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Preventing catheter-associated urinary tract infections Editor's note: The following is adapted from HCPro's new book Preventing Catheter-Associated Urinary Tract Infections: Build an Evidence-Based Program to Improve Patient Outcomes. For more information on this book or any other in our library, visit www.hcmarketplace.com. Catheter-associated urinary tract infections (CAUTIs) are the most common of all hospital-acquired conditions (HACs).

Eighty percent of urinary tract infections (UTIs) result from indwelling urinary catheters, and 12%–16% of patients admitted to acute care hospitals may have indwelling urinary catheters at some point during their stay. One of the best ways to reduce the risk of CAUTI is to reduce the use of catheters. So as the organization begins its journey, it must decide which patients truly need indwelling urinary catheters. Which patient populations with which diagnoses or conditions meet criteria for insertion? How can the organization reduce the use of catheters?

Are both male and female urinals readily available for patients with urinary incontinence? Does the organization have the capability to perform noninvasive bladder scanning to assess post-void residuals? Are there patients who are candidates for intermittent catheterization to manage urinary retention and bladder drainage? These types of questions need to be considered when decisions are made to insert an indwelling urinary catheter to provide bladder drainage. The most effective method for eliminating hospital-acquired CAUTIs is prevention as a result of decreasing the use of indwelling urinary catheters (Robinson et al. 2007). The next best method to reduce infections in patients who meet the conditions for catheter placement

is to limit catheter days by evaluating the reasons for continuing the catheter on a daily basis and removing the catheter at the moment patients no longer meet criteria (Saint et al. , 2000; Munasinghe et al. , 2001). Develop a prevention plan When patients do require indwelling urinary catheters, constantly evaluate the need for use and identify other methods for managing bladder drainage whenever possible.

Developing a prevention plan for your organization will outline steps for physicians and nurses to use in making these important clinical decisions. The prevention plan must include tools to guide clinicians' decision-making regarding the insertion, care, and continuation of indwelling urinary catheters to ensure prevention of CAUTIs in patients admitted for inpatient care. An example of these essential tools is an algorithm for making decisions regarding the insertion, continuation, and removal of urinary catheters and a means of routinely assessing and documenting continued need for the catheter on a daily basis.

In addition, evidence-based care must be provided to patients requiring continued catheter use, so a CAUTI bundle is also an essential CAUTI prevention tool for clinicians. Assess patients at admission As patients enter your organization, assessments and appropriate actions should be taken regarding patients who are symptomatic for UTIs. Having the appropriate tests completed to be able to document that the patient's UTI was present on admission (POA) helps save the organization from being held accountable for a CAUTI in cases where the patient presents with a catheter in place or requires catheter placement shortly after admission.

Detailed assessments of patients by their nurses during the admission process must be carefully partnered with, and supported by, physician documentation to determine whether a patient's UTI preceded placement of the urinary catheter and was POA or whether the infection was acquired as a result of the hospital admission and is then considered an HAC. POA conditions are determined with the following criteria:

- There must be clear differentiation in the presence of diagnosis/condition at time of admission or development of the problem after admission.
- Physician documentation of the condition must exist in the patient's medical record.

If POA, it must be documented concurrently with the physician's admission orders.

- Primary responsibility for complete and accurate documentation lies with the physician/licensed independent practitioner.
- Any incomplete documentation requires provider clarification.

Identify risk factors. Physicians and nurses must work closely as a team to identify patients at high risk for CAUTI and carefully and accurately document findings in patients' medical records. These intraprofessional team members must also share the opinion that the best means of preventing CAUTIs is to reduce catheter use whenever possible.

Starting with comprehensive patient histories on arrival is essential to identify patients' risk factors for developing a CAUTI or to determine whether they already have a UTI on admission. According to current findings in the literature and a record review of patients with CAUTI, the following are risk factors (Lo et al. , 2008):

- Gender (e. g. , women are more likely to have UTIs than men)
- Advanced age
- History of urinary tract problems (e. g. , enlarged prostate or urologic surgery)
- Neurologic conditions (e. g. , spinal

cord injury) causing neurogenic bladder problems • Previous UTIs Previous and/or current abnormal voiding patterns • Current catheter history • Incontinence • Comorbid conditions such as diabetes • Immunosuppression In addition, patient assessments must include documentation of any signs and symptoms of UTIs, including: • A frequent urge to urinate • A painful, burning feeling in the area of the bladder or urethra while urinating • A fullness in the rectum (in men) • Suprapubic tenderness • Passing only a small amount of urine • Cloudy or reddish-colored urine • Fever greater than 100.3° F (38° C) with or without chills • Incontinence • Pain in the back or side

Clinicians should remember that not everyone with a UTI develops signs and symptoms. It is important to distinguish between symptomatic and asymptomatic bacteriuria in these hospitalized patients (Tambyah & Maki, 2000). References Lo, E. , Nicolle, L. , Classen, D. , Arias, K. M. , et al. (2008). " Strategies to prevent catheter-associated urinary tract infections in acute care hospitals. " *Infection Control and Hospital Epidemiology* 29: S41-S50. Munasinghe, R. L. , Yazdani, H. , Siddique, M. , & Hafeez, W. (2001). " Appropriateness of use of indwelling urinary catheters in patients admitted to the medical service. " *Infection Control and Hospital Epidemiology* 22: 647-649. Robinson, S. , Allen, L. , Barnes, M. R. , et al. (2007). " Development of an evidence-based protocol for reduction of indwelling urinary catheter usage. " *MedSurgNursing* 16(3): 157-161. Saint, S. , Weise, J. , Armory, J. K. , et al. (2000). " Are physicians aware of which of their patients have indwelling urinary catheters? " *American Journal of Medicine* 109: 476-480. Tambyah, P. A. , & Maki, D. G. (2000). " Catheter-associated urinary tract

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