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Staff Nurse Perspective of CAUTI Prevention Initiative

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Experience From the “Old Ways”

- Ensure there are orders on file or valid reason to change urinary catheter
- Rely on my own memory to gather materials
- Attempt to perform the catheter change from beginning to the end without any set backs
- Hope for the best

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Some Setbacks From “Old Ways”

- Trusting myself subjectively on performing proper sterile technique
- Possibility of forgetting to gather an item or two that may interrupt the catheter change procedure
- Interrupting process if item is forgotten or notice of breaking sterile technique
  - Reset whole procedure, leave the room, gather materials, start over…

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Some Common Mistakes

- Wrong catheter size
- Wrong catheter type
- Forgetting to bring an empty syringe to empty the balloon to remove catheter
- Testing the balloon prior to insertion

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The Change That No One Expected…

- Per CAUTI Committee recommendations, the use of two licensed personnel to change urinary catheter was highly suggested
- Perineal care twice a day (BID)
- Recertify each nurse on proper catheter change procedure
- Expect nurses to educate their patients on CAUTI prevention and urinary catheter care on each catheter change
- Document education using the "Patient education" template

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The Opposition

- Culture change
- Finding time to recertify
- CAUTI Champions finding the time to educate and recertify nurses in their unit
- More charting
- Having to rely on the availability of someone else to assist
- CAUTI Champions have to find time to conduct tracers to gather data
- Awkward having someone observing you

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Embracing the Change

- Personally, I welcomed the change with open arms
- Advocated for the change among my peers
- CAUTI Champions provided data on how the unit was performing
  - CAUTI rates
  - Tracer data
  - Expectations and goals for the unit
- Contributions on "huddle board" so unit can be part of change

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Teamwork Prevails

- As a resident expert, I thought my technique was impeccable…
  - No, it was not…
- Two pairs of eyes are better than one
- Finding someone else to assist is not as hard once it becomes a standard and not an option
  - Let me explain…
- It started off as, "I could've been done by now…" to "I'm glad someone else was there"

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Closing Remarks

- One-person catheter change tends to be suboptimal
- We are better together
- Patient education is key
- This kind of culture change permeates onto other areas
  - Wound care
  - IV insertion
  - Patient handling
  - Unit cohesiveness

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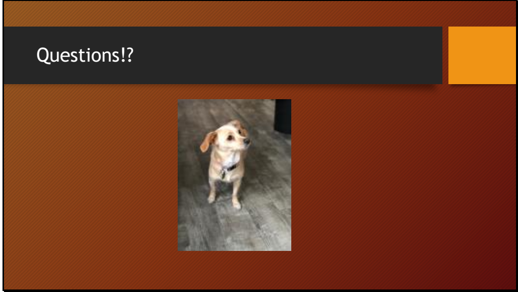

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