CHAIN Preventing HAIs in Minnesota | Collaborative Healthcare-Associated Infection Network

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2016 CHAIN Award for Excellence Winning Nomination
Organization – CentraCare Health – St. Cloud Hospital
Team Name – QLA - CAUTI

The St. Cloud Hospital (SCH) catheter-associated urinary tract infection (CAUTI) Quality Leadership Academy (QLA) formed to identify opportunities for improvement related to hospital CAUTI rates. The QLA is a program which incorporates principles of adaptive leadership to create an environment of improvement directed toward achievement of the Triple Aim. The CAUTI QLA members are a collaborative, multidisciplinary team comprised of leaders, physicians, nursing, patient safety experts, affected department stakeholders, and patients.

While previous work related to CAUTI reduction was implemented (e.g., policy revision, staff education regarding insertion and maintenance care, nurse-driven Urinary Catheter (UC) removal protocol), sustainable results were not achieved. SCH fiscal year 2014 and 2015 CAUTI rates were significantly above NHSN pooled means. A thorough review of our CAUTIs indicated opportunities for improvement related to neurological patients who had UCs inserted < 6 days.

The goal of the CAUTI QLA was to implement a five-fold process to be tested with Neurosurgical and Neurointerventional patients: reduce primary UC insertion within the operating room (OR); remove UC when no longer indicated while the patient is in the OR/PACU (post-anesthesia unit); continue UC “free” status beyond Perioperative Services; provide 100 percent UC insertion competency by Neurosurgical and Neurointerventional OR staff; and provide 100 percent implementation of two-person UC insertion technique.

Utilizing the Plan, Do, Study, Act (PDSA) model of rapid cycle improvement, we implemented the following interventions: revision of surgeon procedure cards to eliminate automatic pre-procedure UC placement; created a communication pathway for UC insertion indications for the specific patient population; two-person UC insertion technique and validated competency of team RNs and Surgical Technologists; and individualized patient assessment for UC need immediately prior to the procedure. During these interventions, we recognized the need to exercise leadership, such as recognizing staff feelings of “blame” for CAUTIs, ensuring product availability for incontinence management, and managing physician resistance to the practice change of automatically placing catheters as directed by the procedure cards versus assessing each patient’s need for a UC. Post-intervention, we monitored incidence of UC placement and continued UCs beyond Perioperative Services, secondary complications (i.e., incontinence-associated dermatitis (IAD), urinary retention) for patients without a UC, and CAUTIs.

One measurable outcome indicated minimal change in the percentage of UCs placed: 28 percent pre-intervention to 25 percent post-intervention. Significant change was achieved with UCs remaining in place beyond Perioperative Services: 76 percent pre-intervention to 41 percent post-intervention. The reduction of UCs beyond Perioperative Services decreased the opportunities for a patient to acquire a CAUTI by 35 percent. Of inpatients monitored, only four percent had urinary retention and no patients had IAD. In the two years preceding the QLA, there were 15 CAUTIs in the ICU neurological patient population. Post intervention, zero CAUTIs have been attributed. Next steps involve planned expansion of interventions to appropriate patients in our general surgery population and Emergency Trauma Center.

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