Creating a Culture of Zero Tolerance for Catheter Associated Urinary Tract Infections
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Problem:
Catheter associated urinary tract infections (CAUTIs) continue to remain the single most common HAI; with external forces, such as mandated public reporting of HAI and the climate of “zero tolerance” for hospital-acquired infections have led to an increased effort in the reduction/elimination of CAUTIs.

Evidence:
An estimated 1.7 million HAIs occur in U.S. hospitals annually. Deaths associated with HAIs in U.S. hospitals were 98, 987 of these 13, 088 were linked with urinary tract infections. Most recently CMS released that as part of a national quality improvement effort it plans to require by 2014 the reporting of rates of CAUTIs publicly by healthcare facilities participating in the Hospital Inpatient Quality Reporting Program.

Strategy:
Conduct an extensive literature review to examine current evidence based guidelines and strategies to reduce the incidence of CAUTIs.

Practice Change:
As a result of the literature review, the researcher was able to define an evidence based process. The process involved a multidisciplinary team responsible for creating a nurse driven protocol for urinary catheter management based on current evidence.

Evaluation:
The pilot test involved intervention implementation of a single 42 bed medical-surgical unit within a 400 bed acute care regional medical center. Data was collected through a retrospective chart analysis over a 6 month period.

Results:
Initial results revealed a 33% reduction in the amount of CAUTIs. During the 6 month period there were zero CAUTIs on the pilot unit.

Recommendations:
As a result of the project success it was decided to expand the evidence based nurse driven protocol hospital wide. Data will continue to be collected on the pilot unit and the facility to determine the long-term impact.
Lessons Learned:
Sustainability is often one of the biggest challenges in changing practice. Realizing this concern it was critical to the project that a method for sustainability be built into the project. As a result a visual audit/communication board was implemented to communicate with staff.

Bibliography:


