The Joint Commission’s new National Patient Safety Goal (NPSG) on preventing indwelling catheter-associated urinary tract infections — which emphasizes prompt removal of unnecessary devices and surveillance for CAUTIs — is effective January 1, 2012 for hospitals. Though there has been some historical tendency to dismiss these as relatively low priority infections, the Centers for Disease Control and Prevention cited a staggering annual mortality figure in a recently posted surveillance document, stating that “more than 13,000 deaths are associated with UTIs.”1,2 "The urinary tract is the most common site of healthcare-associated infection, accounting for more than 30% of infections reported by acute care hospitals,” the CDC reports. “Virtually all healthcare-associated urinary tract infections are caused by instrumentation of the urinary tract. CAUTI can lead to such complications as cystitis, pyelonephritis, gram-negative bacteremia, prostatitis, epididymitis, and orchitis in males and, less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI cause discomfort to the patient, prolonged hospital stay, and increased cost and mortality.” Indeed catheter use in and of itself is associated with negative outcomes other than infection, including nonbacterial urethral inflammation, urethral strictures and mechanical trauma, the Joint Commission notes. “The length of time that a catheter is in place contributes to infection, so limiting catheter use and duration are important to preventing infection,” the Joint Commission recently stressed.3 More than a quarter of the patients with an indwelling urinary catheter for two to 10 days will develop bacteriuria, and a quarter of these will develop a CAUTI. Approximately 450,000 CAUTIs occur annually in hospitals, the Joint Commission reported, citing estimates of the excess cost per case of $1,200 to more than $2,700 and a total annual cost of some $400 million.4-8 Moreover, the Centers for Medicare & Medicaid Services (CMS) lists CAUTIs among the healthcare associated infections targeted for non-reimbursement. “The healthcare-associated conditions that CMS will not cover are high cost or high volume or both; result in the assignment of a case to a diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence-based guidelines,” the Joint Commission states. CAUTI surveillance may be targeted to areas with a high volume of patients using indwelling catheters, the Joint Commission states. High-volume areas should be identified through the hospital’s
risk assessment as required in IC.01.03.01. In that regard, what if your risk assessment reveals CAUTIs are not an issue at your hospital? The Joint Commission recently answered that question (see Q&A, below) providing clarification that included this statement: “This new NPSG has a phase-in period during 2012, during which surveyors will be ensuring that hospitals are planning and preparing for full implementation in 2013. Starting in January 2013, a hospital that has decided, based on its risk assessment, that CAUTI surveillance is not indicated should be prepared to discuss this decision with its survey team and provide a clear rationale. Even if surveillance is not performed, the insertion and management requirements of the goal must still be implemented.”

According to the Joint Commission, NPSG.07.06.01 requires hospital infection control programs to “implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections. (Evidence-based guidelines for CAUTI include the “Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals”: The CAUTI patient safety goal is not applicable to pediatric populations. “Research resulting in evidence-based practices was conducted with adults, and there is not consensus that these practices apply to children,” the Joint Commission notes.

References
1. Centers for Disease Control and Prevention. Available at: http://ow.ly/70gUU