April 14, 2015

Sustaining Change

Speaker 1: The following is a recording for [Cathy Drury 00:00:02], with the American Hospital Association in Chicago, for the April National conference 00:00:06 call on Tuesday, April 14, 2015 at 11 a.m. central time. Excuse me everyone. We now have all of our speakers in conference. Please be aware that each of your lines are in a listen only mode. At the conclusion of today's presentation, we will open the floor for questions. At that time instructions will be given as to the procedure to follow if you would like to ask a question. I would now like to turn the conference over to Ashley [Hoffman 00:00:33]. Ms. [Hoffman 00:00:34], you may now begin.

Ashley: Hello everyone and thanks for joining us. We're excited to have you with us at today's event, which will focus on sustaining your progress and reducing CAUTIs. Before we begin today's presentation, just a quick reminder that this is a webinar. Please be sure that you log in though the webinar link in order to see our slides. Also, a copy of the slides and the recording will be posted on the project website later this week. The power point slides are actually already on the website, if you'd like to save them, along with additional resources. Today's presenter is Dr. Eugene Chu. He is the director of hospital medicine for Boulder community hospitals. Board certified in internal medicine, Dr. Chu earned his medical degree from Tufts University and completed and completed a residency in internal medicine at the University of Colorado health sciences center. Now I'd like to turn the call over to Dr. Chu.

Dr. Chu: Great. Thank you Ashley. It's really great to be here and to be talking about sustainment. Next slide is fine. I just wanted to say that a lot of this work has been done by [Sara Prime 00:01:39], who's also in the call and [Muhammad Fokee 00:01:41], who's one of the principal investigators on the [inaudible 00:01:45] CAUTI project. This will be a synthesis of all of the work that we've done to put together a body of knowledge about sustainment, to help everyone who is on this collaborative sustain the gains we hope everyone's made through the implementation phase. Next slide. There's not a lot of literature on sustainment. I just wanted to include a couple of articles that helped [Sara, Muhammad, 00:02:18] and I shape our ideas about sustainment for your reference. Next slide. What we're going to try to accomplish this session is to learn about the difference between implementation and sustainment, to identify key elements in sustainment of [process and improvement 00:02:38] development initiative, to recognize your unit's readiness for sustainment, and to understand steps that need to take place before moving to sustainment.

Next slide. Just to get an idea of where everyone's at, I wanted to use a few polling questions. Thought the webinar, I was going to try to put in as many audience response questions as possible. I feel like for these webinars, it seems to be one of the downsides is there's not a lot of communication between audience and myself and each other. I wanted to get people thinking and communicating. First question. Are you ready, or is your unit ready for sustainment? Yes, no, or unsure.

Ashley: Okay everyone. A few more seconds to get their response in. Just go ahead and click the radio dial, the blue radio dial for yes, no, or unsure. Then we'll show the results.

Dr. Chu: Okay. Let's go ahead and look at results. Good. Looks like the majority, 60%, almost 2/3 are ready. The majority of the minority is unsure. Then there's a good number, about 1 in 8 or so, 1 in 7, that are not feeling ready. Good. Next question. Do you know the elements that need to be in place before transitioning to sustainment. Yes, no, or unsure. Okay. Why don't we see the results of that. About half say yes, a third unsure, and about 1 in 5 say no. That is also good. Some ambivalence there. I'm glad. If everyone said yes, then we could just end the call and move on with our days.

Next slide. Implementation. Again, we're going to go back to these same slides, the same polling questions, later in the talk to see if we've made some improvements in those areas. Implementation. I'd like for everyone to think about it as an [enzymatic 00:05:12] reaction. In the beginning, as you know, when you're bringing anything together, or trying to get something off the ground, so to speak, start-up costs are pretty high. Our change schema is the four Es. We use [CUSP 00:05:30]. The idea is you engage, educate, and the next slide, execute and evaluate. Again, the four Es of change. Again, the implementation phase should take a lot more resources. Time resources, human resources and financial resources. I think all of you have experienced that in this change process and other ones that you've been through.

