

## TL6 – ADVOCACY AND INFLUENCE

### EXECUTING STRATEGIC CHANGE: CNO ALIGNS TEAMS AND PROCESSES ON ROAD TO QUALITY PATIENT SAFETY GOAL

*Provide one example, with supporting evidence, of the CNO's leadership that led to a strategic organizational change beyond the scope of nursing.*

#### **CNO Leadership for CAUTI Prevention**

Bernadette Khan, DNP, RN, NEA-BC, Group Vice President and Chief Nursing Officer, NewYork-Presbyterian/Columbia University Irving Medical Center (NYP/Columbia), is a seasoned nurse leader and relationship builder. Dr. Khan's leadership has led to many strategic organizational changes throughout her career. Recently, Dr. Khan led the enterprise-wide and NYP/Columbia quality and patient safety (QPS) initiative to decrease catheter-associated urinary tract infections (CAUTIs).

In December 2022, the QPS goals for the NewYork-Presbyterian (NYP) enterprise were shared with the enterprise's leadership team at the NYP QPS Goals Kickoff meeting. Dr. Khan was named co-owner of the enterprise-wide catheter-associated urinary tract infections (CAUTIs) process for which she provided guidance, leadership, and strategic direction to all CAUTI QPS teams across the NYP enterprise. As process co-owner for the enterprise, she also led the NYP/Columbia campus as Campus Team Lead and Local Campus Senior Leader. Dr. Khan's role as the local campus senior leader with authority over the CAUTIs process was to:

- Identify and assign campus team leads who are responsible for each goal locally
- Establish regular meetings with the campus team leads to ensure milestones and progress
- Remove local campus barriers
- Communicate campus goal performance

Dr. Khan's role as the Campus Team Lead responsible for owning the improvement effort at NYP/Columbia was to:

- Represent local campus at enterprise level goal meetings
- Establish and facilitate local campus goal team meetings and determine meeting frequency
- Document and communicate progress and performance to local campus senior leaders and escalate barriers
- Lead campus team through A3 problem-solving steps: evaluating current process, identifying gaps and opportunities, and facilitating performance improvement projects to address gaps
- Function as the face of the goal for the local campus

### [TL6.1—QPS Kickoff Presentation Truncated](#)

In January 2023, Dr. Khan formed a QPS CAUTI team comprised of nurses, physicians, and a project manager. Under her leadership, the team developed a strategic A3 project plan for the CAUTI QPS initiative. The 2023 project goal for the NYP/Columbia campus was to achieve a CAUTI standard infection rate (SIR) of less than or equal to 0.69. Dr. Khan guided the team to describe the background, current process steps, gaps, failure modes, problems, root causes, planned interventions, and action items to reduce the CAUTI SIR. Her leadership to establish the organization's priorities within an established A3 framework prepared the team to solve-problems, develop solutions for change, and to execute the plan in a collaborative environment among invested stakeholders. To develop the A3, Dr. Khan engaged important stakeholders such as infection prevention and control (IPC) experts and physician partners to provide education and mentorship to the QPS CAUTI team. She facilitated critical conversations among the team to reflect on NYP/Columbia's CAUTI challenges and trends over time since they had not consistently achieved the overall NYP SIR goals. These conversations well prepared the interprofessional team, beyond nursing, to make bold strategic changes on the path to reducing the CAUTI SIR. [TL6.2—January 2023 Meeting Minutes and Project A3](#)

### **Strategic Change**

Dr. Khan chaired the 2023 QPS CAUTI team's meeting throughout 2023. She delegated roles and responsibilities to the NYP/Columbia nursing leadership team since CAUTIs were known as a nurse-sensitive clinical indicator. She enlisted medical leadership to partner with others, including nurses, to make strategic organizational changes to align policies and procedures with evidence-based nursing and medicine practices. Dr. Khan leveraged her role as Group Vice President to allocate people, departments, such as information technology (IT/Epic), and supply chain leaders, to mobilize actions necessary for these strategic changes. These strategic change strategies transformed

the CAUTI prevention bundle and were effective at helping the organization achieve milestones that aligned with the NYP mission and vision.

Dr. Khan’s influence launched 3 major strategic changes across the NYP enterprise and NYP/Columbia that set the stage for reducing CAUTI SIR. Strategic changes included:

- New diagnostic stewardship for a ‘Trial of Void’ built into Epic (the electronic medical record)
- Auto-discontinuation of indwelling urethral catheter (IUC) orders with new electronic decision support via Epic to prompt providers and nurses
- Implementing new evidence-based workflows to change indwelling urinary catheters (IUC) that had been in place for at least 48 hours (rather than seven days) prior to collecting a urine culture, known as ‘Clean Slate at 48’

Dr. Khan led the organization to overhaul the CAUTI prevention strategic changes over time. She organized a team of experts, including Janett Pike, MPA, RN, CIC, Corporate Nursing Director, Infection Prevention and Control, and NYP IT communications to widely disseminate each strategic change with clear instructions and guidance. Diagnostic stewardship for a trial of void was built into Epic on March 21, 2023. Then on April 5, 2023, auto-discontinuation orders went live to decrease indwelling urinary catheter usage. Then on July 12, 2023, the removal of indwelling urinary catheters that had been in place for at least 48 hours (rather than seven days) prior to collecting a urine culture, known as “Clean Slate at 48” went live as a significant part to the overall strategic change initiative.

Healthcare team members whose workflows were impacted through the strategic changes were as follows:

Date	Strategic Change	Role	Workflow
March 21, 2023	Trial of void and treatment of underlying conditions	Nursing	When a trial of void is ordered for patients by their provider, the nurse will use a bladder scanner to measure post void residual. If the post void residual is greater than 400mls, then a straight catheterization is performed every 6 hours for 24 hours.
		Physicians/ Practitioners	Best Practice Alert pop-ups occur for providers in the electronic medical record to suggest the use of the new order panels at relevant decision points

			during the ordering process. When suggested, the provider is prompted to order a trial of void panel for acute urinary retention management to optimize patient care and reduce unnecessary catheter days.
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Date	Strategic Change	Role	Workflow
April 5, 2023	Acute IUC orders placed from the urinary management panel will no longer be randomized	Nursing	Clinical nurses will be notified if an indwelling urinary catheter (IUC) order is expiring soon, if the IUC order expired, or if there is an active IUC order without Lines, Drains, Airway (LDA) documentation or active LDA documentation without an IUC order.
		Physicians/Practitioners	Provider Order changes: <ul style="list-style-type: none"> <li>Acute IUC orders have a limit of 2 days before the order expires; providers will no longer be able to change the frequency.</li> <li>Chronic IUC orders have a limit of 3 days before the order expires, which is a new change as the current chronic order has no duration limit.</li> <li>IUC orders placed by urology will require the name of the urologist who approved the order.</li> <li>IUC orders placed for comfort care require the patient to have an active comfort care order.</li> </ul>

Date	Strategic Change	Role	Workflow
July 12, 2023	Clean Slate at 48! Replacement of	Nursing, all healthcare providers,	Any IUC that has been in place for 48 hours should be removed prior to collecting the urine culture and replaced

	indwelling urinary catheters in place for 48 hours prior to culture	clinical managers	<p>only if it is still essential to the care of the patient.</p> <p>The following diagnostic approaches should be considered for patients being evaluated and/or treated for CAUTI if the IUC has been in place for greater than 48 hours:</p> <ul style="list-style-type: none"> <li>• If the IUC is no longer indicated, remove the catheter prior to urine sample collection to reduce the risk of a false-positive urine culture caused by biofilm within the existing catheter.</li> <li>• Consider whether an alternative device (i.e., female external incontinence device or male incontinence device) is an appropriate choice for the patient.</li> <li>• For patients with acute urinary retention, implement the trial of void. If an IUC is still indicated, obtain an order to remove and replace the catheter prior to urine sample collection (unless medically contraindicated).</li> </ul>
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**TL6.3—Organizational Strategic Changes**

