



# Reduction of CAUTI in the ICU's

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# Objectives & About Us

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- The participant will be able to:
  - Identify improvement opportunities outside of their respective work areas
  - List interventions that can contribute to reducing CAUTI along the continuum of care

## **Orlando Regional Medical Center**

Level 1 Trauma Center, 4 Specialty ICU's

Critical Care Collaborative - Joined state initiative



# Barriers & How We Resolved

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- Standardize knowledge – Foley insertion PI
- Review best practice guidelines

## **Opportunities:**

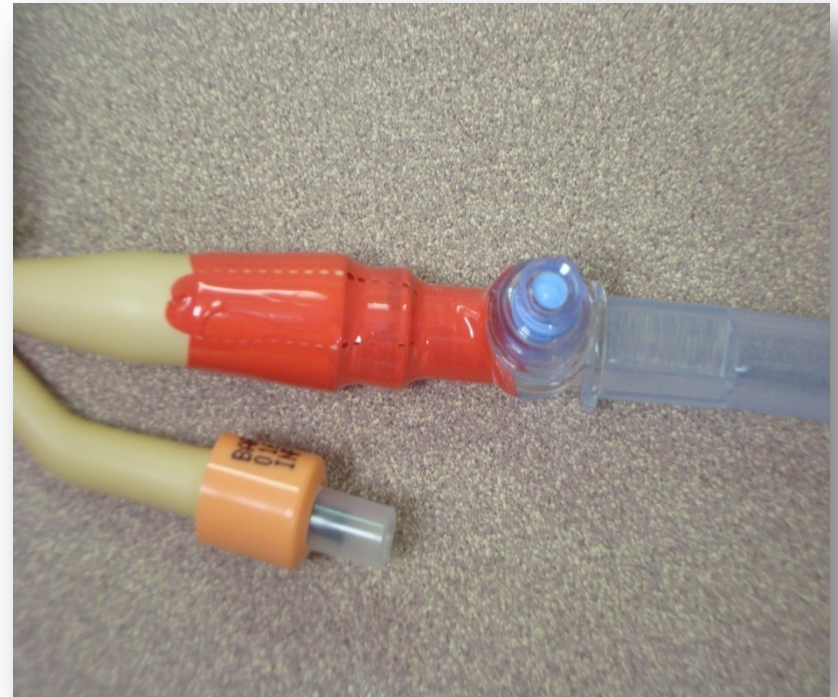
- Reduce need for Foley change (ED, MRI)
- Level of drainage bag
- Maintain connection seal:
  - Drainage bags with urometers for all
  - Radiology contrast delivery