Next slide. Then sustainment, which is the phase that I think a lot of us have gone through in various implementations and are looking towards now, should not cost as much energy, shouldn't take as many resources, and shouldn't be as time intensive. Again, it should be a very different phase. The key is if the implementation is done properly, then sustainment, it still needs work, but it shouldn't be the heavy lifting is done in implementation. Then the cusp is just to show that if you have structured implementation, that you can actually decrease your energy costs and become more efficient. Next slide. Again, the other part of our initiative is that we think of implementation. Again, we're going to transition this into sustainment as both technical and socio-adaptive.

Next slide. The basic part of the technical part is that it's winning minds. Next slide. The socio-adaptive heart is winning hearts. Socio-adaptive part is winning hearts. Sorry about the tongue twister there. Again, in implementation, you have to instill the knowledge and then get people to feel and believe about what is happening. In the whole setting of an environment that's conducive to change, which is the next slide. Once you've won hearts and minds, won your hearts, educated the minds, you create an environment for change that is conducive to success. That's when you have the highest likelihood of having a successful implementation. You really can't go into sustainment without a successful implementation. If your implementation is not successful, you need to back up and try again before thinking about sustainment. You can't really sustain something that was a failure. It sounds obvious, but I think all of us can think of time when we moved to sustainment, where we actually didn't implement well. It's just lost resources when you start trying to do that.

Next slide. Again, in terms of hearts and minds, the hardest part to change are the hearts. It's easy to tell someone what the indication for a Foley catheter are, how many CCs it is for a urinary retention on a bladder scanner, and the definition of CAUTI. I think everyone's capable of teaching and learning that. To believe that this is important and valuable and that this is really what we want to do and what's best for the patient is a huge challenge. What we're trying to do is change culture.

Culture is defined as a shared set of social values and beliefs that guides actions and decisions within an organization or a unit or a family. If you think about the culture of your unit, of your family, of your nation, think about your values and beliefs and how they guide actions and decisions, and specifically about CAUTI culture. Think about what the values and beliefs about urinary catheters are, and how they guide the actions and decisions, particularly when you place them, when you remove them, how you place them, how you maintain them, and how you remove them, and then about urinary culture, urinary culture. What are your attitudes and beliefs about urinary cultures. How does that guide your actions and decisions? That's what we're really trying to get at. I'd say one big pitfall in moving from implementation to sustainment, is you can have a lot of processes set up, but if your culture is still to putting catheters in every patient that comes through the ED that has mental status change, you're really not going to gain traction. You can always work around different processes if you don't believe in them.

Next slide. What we're trying to do is develop a coherent culture about urinary catheters. We want widespread agreement about the core values and beliefs that are going to drive people's actions and decisions. That is what we're trying to achieve socio-adaptively within a unit, an organization or a state, or as a nation. Next slide. How do you know when you achieve culture change? [inaudible 00:11:04] the socio-adaptive part. I think a lot of us have heard this anecdote. [Potter Stewart 00:11:09], he was a supreme court justice. We don't have great culture change measurement tools. We have the [inaudible 00:11:18] and things like that. I don't think we have anything particular to CAUTI. He provided over a case in the 60s in Ohio where a theater owner was fined and convicted of showing obscene movies. It was a French film called [inaudible 00:11:45]. He went to a supreme court justice to say, "Is this obscenity?" The crude word would be pornography. He said, "Look. I don't know what the exact definition of obscenity is, but I know it when I see it, and this is not pornography or obscenity."

I would challenge everyone to have a pulse on their unit or on their organization or the different subgroups of nurses and physicians, and to have a feeling for whether the culture has changes about urinary catheters. Do people really believe that they have a lot of harms and that we should really be strict about how we put them in, when we put them in, and when we take them out. Or is it still like, "No, they're not really that harmful. Even if they're on the floor, I need my [Is and Os 00:12:41]. That's more important than the potential harm."