**CNO Strategic Change Leadership Exemplar**

Dr. Khan served as spokesperson for the strategic changes in various NYP/Columbia and enterprise-wide committees and meetings. As the CAUTI prevention leader she stimulated conversations about barriers and challenges among her CNO peer group and NYP/Columbia leaders. She readily shared her passion for sustaining change as she addressed the members of the June 2023 Nursing Board. The Nursing Board is an enterprise-wide committee of nursing leaders, including NYP/Columbia directors of nursing, and CNOs and their respective teams from each NYP campus. During the June 27, 2023 Nursing Board, Dr. Khan described the ‘Clean Slate at 48’ change strategy

that was recommended by Vizient. She explained how she and the QPS CAUTI team enlisted the services of Vizient, an external healthcare services partner, to help drive quality improvements, efficiencies, and performance to reduce CAUTI SIR. She communicated the evidence-based practice change planned for July 2023, known as 'clean slate at 48'. Clean slate at 48 meant that the organization was switching from a 7-day policy for changing IUCs to a policy of changing IUCs after 48 hours. Emphasizing the need for change and alignment with the NYP QPS goals, Dr. Khan directed local nursing team members who represent their campus at committees to assume accountability as change agents. She stressed the role of everyone to disseminate information, embrace recommended changes, and implement these change practices across the enterprise. [TL6.4—June 2023 Nursing Board](#)

In preparation for the NYP QPS hospital-associated infection (HAI) update in September 2023, Dr. Khan collaborated with Purvi Shah, MD, NYP Vice President and Chief Medical Officer, Ms. Pike, and other QPS CAUTI team members to design key talking points that summarized the strategic changes led by Dr. Khan and the team. The nurses and providers worked together to choose a case study that demonstrated the return on investments for the strategic changes. The focus of the presentation was to communicate the importance for sustaining changes and outlined new opportunities for improvement in 2023-2024.

In October 2023, Dr. Khan reviewed the organization's performance for CAUTI SIR and the overall CAUTI prevention strategies that were implemented under her leadership thus far. She noted that the CAUTI SIR decreased from 1.05 in 2022 to 1.03 in 2023 (through October 2023, year to date) which signified a major milestone achievement. Dr. Khan reaffirmed her passion and commitment to the strategic priorities of the organization and looked forward to leading the efforts throughout 2023 and 2024. [TL6.5—CAUTI Presentation and Performance](#)

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QPS Goals Kick-Off

December 5, 2022

Courtney Myers, MS, NP

Jessica O'Brien, MS, RN, AGCNS-BC, PCCN

Jason Adelman, MD

# Agenda

- QPS Goals Overview
- Campus Lead Role and Expectations
- Important Dates
- Tools for Success

# QPS Goals Overview: 2023 Goals/Enterprise Roles

#	2023 Goal	Executive Sponsor	Process Owner	Project Manager
1	Achieve a target mortality index of $\leq 0.85$	Peter Fleischut	Lisa Linsangan Xenia Frisby	Josephine Porco
2	Improve adherence with the 3 hour surviving sepsis bundle in the ED by 10%	Bob Blenderman	Robert Bloise Jason Adelman	Aarti Patel
3	Achieve a target SIR of $\leq 0.55$ for <i>C.diff</i>	Emily Jackson	Steven Kaplan Christa Kleinschmidt	Katie Schimanski
4	Achieve a target SIR of $\leq 0.69$ for CAUTI	Purvi Shah	Bernadette Khan Janett Pike	Laura D'Angelis
5	Achieve a target SIR of $\leq 0.94$ for CLABSI	Laureen Hill	David Calfe Rosanne Raso	Jake Gold
6	Implement artificial intelligence fetal heart tracing management system enterprise wide	Steven Kernie Leo Boden	Brianne Genow Barbara Alba	Lejdisa Mrija
7	Implement a standardized process for Screening of Social Drivers of Health (SDH) upon admission and process to track positive screens	Julia Iyasere	Amelia Shapiro Brenda Sauer	Kathy Alexis
8	Creation of a standardized review process for OPPE/FPPE utilizing KEEPSAFE surgical complications and other surgical data for the departments of surgery across the enterprise	Amir Jaffer	Dan Crossman Christine Teijo	Myrna Diaz
9	90% compliance with elopement screening and implementation of safety interventions for at risk patients	Phil Wilner	Denise Leung Melaney Gordon	Jennifer Powell
10	Achieve 95% or greater compliance with Bar Code Medication Administration (BCMA)	Willie Manzano	Mary Quinn Jorie Frasiolas	Bryan Conway

# Local Team Composition, Roles, and Responsibilities

Local Quality Team	Campus Team Lead	Frontline Staff/Subject Matter Experts	Local Campus Senior Leaders
<p><b>Who:</b></p> <ul style="list-style-type: none"> <li>Representatives overseeing quality at the local campus</li> </ul> <p><b>What they do:</b></p> <ul style="list-style-type: none"> <li>Attend enterprise wide goal meetings</li> <li>Track progress of QPS Goals at their campus</li> <li>Offer guidance to Campus Team Leads as needed (i.e. escalation pathway for barriers, quality improvement methodology, etc.)</li> <li>Facilitate communication between the Campus Team Lead and the Campus Senior Leaders</li> </ul> <p>*QPS Directors and ACQOs may be assigned as process owners and follow the description of that role for their goal with their team as support</p>	<p><b>Who:</b></p> <ul style="list-style-type: none"> <li>Has responsibility over the process at local campus. Owns the improvement effort locally</li> </ul> <p><b>What they do:</b></p> <ul style="list-style-type: none"> <li>Represent local campus at enterprise level goal meetings</li> <li>Establish and facilitate local campus goal team meetings and determine meeting frequency</li> <li>Document and communicate progress and performance to local campus senior leaders and escalate barriers</li> <li>Lead campus team through A3 problem solving steps: evaluating current process, identifying gaps and opportunities, facilitating performance improvement projects to address gaps</li> <li>Function as the face of goal for local campus</li> </ul>	<p><b>Who:</b></p> <ul style="list-style-type: none"> <li>Representation from all disciplines/stakeholders involved in influencing the goal</li> </ul> <p><b>What they do:</b></p> <ul style="list-style-type: none"> <li>Attend local campus goal team meetings (<i>as needed</i>) and actively participate in the work and development of improved processes</li> <li>Assist in problem solving and data collection activities</li> <li>Execute key deliverables according to project plan</li> <li>Engage colleagues in improvement work</li> <li>Ensure that the facts and details are correct so that the interventions are aligned with policies, standards, regulations and best practices</li> </ul>	<p><b>Who:</b></p> <ul style="list-style-type: none"> <li>Senior Leaders with authority over the process at campus (i.e. COO, CMO, CNO, ACQO)</li> </ul> <p><b>What they do:</b></p> <ul style="list-style-type: none"> <li>Identify and assign campus team leads who are responsible for each goal locally</li> <li>Establish regular meetings with the campus team leads to ensure milestones and progress</li> <li>Remove local campus barriers.</li> <li>Communicate campus goal performance at SLPSC</li> </ul>

# Campus Level – Local Lead Expectations

## Role:

- The campus lead knows the local clinical environment, resources, and relationships to drive process change around their specific goal
- Ultimately owns the improvement effort locally, has responsibility over the process at local campus, and is the face of the goal for the local campus

## Responsibilities:

- Plan a kick-off meeting in January 2023
- Lead local workgroup meetings
  - Recommend biweekly
- Understand (and examine) your campus' local performance
- Establish work group to facilitate process improvement
- Follow A3 problem solving steps
- Communicate progress and performance to local campus senior leaders and escalate barriers at the local QPS Goal Forum

**NYP-Columbia**  
**Milstein CAUTI Workgroup Meeting Minutes**  
**MEETING DATE: January 11, 2023**  
**TIME: 12pm-1pm**

Attendees: Bernadette Khan (CNO, Owner), Vanessa Delos Reyes, PCD, Dr. Madeline Kaufman, Jason Johnson (CNM), Dr. Tony Lin (QPS), Jessie O'Brien (DON-Quality), Lovie Amolo (CNS), Dr. Ruttman (Urology), Osnat Dermenzhi (QPS),

- 2022: Goal (enterprise-wide): 0.74
- CU at 1.05
- Developed A3 led by Bernadette
- In the pipeline: Daily Quality checklist for providers (why catheter is needed)
- Standardization of documentation:
  1. Post-void residuals - look at nursing documentation (does not transfer over to providers; has to be sought out)
  2. Variation in difficulty with catheter insertion ("difficult" needs to be defined)

**CUIMC CAUTI Prevention QPS Goal: Achieve a target SIR of  $\leq 0.69$**

**QPS Goal:**

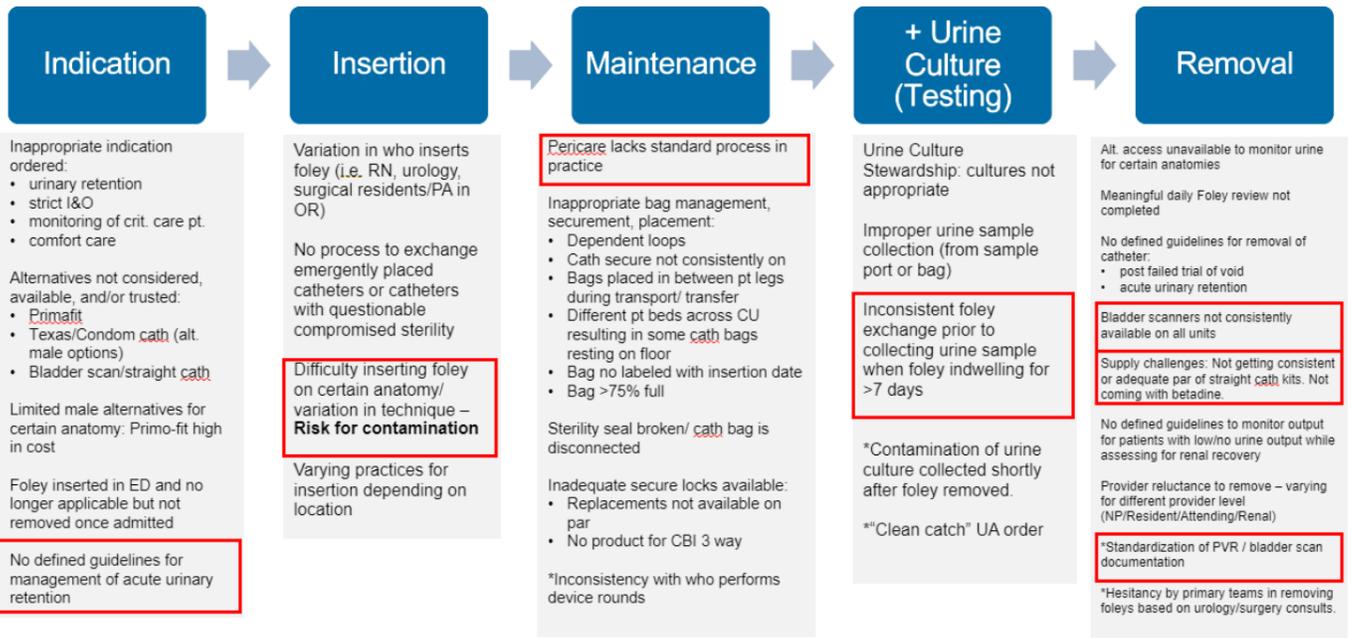
- ☐ Achieve a CAUTI standardized infection ratio (SIR)  $\leq 0.69$  between 1/1/2023 – 10/31/23. Performance will be measured using the SIR, which compares the actual number of CAUTI at a hospital to the predicted number of CAUTI. CAUTI are identified by Infection Prevention & Control and entered into the CDC's NHSN database and SIR is calculated by the NHSN system.
- ☐ The scope of this project includes all inpatients with indwelling urinary catheters at CU.

**Background:**

- ☐ CAUTI is one of the most commonly occurring HAIs in acute care facilities. It is a device related infection that can increase a patient's length of stay, increase the cost of hospitalization, and can increase exposure to antibiotics (this can in turn lead to the development of drug resistant infections in patients). Indwelling urinary catheters (IUCs) are one of the most frequently used medical devices and while preventing the infections associated with them is particularly challenging, risk can be mitigated through adherence to evidence-based practices during insertion and maintenance as well as with prompt removal of IUCs that are no longer clinically indicated.
- ☐ CAUTI prevention has been an NYP QPS goal for several years. Improvements in the overall CAUTI SIR have been difficult to achieve and sustain (though within the organization individual hospitals have achieved the goal SIR). This suggests that patients may be at greater risk for developing a preventable infection and places NYP at risk for financial and other penalties (such as VBP, HAC penalty, and other hospital comparison programs). The COVID-19 pandemic has further challenged CAUTI prevention due to staffing challenges, supply chain challenges, and at times, larger population of critically ill patients many of whom had IUCs. In 2022 CUIMC improved performance over the preceding 4 years. Although CUIMC did not meet enterprise SIR goal in 2022 (SIR 1.02 – January to October 31, 2022 measurement period), the number of CAUTI events as well as the IUC utilization decreased in 2022. This year the goal of 0.69 is 30% more aggressive when compared to the 2022 goal of 0.99.
- ☐ In aggregate, CAUTI interventions work synergistically to achieve prevention. Each targets a different area of focus in the life-cycle of an IUC.

**Current Process Steps and Gaps:**

**The "Life Cycle" of a CAUTI with Failure Modes**



**Problem / Root Cause / Interventions:**

Problem	Root Cause	Intervention
Use of an indwelling urinary catheters not consistently restricted to very specific clinical indications warranting the use of an IUC for the proper management of patients. There are alternative, less invasive, devices that can be used in place of an IUC for a large number of patients.	<ul style="list-style-type: none"> <li>Failure to consider alternatives to IUC's (e.g., condom catheter, external female incontinence device).</li> <li>Provider's unaware of options</li> <li>Convenient to have IUC in place</li> <li>Lack of acceptable alternative to the IUC for female patients</li> </ul>	<ul style="list-style-type: none"> <li>Education and clinical decision support of the use of both male and female alternative devices</li> <li>Monitor use of alternatives on target units</li> <li>Feed back data to increase usage</li> </ul>
Catheter necessity is assessed by provider at least daily and by nursing during each shift	<ul style="list-style-type: none"> <li>Failure of clinical team to critically consider necessity when completing necessity review</li> <li>IUC necessity is not always included in routine patient care and/or interdisciplinary rounds.</li> </ul>	<ul style="list-style-type: none"> <li>Provider education and enhanced engagement</li> <li>Daily IUC list sent to UMD's and PCD's</li> </ul>
Over-culturing can result in false positive CAUTI cases	Pan-culturing results in over diagnosis of CAUTI <ul style="list-style-type: none"> <li>Urine cultures not restricted to instances of clinical suspicion of CAUTI</li> <li>Work-up for each individual patient is determined by individual providers based on patient-specific information, provider's prior experience and knowledge, and other factor</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced provider engagement</li> <li>Provider education and resources on IP&amp;C CAUTI webpage</li> </ul>
Inconsistent use of bladder scanning as a strategy to prevent reinsertion of IUC's	<ul style="list-style-type: none"> <li>Lack of standardized protocol for RN's to follow</li> <li>Lack of awareness of providers of bladder scanning as an option to avoid catheterization</li> </ul>	<ul style="list-style-type: none"> <li>Roll-out of AUR/TOV algorithm in 2023</li> </ul>

**CUIMC CAUTI Prevention QPS Goal: Achieve a target SIR of  $\leq 0.69$**

Executive Sponsor: Bernadette Khan

Process Owner(s): Vanessa Delos Reyes, RN (PCD), Dr. Madeline Kauffman (Hospitalist), & Aimee Rizzi (DON)

Action Items		
Action Items - "What, Who, When":		
What?	Who?	By When? (completion status: red/green)
Device Rounds	IP&C, Nursing	Ongoing
Daily list of patients with IUC's sent to PCDs and medical directors	Analytics	Ongoing
Randomized Control Trial of Auto-Discontinue order	QPS	Ongoing
Optimization and roll out of 'trial of void' process to reduce IUC utilization	QPS/Nursing	In progress
Use of alternative devices to reduce catheter utilization	Providers/Nursing	Ongoing
Catheter necessity is assessed by provider at least daily and by nursing each shift	Providers/Nursing	Ongoing

Measures and Follow-up
Outcomes measure: <ul style="list-style-type: none"> <li>• SIR Rate</li> <li>• IUC days</li> <li>• IUC utilization</li> </ul>

Enterprise QPS Goal Achievement:
Goal Achieved: <input type="checkbox"/> Yes or <input type="checkbox"/> No (check)
<input type="checkbox"/> Describe outcome performance here (or attach):

**From:** Clinical IT Announcements <[epictogetherupdate@communication01.nyp.org](mailto:epictogetherupdate@communication01.nyp.org)>  
**Sent:** Tuesday, March 21, 2023 3:44 PM  
**To:** Pike, Janett <[jpike@nyp.org](mailto:jpike@nyp.org)>  
**Subject:** CAUTI: Trial of Void and Treatment of Underlying Conditions order panels

**Who this message is for:**

All ordering providers and clinicians caring for patients with Acute Urinary Retention or with an Indwelling Urinary Catheter (IUC) in place.

**Who this message is for:**

All ordering providers and clinicians caring for patients with Acute Urinary Retention or with an Indwelling Urinary Catheter (IUC) in place.

**What is happening:**

To reduce excess IUC days and prevent CAUTIs (catheter-associated urinary tract infections), NYP has implemented an algorithm for clinical management of acute urinary retention (attached) and added two new orderpanels to Epic.

- The “Underlying Conditions” orderpanel includes orders recommended to address potential underlying etiologies of acute retention. When a patient presents with or develops an inability to void, use this orderpanel to optimize management.

Treatment of Underlying Conditions for Acute Urinary Retention ✓ Accept

Assess underlying conditions for acute urinary retention and consider ordering the Acute Urinary Retention and Trial of Void order panel  
Consider discontinuing predisposing medications such as opioids, anticholinergics, alpha-adrenergic agonists, etc

**Bladder Outlet Obstruction due to BPH consider:**

taMSULOSIN (FLOMAX) 24 hr capsule  
Starting 1/6/23

**Constipation**

Goal: at least one soft bowel movement per day.

Bowel Regimen

**Mobility**

Activity  
Starting 1/6/23

PT Evaluation and Treatment  
Starting 1/6/23

ⓘ Next Required ✓ Accept

- The “Trial of Void” (TOV) order panel includes orders necessary for nurses to utilize bladder scanning and intermittent catheterization to allow patients at least 24 hours to void spontaneously prior to considering (re)placement of the IUC or continuation of the intermittent bladder scan/straight catheterization schedule. This orderpanel can be used to manage acute urinary retention without an IUC, or it can be used after discontinuation of an IUC if a patient does not void spontaneously in the first 6 hours. (TOV Link: [Access HERE](#))

Inpatient Trial of Void Orderpanel ✓ Accept

Orders in this panel support implementation of TOV algorithm.  
- [Link to Trial of Void Algorithm](#)

Post-Void Residual - Bladder Scan  
Every 4 Hours PRN, Starting 3/14/23, Assess and document PVR after first and second spontaneous voids.

Bladder Scan, PRN  
Every 6 Hours PRN, Starting today at 1219, Until Specified  
No spontaneous void in 6 hours. If > 400cc or symptomatic, straight cath. If < 400cc and asymptomatic, bladder scan in 4 hours or sooner if the patient becomes symptomatic.

Straight Cath. PRN  
Every 6 Hours PRN, Starting today at 1219, Until Specified  
PRN Reason: bladder scan >400cc or symptomatic. Document volume.

ⓘ Next Required ✓ Accept

### How this will affect you:

**Ordering providers and clinicians:** BPAs will fire suggesting use of the new orderpanels at relevant decision points during the ordering process. When suggested, please consider implementing these orderpanels to optimize patient care and reduce unnecessary catheter days.

**Clinical nurses:** Review the protocol and suggest the use of these new orderpanels to providers when relevant to your patients.

**Who to contact with Questions/Feedback:**

For questions about implementing the Algorithm, please contact your Campus Leads for CAUTI. For Epic questions, please contact your institutional help desk.

- NYP: 4-HELP or 212-746-4357
- CUIMC: 5-HELP or 212-305-4357
- WCM: 212-746-4878



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**From:** Clinical IT Announcements <epictogetherupdate@communication01.nyp.org>  
**Sent:** Wednesday, April 5, 2023 4:15 PM  
**To:** Khan, Bernadette <bkhan@nyp.org>  
**Subject:** CAUTI Prevention & Indwelling Urinary Catheter (IUC) Optimization

**Who this message is for:**

All physicians, PAs, NPs & Inpatient Registered Nurses.

**Why this is happening:**

- To avoid unnecessary IUC ordering and promote usage of alternatives, prompt early removal and educate staff on CAUTI prevention.
- The Epic build has been simplified and standardized to positively influence CAUTI reduction.
- Updated Provider Ordering Panels & Best Practice Alerts (BPA's) will improve decision-making, communication, as well as collaboration between clinicians.

**What is happening:**

**Note:** *Acute IUC orders placed from the Urinary Management panel will no longer be randomized.*

**Order changes:**

- Acute IUC orders have a limit of 2 days before the order expires, providers will no longer be able to change the frequency.
- Chronic IUC orders have a limit of 3 days before the order expires, which is a new change as the current chronic order has no duration limit.
- IUC orders placed by urology will require the urology physician that approved the order.
- IUC orders placed for comfort care require the patient to have an active comfort care order.

**New/ Updated Best Practice Alerts (BPA's) will notify RN and Provider staff of:**

- IUC order expiring soon
- IUC order expired
- Active IUC Order without LDA Documentation
- Active LDA Documentation without IUC Order

**Please review Below Tipsheets:**

- [Nursing](#)
- [Providers](#)

**When this is happening:**

**Thursday, April 6, 2023**

**Who to contact with Questions/Feedback:**

Contact your Patient Care Director or Clinical Leadership Groups (CLGs), or contact your Service Desk.



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## Clean Slate at 48!

Replacement of Indwelling Urinary Catheters in Place for 48 Hours Prior to Culture

July 12, 2023

**Who this message is for:** All healthcare providers, clinical managers and inpatient registered nurses

### What is this message about:

Implementation of a new recommendation when collecting urine cultures on patients with Indwelling Urinary Catheters (IUCs). Any IUC that has been place for 48 hours should be removed prior to collecting the urine culture (and replaced only if still essential to the care of the patient).

