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

**ED Mini-Presentation to Accompany May 5, 2015 ED Coaching Call**

Jeannine: Hello everyone, and thank you for listening today. My name is Jeannine [Risinger 00:04], and I'm a program manager with the health research and educational trust. Welcome to the third mini presentation and the CAUDI ED cohort 9 educational webinar series. Today's topic is no more CAUTI, preventing catheter associated UTI. We encourage you to watch this short presentation with your team. In the presentation itself, there are a few case scenarios to talk about as a group before joining the May 5th ED Coaching Call hosted by New Jersey hospital association.

 I'd like to introduce today's speaker, Elizabeth Mizerek. She's an assistant professor of nursing at Mercer County community college, a staff nurse in the emergency department at Robert Wood Johnson Hamilton, in Hamilton, New Jersey. Liz is currently the New Jersey state council of emergency nurse association president elect. She's also been a part of the New Jersey ENA team that worked with the New Jersey hospital association to recruit hospitals to join the national CAUDI CUSP project. At her home hospital, she was part of the CAUDI team and took the lead in educating staff about CAUDI prevention best practices. She's also presented for New Jersey Hospital association and New Jersey ENA on educational approaches to CAUDI prevention, including these as simulation. Finally, Liz served as a national mentor to 2 fellows in the project protect infection prevention fellowship hosted by the American Hospital Association. Liz, I'd like to turn it over to you.

Elizabeth: Thank you, Jeannine. Today, we're going to be talking specifically about the education component in your CAUDI prevention program. I'd like to give you a little road map here of things that you may want to consider, including in your education. Obviously, no education about CAUDI would start without the definition of CAUDI and what the impact, particularly looking at the financial impact. For a lot of people, part of their CAUDI prevention program is not only looking at appropriate indication, but making sure that you have appropriate orders present for the catheter insertion. Without an appropriate order, you can't bill, and then the hospital loses money. It's nice to include those financial impacts that directly relate to people at the bedside.

 Certainly, appropriate insertion indications are good, but it's also really important to talk about what inappropriate insertion indications are. Throw out some scenarios. We'll talk more about that in a little bit. Obviously a review of policy and procedures, and I'm really a big plan of a demonstrated insertion competency. If you consider that we're reducing the number of overall Foley's that are being placed, it becomes a high risk, low volume procedure, and any educator will tell you, high risk, low volume procedures are the things that we need to see people demonstrate their competency on.

 When we talk about our insertion indications, I do like to put pictures to it. People tend to be visual learners as much as they are verbal learners. By showing some pictures here, that usually helps a little bit. We talk about urinary retention and urinary flow obstruction issues. We talk about monitoring fluids in the critically ill patients, and this is a great example to show that we're talking about truly critical ill patients. If the patient has more IV pumps than there are people in the room, they're probably ICU caliber.

 Healing of very significant sacral or perineal wounds. Again, this is a good visual of we're not talking about just a little stage 1 or stage 2 pressure ulcer. Improving comfort at the end of life, selected perioperative use. That's certainly something to talk more about when we get into appropriate versus inappropriate indications. Immobilization due to trauma. Talk very carefully about the alternatives to an indwelling catheter. We know that the burden of toileting a patient is going to fall primarily on the nursing staff. What are the options for the indwelling catheter? Can we do bladder scanners to assess the residual volume of urine, rather than cathing a patient? Can we talk about intermittent straight cath, can we talk about condom catheters, female urinals? What are our alternatives to an indwelling catheter?

 Now's the time to transition over to inappropriate catheter indications. The first one is incontinence. People have the misconception that catheters will protect the skin in an incontinent patient. That's really something that we need to point out is not necessarily accurate. The catheter itself can actually cause pressure ulcers just as much as incontinence can. Again, recognizing that the burden of toileting these patients and making sure these patients are clean and dry does sit heavily on the nursing staff. What alternatives do you have to help the incontinent patient to maintain intact skin?