Next slide. Four Es of change. We've talked about this a little bit. I kind of substitute environment for execution. It's something that, over time, I've thought of. Just to be clear, it is technically execution. Next slide. Sustainment is about effectiveness. Again, you really shouldn't move into sustainment unless you had an effective implementation. If you didn't do anything you're not going to sustain anything. If you got worse, you definitely don't want to sustain that. It's not good enough to feel like you had something. You need to actually prove it. That will help you move into sustainment, by saying, "Look. Here are the things." We'll go into that later.

Institutionalization. That idea is hard wiring, putting things into place in the institution. That again, is an environmental change. Capacity is having the appropriate resources, time, people, and finances. That again, shouldn't be as much as implementation capacity, but shouldn't be nothing. If you don't give any capacity, or if you built capacity and don't sustain capacity, your sustainment won't be successful. Context is about having internal and external environments, [Sara's 00:14:08] done a lot of work on this, that continue to give you motivation for sustainment. Part of that context is motivation to measure and continue to give feedback as some more background level, to the groups that have already experienced the change.

Next slide. Again, we're moving from implementation, engage, educate, environment, and evaluate, to sustainment, which is showing effectiveness, hard wiring, having appropriate resources, and the appropriate context in terms of continued motivation and feedback. Next slide. We're going to correlate engagement with effectiveness. To sustain engagement we're going to go with effectiveness. Next slide. Those of you who have heard me talk about change management, the way we engage staff, human beings, people. It's three prongs. One, we engage through vision. Again, that's part of leadership, is to have a vision of where we're going to be going with this. We engage through tapping into people's passion. For people in health care, that's really healing, helping people. Then we engage through finances. Again, as we know is cusps, we want to engage our administration. Our administration, these stewards and the stewards of our mission, which is to help people. To steward it properly, it has to be financially viable. We all know that. We need to show financial engagement too.

Next slide. This is a patient that I just took care of within the last month here in Boulder. This is a story about a patient that actually, where we're at baseline, where we haven't implemented. We're not ready for sustainment. He's in his early to mid-80s. He came in. He actually lived in Indiana and he fell. His family's here in Boulder. His daughters are, at least some of his daughters. He fell. He was getting up and he fell back, retropulsed onto the toilet bowl, hurt his femur and hip. Then he was not moving well. They brought him into the ED. The ED took X-rays and he didn't have any fractures. He was living independently. He couldn't go back home. He was wheelchair bound. He was on a walker before. He was being set up for placement in the [inaudible 00:16:59] nursing building. He was immobile and had [inaudible 00:17:03]. He went to [inaudible 00:17:05] nursing facility, stayed there for a while, and then his family brought him here to Colorado. He was in another [inaudible 00:17:14] nursing facility in Colorado.

Four days before admission, he looks down at his [00:17:21] catheter and goes, "What's this doing inside me?" He had some dementia and whatnot, so that got blown off. Nothing really happened. Four days later, on his day of admission, he didn't show up for breakfast. He was found obtunded, or with a very hypoactive delirium in his room. He was brought in. He had a white count of 20. He was [inaudible 00:17:49]. He was mildly hypotensive. He was a little a little resuscitated. Chest X-ray showed maybe a minimal [inaudible 00:17:57]. He had no cough prior to this. He had no diarrhea. His urine was quite cloudy. We wouldn't culture the urine just for being cloudy. No. We don't do that. We had no other source for infections, so we cultured the urine [inaudible 00:18:13]. He was sent though the ICU for [inaudible 00:18:18] secondary to urinary source. I shouldn't have said that. Anyway, he actually ended up never recovering from his delirium. He actually ended up going to hospice.

Let's go to the next page. What is the diagnosis? Okay. Let's look at the answers. He had CAUTI. Next question. What was the HICPAC approved indication for urinary catheter placement for him? Okay. Yes. Again, a little bit of a tricky question, but I think everyone in the audience is ready for sustainment. There was no indication. This is a story that you hear in a health care facility that is not ready for sustainment. You still have a lot of these catheters that are not being placed appropriately. You have a lot of bad outcomes because of this. I will say he died an early death because of this urinary catheter. It never needed to happen. He lost time with his family, time that he could have been alive, doing things that he valued. It's tragic.