### CATHETER URINE SPECIMEN COLLECTION:

Note: The following diagnostic approaches should be considered for patients being evaluated and/or treated for CAUTI if the Indwelling Urinary Catheter (IUC) has been in place for > 48 hours:

- **If the IUC is no longer indicated, remove the catheter PRIOR to urine sample collection** to reduce the risk of a false-positive urine culture caused by biofilm within the existing catheter.
- Consider whether an alternative device (i.e., female external incontinence device or male incontinence device) is an appropriate choice for the patient.
- For patients with acute urinary retention, implement the trial of void.  
**If an IUC is still indicated, obtain an order to remove and replace the catheter PRIOR to urine sample collection (unless medically contraindicated).**

### Why this information is important:

Indwelling urinary catheters become colonized at 3-5% /day. This new recommendation is being added to avoid detection of colonization, which can be falsely interpreted as infection, and to promote early removal, use of alternatives, and 'the trial of void.'

### What we need from you:

Please carefully review this information.

**NEWYORK-PRESBYTERIAN**  
**Nursing Board**

Date: **June 27, 2023**  
Time: **10:00 AM - 11:00 AM**  
Location: Zoom Meeting

Chair: Wilhelmina Manzano, MA, RN, NEA-BC, FAAN, Group Senior Vice President, CNE, COO Perioperative Services, NYP

Topic/Action Item	Discussion	Decision/Action	Follow-Up Date & Responsible Person
<p><b>The meeting was called to order at 10:00AM by W. Manzano, RN</b></p> <p>Quorum*</p> <p>Minutes</p>	<p>A quorum was present.</p> <p>W. Manzano, RN requested motion for review and approval of the 5/23/2023 meeting minutes.</p>	<p>Nursing Board accepted as submitted.</p>	<p>Filed.</p>
<p><b>Announcements/ Member Recognition</b></p>	<ul style="list-style-type: none"> <li>- L. Elgin, RN introduced V. Petgrave, RN Interim DON for Maternal Child Health at NYP-Q.</li> <li>- M. Prado-Inzerillo, RN announced that G. Nastasi, RN will be leaving NYP for an external opportunity. Ms. Prado-Inzerillo and W. Manzano, RN thanked Ms. Nastasi for her support for NYP's nurses and contributions to improving the clinical nurses' work environment. Ms. Nastasi thanked the Nursing Board for their support.</li> <li>- G. Nastasi, RN announced that M. Dia, RN was named a Fellow of HIMSS – Healthcare Information and Management Systems Society.</li> <li>- J. Halpern, RN announced that G. Rodriguez, RN has been promoted to VP &amp; CNO of NYP-LMH. Ms. Halpern and W. Manzano, RN congratulated Mr. Rodriguez.</li> <li>- W. Manzano, RN congratulated J. Halpern, RN on her appointment as VP &amp; CNO of NYP/WC; this is Ms. Halpern's first Nursing Board meeting in her new role.</li> <li>- B. Khan, RN announced that M. Gordon, RN has been promoted to VP &amp; CNO of NYP-MSCH. Ms. Khan and W. Manzano, RN congratulated Ms. Gordon.</li> <li>- <b>Executive Comments:</b> W. Manzano, RN announced that M. Cassai, SVP of Perioperative Services has taken an amazing opportunity outside of NYP as the Executive Vice President at HSS. Ms. Manzano and the Nursing Board acknowledged the contributions of Ms. Cassai and wished her ongoing success in this new role. Recruitment and transition plans are underway. W. Manzano, RN said that USNWR rankings will be released in July; regardless of result, the message is the same, quality and safe care is the priority.</li> </ul>		<p>Noted.</p>
<p><b>Old Business</b></p>	<p>None.</p>		
<p><b>Quality &amp; Patient Safety / Regulatory</b></p> <p>A. Great Catch – NYP-Q</p>	<p>J. Burns, RN presented a great catch by an NYP-Q perioperative nurse. The nurse found the patient lying on the floor with a blanket in the pre-op holding area; the patient reported he was resting. Upon their initial interaction, the RN noted the patient's behavior and demeanor was</p>		<p>Noted. Presentation filed.</p>

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	<p>unusual. The nurse confirmed the patient did not fall, but the patient explained that he was more comfortable lying on the floor. The patient moved to the recliner and the nurse was able to finish her preoperative assessment; the patient was noted to answer the questions appropriately and was alert and oriented and vital signs were stable. However, the nurse was concerned over the patient's behavior and she reported her assessment to both the anesthesiologist and the surgeon. As a result, a urine toxicology test and alcohol level were ordered and sent. The results indicated a high alcohol level and an abnormal urine toxicology. The surgery was cancelled. Though the patient was upset the surgery was cancelled, the nurse was instrumental in ensuring that the patient's safety was not compromised. This nurse acted responsibly as the patient's advocate, given the patient's judgment was compromised. This nurse is thanked for her awareness and diligence in ensuring patient safety.</p>		
<p>B. JCR Mock Survey Update</p>	<p>M. Quinn, RN presented updates on the enterprise response to the recent NYPH JCR Mock Survey. The final report contained approximately 90 findings, for which various teams are action planning. Priority areas are life safety, environment of care, IP&amp;C, and NPSG findings which are in the high risk/widespread category of the SAFER matrix. Action plans and implementation are due 7/12. Measurement and monitoring will follow to ensure resolutions are sustained.</p>		<p>Noted. Presentation filed.</p>
<p>C. Performance Improvement • Nursing Sensitive Clinical Indicators – May 2023</p>	<p>M. Quinn, RN presented May 2023 YTD performance on nursing sensitive clinical indicators: unassisted falls, HAPI, CAUTI, and CLABSI. Unassisted falls reduction is trending favorably; currently at -7% toward -10% goal. The enterprise-wide Falls Reduction Committee and each site has shared their best practices to reduce falls. HAPI performance shows a 14% increase compared to 2022 and is not meeting target, except for HVH. For CAUTI, the enterprise is close to, but not yet meeting the SIR target. Enterprise CLABSI performance is exceeding target. AH, Q, and HVH have had zero CLABSIs in 2023.</p> <ul style="list-style-type: none"> <li>- C. Kleinschmidt, RN said that HAPI performance is measured using coded discharge data; when reconciling discharge data vs. dashboard data AH leadership is finding discrepancies. M. Quinn, RN said EPSI's coded discharge data is source of truth for PI reporting and also feeds the dashboards. The confusion may be due to filters on the dashboard. Data does get adjusted as the coders recode. However, the bottom line is that teams should focus on prevention. Nursing Quality will review the dashboard with AH and any other site that would like.</li> <li>- M. Gallagher, RN said HAPI reduction work is ongoing by the interdisciplinary HAPI reduction team. There has been great partnership between the HAPI team and the Products Standardization Committee; Mepilex 5x5 will be available on units this week, which will help respiratory therapy device related HAPIs. The team is working</li> </ul>		<p>Noted. Presentation filed.</p>

