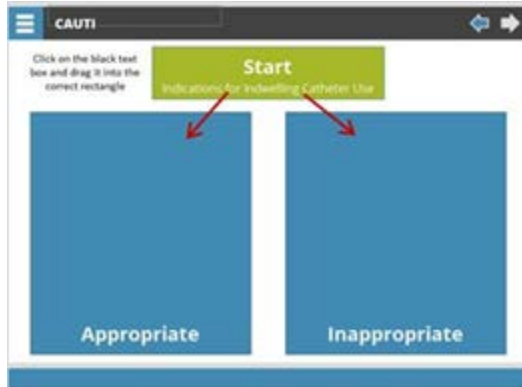
CAUTI

Saves time for the bedside nurse

With infection complications, extended stay and other risks, it does not save time

Indications

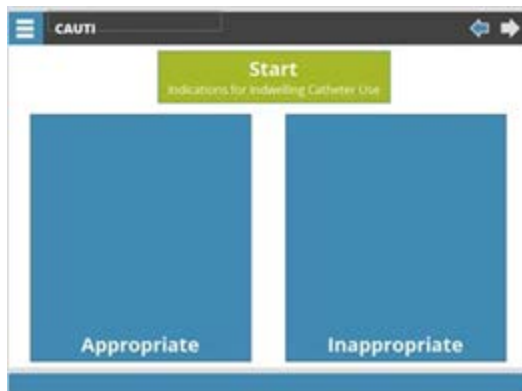
Click on start to reveal indications for indwelling catheter use. Drag each indication into the correctly labeled rectangle. Click submit when you have finished. Selecting the incorrect answer will result in the indication returning to the top of the screen.



Drag Item	Drop Target
Obtain urine culture in patients able to voluntarily void	inappropriate
Accurate, frequent urinary output monitoring in critical illness	appropriate
Patients who have acute urinary retention or bladder outlet obstruction	appropriate
Prolonged immobilization (e.g., unstable thoracic or lumbar spine, unstable pelvic fracture)	appropriate
Promote healing of open sacral or perineal wounds in incontinent patients	appropriate
To promote hygiene in incontinent patients	inappropriate



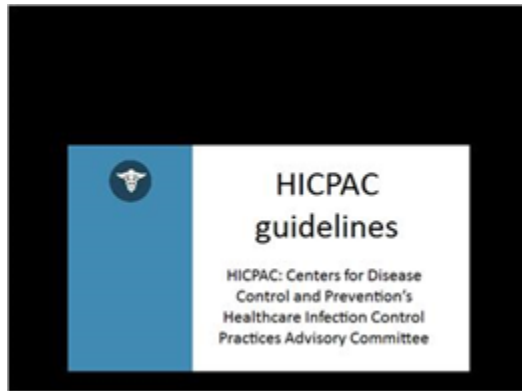
Here are a few more indications to consider. Drag each one into the correct rectangle and click submit.



Drag Item	Drop Target
Urologic surgery or surgery of the genitourinary tract	appropriate
Prone positioning is required	inappropriate
Preoperative urinalysis is needed	inappropriate
To be admitted to ICU postoperatively	inappropriate
Prolonged duration of surgical procedure	appropriate
Monitoring of urinary output during surgery	appropriate
Large volume of fluid or diuretic use during surgery	appropriate



HICPAC



The Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee, HICPAC, has issued recommendations for the appropriate use of indwelling catheters listed on the screen.

- Critically ill patients
 - This does not mean every patient who is admitted to the ICU is critically ill.
 - Confirmation of lack of other options for urinary output measurement should be clear and documented.
- The patient with urinary retention or obstruction
 - Use a bladder scanner or bedside ultrasound first to identify retention and amount retained.
 - To limit exposure, consider straight catheter use instead of an indwelling catheter.
- The patient who requires immobilization for trauma or surgery
 - Inquire about the length of the surgical procedure before catheter placement or communicate with the OR staff to see if they would prefer to place the catheter and remove it immediately after the surgical procedure. If the catheter is placed for the length of the surgical procedure, communication with the PACU nurse will also facilitate prompt removal.
- The patient who is incontinent with open sacral or perineal wounds
 - Consult with the wound care specialist to make the best care decision for each patient.
- The patient at the end of life or in hospice care
 - Be sure being catheterized is congruent with the patient's wishes prior to insertion.
- The patient with chronic or existing catheter use

- Some patients may present with a catheter in place, and each one is evaluated for continued use upon arrival.
- Reevaluate the need and discuss with the provider.

HICPAC guidelines:

- Critically ill patients requiring accurate output measurement
- Urinary retention/obstruction
- Immobilization needed for trauma or surgery
- Incontinent with open sacral/perineal wounds
- End of life, or hospice care
- Chronic or existing catheter use

CAUTI Guidelines

Gould, C. V., Umscheid, C. A., Agarwal, R. J., Kuntz, G., Pegues, D. A., & the Healthcare Infection Control Practices Advisory Committee. (2009). *Guideline for prevention of catheter-associated urinary tract infections 2009*. Retrieved from the Centers for Disease Prevention and Control website: [CAUTI Guidelines](#)

In certain web browsers you may need to click **alt+tab** to return to module

A complete list of resources can be obtained by clicking on the resource tab in the upper right hand corner of the main slides

CAUTI

- Critically ill patients requiring accurate output measurement

- **Every patient admitted to ICU is NOT critically ill**
- **Confirmation of lack of other options should be clear and documented**

CAUTI

- Urinary retention/obstruction

- **Bladder scanner or bedside ultrasound to identify retention amounts**
- **Straight catheter can limit exposure**