Next slide. This is a story that I heard in Nevada. Last year when I was working with them in the final learning session. I thought this was quite inspiring. This was a learning session three, getting ready for sustainment. This is the kind of story that you want to be telling to the unit and to the people that are involved. It motivates for sustainments. This is actually an [L pack 00:20:49], a long term [inaudible 00:20:49] care center, or a [inaudible 00:20:51] nurse facility. They received a patient that had a Foley catheter from another facility. They looked at the indications. They said it's placed for incontinence. We know that that's not what we need, what we should be doing. They wanted to take the Foley catheter out, but the patient was like, "I like my Foley catheter. It makes me comfortable. I don't have to worry about getting up. I don't have to worry about wetting myself." and things like that. They reassured her, "We'll take of your skin. We'll make sure that we give you help. We'll do scheduled [voiding 00:21:28] with you." but she wanted her Foley catheter in place.

Next slide. What did the staff do with Mrs. B's urinary catheter? They changed it to an antimicrobial catheter. They said, "It's going to be there a long time. You might as well make sure we have something that prevents infection. Just leave it in." There's not data for antimicrobial catheters. It's more convenient for everyone if she doesn't want it. "Change it out every three weeks." Maybe we can compromise here. Instead of just leaving it out, we'll just change it every three weeks. There's some evidence for that, right? Wait until she fell asleep to take it out.

Next slide. They actually waited until she fell asleep and then they took it out. They actually showed how they snuck up. They were really quiet. It was actually quite inspiring to hear how dedicated they were to removing her from harm's way. That's what they did. I think these are the stories. I have stories from my own organization where nurses will say to family members, "I know you're worried about the incontinence and things like that, but we don't want your loved one to have to suffer an infection from this. I'll take care of the skin. I'll take care of the cleanliness. I'll make her comfortable." and reassuring her. Those are the things that really inspire you to sustain the changes that we've made. You need the stories.

Next slide. You need the finances. This comes from catheterout.org. [Sanjay Saints 00:23:20] and his group in Michigan put this together. It's a really fantastic resource if everyone hasn't been there. You can put in numbers for your own organization. I just put in some crude number to show that you can save from a quarter million to a million dollars just on urinary catheter interventions. Again, this is the baseline and implementation data. This is what gets you on the map with administrators to say, "We need this money. We need this time to do this," because you need to show a return on investments.

Next slide. When you're actually moving to sustainment, what you need to do. This no longer works when you're going to sustainment. When you're asking for resources for sustainments, you can't really go to productions. You have to go to accomplishments. What you need to do is show urinary catheter decrease [fatalities 00:24:20], decreased utilization, and in that sense, translate it into money. There are ways to translate it into money. Estimates of decreased cost for CAUTI, $1,000 CAUTI. Then looking at also value based purchasing and a contribution to that. Again, part of your team should be a financial person, or you should be able to go to [your CFO 00:24:45] or one of his staff members, to help you create a financial impact. Again, money is really important for every organization. If you're going to ask for sustainment resources, you need to show that you've created value in your implementation.

Next. Vision. Again, transformational leadership, as [Sanjay 00:25:14] will talk about, a lot of that is based on visionary type leadership. All of us have worked as leaders for this initiative and others. I think as leaders, one thing that is really helpful is to have a clear and succinct vision. That vision would be for CAUTI, very simple. Our vision would be to aspire to an environment, or unit, or hospital, where no patient is unnecessarily harmed by a urinary catheter. It's very simple. It could be an infectious harm. It could be a noninfectious harm. We just don't want any patient to ever be unnecessarily harmed by a urinary catheter. What does that mean to us? It means that every catheter that is placed has an indication. Once that indication is over, it is immediately removed. When it's placed, it's placed in a sterile aseptic manner and maintained properly. Any culture that is drawn is drawn appropriately. That's really our vision. It's very simple. It's something that we can talk about and something that people can understand.

Next slide. I think it's important to be able to speak to that vision when you're moving to sustainment, to be able to tell people, "Wow. I see a unit where no one is being harmed unnecessarily by a urinary catheter, where every catheter that's being placed, is being placed appropriately. Once it's not indicated anymore, it's being removed. It's amazing what we've done. We've reached that point. I think speaking to the vision, speaking to a journey and place in the journey and then saying, "I want us to keep this up." This is important that we don't let it slide back.

Next. The next part about change is again, engagement is about winning the hearts. Education is about the minds. We're going to talk about hard wiring the minds and giving capacity. Next. Again, we educate about facts and flow. It's about all the different factoids. We'll go into those, and how to do things. Next. Then through sustainments, the education's much easier. It's really hard to get your first degree as whatever you are, a nurse, and infection preventionist, a physician, but you can sustain it in a much easier fashion. The start-up costs are gone.

Next. The fact. I think a lot of us are familiar with these facts. I think everyone recognizes that when we're starting off on this journey, when we're implementing, it takes a lot of energy, a lot of time to get people educated. Next. Then the flows. How do we do things? How do we do the skin care? How do we use the bladder scanner? How do we use the condom catheters? Things that sometimes may seem simple. If you dig down, there's a lot of variability in how people are doing things. Education is really important to decrease variability.

Next. Here's an example. We all learned the definition of CAUTI. 2008 it changed to symptomatic UTI. 2013 it changed to give correlation between lab findings, urinary catheter and clinical findings. 2015 we had more changes. This was taken from a slide that was just presented within the last few months in this one. What are the CAUTI definition changes for 2015? Requirement for greater than 10 to the fifth organisms, exclusion of non-bacteria as sole pathogens, use of same pathogen list for symptomatic and asymptomatic UTIs, all of the above. Let's look at the answers. It's all of the above. Again, we can do the initial education, but maintaining that is going to be important. Again, if you can realize the maintenance is not nearly as time or resource intensive as the implementation.

Next. Environment. I think everyone can realize that change often doesn't happen unless you're in the right environment. If you look at negative aspects of change, there's the reports in the Vietnam War or heavy, heavy, heavy heroin use amongst Vietnam soldiers. When the Vietnam War was over, they actually looked at all the different programs they need to put into place to support the soldiers coming back from Vietnam. They thought they were going to have an epidemic of heroin addiction amongst this generation of young men. What they actually found was when they went back to their home towns and this and that, the vast, vast, vast majority of the soldiers stopped using heroine. That really [inaudible 00:30:43] to the fact that the environment itself had a huge impact to change. What we want to do is create hard wiring and capacity. Again, this process [inaudible 00:30:54] two or three pillars [to equality 00:30:57]. Within structure we have people and things. Within process we have procedures and protocols. Same idea. Once we put into place good structure and good process, it's a matter of maintenance.

Next. The people. Again, I think everyone has formed teams, hopefully well working teams. Nursing, physicians, infection preventionists. As we've said, finance can be involved, project management, administration. We need the people. Next. One thing that has been identified in sustainment literature is the fact that what you really need to sustain is not only the team, but someone that's a leader, or someone that remains responsible for the initiative. In this sense, again, [Sandra 00:31:58] will talk about transformational and transactional leadership. This may be someone who has more of a tendency towards transactional leadership, keeping things maintained, performance management and things like that, and not necessarily a big transformation. Again, someone needs to [inaudible 00:32:17] and given the capacity to continue that.

Next. The things I think most of the group has put into place, condom catheters, made sure there were enough beside commodes, bladder scanners, male and female urinary urinals. Next slide. Again, new bladder scanners come out. New condom catheters come out. New female urinals come out. There are different things that are always evolving. Then there's the idea of refreshing things. Every three years a new laptop or a new desktop. Same thing with the equipment that you have. The people and the structures. Then the protocols. We have our nurse-driven protocols, [insertion removal 00:33:12] protocols. You can have order sets to ensure that any urinary catheter that is inserted had an indication. There may be skin care protocols, [inaudible 00:33:32] retention protocols. Those all are implemented. Next. Then maintained. Sometimes maintenance may be transitioning them over to electronic form or the HICPAC guidelines may be updated. Again, CAUTI definitions, maintaining them.

