the HEART OF SAFETY

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Poster Information:

Poster Title: Establishment of a multidisciplinary team approach to monitor insertion and maintenance of Foley catheters led to a dramatic decline in insertion of Foley catheters and catheter associated urinary tract infection (CAUTI) rates, thereby enhancing Patient Safety

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INTRODUCTION

CAUTIS have become a leading cause of Sepsis in our hospital due to indiscriminate use of Foley catheters and absence of any defined criteria for insertion, their maintenance and parameters for continued use.

At the direction of the executive staff of the hospital, a multidisciplinary team approach was instituted to establish defined criteria for Foley catheter insertions to decrease the overall insertion of catheters, to monitor on a daily basis the need for keeping the catheters and their appropriate maintenance. The team included RN's, CNA's, MD's, Infection control nurses and unit clerical staff.

METHODOLOGY

Strict guidelines for Foley insertion were instituted. Bladder scanners were purchased and placed in the units. RN's were instructed on how to scan the bladder for urinary retention. Noninvasive means were reviewed with staff so that these were tried before a Foley was inserted. Whenever possible, alternatives such as condom catheters and vaginal pouches were tried. Intermittent straight catheterization when appropriate was preferred over continuous Foley drainage. Appropriate maintenance of the catheters, with special emphasis on maintaining a closed sterile drainage system, was reviewed with nursing staff in all the units. A central monitoring team sent out a list of all patients in the unit who had a catheter, so that their continued use could be reviewed during multidisciplinary rounds at the bedside. If a Foley was deemed necessary then the MD had to sign a form indicating the justification for its continued use and it was monitored closely by the team members. Continuous feedback was provided to each unit on their data. A learning environment was created so that if there was a CAUTI in the unit a mini root cause analysis was done immediately to find out where the breakdown occurred and lessons learned shared with the entire organization.

RESULTS

As a result of these interventions we noted a sharp decrease in the number of Foley catheter insertions and overall catheter days. We also noticed a dramatic decrease of CAUTI'S at our institution- going down from a rate as high as 11.86 to an average of 2.61. We have sustained the positive trends over the last 18 months. Over the past 12 months the rate has further declined to an average of 1.49, with 3 months with a rate of zero. The number of Foley catheter days which were averaging over a 1000 before start of this initiative now have come down to about 875 over the past 18 months.

CONCLUSION

Creation of a multidisciplinary team approach to monitor Foley catheter insertions and their maintenance has led to a dramatic decrease in CAUTI's at our institution. This has led to an overall decrease in nosocomial Sepsis rates thereby enhancing Patient Safety. Continuous feedback to individual units and reinforcement has helped sustain this Patient Safety initiative.