CAUTI

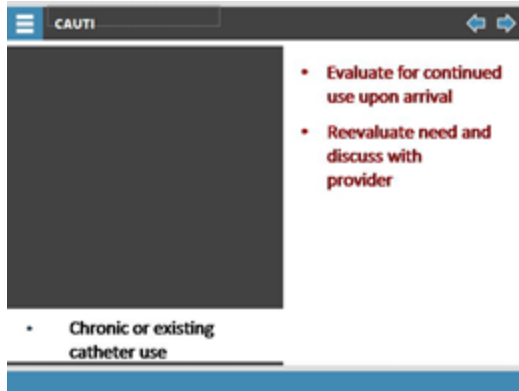
- Immobilization needed for trauma or surgery

- **Inquire about length of surgery**
- **Communicate with OR and PACU staff**

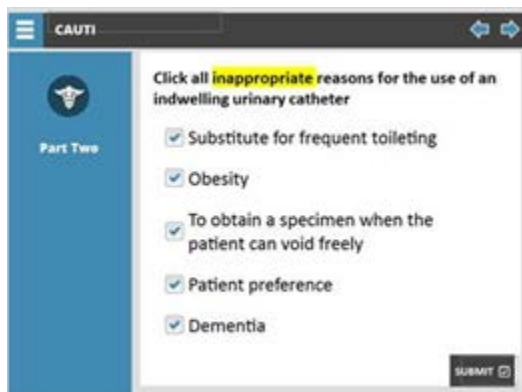
CAUTI

- Incontinent with open sacral/perineal wounds

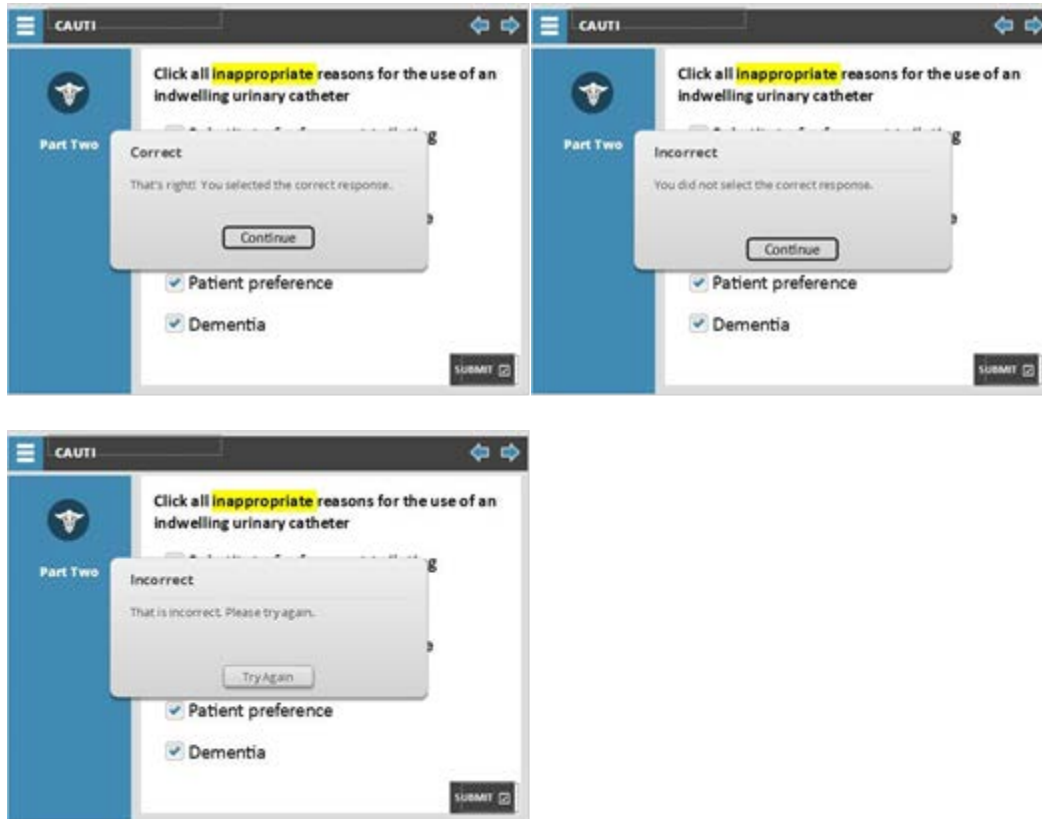
- **Consult with wound care specialist**



Click all inappropriate reasons for use of an indwelling urinary catheter and click submit.