Next. The procedures. Again, I think all of us recognize and advocate for economies of scale, where if you're looking at urinary catheters, you put that into a device risk evaluation tool, where you're looking at all the devices, lines, central lines, urinary catheters, ventilators, etc. Next slide. Again, that would need to be maintained. Next slide. The last part is the evaluation, which is creating a context for your implementation or sustainments. Next slide. In terms of context, we think of those in terms of internal and external. Again, [Sara 00:34:51] has written on this, and may be able to help us later with filling this out. In terms of internal, a lot of this is about where the organization is. Part of this is culture and part of it is just mechanic operations. If your organization really has a culture of safety and is looking at hospital acquired conditions, and the leaders are advocating it, then you create an internal environment that gives you more probability of sustaining success.

Next slide. Then there is external environments. External environments is how the states and the nation and the region put pressure on you internally to change and sustain change. I think we all are aware of hospital acquired conditions. That's value based purchasing and things like that. Next slide. Again, when you think about evaluation, I think all of us are submitting data through this collaborative. If you look at the data submission for CAUTI rates, the first five months are monthly and then after that it's quarterly. The idea there is that if you've actually had success, again, you [ratchet 00:36:17] it down, bring it a little bit down, less time, less energy intensive, and spread it out. What that actually means to you with CAUTI rate reporting or urinary catheter prevalence, it's going to be individual. Some of it will depend on how much energy it takes to extract data.

Next slide. Again, metric. Again, nation, state, hospital, unit, and provider level metrics. Again, for physicians, if you see for a surgeon, your perioperatives wound infection section rate is high, or your complication rate is high. Then you're actually going to be motivated to change. If you get it low, you're going to want to keep it low. Physicians are intensely competitive by nature. No matter what they tell you, they are. I lead a physician group and that is very helpful, to have transparency in data, to show people their quality, their finances, their performance. That really is something that is helpful in terms of driving change and sustaining it.

Next. Your individual units. How do you get your metrics, your CAUTI rates, and your urinary catheter prevalence and appropriateness? Let's leave out appropriateness. I think that's almost always going to be chart reviewed. Urinary catheter prevalence and CAUTI rates, is it chart reviewed, is it automated, or is it mixed? Let's look at the answers here. Mixed. Not a lot have it fully automated. This is what I would expect is that there's a lot of mix. Again, I think we all appreciate how time intensive metrics can be. That may be why a lot of times we don't get metrics that are helpful and physicians notoriously have a [posse 00:38:31] of metrics to drive performance.

Again, if you can just ratchet it down to spot checking or something to keep giving some feedback to units and to providers about their CAUTI and their urinary catheter utilization, that will be essential to keeping your change sustained. Obviously if it's automated, you have a lot higher chance of being able to do that. I'd say in the other hand, moving other things to the top is important and keeping CAUTI on the back burner, but still there. It's important. You don't want to get in the space too much and turn people off and get people numb to it. Anyway, again metrics are very important. Context. Context would be internal and external drivers to sustainments. Then showing your metrics.

Next slide. About that, again, in terms of culture, celebrating success, celebrating your metrics is really important. Don't forget the cookies. Next slide. Again, wrapping things up in terms of this part of the talk, think about the overall idea of moving from implementation to sustainment and the need to ratchet things down and talk about effectiveness, institutionalization, capacity, and context in the sustainment period. Next. Again, just what we went over. The different ideas and the different phases. Next. Now it's your turn. We thought it'd be great if everyone in attendance could chime in on where they are in sustainments and what their concerns are, what they feel like they've done well, and where they feel like they could do better.

