The 10K –Change Ideas Worksheet for UTI

Change Idea	Priority	Improvements Needed	Action Items (Who, What, When)
Implement evidence-informed strategies to prevent urinary tract infections			
Insert catheters only for appropriate cases, and leave in place only as long as needed			
Use urinary catheters in operative patients only as necessary, rather than routinely			
For operative patients who have an indication for an indwelling catheter, remove the catheter as soon as possible postoperatively, preferably within 24 hours, unless there are appropriate indications for continued use.			
Use a checklist of catheter criteria to aid in verification			
Empower and expect nursing and other clinical staff to not proceed with catheter insertion when criteria are not met and to contact physicians to clarify and discuss alternatives			
Include a checklist in catheter insertion packs in a format that allows for easy documentation			
Build criteria for catheter insertion into computerized order entry systems and require documentation of need at time of order			

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Ensure that departments where catheters are inserted frequently, such as the emergency department, have adequate supplies of alternatives to indwelling catheters (e.g., intermittent and external condom catheters)			
Educate staff regarding indications, criteria and alternatives for urinary catheters			
Create standard supply kits that include catheter and all necessary items in one place, or work with supply vendors to revise kits			
Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site			
Ensure that only properly trained persons (e.g., hospital personnel, family members, or patients themselves) who know the correct technique of aseptic catheter insertion and maintenance are given this responsibility			
Include appropriate technique in insertion checklist (one checklist for criteria and technique)			
Properly secure indwelling catheters after insertion to prevent movement and urethral traction			
Unless otherwise clinically indicated, consider using the smallest bore catheter possible, consistent with good drainage, to minimize bladder neck and urethral trauma			

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If intermittent catheterization is used, perform it at regular intervals to prevent bladder over distension			
Use a small-sized checklist (index card or sticker) and place it in urinary catheter kits for reference and ease of documentation			
Consider using a portable ultrasound device to assess urine volume in patients undergoing intermittent catheterization and reduce unnecessary catheter insertions			
Measure as an all-or-nothing process with the goal of ensuring that all checklist items are completed every time, for every patient			
Assign responsibility for stocking standard kits to ensure adequate supply at all times, especially in high-use areas such as the emergency department or operating room			
Verify and document the five items listed under routine maintenance every shift (add to existing documentation systems)			
Consider using urinary catheter systems with pre-connected, sealed catheter-tubing junctions			
Ensure that all care items – hand hygiene supplies, individual containers for drainage, hygiene supplies for meatal cleaning – are always available at or near the point of care			

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Maintain unobstructed urine flow			
Place paper documentation materials at the bedside so that they are visible and accessible to staff			
Engage patients and families in the process by educating them about the appropriate care and encouraging them to ask or remind staff			
Use alerts in computer systems to prompt staff on the five routine maintenance items and require documentation			
Assign responsibility for checking and routine restocking of supplies			
Provide supplies for collection of samples in one place or as a standard kit, at or near the point of care			
Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised			
Unless clinical indications exist (e.g., in patients with bacteriuria upon catheter removal post urologic surgery), do not use systemic antimicrobials routinely to prevent CAUTI in patients requiring either short or long-term catheterization			

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Do not clean the peri-urethral area with antiseptics to prevent CAUTI while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate			
Unless obstruction is anticipated (e.g., as might occur with bleeding after prostatic or bladder surgery) bladder irrigation is not recommended			
Clamping indwelling catheters prior to removal is not necessary			
Include catheter necessity in the daily nursing assessments at the start of every shift, with the requirement to contact physician if criteria are not met			
Develop nursing protocols that allow for removal of urinary catheters if criteria for necessity are not met and there are no contraindications for removal			
Implement automatic stop orders for 48 to 72 hours after insertion, with continuation only when indication is documented in renewal order			
Place reminders in paper patient records and use alerts in computerized ordering systems requiring physicians to document indication for continuation of catheter			

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Enhance Team-Based Care			
Raise awareness of the impact of power and conflict on team performance and patient outcomes			
Provide opportunities for team coaching and feedback on effective communication tools and techniques			
Create opportunities for team members to provide input through tools such as learning boards, huddles, briefings and debriefings. Take action on issues that arise			
Welcome the reporting of safety concerns on the unit by encouraging reporting and loop closure on reported events			
Provide staff education sessions on non-technical skills such as teamwork and communication, situation awareness and leadership			
Develop daily goals sheets to foster clinician-to-clinician communication			
Conduct daily multidisciplinary rounds on units			

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Utilize tools for patient handover and clinician to clinician patient information sharing			
Implement team huddles			
Implement ad hoc briefings and debriefings to support “just in time learning” following adverse events and near misses			
Develop and maintain a learning board on the unit			
Implement safety crosses to share data with front-line staff			
Create a shared vision with leadership			
Implement leadership walk-arounds			
Trial other channels to invite leadership to spend time with front-line staff, patients and families – (e.g. joining team huddles). Foster regular visits to the unit to meet with team			