 The morbidly obese patient is another common patient that people think must have a catheter. We need to remind staff that the patient who is morbidly obese was toileting themselves prior to their entry into the hospital, so we need to work with that patient to see how they were toileting themselves and how we can continue to maintain their functional independence to allow them to continue toileting themselves. The patient with limited mobility. We have the impression that somebody who isn't very mobile, the frail, elderly, a catheter's going to help them. It's going to prevent falls. It's really not an accurate statement. That catheter in someone with limited mobility actually acts as a tether and actually increases a fall risk. It's just one more thing for somebody to get tangled up in. If your patient's not real stable on their feet, you don't want to add something else that they have to worry about holding on to if they're trying to ambulate.

 This is one of my favorites. The confused patients. In all honesty, we have to remember that a lot of times these things are going to go together, they're going to layer on top of each other. You're going to have a frail person who is confused, who has limited mobility. All these things will layer on top of each other, but the catheter preventing falls in the patient with confusion is really interesting, because what do we do when we tell someone with a catheter? They said "Oh, I have to go to the bathroom." We say, "Okay, okay, just go." Because there's a catheter in place. The patient doesn't understand that, and so the patient tries to get out of the bed and go to the bathroom with the catheter in place tethering her to the bed. Catheters aren't going to make anybody any less confused, in fact they'll probably make them quite more confused.

 Monitoring fluids in the non-critically ill patients. We can monitor output in so many ways. Urinal, hats, there are female urinals available for us. I have actually heard of facilities that are doing what they do in the NICU and weighing the Chux pads or the diapers of incontinent patients to manage their output. We also have to remember that outside of the ICU setting and sometimes in the ICU setting, that strict I&O really isn't driving our care. There's really not a huge difference if somebody outputs 30 mls versus 50 mls. We're not necessarily going to change our care based on the exact number in the urine output.

 Urine specimen collection is another opportunity. I still see many staff nurses who will say, "Well, I need a specimen, and they can't provide me a specimen, so I'm just going to cath them for the specimen." Which is okay, but then they choose to use an indwelling catheter and leave it in because they're just going to be admitted anyway. There's really no good indication for this. In cases where patients are unable to provide us with a sterile specimen, then a straight cath is a more appropriate option.

 Patient or family request. It is truly amazing to me how many people still are requesting a catheter. Many family members believe falsely that it will protect skin or prevent falls. Our job here is really to educate the patient and family that catheters aren't going to protect their skin, they aren't going to prevent falls in the way that they expect. While it may appear to be more convenient, the risk associated with a catheter acquired urinary tract infection does not outweigh the convenience there.

 Of course, there's staff convenience. The impression that catheters are going to save us time because we're not going to need to toilet the patient, isn't necessarily true. That confused patient with a catheter is still going to be confused, is still going to be ringing the call bell to go to the bathroom. Certainly, the patient that develops a CAUDI is not going to be less heavy of a workload for the nursing staff.

 Here's where I strongly suggest you consider throwing out some decision making scenarios. Now you've set it up. You've talked about appropriate indications, you've talked about inappropriate indications. Now, you want to take it to the bedside and do what they're doing on a daily basis. It's not enough to say do this, don't do that. You really want to make it applicable to the practice.

 What we have next are some scenarios. We're actually not going to discuss them at this time. I suggest that you discuss this with your team when you view this recording. Pause after each of these slides. I'll click through them a little slower, so that you can discuss what you would do with that. There are some that are appropriate, and there are some that are non-appropriate. You can feel free to add in the kinds of patients that you encounter in your facility. The ones that you're seeing that aren't appropriate for catheters, but yet staff continue to believe that they are. Everyone recognizes these patients. When you make it more applicable to the learner, it engages them more in an active learning style, and it really cements their learning in a way that just reading off a list of indications does not.

 The first scenario is an acute stroke patient with left sided weakness who's going to receive IV t-PA. The second patient is a family who requests a Foley for the patient and a provider who orders it. Next, a hip fracture who's going to the operating room, eventually. An elderly confused non-ambulatory patient. A critically ill ICU patient. A patient unable to provide the clean catch urine. An acute CHF patient receiving lasix who's on bi-pap.

 These scenarios really help you have discussions about what you can do, what your alternatives are. I think the last scenario with the acute CHF patient is probably the one that engenders the most discussion in most of our groups. The very last thing I want to bring up to you is this concept of a demonstrated competency. Think, for a moment, when, where, and how do nurses learn to place indwelling urinary catheters, and does the learning environment match the practice environment? You have 2 groups of people. You have people who have been nurses for a long time who learned to place catheters many years ago and perhaps have not had their practices updated with the most current evidence on how to place a catheter. Then, you have nurses who are new to the practice who haven't actually placed catheters on many patients at all. The majority of their catheter placements have been in simulation or on mannequins.