# Revised Foley Set-up for Cystograms

**Foley connected to drainage  
system**

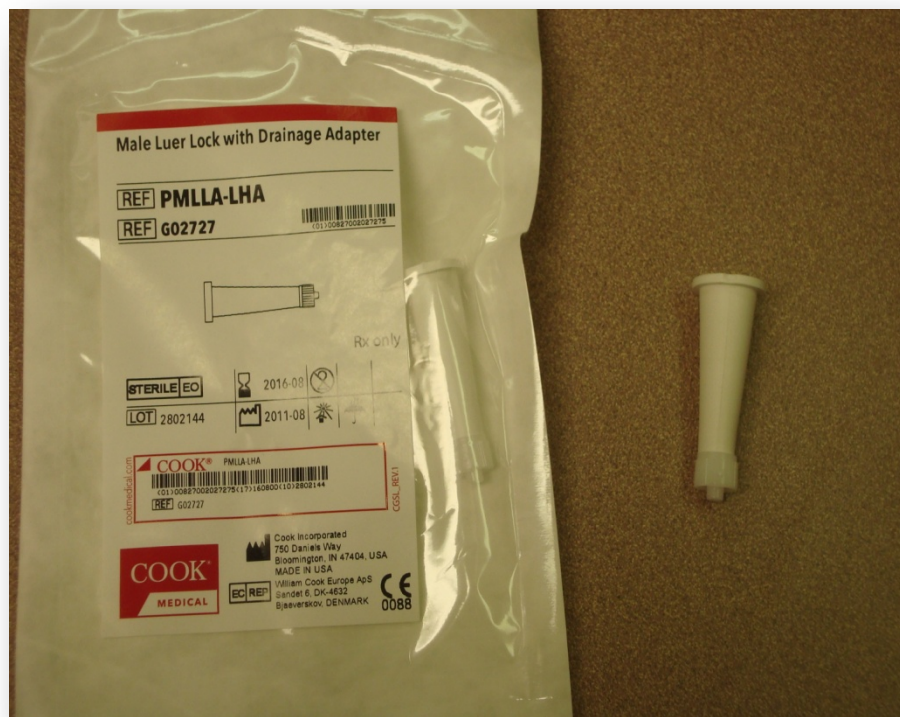


**Top View**



# Revised Foley Set-up continued

## Male Luer w/Drainage Adapter



## Fluid Spike Transfer Tubing



# Revised Foley Set-up continued

Clean the specimen port for 15 seconds with alcohol wipe. Let dry for 15 seconds.



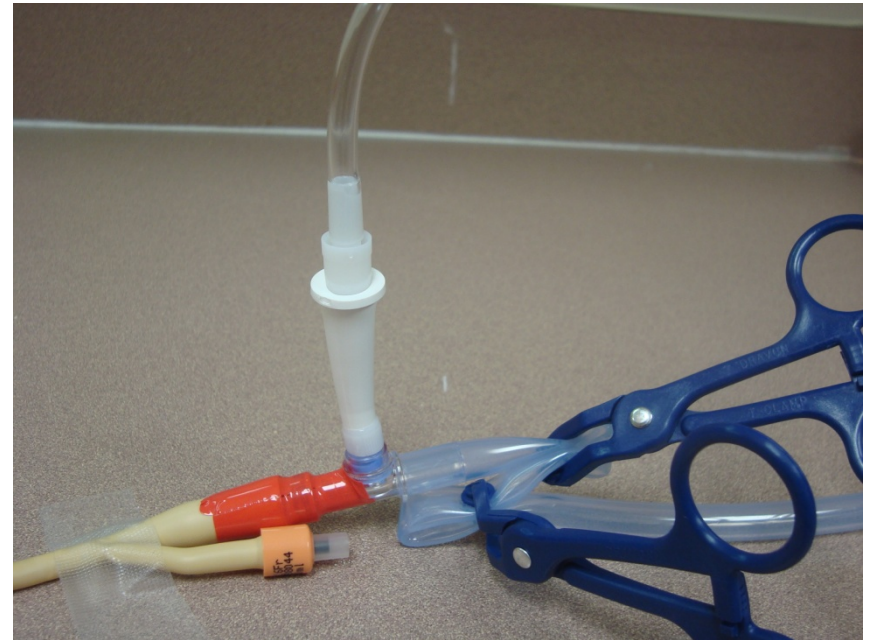
Attach adapter to specimen port.



# Revised Foley Set-up continued

**Kink and clamp to prevent contrast from emptying into the drainage system.**

**Keep fluid transfer tubing end and adapter sterile during set-up.**





# Measures – What & How

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- Critical Care reviews EVERY device associated infection in a collaborative group of clinical and operational leaders
- All reports are shared in committee and on the units – “Days since last CAUTI” displayed on digital monitors
- Nursing: Staff nurse peer audit



