Leading The Way in Catheter Care

An Audit on the Insertion & Management of Urinary Catheters

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Introduction

The aim of the audit was to examine certain aspects of urinary catheter insertion and to highlight any deficiencies so corrective action if found to be necessary, could be taken and to establish if urinary catheter insertion was as per the local best practice guideline on urinary catheterisation and catheter care[1].

In addition to undertaking the audit the authors wished to:

- Ascertain the rates of catheter associated urinary tract infections in Letterkenny General Hospital.
- Carry out a literature review as the current Best Practice Guidelines were due to be reviewed and updated.

Method

A concurrent audit of all in-patients with urinary catheters in Letterkenny General Hospital on one particular day (06/05/2011).

Excluded from the audit were the Paediatric Ward, Medical Assessment Unit and patients performing self intermittent catheterisation.

Population Identification

On the morning of the audit a Staff Nurse on Night Duty in each particular ward identified the patients with a urinary catheter in situ for the auditors.

Forty seven patients were identified by the Night Nursing Staff as having urinary catheters in situ, however:

- 7 patients had their catheter removed later that morning
- 2 patients were discharged prior to an audit team reaching their particular wards
- 1 patient had a urostomy

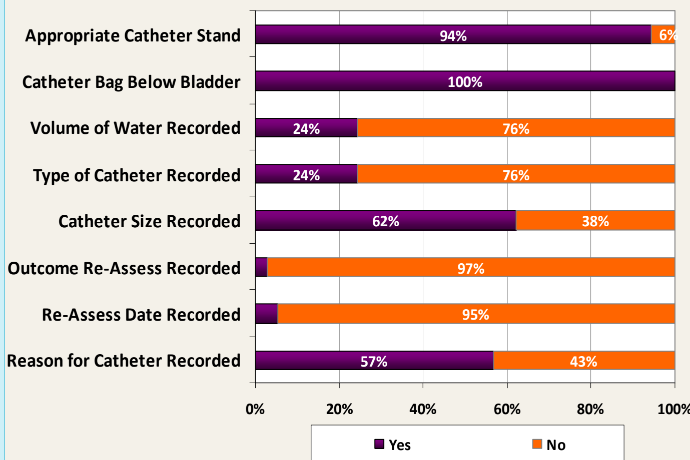
Therefore 37 patients with urinary catheters were included in the audit.

Data Collection

Data was collected from the Medical and Nursing notes and by direct observation by the auditors.

Data was collected by means of a questionnaire based around determining adherence to the local best practice guideline[1].

Audit Results



National Point Prevalence Survey Findings[2]

The HPSC (2012) undertook a national point prevalence survey of hospital acquired infections. Urinary tract infection (UTI) was the third most common Hospital Acquired Infection (HAI), with 75 cases (15%) reported (see Figure 1). Of the 75 UTI cases, 31 (41%) were associated with the presence of a urinary catheter.

There were 501 active HAI identified in 467 patients of the 9,030 eligible patients surveyed. The prevalence of HAI were greater in patients who had risk factors such as surgery or a medical device insitu. Of the 467 patients 31% had a catheter insitu. (see Figure 2).

The authors wished to ascertain the rates of catheter associated UTI in LGH. Due to samples being mislabelled as “urine” rather than “MSU” or “CSU” it was impossible to establish the rate. It was decided to promote through education the importance of proper labelling of samples and to use the national findings as our baseline for further audit.

Figure 1: Percentage of HAI, by HAI Type

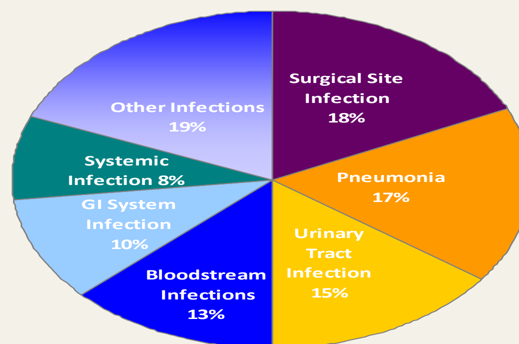
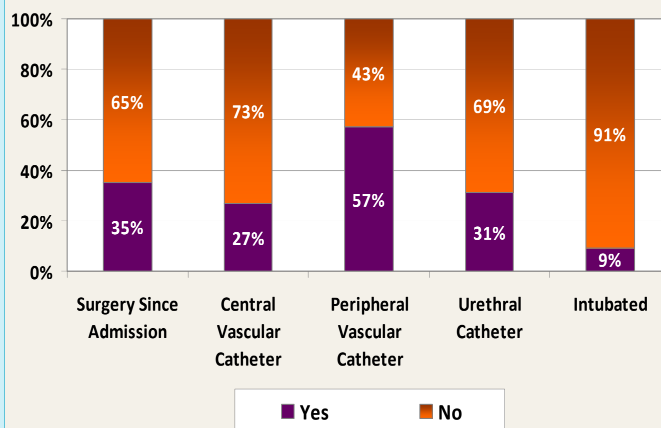


Figure 2: Prevalence of HAI Risk Factors in Patients with HAI



Quality Improvements Implemented

Based on the audit findings locally, it was decided following consultation with the Director of Nursing that corrective action was required. This included:

Rolling cycle of presentation of audit findings to Assistant Directors of Nursing, Clinical Nurse Managers, Staff Nurses, Consultants & Junior Doctors to highlight the deficiencies found and to educate staff on catheter insertion & care.

A launch was held of the recently reviewed best practice statement on urinary catheterisation & catheter care, which was updated to include the recommendations from Guidelines for the Prevention of Catheter associated Urinary Tract Infection, published on behalf of SARI by the HSE Health Protection Surveillance Centre 2011[3]. There was also a launch of the new guideline on the discharge of patients with an indwelling urinary catheter.

Introduction of a Urinary Catheter Insertion Checklist:
This provides all the details of the catheterisation procedure to ensure professional accountability by the person inserting the medical device. This is kept in the patient notes and can be copied to send with the patient if necessary on discharge.

Introduction of Urinary Catheter Care Bundle:
This ensures that the need for the catheter is assessed and that appropriate catheter care is carried out on a daily basis.

Introduction of IPMS (Hospital Computer System) Generated Discharge Letter:
This ensures that when a patient is discharged from hospital with a urinary catheter insitu that there is continuity of care between the hospital and community health service. This is to ensure better patient outcomes and fewer catheter associated adverse events.

Patient Information Leaflet and Home Care Pack:
This ensures that the patient has all the resources they need to appropriately care for their catheter at home.

Re-audit February 2013

References

1. HSE West Letterkenny General Hospital and Community Services Donegal (2008) Urinary catheterisation and catheter care: Best Practice Guideline.
2. Health Protection Surveillance Centre, Point Prevalence Survey of Hospital Acquired Infections & Antimicrobial Use in European Acute Care Hospitals: May 2012 – Republic of Ireland National Report: November 2012.
3. Health Protection Surveillance Centre on behalf of SARI (2011). Guidelines for the prevention of catheter associated urinary tract infection.

Acknowledgements

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