# Appendix K.

# CAUTI Case Review Form

## Purpose

The CAUTI Case Review Form is a performance improvement look-back tool that assists long-term care (LTC) facilities with identifying possible resident care issues that might have contributed to a catheter-associated urinary tract infection (CAUTI). This form is designed to identify contributing factors to and the root cause of a CAUTI that meets the National Healthcare Safety Network (NHSN) LTC surveillance criteria.

Findings can then be shared with frontline staff and administration to potentially prevent future infections. Results can also be discussed at the Infection Prevention and Control, Resident Safety, and Performance Improvement Committee meetings.

## Instructions for Use

1. Hold debrief with the team as soon as possible after the CAUTI occurs to exchange information to improve performance. Involve unit leadership, quality assurance/performance improvement, infection prevention, bedside caregivers, and the resident, if appropriate.
2. Utilize data from the resident’s chart and other resources (e.g., NHSN Definition CAUTI Criteria Pocket Card and the indwelling urinary catheter insertion and maintenance checklists) to assist in the case review.
3. Complete this form in its entirety. If you answer “No” to any of the questions on the first page of the document, use the open field text in the column on the right to identify how this factor could have contributed to the development of a CAUTI.
4. Forward completed review to Infection Prevention and/or the designated champion to oversee that the action plan is fully executed.

### Bibliography

Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP Revisions--Interpretive Guidelines for Long Term Care Facilities, Tag 441. December 2009. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r55soma.pdf. Accessed January 28, 2016.

Centers for Medicare and Medicaid Services. State Operations Manual. Appendix PP Guidance to Surveyors for

Long Term Care Facilities. June 2016. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\_pp\_guidelines\_ltcf.pdf. Accessed August 18, 2016.

Lo E, Nicolle LE, Coffin SE, et al. Strategies to prevent catheter-associated urinary tract infections in acute care hospitals: 2014 update. Infect Control Hosp Epidemiol. 2014 May; 35(5): 464-79. PMID: 24709715.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident Label

Reviewers: \_\_\_\_\_\_\_ Catheter last inserted on: \_\_\_\_\_\_\_\_\_\_ Location/Room number: \_\_\_\_\_\_\_\_

Date of first sign or symptom of infection: \_\_\_\_\_\_\_ Signs and symptoms of infection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of positive urine culture: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organism(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of positive blood culture, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Antibiotic(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sensitive: Y – N

|  |  |  |  |
| --- | --- | --- | --- |
| **Contributing Factors** |  | | **If NO, how could this factor have contributed to the development of a CAUTI?** |
| **YES** | **NO** |
| Was the catheter inserted for a clinically indicated reason?   * Acute urinary retention or bladder outlet obstruction * To assist in healing in stage III or IV open sacral or perineal wounds in incontinent residents * To improve comfort for end-of-life care | ☐ | ☐ |  |
| Was catheter necessity reviewed per facility policy and documented? | ☐ | ☐ |  |
| Does the catheter and balloon size match the prescribing order? | ☐ | ☐ |  |
| Was the catheter inserted using aseptic technique? | ☐ | ☐ |  |
| Did the inserting provider complete a catheter insertion competency training? | ☐ | ☐ |  |
| Was catheter care followed per facility policy? | ☐ | ☐ |  |
| Was catheter care documented? | ☐ | ☐ |  |
| Did the frontline staff complete catheter care competency training? | ☐ | ☐ |  |
| Was a securement device used? | ☐ | ☐ |  |
| Was a closed system maintained? | ☐ | ☐ |  |
| Was the drainage/leg bag kept below the level of the bladder? | ☐ | ☐ |  |
| Is the urine collection device dated, with a resident identifier? | ☐ | ☐ |  |

Number of days of therapy: \_\_\_\_\_\_\_\_\_ Catheter removed / replaced / N/A

## Lessons Learned

1. Using the responses to contributing factors above, what contributed to the resident developing a CAUTI? If it is possible to determine the root cause of this CAUTI, please explain.
2. How might the team prevent this situation from happening again?

## Action Plan

### Immediate Next Steps for Resident’s Care

1. What care change(s) need to be made?

☐ Remove catheter now

☐ Replace catheter now

☐ Place condom catheter

☐ Scheduled toileting with purposeful rounding

☐ Increase frequency of catheter care

☐ If resident is retaining urine, bladder scan/straight catheter per physician order

☐ Communicate plan changes to RN/LPN/\*

☐ Communicate plan changes to resident/family

☐ Urology consult

☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ None at this time

1. Who is responsible for executing and documenting the change to the care plan?

### Additional Steps To Improve Catheter Insertion or Care

1. What other steps need do we need to take to improve catheter insertion or care?

☐ Conduct catheter rounds, with targeted education to optimize appropriate use

☐ Provide feedback on infection prevention, catheter use and care to staff in real time

☐ Review current catheter insertion and care policies to ensure evidence-based guidelines are driving practices

☐ Educate staff, residents, and families on catheter alternatives

☐ Evaluate current competency-based training policy and practices for frontline staff that insert or care for catheters

☐ Observe and document competency of catheter insertion or care and maintenance

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Who is responsible for executing and documenting the change to the care plan?

### Communicating Key Learning Points

1. How will these key learning points be communicated to frontline staff and providers?
2. Who will communicate the learning points?
3. By when will the learning points be communicated?

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\*registered nurse/licensed practical nurse/certified nursing assistant