Hospital acquired infection (HAI) is a critical patient safety concern. These infections reflect the quality of hospital care provided to patients. The prevalence of HAI is widespread with catheter acquired urinary tract infections (CAUTIs) accounting for approximately 40% of HAIs. Therefore we identified the need to pursue an initiative aimed at lowering our CAUTI rates.

At the University of Kentucky HealthCare our rates far exceeded our targets. Due to the severity of these infections, we recognized that decreasing the number of infections was essential for patient safety and the provision of quality patient care. Decreasing CAUTI rates was a top priority of the University of Kentucky leadership.

The primary objective for our process improvement was to decrease known risk factors associated with the incidence of CAUTI, with the ultimate aim of preventing harm to our patients.

Methods

An collaboration was formed with senior nursing leadership, clinical nurse specialists and our colleagues in Infection Prevention and Control. This alliance led to a workflow algorithm that outlined an organizational structure consisting of a CAUTI workgroup that reported up to a CAUTI Steering Committee, led by senior nursing leadership. The work group met weekly and followed a systematic process that identified gaps in care and implemented the measures. The Steering Committee met monthly to review and examine the progress of the workgroup. The Steering Committee provided the leadership and oversight to support the interventions and the authority to move forward with the implementations. This organizational structure was instrumental in guiding and directing improvement processes.

Results Through Enterprise Approach

This support structure and the systematic workflow of the CAUTI/RCA workgroups proved to be the pivotal crux to decreasing CAUTIs.

CAUTI

With the organizational support structure endorsing the standardized work products of the workgroup, our enterprise-wide ICU CAUTI rates decreased 76%, from 11.3 to 2.7 over an 18-month period.

Conclusion

Having a well-defined organizational structure to centralize identification and interventions provided the support needed to decrease our high infection rate. This model has shown very positive outcomes and has provided a clear line of communication between hospital administration, physician services, nursing leadership, clinical nurse specialists, staff development, nursing staff and Infection Prevention and Control. The model has been duplicated to direct our work with combating other nurse sensitive indicators including central line infections, pressure ulcers and venous thromboembolism. When implementing enterprise-wide interventions, a well define and supportive organizational structure is key. This provides the foundation to maintaining a single focus.

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