Next. Are you ready for sustainment? We already asked that. Let's answer again, now that we've talked a little bit more formally about it. Good. Three quarters. It's actually gone up. I think it was 60% in the beginning. Good. Less people unsure. I think people have more clarity on their readiness state. Good. Next. Do you have evidence of effectiveness through your implementation? Do you feel like you can transition from implementation to sustainment and tell people about how effective you've been? Let's answer that. Good. A lot of good evidence. Good. Again, just be honest. This is all anonymous. You don't have to be ready for sustainment. This is for everyone to be able to become prepared or to feel more confident about it. Good. Some of the people.

Where is your evidence coming from? I have stories. I'm ready to tell stories. I can go to administration, to the [inaudible 00:42:07] [suit 00:42:07] with financial numbers. Again, it doesn't have to be fancy. It can just be number of CAUTI [reviews 00:42:13] converted back to numbers. Talk about value based purchasing and estimate how much CAUTI's contributed to that. Hospital acquired conditions committee, go to them. Vision, I can talk about where I see the unit. I have some mix of those. I have all of them or one of them. Go ahead and give your answer. Good. Almost a third, a quarter have all, which is fantastic. Almost 2/3 have a mix, which is great also. A lot of people have a little bit of other things. That's really fantastic. I think everyone should be proud of what they've accomplished in this collaborative.

Next. Our nurses know. This is just again, an idea of where education is in terms of readiness, HICPAC indications, proper insertion technique, how to maintain a closed system. They know about the Urimeter issue. They know about where the bag should be when they're transporting. We're confident in their aseptic technique. All, none, some, or one. Let's look at the answers. Good. The majority is some or all. The vast majority is some or all. That's fantastic. Again, moving to sustainment, you don't have to be perfect. You should be pretty darn confident. I think a lot of people might be like, "Insertion technique, we still have some variability there or HICPAC indications." You can still work on some things.

Next. Physicians, are they ready for sustainment. Do they know the HICPAC indications? Do they know what the indications of culturing are? Do they know when you need a catheter for [Is and Os 00:44:18]? None of that, some of that, or all. If the physicians don't know any of that, I'd be hesitant to move into sustainment. Good. Again, the physicians aren't perfect yet. Still need a little work it seems like. Looks like there's a decent amount of readiness. Next. We have institutionalized. We have hard wired into an environment, a nurse [inaudible 00:44:50] protocol. It can be paper or computerized. Urine and catheter insertion orders that so when you order something you have to pick an indication. Device [rounds 00:45:03]. All, some, or none. Again, we're just trying to get an idea of how hard wired your institution has become. Okay. Wow. A full quarter have done all of that. That is fantastic. 75% have done all or some. Sounds like there's some good readiness here.

Next one. We have built capacity. We have bladder scanners. We have condom catheters. We have appropriate skin care. [inaudible 00:45:38], or wound care, or infrastructure for skin care. We have all, some, or none. Great. 2/3 have all of that. The vast majority has all of that. That's fantastic. Next. We have a team identified. We know who's going to be continuing to work on this in sustainment. Let's look at the answers. Good. Most people know who the team is. This is the key one. Is that team sustainable? Will they hold together? Do you think they're going to hold together? Let's look at the answers. Good. A good amount of confidence and then some uncertainty. Very good. Again, having the right amount of time. Is the leader identified? Is someone going to continue to lead this? Let's look at the answers. Good. Almost everyone knows who the leader's going to be. Next question. Is that leader sustainable? Is that person going to be able to keep on top of this? Have enough time? Good.

Next slide. Is there a plan for continued metrics, or are we just going to say, "Thank goodness this is over. I'm not looking at one more chart about urinary catheters ever?" Let's look at this. Yes. This is looking good. For this or whatever change implementation you're doing, you should go through this exercise. Next. Again, the leader is going to hold the people accountable for the metrics. Correct. Then the key question. Have you achieved culture change? Do people believe it? Do people believe urinary catheters are harmful and that you don't need them for [Is and Os 00:47:59] on the floor, and you don't need them for comfort, and you don't need them for incontinence? Do you believe that your culture has changed? Yes, no, or maybe.