 You have to consider those 2 different groups, and your approach to those 2 different groups might be a little bit different. Another thing to think about is does the learning environment match the practice environment? Again, when we talk, talk, talk, about different concepts about do this and don't do that, it's really helpful to actually simulate as close to their practice environment as possible. One of the things we were able to do in our facility was use our simulation lab. We have a simulation mannequin. They are in a patient bed, in a typical looking patient care room. As you look a little bit closer at this patient, you will find that this patient is not ready for her catheter insertion. I had 2 versions, by the way. One was a little more interesting than the other.

 What this made us do, was it really had the staff take care of that patient. It wasn't just a mannequin that they could throw a catheter in. They had to look at the patient, recognize that they were dirty, which led us into a good conversation about perineal hygiene prior to even opening the catheter kit. They had to go to the bathroom, get a wash basin, and actually wash the mannequin before they could then go in and insert the catheter. We made it as realistic as possible for the staff. Another thing you'll notice in this picture here, is that I have 2 staff members doing this. We had our techs as well as our nurses go through our simulation scenario. While, at my facility, our patient care techs are not allowed to put in catheters, we really wanted to get them to understand that they had an important role to play in assisting with the catheter insertion, maintenance of good sterile technique, the appropriateness of the 4 eyes, 4 hands approach.

 They heard the whole presentation. They learned about appropriate and inappropriate indications as well. Don't underestimate how much influence all the members of your team have on this. Remember, nursing is bearing the burden of this toileting, and in all honesty, it's usually our techs and our nursing assistants who are having to do the vast majority of toileting in some of these patients, and they are frequently ones who will place pressure on nursing to put a catheter in if they find somebody to be inconvenient to toilet frequently.

 Just some additional thoughts, and before I forget, some people do ask some questions about the simulation portion of that. For the more yeasty approach, that was plain ordinary vanilla pudding mixed with some baby powder. It gives a very unattractive appearance. For the stool version, that was chocolate pudding with some mixed up crackers. Most of us have these things easily available in our patient care refrigerators to use. It wasn't any magical formulas. I do caution you to wash it off right away, or else it gets very difficult to remove. If you don't have the availability of the simulation lab or your own simulation mannequins, consider partnering with your local community colleges. Many of them do have mannequins. When we have done bigger simulation events, we've borrowed some additional mannequins from the nursing school. You may consider that as an option for your simulation activities.

 Just to wrap up, a couple of additional thoughts. As I mentioned before, we trained both our nurses and our techs together. We really wanted that shared mental model to use the team steps nomenclature here. That teamwork was really important to facilitate placement. The four eyes, four hands approach. Really empowering the staff when a breach in sterile technique is noted, making it all about patient safety, not necessarily about who's right and who's wrong, but making it about the patient. We, as a team steps facility, we were able to incorporate these concepts in our CAUDI prevention training as well. That really helped to reinforce both our commitment to patient safety through the use of our team steps tool, as well as the need for appropriate catheter insertion techniques.

 In conclusion, I'd like you to think about the fact that in indwelling urinary catheter, is almost never a life-saving procedure. We should encourage staff to think about it, do they really need the catheter? Slow down, take your time. Appropriate prepare the patient. Use good technique, and as always, safe practice and safe care. Thank you for your attention this afternoon.

Jeannine: Great, thank you so much, Liz. Really appreciate all of your information. If you do have questions for Liz, here is her email address. She will again be joining us on the May 5th ED Coaching Call and will be available for questions and comments there as well. Just like to take a moment to ask you to please fill out an evaluation of this mini presentation. The link is here. You can enter it into your web browser. We really do appreciate your feedback and look forward to hearing how you enjoy the educational content, or what we can do to help improve the experience. We hope you will join us for the upcoming May 5th ED Coaching Call. That will be at 2:00 PM Eastern, where Liz will be available to answer any questions you may have regarding these teamwork tools. Thank you very much again for joining us.