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	<p>on reviewing orders to ensure that orders match what is available on unit. The team is doing work to reinforce practices for 2RN skin checks on admission, transfer and at discharge. Another focus is positioning; CU and LMH had significant HAPI improvements in ICU patients using the Tortoise device. Safe Patient Handling pushes back on the Tortoise because they advocate for AirTAP; AirTAP is really a solution for safe patient handling and can cause HAPI if used incorrectly. The team is focusing on accurately capturing and sharing incidence data. Additionally, the male external incontinence device is being trialed at CU and AH ICUs.</p> <ul style="list-style-type: none"> <li>- B. Khan, RN said the CAUTI cross-campus group has begun a new campaign for "Clean Slate at 48". Vizient's recommendation was to change Foleys after 48 hours if a culture is needed; current practice is 7 days. Additionally, if a Foley is appropriately removed after 48 hours, there is a possibility is that a new Foley is not needed, so the team is also advocating for a trial of void at this checkpoint. Basic practice standards remain including daily assessments and peri-care. W. Manzano, RN said it is good that peri-care remains a focus because basic practices have been inconsistent.</li> <li>- B. Khan, RN said that local nursing team members who represent their campus at enterprise committees must bring information back to local leadership so information can be disseminated, teams can embrace recommended changes, and practice can change across the enterprise.</li> <li>- W. Manzano, RN asked why improvements are not consistently sustained; CAUTI, falls, HAPI are all problem areas. If staff are to be held accountable for practice, leaders must hold themselves accountable for culture.               <ul style="list-style-type: none"> <li>▪ C. Kleinschmidt, RN said accountability must be hardwired; use of best practices must be engrained and remain consistent even when leaders and staff change.</li> <li>▪ J. Halpern, RN said that there is an increased accountability of providers and physicians at WC; the medical teams are locking arms with nursing on HAIs; with that partnership and collaboration, success will be exponential.</li> <li>▪ E. Jackson, RN said that HVH's structure is incredible; every morning after tiered huddle, all lines are discussed and IDRs are rigorous. The structure supports outcomes.</li> <li>▪ A. Rizzi, RN said a lot of work is done within nursing, so the MSCH team is also focusing on working more collaboratively with provider partners to spread those best practices and improve outcomes.</li> </ul> </li> </ul>		

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	<ul style="list-style-type: none"> <li>▪ E. Ladson-Barnes, RN said LMH nursing leaders closely partner with the medical team and do device rounds 2-3 times per week for direct feedback with staff. LMH is working closely with an interdisciplinary team on CLABSI, which has been a recent challenge.</li> </ul>		
<ul style="list-style-type: none"> <li>• Patient Experience Nursing Domains – May 2023</li> </ul>	<p>M. Quinn, RN presented patient experience nursing domains as of May 2023 YTD. The enterprise is not achieving the 4-star target in any of the five nursing sensitive domains. Performance by site is highly variable.</p> <ul style="list-style-type: none"> <li>– L. Elgin, RN said BMH is not meeting targets in several areas; nursing is partnering with the local PX team, drilling down, doing additional rounds, making sure there is a common language, has secret shoppers and observers, immediately correcting behavior, and working on accountability.</li> <li>– C. Kleinschmidt, RN said AH’s focus over the last year was to have a solid leadership structure in place to drive a clear and consistent message about expectations. Leaders perform daily recognition to get messages to front line staff. Responsiveness Retreats have been well-received.</li> <li>– F. Wang, RN said the PFX NSP team is working on a plan to roll out Responsiveness Retreats to all sites given how successful they have been at AH and W.</li> <li>– B. Ku, RN said Responsiveness Retreats were not an overnight solution at AH; the improvement took focused effort over the course of a year. The key was involving all staff at the site.</li> </ul>		Noted. Presentation filed.
<ul style="list-style-type: none"> <li>• 2023 QPS Goals Update – BCMA</li> </ul>	<p>M. Quinn, RN presented inpatient BCMA compliance data as of May 2023. The enterprise is achieving the 95% target. This is a result of an enterprise-wide interdisciplinary effort. The dashboard is pending final updates and will be made available for real-time data. Clinical nurses have raised scanning of plain IV solution bags; Baxter is coming on site to investigate whether there is something technical Baxter can do to help and what short- and long-term options are. M. Quinn, RN asked leaders to thank their nurses, who have been actively engaged and instrumental in this improvement. An issue still pending resolution is the roll out of replacement iPhones; IT is behind schedule on this.</p> <ul style="list-style-type: none"> <li>– W. Manzano, RN said improvement in BCMA compliance great news for patient safety. Additionally, this is an important Leapfrog indicator. M. Quinn, RN said five sites got BCMA Leapfrog credit this year, an improvement from one site last year.</li> </ul>		Noted. Presentation filed.
<ul style="list-style-type: none"> <li>D. Reportable Events Summary – January – May 2023</li> </ul>	<p>M. Quinn, RN presented the reportable events scorecard for January – May 2023. For many events, performance is better than the year prior. Falls and medication errors are the biggest</p>		Noted. Presentation filed.

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	<p>opportunities for improvement. Suicide attempts are down as a result of a lot of work on suicide risk screening and prevention efforts.</p> <ul style="list-style-type: none"> <li>- W. Manzano, RN said that any retained foreign body is unacceptable. K. Duvall, RN said that some retained foreign bodies are guidewires retained from procedures in non-OR spaces.</li> </ul>		
<p><b>New Business</b> A. Nursing Strategic Plan – Patient-Family Experience</p>	<ul style="list-style-type: none"> <li>• T. McGarvey, RN presented <b>Patient-Family Experience</b> nursing strategic plan team’s updates including progress toward goals, strategies to achieve goals, desired outcomes, and current timeline/status.</li> <li>- W. Manzano, RN said that these are best practices; when hardwired, organizations see the results they want. Leaders must hold teams accountable through conversations, rounding, tiered huddles. The quality and consistency of leaders’ enculturating this will make the difference.</li> </ul>		<p>Noted. Presentation filed.</p>

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<b>Hospital &amp; Nursing Policies: Review &amp; Approval</b>	<b>Title</b>	<b>Key Points</b>	All policies accepted and approved by the Nursing Board.	Noted.
	<b>Hospital Policy and Procedure Manual</b>			
	A260 Allegation of Sexual Misconduct Involving a Patient	<p><b>Expedite Approval via email on 6/1/2023.</b></p> <ul style="list-style-type: none"> <li>• New Hospital Policy that delineates the prompt reporting, escalation, and investigation requirements related to sexual misconduct allegations on non-behavioral health units.</li> <li>• All investigations are done by Human Resources, Patient Services and Security in conjunction with Departmental leadership and the Office of Legal Affairs and Risk Management.</li> <li>• Definition of “sexual misconduct”</li> <li>• Procedure steps on: <ul style="list-style-type: none"> <li>– Reporting / Notification</li> <li>– Preliminary Review</li> <li>– Investigation and follow up</li> <li>– Record Keeping</li> </ul> </li> </ul>		
C325 CHG Skin Treatment	<p>Interim review.</p> <ul style="list-style-type: none"> <li>• Revised indication of using CHG skin treatment for pediatrics: <b>Daily CLASBI and MRSA Infection Prevention:</b> - All pediatric patient in ICU ≥ 2 month of age - All pediatric Non-ICU patients with central lines ≥ 2 month of age</li> <li>• Deleted pediatrics &gt; 30 Kg from Appendix A diagram, and added to Appendix B.</li> </ul>			

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C132 Informed Consent	<p>Interim review.</p> <ul style="list-style-type: none"> <li>Added below language: <b>“When different physicians plan to perform more than one procedure at the same time on the same patient separate consent discussions about risk, benefits, and alternatives of each component are required.”</b></li> </ul>		
U100 Universal Protocol for Correct Patient, Procedure, Site/Side Verification	<p>Interim review.</p> <ul style="list-style-type: none"> <li>Added below language: <b>“The practitioner of record for the procedure must sign both the consent and the history and physical examination update before the time out begins.”</b></li> <li>Added a section on <b>Performing Additional Time Outs</b> <ul style="list-style-type: none"> <li><b>When a new physician joins the case after the initial time out, a new time out is performed</b></li> <li><b>If there is a disagreement or uncertainty about the number of time outs needed, the time out should be performed.</b></li> </ul> </li> </ul>		
A112 Victim of Domestic, Intimate Partner Violence, and/or Human Trafficking	<p>Biennial review.</p> <ul style="list-style-type: none"> <li>Updated outlined campus protocols.</li> <li>Standardized process across sites.</li> <li>Added clarification that training is required for specific disciplines.</li> </ul>		
A300 Automatic Chest Compression System	<p>Biennial review. No practice changes.</p>		
D120 Discharge Planning and The Continuum of Care	<p>Biennial review. No practice changes.</p> <ul style="list-style-type: none"> <li>Removed redundancies, fine-tuned the verbiage.</li> <li>Added some references to other existing policies.</li> </ul>		