A little bit more ambivalence here. Again, you can have a lot of stuff, but if you have people who don't believe it, I think it's going to be a little bit of a struggle. There might be some backslide. I would say one of the things to do is to really talk off the gains, to talk up the numbers that everyone has, to really recognize the people that are the believers and that have done a great job, talk about all the things, the patient stories, the money and things like that, and slowly work on the people that are still not part of the culture we're trying to create for urinary catheters.

Next. Are you ready? This is the last time. We're going back to the beginning. Are you ready for sustainment? Yes, no, or maybe. This is the third time we've answered this. Let's look. Good. A lot of feeling that there's readiness for change, for transition, and to sustainments. I think maybe there are a little bit more maybes than the second time. I think maybe the culture thing is something that I think is something that may be one of the last things to really work on, and maybe physician education too, is what we found. Next. Do you now know the elements that you need to have to sustain your gains? I'm going to take this personally. Thank you. The next slide. I think that is the end.

At this point we're just going to open it up for discussion amongst the group to talk about what they're thinking about with their implementation and sustainment.

Speaker 1: Thank you. At this time we will open the floor for questions. If you would like to ask a question, please press the start key followed by the 1 key on your touch tone phone now. Again, that was star 1. Question will be taken in the order in which they are received. Please limit your questions to one at a time. Again, to ask a question for our presenter, please press star 1. Our first question comes from [Cathy Schlough 00:50:42] with Michigan.

Cathy: Yes. I was wondering. I've been using the indications here. We have a nurse driven Foley catheter removal protocol. [inaudible 00:50:56] or ICU only. We came across an issue with the provider thing that he went to the website for [inaudible 00:51:11] board of nephrology. If a patient has encephalitis, if they couldn't go on their own possibly in the urinal and they might go in the bed and they might go on the floor, and they want an accurate INO, but it wasn't an ICU setting.

Dr. Chu: I see. Basically, the idea that if they're incontinent for whatever reason. This is on the floor? Is that correct?

Cathy: Yes. Also, our patients, they weren't going to put them in the unit, but they needed accurate INO or acute renal failure, but the patient was on, I can't remember. [inaudible 00:52:13]

Dr. Chu: What hospitals have done is a couple things. I think that the getting of the daily waste is really important. It's ironic. Most people look at the [Is and Os 00:52:39] and even when we're using Foley's, they don't believe them. They always look at the [Is and Os 00:52:43], the waste and the clinical status. Again, [busting 00:52:46] up the ability to really get daily waste. The other way to do it is to use the pads. A lot of hospitals have implemented super absorbent pads, especially adult diapers and then to weight the pads, just like you would for a child, and to get [Is and Os 00:53:02] that way. Again, if they're DNR then you have to think, "Well okay." There are times where is this really an exception where you really don't have confidence in your clinical volume assessment and your ability to get daily waste, to get an indirect measurement through weighing the pads.

Then if they're DNR then you almost might say, "Gosh. We put a Foley catheter in them and they get a UTI. That might be the end." They're not going to be put on [inaudible 00:53:47]. They're going to die. It's kind of a back and forth. We've done this [inaudible 00:53:56] Nephrologists have been on board. They feel like they can manage things without the [Is and Os 00:54:02]. Again, maybe having a champion who is a Nephrologist, they can say, "This is how I do it." Have a peer come by and say, "Yeah, in this case we can use the daily waste." Something like that. I think those are all strategies. Sometimes there are times where there's certain [last actions 00:54:29] where there are hold outs over time. Either it'll be attrition. They'll go away. They'll retire and they'll go somewhere else, or they'll finally be like, "I can't be the only one in the hospital that's demanding this." Then they'll change.

Cathy: Okay. Thank you.

Dr. Chu: Yeah.

Speaker 1: Thank you. Again, if you would like to ask a question please press star 1. We have no questions at this time.

Dr. Chu: Great. Thanks for everyone attending and Ashley has my e-mail. Please feel free to e-mail me with any other questions that come up. Enjoy the rest of your day. Thank you.