Review a minimum of **5** and a maximum of **10** medical records.

Focus:

For this review, review randomly selected charts of inpatients (e.g. the last 5) who had a diagnosis of a CAUTI made while an inpatient. Do not include patients who were admitted with a diagnosis of a CAUTI.

Instructions:

When reviewing the medical record, if documentation is found for the process, mark "**Yes**" in the box. If documentation is not found for the process, mark "**No**". If the process being reviewed is not applicable to the medical record, mark "**N/A**". After completing the review of all records, note the rows with the highest number of "*No*" responses. This will identify priority focus areas for improvement.

Note: Do not spend more than 20-30 minutes per medical record.

SUBMIT YOUR DISCOVERY TOOL FINDINGS WHEN COMPLETE: Take a 2 minute survey to report your findings. By submitting your findings, you will have taken the time to identify process gaps in which to focus improvement and to guide educational activities.

CLICK HERE TO SUBMIT YOUR FINDINGS

Chart Identifier	Pt A	Pt B	Pt C	Pt D	Pt E	Pt F	Pt G	Pt H	Pt I	Pt J
(INSERTION) The patient had:										
An order to insert a urinary catheter										
A hospital-defined clinical indication for a urinary catheter										
Urinary catheter inserted using sterile technique. Perineal wash and meatal cleansing performed prior to insertion										
A two-person insertion (e.g., two nurses)										
Alternatives to urinary catheter (e.g., external catheter) considered and documented										
(SIGNS/SYMPTOMS) The patient had:										
At least one of the following: new onset or worsening of fever, rigors, altered mental status, malaise or lethargy with no other identified cause; flank pain, costovertebral angle tenderness; acute hematuria; pelvic discomfort										
A urinalysis that demonstrated at least one abnormality (e.g., + Nitrite, + Leukocyte esterase (LE), ≥ 5 WBC/hpf)										
(DOCUMENTATION) The patient had:										
Assessment and documentation for the clinical necessity for continued use of urinary catheter per hospital policy										
Documentation of catheter care (e.g., closed system maintenance with seal intact, bag and tubing off the floor, no dependent loops, drainage bag secured) per hospital policy										

Peri-care done and routinely documented (e.g., per hospital policy after fecal incontinence)										
There is evidence that patient and/or family was educated about the risks associated with urinary catheters that are no longer clinically indicated										
(TREATMENT) This patient was:										
Given antibiotics for a CAUTI AND also had clinical signs/symptoms of a UTI (see above)										
(OTHER) - Please specify:										
What department was the patient in when the catheter was inserted? (Enter name of department for trending purposes) This element is not scored.										

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