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D220 Dispensing of Naloxone Rescue Kit	Biennial review. Added inpatient areas Naloxone Rescue kit process.		
E157 Early Recognition and Response System using RRT	Interim review. <ul style="list-style-type: none"> <li>Expanded RRT response locations at AH to include non-clinical and outpatient areas</li> <li>Added Milstein Lobby and Cafeteria to RRT locations at CUIMC</li> <li>Added BMH RRT phone # and response locations</li> </ul>		
E300 Chart Etiquette and Optimal Use of Shared EHR Guidelines	Biennial review. No practice changes.		
H220 Handling and Administration of Pasteurized Donor Human Milk (PDHM)	Biennial review. Applies to WC & MSCH only. <ul style="list-style-type: none"> <li>Added a section on Quality Assurance, performing monthly monitoring of the appropriate sample size to verify compliance with policy, documentation, and tissue bank requirements</li> </ul>		
I111 Administration of Influenza and Pneumococcal Vaccines for Adults	Biennial review. No practice changes. <ul style="list-style-type: none"> <li>Updated references</li> </ul>		
I263 Administration of Influenza Vaccine for Children and Adolescents in ACN	Biennial review. No practice changes. <ul style="list-style-type: none"> <li>Updated references</li> </ul>		
L108 Linen and Bedmaking Guidelines	Biennial review. No practice changes.		
<p>– F. Wang, RN reminded the Nursing Board that the expectation is to reply promptly via email with approval or questions when expedited review/approval of policies is required. W. Manzano, RN highlighted the role of Nursing Board members in not only meeting attendance and participation but also awareness of other communications related to nursing, such as requests for review and approval of policies and timely response to these requests.</p>			

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<b>Adjournment &amp; Next Meeting</b>	The group will reconvene on July 19, 2023 at NYP/WC Griffis Faculty Club, 9:30am - 11:00am.		

**Minutes Reviewed /Approved By:** *[Signature]* **Chair**      **Date:** 7/19/2023

**RECORDER: Kristyn Baccaglini, MPA**

Quorum-a majority of all members

Reference: DeVries, M. A. 1998. The New Robert's Rules of Order. Second Edition, New York: Signet Publications

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**NURSING BOARD ATTENDANCE/MEMBERSHIP**

**LEGEND: V - VIDEOCONFERENCE**

**June 2023 Attendance**

<b>Name/Credentials – example: BSN, MSN, DNP, RN, Certification</b>	<b>Title</b>	<b>Jun</b>
Aimee Rizzi, MSN, RN, CEN	Director of Nursing, NYP/CUIMC	V
Alexa Shelley, MS, RN-BC, FNP-BC	Magnet Program Director, NYP-LMH	V
Barbara Alba, PhD., RN	Director of Nursing, Maternal Child Health, NYP-LMH	V
<b>Bernadette Khan, DNP, RN, NEA-BC</b>	<b>Vice President &amp; Chief Nursing Officer, Columbia Division</b>	<b>V</b>
Bertha Ku, DNP, MPH, RN, NEA-BC	Director of Nursing Quality, NYP-AH & NYP-W	V
Brian Schneider, PhD, RN, NE-BC	Director of Nursing, NYP/WC	V
Carrie Gerber, DNP, RN, NE-BC	Magnet Program Director, NYP-BMH	V
Catherine Halliday, MSN, RN, NEA-BC	Director of Nursing, Cardiovascular, NYP/CUIMC	V
Catherine Lombardi, MS, RN	Director of Nursing, NYP-W	V
Catherine Palmese, MA, BS, RN, NE-BC	Magnet Program Director, NYP-Q	V
Christa Kleinschmidt, MS, RN, FNP-BC	Vice President & Chief Nursing Officer, NYP-AH	V
Christina Sansolo, MSN, RN, CNL	Magnet Program Director, NYP-W & NYP-AH	V
Christine Demo, DHA, MSN, RN, NEA-BC	Director of Nursing, NYP-HVH	V
Coretta Green, MSN, RN, RNC-OB, C-EFM	Director of Nursing, NYP-AH	V
Cosme Taipe, MPA, BSN, RN, CCRN-K	Magnet Program Director, NYP/WC	V
Cristina Zullo, RN, MSN, CCRN	Director of Nursing, NYP-Queens	V
Danielle Lestrage, MSN, MBA, RN	Director of Clinical Care and Emergency Services, NYP-Lawrence	V

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Emily Jackson, RN, MBOE, CNOR, CSSBB	VP and CNO, NYP-HVH	V
Esteen Ladson-Barnes, DNP, MPA, RN, NEA-BC, CCRN	Director of Nursing, NYP-LMH	V
Faye Wang, DNP, RN, NEA-BC	Senior Director of Nursing Practice, NYPH	V
Francine Fakih, MA, RN	Director of Nursing, GSH	V
Geeta Nastasi, MS, RN	Chief Nursing Informatics Officer, NYP	V
German Rodriguez, MSN, RN	Director of Nursing, Oncology Services, NYP/WC	V
Grace Su, DNP, RN, NEA-BC, ANP	Corp Director of Nursing Finance, NYP	V
Janet Ferguson, MSN, RN, PMHCNS- BC	Director, Nursing and Quality, NYP-WBHC and NYP/WC PWM	V
Janice Burns, MSN, RN, CIC	Director of Infection Control and Nursing Quality, NYP-Q	V
Joan Halpern, MS, RNC, NNP	Vice President & Chief Nursing Officer, NYP-LMH	V
Joanna Villamayor, MA, RN, NEA-BC, CCRN	Director of Nursing, NYP-Q	V
Joanne Connor, PhD, MSN, MPA, RN, NEA-BC, CPHQ	Corporate Director, Perioperative Services, NYP/WC, NYP-LMH, NYP-BMH, NYP-Q	V
Kelly Duvall, MPH, RN, CCRN-K, CLNC	Director of Nursing Quality, Periop Services, NYP	V
Kristina Salabay, MSN, RN, NEA-BC	Director of Nursing, NYP-MSCH	V
Kristyn Baccaglini, MPA	Manager of Operations, Corporate Nursing, NYP	V
Larissa Elgin, MSN, CCRN, NE-BC	Director of Nursing, NYP-BMH	V
Laurie Walsh, DNP, RN	Vice President, Patient Care Services, NYP-W	V
Leon George, RN, MBA, CNEA	Director of Nursing, NYP-HVH	V
Leonid Lenderman, MPA, BSN, RN, CNOR, NEA-BC	Director of Nursing, Perioperative Services, NYP/WC	V