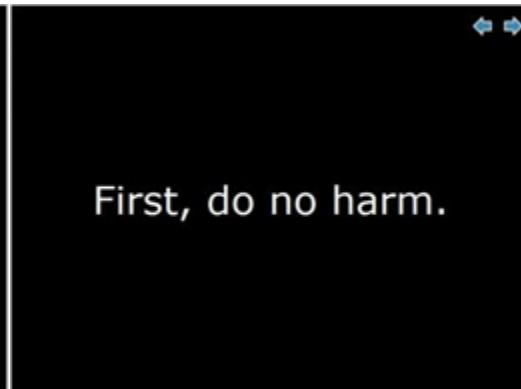
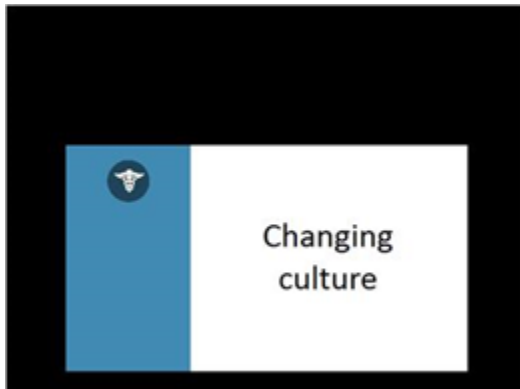
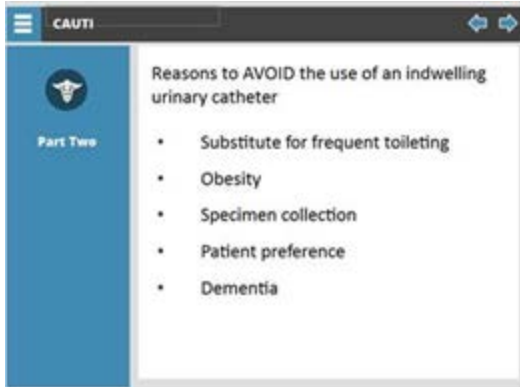
Correct	Choice
X	Substitute for frequent toileting
X	Obesity
X	To obtain a specimen when the patient can void freely
X	Patient preference
X	Dementia



Inappropriate Reasons

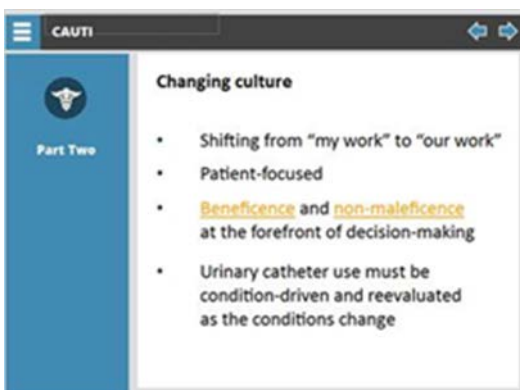
These are all reasons a catheter is not to be used. Many of the contraindications are related to convenience, but a catheter is not to be used merely for the convenience of the staff.

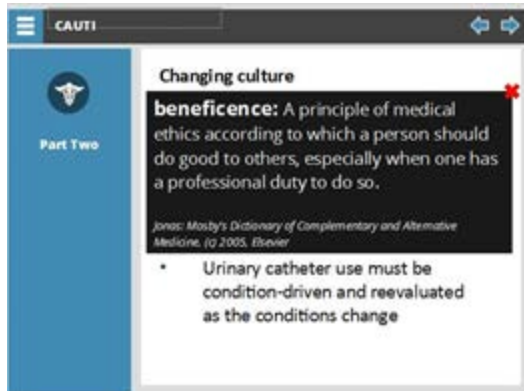
- Catheterization is not a substitute for frequent toileting. Toileting schedules promote continence and the use of a catheter can interfere with that continence training process.
- Obesity can limit movement and the obese patient may require additional staff members to get the patient up to toilet, but a catheter is not a solution for this.
- Even if a catheter is necessary because the patient is unable to provide urine for laboratory analysis, consider the use of a straight catheter for specimen collection.
- There may be patients who will ask for a catheter, but that cannot be the only reason.
- Dementia is a contraindication because catheter placement in the patient with dementia may increase the agitation as confusion worsens with nightfall or illness.



Beneficence

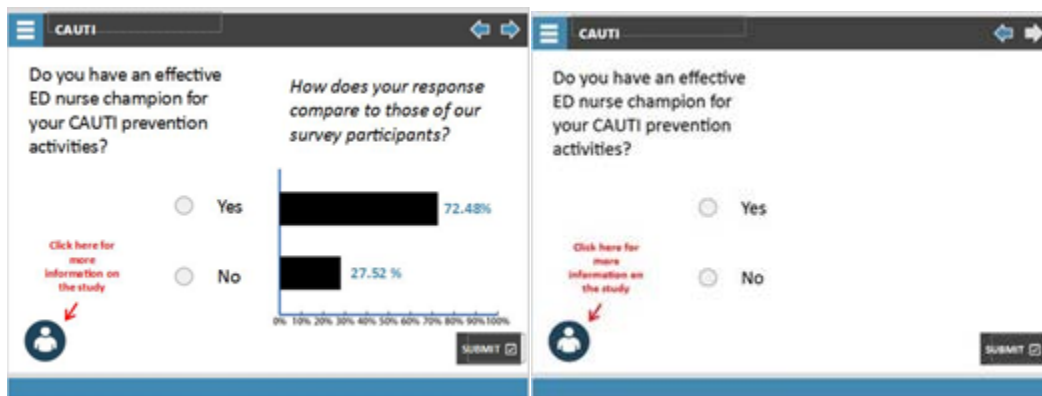
Guidelines for appropriate catheter use exist, but the translation of those guidelines to practice has proven difficult. A culture change that shifts from “my work” to “our work” is necessary to underpin this practice change. In addition, implementing these practice changes warrants a focus on the patients so that all decisions are based on what is best for them. Patient-care decision-making is based on the ethical principles of beneficence and non-maleficence. In order to keep the patient safe, the use of urinary catheters has to be condition-driven and continually reevaluated. All obstacles must be removed to make that happen.





Nurse Champions Survey

Answer the following survey question as it relates to your institution, then click submit.



Nurse Champions

Nurses, both as bedside staff and as unit leaders, create the care environment. They set standards for practice, behavior, and education. Changing the culture and generating practice change needs to come from within.

Enter the role of nurse champion, who can be instrumental in changing the culture and shaking up the status quo. Their leadership can improve communication and training efforts.

