NURSING SHARED GOVERNANCE HELPS ELIMINATE "SACRED COW" USING AN EVIDENCE BASED RAPID CYCLE IMPROVEMENT PROCESS

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Background Information: Home instructions for clients who require an indwelling urinary catheter after a urologic surgical procedure have not changed significantly since the 1990's despite the focus on Evidence Based Decision Making in healthcare. The practice of daily rinsing of the urinary drainage bag with a vinegar or bleach solution has been largely unquestioned until recently.

An anxious and overwhelmed patient with an interpreter, who required an unexpected temporary indwelling catheterization during a urologic procedure, inspired the writer to question the therapeutic value of including a complex series of discharge instructions on rinsing the drainage bag at home.

This led to a PICOT question related to discharge education for similar surgical patients:

P: For patients who require an indwelling urinary catheter for a temporary duration at home
I: is including instructions on rinsing the drainage bag with an additive solution
C: vs. omission of this content
O: more effective for patient comfort and safety
T: prior to discharge?

Objectives of Project: The shared governance committee intended to eliminate a complicated practice based in tradition vs. evidence, a "Sacred Cow", from their hospital's Discharge Instructions for Indwelling Urinary Catheter management.

Process of Implementation: A literature review of evidence was compiled in the hospital's perioperative nursing shared governance meeting. A similar review (Hus et al, 2012) found little evidence to support the use of additives to reduce CAUTI or odor. The CDC and The Joint Commission did not support the practice in their CAUTI guidelines, citing weak evidence.

Utilizing EBDM, the team decided to eliminate rinses from their discharge instructions, to simplify teaching content. With Urology Department support, a custom instruction was drafted.

Early analysis of the draft revealed several limitations, and the team revisited the PDSA cycle to attempt to update the standardized discharge instructions with their Computerized Patient Information provider.

Statement of Successful Practice: After emailing the team's evidence and observations, the editorial board chose to eliminate the additive instructions from standardized Discharge Instructions, affecting over 1000 healthcare providers worldwide.

Implications for Advancing the Practice of Perianesthesia Nursing: Opportunities for future study include the impact on Patient Satisfaction and Engagement; and evaluation of the closed "Link System" the standard of care in the UK, only utilized by 2% of US patients.