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Linda Gibbons, MS, RN	Director of Nursing, Women's, NYP/WC	V
Lorelle Wuerz, PhD, RN, VA-BC, NEA-BC	Director of Nursing Practice & Quality, NYP-BMH	V
Lori M. Perlstein, DNP, RN-BC, NEA-BC	Director, Nursing Professional Practice and Continuing Education, NYPH	V
Lynsey Lipowicz, BSN, MBA	Director of Nursing, NYP-CUIMC	V
Lystra Swift, MA, RN, CNOR	Corporate Director, Perioperative Services, NYP/CUIMC, NYP-MSCH, NYP-AH, NYP-HVH	V
Margaret Cartmell, MSN, RN, CEN	Clinical Nursing Director Ambulatory Care, NYP-Q	V
MariLou Prado-Inzerillo, DNP, RN, NEA-BC	Vice President, Nursing Operations, NYP	V
Mark Krugman, MPA, BSN, RN	Director of Nursing, Ambulatory Care Network, NYP/WC ACN	V
Mary E. Quinn, DNP, RN	Director, Nursing Patient Safety & Improvement Initiatives, NYP	V
Mary Gallagher, DNP, RN-BC	Director, Nursing Quality, NYP/WC and NYP-LM	V
Melaney Gordon, MSN, RN	Director of Nursing, NYP/WC	V
Michael Radosta, MA, MS, RN, NEA-BC	Chief Nursing Officer and VP, Behavioral Health	V
Natalya Stark, MSA, RN	Director of Nursing, Perioperative Services, NYP-BMH	V
Patricia Prufeta, DNP, RN, NEA-BC	Director of Nursing, Surgery, NYP/WC	V
Peter Stoffan, DNP, MPA, RN, CCRN, NEA-BC, CPXP	Magnet Program Director, NYP-MSCH	V
Rhoda Redulla, DNP, RN, NPD-BC, FAAN	Director of Nursing Excellence - Magnet Recognition, NYP	V
Seema Kurian, MSN, RN	Clinical Nursing Director, NYP-Q	V
Sheryl Gatz-Jacolbe, MS, RN	Director of Nursing, NYP-Q	V
Shirley Beauvais, PhD, RN	Corporate Director, Central Sterile & Endoscopy Reprocessing, NYP	V

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Suzanne Pugh, MSN, RN, CEN	Director of Nursing, NYP-Q	V
Tammy Compagnone, DNP, MSN, RN, CPEN	Director of Nursing, NYP-MSCH	V
Theresa Fay Conte, MSN, RN, NE-BC	Director of Nursing, NYP-MSCH	V
Timothy McGarvey, MSN, LMSW, RN	Executive Director and CNO, GSH	V
Uvannie Enriquez, MPA, BSN, RN, NEA-BC	Magnet Program Director, NYP/CUIMC	V
Vepuka E. Kauari, MSN, RN, CEN	Director of Nursing, NYP-MSCH & Sloane	V
Wilhelmina Manzano, MA, RN, NEA-BC, FAAN	Group SVP, Chief Nursing Executive & COO, Peri Op Services, NYP	V
<b>Guests</b>		
Tedman Lau	Administrative Team Lead	V
Vanessa Petgrave	Patient Care Director, NYP-Q	V

# CAUTI 2023 QPS HAI GOAL UPDATE

Executive Sponsor: Purvi Shah, Process owners: **Bernadette Khan** & Janett Pike

# What's new in 2023?

## Necessity .. Necessity .. Necessity!

- Support increased daily interdisciplinary communication and alignment around medical necessity of the urinary catheter

FOUNDATIONAL

## Acute Urinary Retention and Trial of Void (TOV) Optimization

- Diagnostic Stewardship for TOV built in EPIC
- Implemented 3/21/23

NEW!

## Auto-discontinue Order

- Decrease device utilization through auto-discontinue order
- Implemented for ALL eligible patients 4/5/23

NEW

## Enhanced KEEPSAFE & Mini RCA process

- Sharing Lessons learned at all levels (unit, hospital, enterprise)

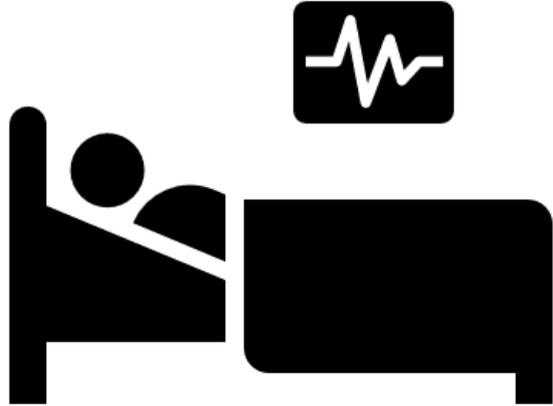
NEW!

## Implement Clean Slate at 48!

- Remove IUCs that have been in place for at least 48h PRIOR to collecting culture specimens
- Implemented 7/10/23

NEW!

# A Case Study....



88 year- old female with heart failure, chief complaint shortness of breath

- Admitted to step-down unit for IV meds and bipap

IUC ordered with indication 'critically ill/hourly I&O'

- Urine output measured every two hours

Day 2 –breathing improved, downgraded to nasal canula, IV meds changed to PO

- Transferred out of SDU to inpatient medicine floor on Day 3

Day 4 -IUC order auto-discontinued but reordered by provider

- Indication still noted to be critically ill/hourly I&O
- Output now measured Q shift

Day 5-IUC removed but replaced after 6 hours and bladder scan of 300cc

- Patient complains of abdominal discomfort/pressure the next day

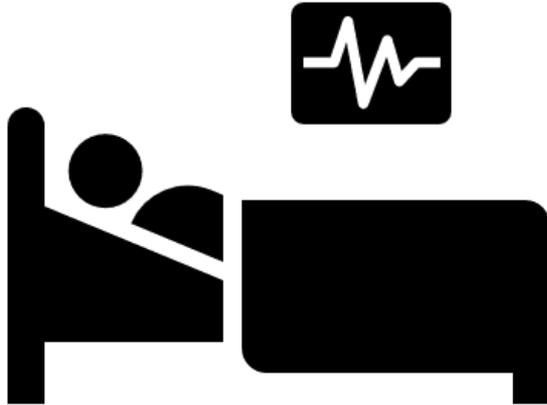
Day 7-Urine culture ordered; reflex test bypassed; specimen obtained from drainage bag

- Positive culture with >100,000 e. coli

Day 8-IUC discontinued

- IUC discontinued after specimen collected, patient discomfort resolved, voided spontaneously, discharged the following day on antibiotics for a CAUTI

# Opportunities to Improve .....



## Approved indication

- Hourly I&O is not an approved indication

## Use of an alternative device

- Female external device allows for measurement of output

## Necessity, necessity, necessity!

- Daily conversations on continued need is a must
- Allow the auto-d/c order to do the work for you

## Use of 'trial of void' (TOV)

- TOV algorithm addresses root causes of failure to void

## Aseptic collection for specimen collection

- from the port of the tubing
- straight cath
- clean catch

## Remove the IUC PRIOR to obtaining the urine culture

- Prevent false positive results

## Use the 'reflex' test order when sending urine cultures

- Prevent false positive results

## What we need from you...

- **Check in with the clinical teams!**
  - **Keep the Catheters out!**
  - **Auto-discontinue** order every **48h**
  - **Remove** IUC's that have been in for **48h** BEFORE obtaining urine cultures
  - **S-T-R-E-T-C-H** the 'Trial of Void', aim for **48h**

# Clean Slate at 48!

STAY  
AMAZING

NewYork-  
Presbyterian

Questions .. ?

# B. Khan Update, October 2023

## CAUTI Data



Filter by Campus

NYP-CU

Filter by Unit

All

Better than Goal (0.69)

- yes
- no

Select Date Range

January 1, 2023 to October 31, 2023

		2023										Total
		Q1			Q2			Q3		Q4		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Total	CAUTIs	6	3	5	2	4	2	3	3	2	2	32
	CAUTI SIR	1.80	1.04	1.46	0.66	1.28	0.61	0.95	0.99	0.73	0.64	1.03
	IUC Days	2,266	1,932	2,312	2,001	2,124	2,176	2,086	2,058	1,866	2,063	20,884
NYP-CU	CAUTIs	6	3	5	2	4	2	3	3	2	2	32
	CAUTI SIR	1.80	1.04	1.46	0.66	1.28	0.61	0.95	0.99	0.73	0.64	1.03
	IUC Days	2,266	1,932	2,312	2,001	2,124	2,176	2,086	2,058	1,866	2,063	20,884