Over 72 percent of the nurses surveyed reported having an effective nurse champion in the pursuit of CAUTI reduction. “Champion” is a word often thrown around, sometimes with no definition as to what the role entails and what the characteristics of an effective nurse champion are.

The nurse champion is recognized as an expert on the issue. He or she is the person to whom the staff goes for questions related to practice, research, and protocols.

The nurse champion is informed on all current research and knows how it is applied to practice. He or she knows what the real-life obstacles are to implementation and how they can be overcome. This results from networking with others in similar positions at other facilities.

Enthusiasm is what will drive the practice change. Unless there is a willingness among the staff to follow a new protocol, all efforts will be useless. A champion who does not have a clear dedication to the cause will never be successful.

Above all, the nurse champion is a patient advocate who knows that the motivation for outcome of any project is improved patient care, and that all decisions are based on that premise.

The nurse champion may also—

- Review for appropriate insertion criteria and indications for removal prior to transfer
- Review orders and indications
- Communicate information to staff
- Provide real-time assessment of technique
- Support and normalize practice change



CAUTI

Nurse champion

- Recognized
- Informed
- Enthusiastic
- Patient advocate

Nurse champion

- Recognized
- An expert in the field
- "Go to" person for questions related to practice, research and protocols

CAUTI

Nurse champion

- Informed
- Knows current research and its application
- Identifies and addresses obstacles to research implementation
- Builds a network of resources

Nurse champion

- Enthusiastic
- Objective team leader who can get fellow staff to buy into evidence-based practice change

CAUTI

Nurse champion

- Improves patient care
- Patient advocate

Nurse champion responsibilities

- Review for appropriate insertion criteria and indications for removal
- Review orders and indications
- Communicate information to staff
- Provide real-time assessment of technique
- Support and normalize practice change

Part Two

Improving training and observation

Changes in Training

We have already made the argument for sterile urinary catheter placement to be considered high risk and the need for competency periodically demonstrated. We have also addressed the benefit of two-person insertion procedures to promote the practice of sterile technique.

But how should we train nurses in sterile urinary catheter insertion? While lecture and simulation may promote comfort in identifying sterile fields and teach the steps to a sterile insertion, documented demonstration with actual patients is a better confirmation of competency. This skill needs to be observed, evaluated, and documented systematically, not treated as a formality or an annual check off. Although personnel who insert catheters are almost exclusively nurses, this training should extend to others who perform the skill, including medical students, residents, and patient care technicians.



This quote represents a response by a focus group member regarding barriers and CAUTI reduction and catheter insertion.



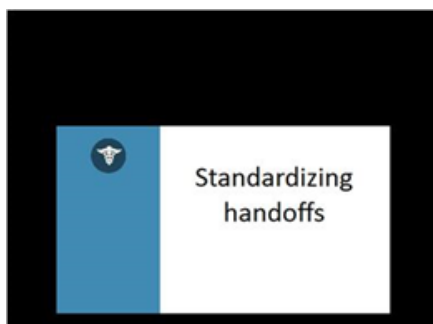
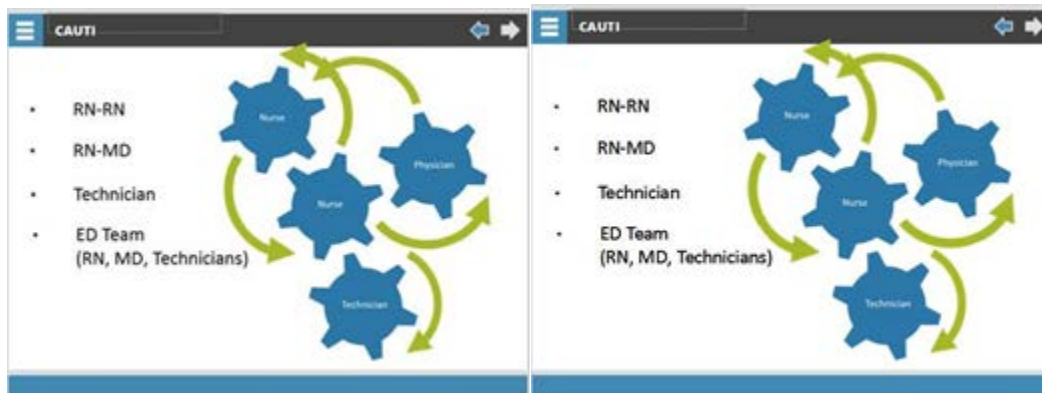


Communication

Nurse-to-nurse communication often centers around handoffs, either to the next shift, relief nurse, or admitting nurse on the inpatient unit. This communication assures continuity of care.

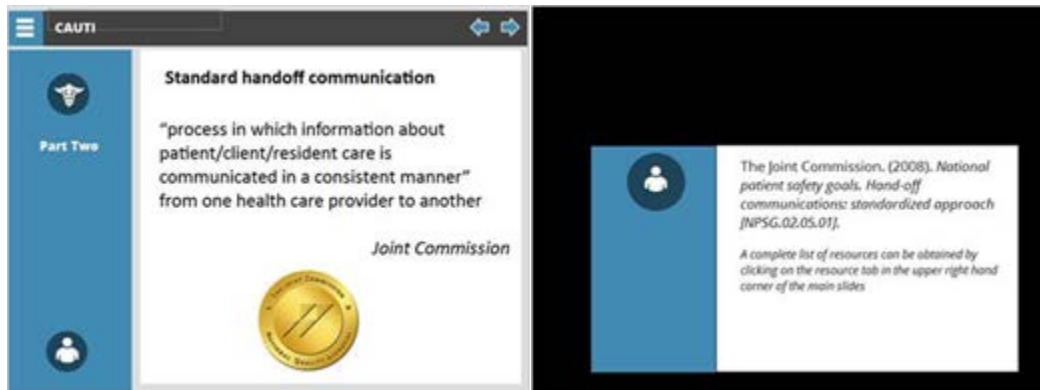
Discussion about the need for a catheter is generally between the nurse and physician or provider, covering the risks and benefits to the individual patient and indications for continuing use or removal. Much of this communication is verbal, but should include collaboration on assuring that an order, with rationale, is entered into the medical record.