# Daily Reminder Daily Recognition



As of 6/12/12



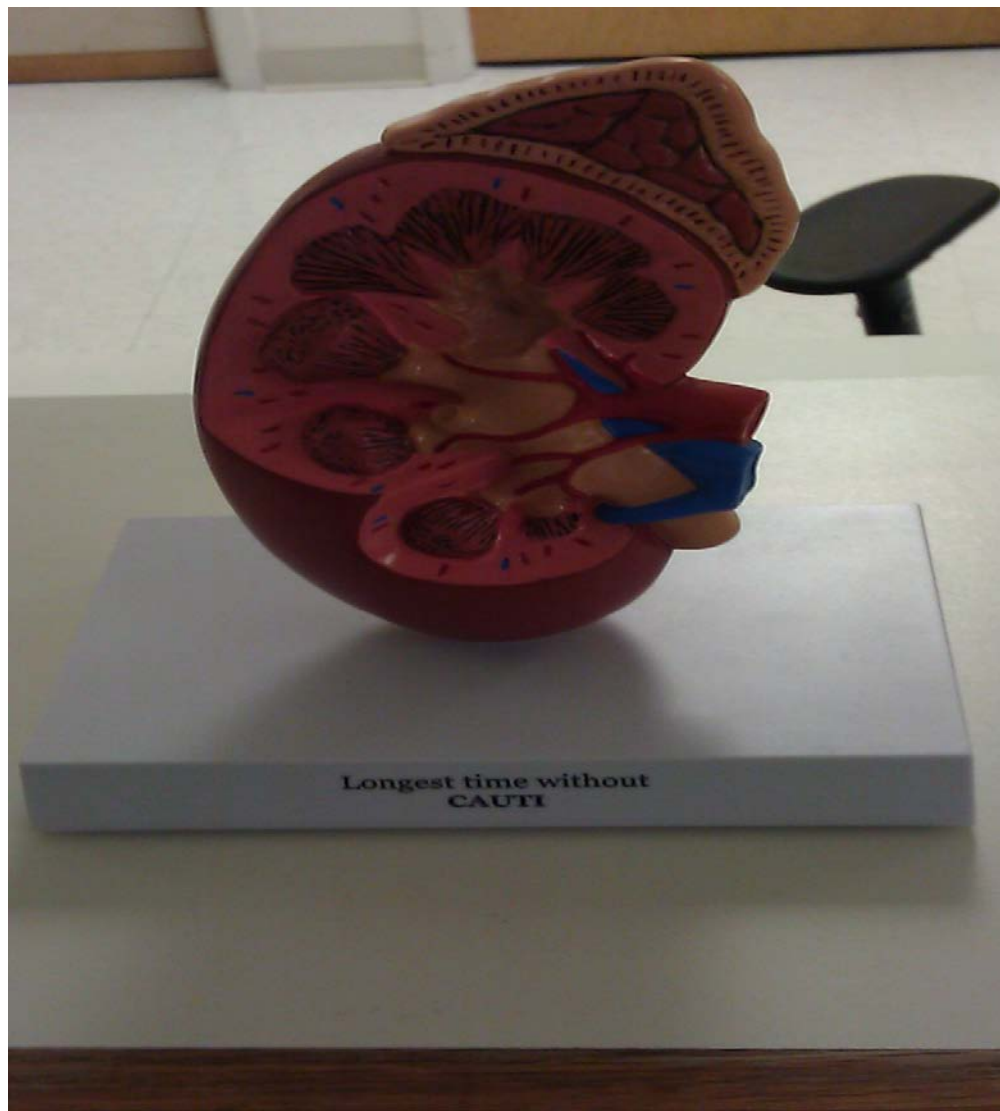
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# Longest Time Without CAUTI Award



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# Staff Created Peer Audit Tool

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Bundle intervention	Documented	Observed on patient
1. Insertion place and date		
2. Foley secured		
3. Foley care documented every shift		
4. Foley bag below level of bladder		
5. Does patient need the Foley		
6. Has patient traveled outside the ICU?		



# Tests & What We Learned

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- Individual unit – Opportunities for improvement
- System issues
- We can not be successful working in silos
- Sharing and Teamwork:
  - Critical Care Collaborative
  - Engaged Physicians, Executive Leadership, CNS's, Unit Leadership, Infection Preventionists & Staff Nurse Practice Councils



# Advice For Others

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- Be all inclusive
- Understand practice outside of your unit
- Communicate
- Meaningful recognition
- Share your outcome data with non-inpatient units that share in the provision of care
- “Thank You” goes a long way
- Team ownership of outcomes



# Wrap Up & Next Steps

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- Teamwork was essential to the success of our initiative.
- **Next Steps:**
  - Foley removal – opportunities
  - Continuous assessment and re-assessment of practice
- **Questions?**

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