CAUTI Kudos!

44%
REDUCTION!
2011 to 2014

In 2014, 68 fewer patients suffered catheter-associated urinary tract infection (CAUTI) compared to 2011

Total Annual Number of CAUTI			
2011	2012	2013	2014
154	112	99	86

The single greatest risk factor for catheter-associated urinary tract infection (CAUTI) is the length of time that the catheter remains in place. The nurse driven protocol for foley removal has been instrumental in getting foleys out quickly, without the need to wait and consult the ordering physician.

Average duration

26%
REDUCTION!
2012 to 2014

The average duration of foley dwell time dropped from 91 hours in 2012 to **67 hours** in 2014.

Every day **that the catheter remains in place, there is roughly a** ***5% risk*** **of bacteriuria developing in the patient.**

Total foley-days

25%
REDUCTION!
2011 to 2014

One patient with a foley for one day = one foley-day. Foley-days dropped from 37,108 in 2011 to **27,665** in 2014.

Patient rounds should ALWAYS include the question,

"CAN THE FOLEY COME OUT?"

Alternatives to an indwelling foley include:

- Condom catheter for male patients
- Female urinal
- Male urinal
- Bed pans
- Bedside commode
- Intermittent straight catheterization
- Incontinence pads (can be weighed to measure output: 1 milliliter of urine = 1 gram)

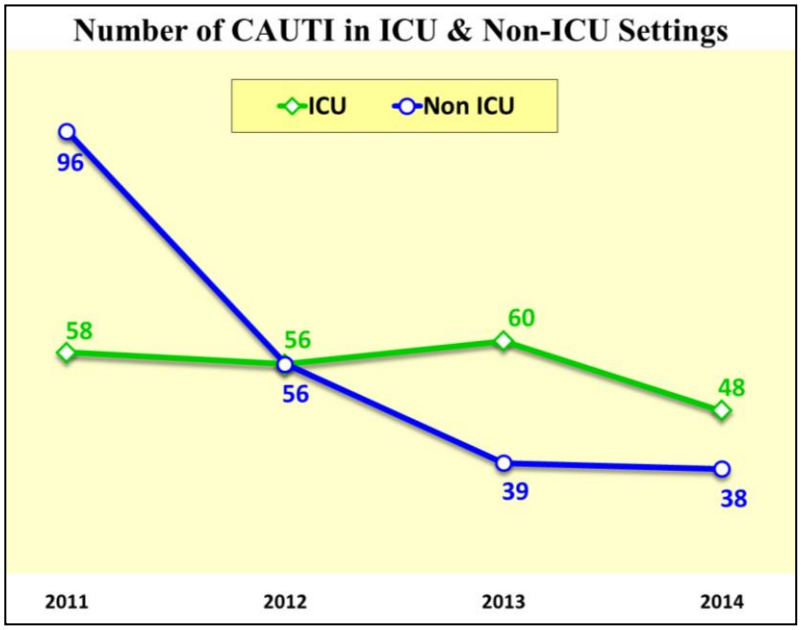
Still work to do:
Despite all of our collective effort and success, UWHC still fails to meet the CAUTI benchmarks used for public reporting and CMS reimbursement.

Four Year Snapshot

Non-ICUs:
As foley use has dramatically declined, so has CAUTI. Declines in non-ICU settings have leveled off, highlighting the need for proper catheter care and maintenance as well as peri care.

ICUs:
Challenges remain in removing catheters from critically ill patients, often because output is being closely monitored. As an alternative to a foley, consider weighable incontinence pads to measure urine output.

2014 recorded:
***LOWEST** number of CAUTI.*
***LOWEST** number of foley-days.*
***SHORTEST** average foley duration.*
***FIRST DECLINE** in ICU CAUTI rate.*



Positive urine culture ≠ active infection.

A positive urine culture alone does NOT equal active infection. Obtaining a urine culture from a patient being admitted with fever of unknown origin may be an appropriate assessment tool. However, in most cases, the presence of bacteria in the urine of a hospitalized inpatient is asymptomatic and does not require treatment. Up to one third of unnecessary antibiotic use in hospitals is due to inappropriate treatment of asymptomatic bacteriuria.

Urine cultures obtained from patients without specific signs or symptoms of urinary tract infection artificially drive up our CAUTI rates. Like any diagnostic test, urinalysis and urine cultures must be used judiciously.

Discourage Urine Culture Use
DO NOT order urine cultures in patients who have pyuria but are asymptomatic. Note that pyuria is common in catheterized patients due to mechanical irritation.
All orders for urinalysis or urine culture should have an indication, not just ordered routinely for screening purposes, isolated leukocytosis or confusion without other infectious signs, or as part of PAN culturing.
Urine qualities (e.g., color, smell, sediments, turbidity) DO NOT constitute signs of infection.
There is no clinical benefit to repeat urine cultures just to document clearing of bacteriuria.
Patients who have chronic urinary catheters will often have a positive urine culture due to colonization.

Appropriate Urine Culture Use
Fever in a hospitalized patient is rarely due to uncomplicated urinary tract infection. Therefore, order a urine culture only if other sources of fever have been clinically evaluated and deemed unlikely.
Obtain a urine culture as part of an evaluation of sepsis or acute confusion in select patients when other more likely etiologies are not present.
Obtain a urine culture as part of a physical assessment suggestive of UTI (for example, patient has flank pain or pelvic discomfort).
Obtain a urine culture prior to urologic surgeries where mucosal bleeding is anticipated, or transurethral resection of the prostate.
Obtain urine culture in pregnancy (once, as screening).

Thank you for all of your diligence in reducing CAUTI risk by adhering strictly to the CAUTI insertion checklist of best practices, keeping foley bags below the level of the bladder, performing proper catheter maintenance and perineal care, and considering alternatives to getting the foley out as soon as medically possible.

FOR MORE INFORMATION:
CAUTI Prevention Resources are available on the Infection Control Department website on Uconnect, available at this link: Infection Control Website