Communication with the entire team covers all of that and more. This communication includes confirming the patient care technicians are aware of care required for safe catheter usage, knowing what surgical interventions may be planned, and what might be needed for other departments or diagnostic testing. Finally, but maybe most important, is the communication with the patient and family to determine what they know and expect.



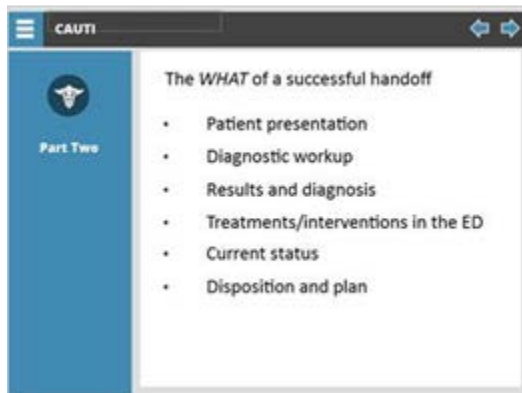
Handoffs and the Joint Commission

The Joint Commission definition of standardized handoff communication is “a process in which information about patient/client/resident care is communicated in a consistent manner” from one health care provider to another. The handoff facilitates continuity of care within the ED, as well as a smooth transition to an inpatient unit or another facility.



What is included in a successful handoff?

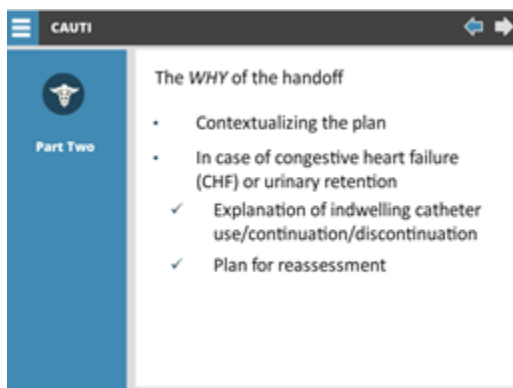
- Patient presentation: What was the chief complaint?
- Diagnostic workup: What additional information was obtained from laboratory testing, imaging, and clinical examination?
- Results and diagnosis: How was a diagnosis determined based on those results?
- Treatments/interventions in the ED: What interventions were started, completed, and reassessed? Did this change the plan for ongoing care?
- Current status: Is the original chief complaint still relevant or have other priorities emerged?
- Where they are going? What is the disposition or plan?



Contextualizing the Plan or Putting it Into Action

In the case of congestive heart failure (CHF) or urinary retention—

- Once treatment has begun and a reassessment completed, is the indication for the catheter still applicable? For example, once the patient with CHF has been diuresed, has urinary output been adequate? Is the work of breathing decreased and shortness of breath improved? Are the breath sounds clearer? All of this information is included in a good handoff to promote collaboration on the decision to retain or remove the catheter.



Report on a Bad Day on the Floor (sample handoff)

ED RN: Hey there! Hope your day is going better than mine.

M/S RN: Worst. Day. Ever.

ED RN: Sorry. Listen, let me tell you about Davy Jones. He's a 65-year-old man with a history of CHF and AFib. He came into the ER with a complaint of shortness of breath, and we found him to have crackles 2/3 of the way up and an O₂ sat of 88 percent. His respiratory rate was 24. He was working.

M/S RN: Yeah. Lotta that going around.

ED RN: His chest X-ray was fluffy, and his BNP was 2800, so we gave him 160 of furosemide to dry him out a little.

M/S RN: How much did he put out?

ED RN: Two thousand mLs of clear pale urine. His crackles are now only at the bases, which is baseline for him. His SaO₂ is 96 percent, and his respiratory rate has dropped from 24 to 14.

M/S RN: Okay. Anything else? What's in his Foley now?

ED RN: He doesn't have a Foley. We removed it once he improved. He's using a urinal now, and has put out an additional 500 mLs for me.

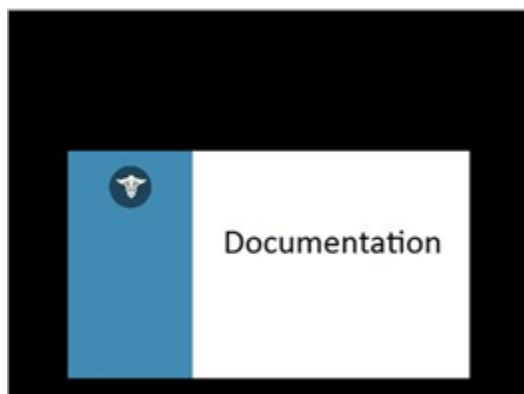
M/S RN: Really?

ED RN: He didn't need a catheter. He could use a urinal, we measured his output, and he can ambulate by himself to the bathroom now that he can breathe.

M/S RN: I get that it's better for him, but I'm glad to hear he can ambulate. I've got six patients today, and I'm in charge here. I just can't toilet another one.

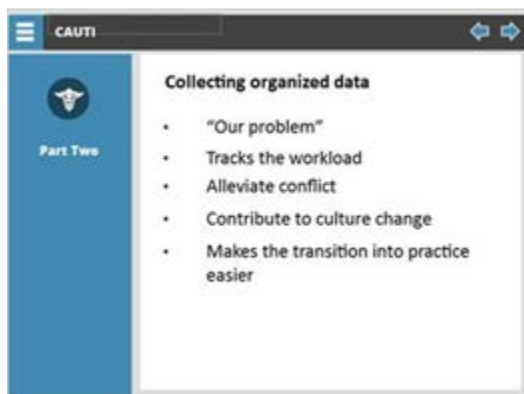
ED RN: Are you doing the CAUTI reduction thing too? I know we just started trying to use fewer catheters and looking at taking them out. We've never done that, but it seems to make sense. Are you looking at catheter use up there too?

M/S RN: We are. It sometimes seems like more work, but we're finding it to work out better. So, if he's going to need any extra help toileting, let me see about switching him to a nurse with a smaller assignment. I have someone who's got four patients and an upcoming discharge. I'll pass along your report and you can send him up when you're ready.



Organized Data

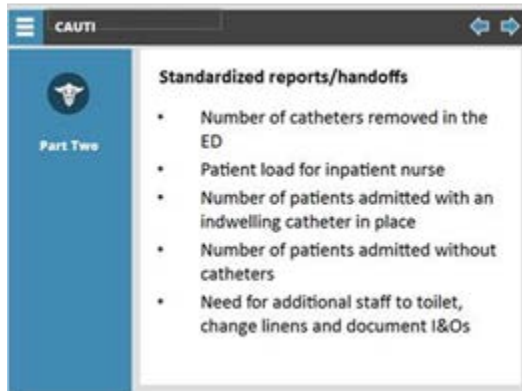
Collecting organized data will help turn the concept of “your problem” and “my problem” into “our problem.” All parties have a stake in the data collection as it tracks the workload objectively, and this may help alleviate conflict and contribute to changing the culture of the institution. Good data ideally makes for easier translation of plans into practice.



Standardized Handoffs

A well-constructed handoff can be useful as a data collection tool as you track efforts related to CAUTI reduction. Information in this tool can include:

- The number of catheters removed in the ED prior to admission
- The patient load for the inpatient nurse who may be receiving a patient with an indwelling catheter
- The number of patients admitted with an indwelling catheter in place
- The number of patients admitted without catheters
- Any anticipated need for additional staff for non-catheterized patients for more frequent linen changes, toileting needs, or documentation of intake and output



Sample Handoff

This is a sample handoff sheet that can easily collect data for your CAUTI reduction plan, whether this data is for the national initiative or your own quality improvement project. Recommended data include patient identifier, admitting diagnosis, location, date and time of catheter insertion, and of removal, if applicable. Also include the rationale for continued use or plan for removal. The nurse-to-patient ratio and receiving unit may help determine staffing needs.



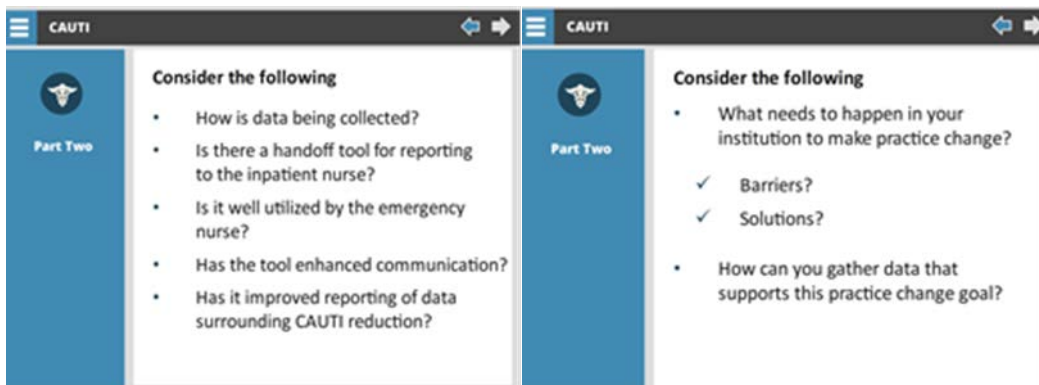
Date	Pt ID	Admitting Dx	Catheter Insertion	Catheter Removal	Plan	Unit	RN/patient ratio
11-Feb	12345	CHF exacerbation	In ED 14:30	In ED 18:45	observe, diuresis, bladder scan for residual	telemetry	1:04
12-Feb	123456	Urinary retention/ BPH	In ED 09:20	No	Remove 2/13	M/S	1:06

Questions

Consider each of the following questions and how it pertains to you and your institution.

- How are data being collected?
- Is there a handoff tool for reporting to the inpatient nurse?
- Is it well utilized by the emergency nurse?
- Has the handoff tool enhanced communication with the inpatient staff? If so, how?
- Has it improved reporting of data surrounding CAUTI reduction?

Finally, if it has not produced improvement, what needs to happen in your institution to make this practice change? What are the barriers? What solutions might exist? How can you gather data to support your efforts?

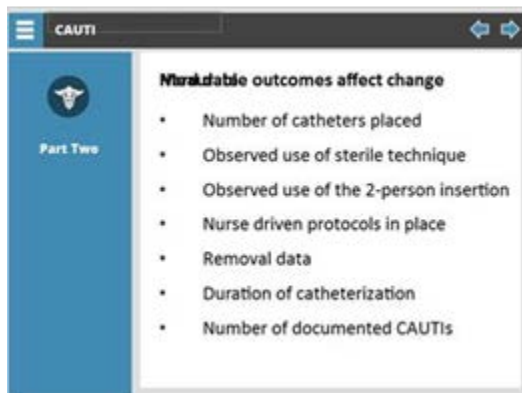


The image shows two side-by-side screenshots of a CAUTI handoff tool interface. Both screens have a dark header with 'CAUTI' and navigation arrows. The left screen, labeled 'Part Two', has a blue sidebar with a white medical icon and contains the text 'Consider the following' followed by five bullet points: 'How is data being collected?', 'Is there a handoff tool for reporting to the inpatient nurse?', 'Is it well utilized by the emergency nurse?', 'Has the tool enhanced communication?', and 'Has it improved reporting of data surrounding CAUTI reduction?'. The right screen, also labeled 'Part Two', has a blue sidebar with a white medical icon and contains the text 'Consider the following' followed by three bullet points: 'What needs to happen in your institution to make practice change?' (with sub-bullets 'Barriers?' and 'Solutions?' marked with checkmarks), and 'How can you gather data that supports this practice change goal?'.

Hard Data

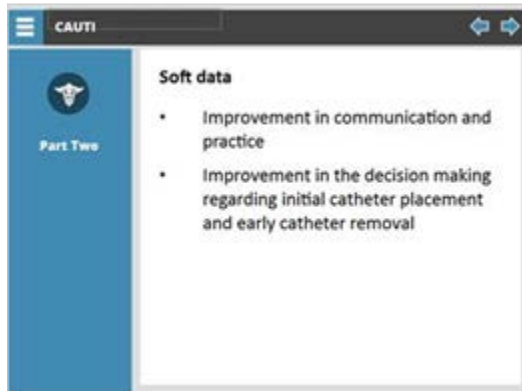
We need to have measurable outcomes to effect change. This involves collecting both hard and soft data. Hard data include—

- The number of catheters placed in the ED
- The observed use of sterile technique during the catheter insertion procedure
- The observed consistent use of two-person catheter insertion
- The existence and acceptance of nurse-driven protocols to support the decision-making process for catheter placement and removal
- The number of indwelling urinary catheters removed before patients transfer from the ED to the inpatient units
- The duration of catheterization
- The number of documented catheter-associated infections



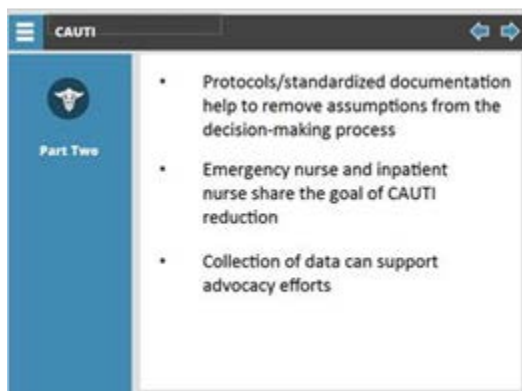
Soft Data

Soft data is a little more difficult to capture as it is more subjective, but it is equally crucial in effecting practice change. Here, we measured styles and practices in communications between nurses, nurses and physicians, and nurses and the entire team. This led to the development of a handoff tool to facilitate some of this communication. Other aspects included in the soft data were competence and confidence in the skills and process of decision making and how they related to reducing catheter usage and ensuring timely catheter removal.



Data Drive Change

Collaboratively developed protocols and standardized documentation for communications between emergency and inpatient nurses help to remove assumptions from the decision-making process. Both staffs share the goal of reducing the utilization of urinary catheters with their associated infections. Having data to present to administrators can also support the nurse or nurse champion in advocating for more resources and personnel.



Case Study

Now, let's apply what you've learned to a patient.

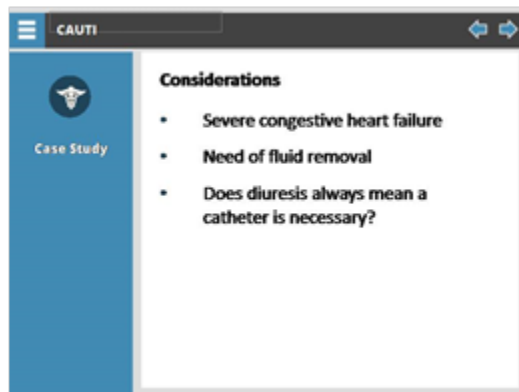
She is an 80-year-old female who presents to the ED via ambulance from an assisted living facility. She complains of difficulty breathing, is using accessory muscles, and complains of shortness of breath. Her BNP is elevated, indicating congestive heart failure. Assessment of her breath sounds reveal rales or crackles bilaterally halfway up the lower lung fields. Her oxygen saturation is low at 89 percent. She sits in a Fowler position, unwilling to lie supine. She is able to reposition herself in the bed, but ambulation produces severe shortness of breath. The chest radiograph reveals an enlarged cardiac shadow with consolidation in both lower lung fields. Diuresis is ordered along with an indwelling urinary catheter.



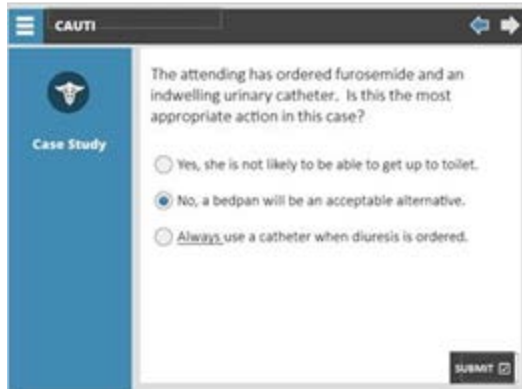
Let's examine her clinical situation and whether the order for a urinary catheter is appropriate.

She is demonstrating severe congestive heart failure. She is clearly in need of fluid removal to improve her mobility and cardiac function, and to prevent complications from excess fluid.

Does diuresis always mean a catheter is necessary?

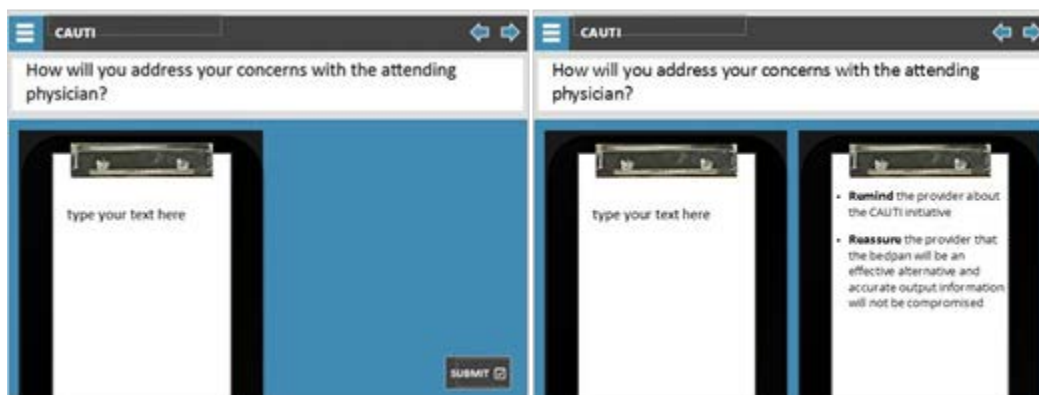


The attending physician has ordered furosemide and an indwelling urinary catheter. Is this the most appropriate action in this case?



She is able to reposition herself on the stretcher, so a bedpan may be an acceptable alternative. She is not likely to be able to get up to toilet, as her ability to ambulate is limited. However, with planning and preparation, a catheter may be unnecessary for her.

Since the order has already been written, how will you address your concerns to the attending physician? Enter your answer on to the clipboard on the left of your screen. After you have finished, click submit.



Remind the provider that there is a national initiative to reduce the use of catheters in order to prevent CAUTI. Reassure the provider that with planning and preparation, the bedpan will prove an effective alternative to a catheter, and obtaining accurate output information will not be compromised. As we have discussed, elimination and output is within the realm of the nurse, and when explained well, and responsibility accepted, the provider is likely to agree.

Before the expected response to the diuretic becomes urgent, plans for toileting will be included in communications with the patient care technician in order to prevent incontinence. Ideally, the technician is included in the goal of reducing catheter usage and CAUTI, and will understand the reasons behind the decision.

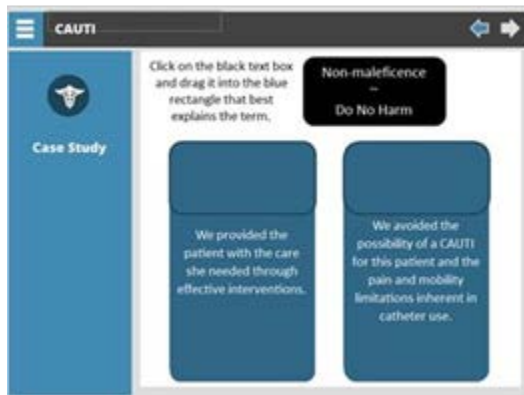
Following the administration of furosemide, the patient voids 1200 mL of clear, pale yellow urine. Her breath sounds are now clear throughout, oxygen saturation has improved, the work of breathing has lessened, and she is now much more comfortable.

The nurse prepares her for admission to the medical unit.

In handing off the patient to the admitting nurse, review the rationale for not placing a urinary catheter. Review the decision in light of acceptable alternatives and the needs of the patient.

Ideally, the inpatient units will have their own process for reducing catheter insertions and CAUTIs. If not, relate the evidence and the protocol in place in the ED.

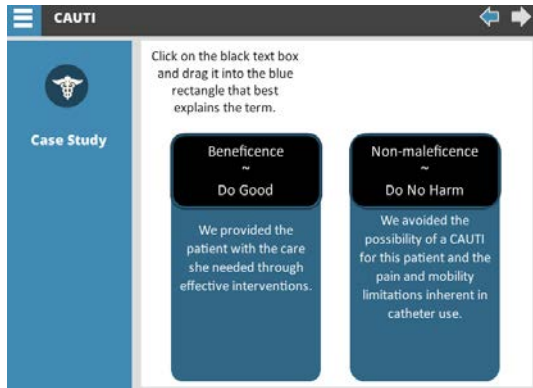
Next, match the terms of beneficence and non-maleficence to the proper rationale for not using an indwelling urinary catheter that you could report to the inpatient nurse during handoff.



Drag Item	Drop Target
Beneficence ~ Do Good	Rectangle 5
Non-maleficence ~ Do No Harm	Rectangle 6

Applying the ethical principle of beneficence to this case, we provided the patient with the care they needed through effective interventions.

Considering the ethical principle of non-maleficence, we avoided the possibility of a CAUTI for this patient and the pain and mobility limitations inherent in catheter use.



Conclusion

CAUTI is preventable. CAUTI reduction improves patient care and outcomes, limits complications, and prevents extended lengths of stay. Reducing CAUTI is a shared responsibility of the health care team, including the emergency nurse. Communication about practice change is essential. Decision-making based on sound evidence, best practice, and established guidelines can foster positive nurse-driven change, resulting in safer patient care and improved patient outcomes.

