CAUTIs INVESTIGATION WORKSHEET

ADULT ACUTE CARE SETTINGS

Use this worksheet to identify the modifiable risk factors that contribute to the acquisition of a CAUTI.
This investigation should be led by the local infection and prevention control unit and may require support from other services (medical records, pharmacy, pathology, continence). Findings from the investigation should be reported back to the unit and treating team involved.

Patient Name:	Patient MRN:	IIMs Incident#:	Treating medical officer:	CAUTI: Catheter associated urinary tract infection CHG: Chlorhexidine gluconate IDC: Indwelling urinary catheter SPC: Suprapubic catheter

SECTION A: TIMELINE (complete for all catheters)

	Most recent discharge	Admission to unit	First catheter insertion	UTI symptoms first documented	Collection of first positive urine culture	CAUTIs episode confirmed	Final catheter removal
Date							
Hospital Unit							

SECTION B: BEFORE INSERTION OF THE INITIAL CATHETER (complete for all catheters)

1. Were UTI signs and symptoms observed prior to catheter insertion?	NO YES, describe:
2. Was there any recent history of any other colonisation or infection?	NO YES, where and what organism:
3. Was there a UTI, asymptomatic bacteriuria or any history of CAUTI?	NO YES, describe:
4. Did the patient have any wounds, ulcers or burns?	NO YES, where:
5. Did the patient have any invasive devices in place?	NO YES, describe:
6. Has the patient had any surgery in the past 30 days?	NO YES, where:
7. Was the patient on any antibiotic therapy prior to insertion of IDC?	NO YES ☐ *Tick if antimicrobial therapy was not appropriate*
8. Was the patient immunosuppressed?	NO YES, describe:

SECTION C: CATHETER INSERTION (complete for intermittent, IDC, SPC)

1. In which unit was the catheter inserted?	ED Perioperative/OR Maternity Other:
2. Who inserted the catheter?	Medical officer Nurse/Midwife Unknown
3. What was the indication for initial catheter insertion?	Indication: ☐ *Tick if indication was not appropriate*
4. Which catheter type was used?	In/Out IDC SPC External sheath ☐ *Tick if catheter option was not appropriate*
5. Was a bladder scan done to confirm retention?	NO YES Not documented N/A
6. What was the size of the catheter that was used (Fr)?	Size: ☐ *Tick if size was not appropriate*
7. What material was the catheter made of?	Silicone Latex Silicone/latex mix Unknown Other: ☐ *Tick if material was not appropriate*
8. What was used to clean the insertion site?	Sterile saline Aqueous CHG Not cleaned Unknown Other: ☐ *Tick if cleaning solution was not appropriate*
9. Was any trauma/abnormalities observed or documented during insertion*?	NO YES, describe:
10. Was catheter secured to the patient?	NO YES Not documented N/A
11. Was any antibiotic prophylaxis for catheter insertion given to the patient:	NO YES ☐ *Tick if prophylaxis was not clinically indicated*

*Trauma/abnormalities includes multiple catheter insertion attempts.

SECTION D: POST INSERTION (complete for all catheters)

1. Was a standing order for catheterisation documented?	NO YES
2. Were any abnormalities with the catheter or drainage device documented?	NO YES, describe:
3. Was faecal soiling or faecal incontinence documented?	NO YES
4. Has the patient or visitor manipulated the insertion site?	NO YES Unsure
5. Were any perineal or inguinal wounds observed?	NO YES, describe:
6. Were any other infections observed while the catheter was *in situ*?	NO YES, describe:
7. Was the catheter changed after it was initially inserted?	NO YES, provide dates of catheter change(s):
8. How long was the total period of catheterisation (hrs)?	Duration: ☐ *Tick if duration was not clinically appropriate*

SECTION E: CATHETER REMOVAL (complete for IDC and SPC)

1. Was a catheter removal order documented:	NO YES
2. Has the catheter been removed:	NO YES
3.Were any abnormalities observed during removal:	NO YES, describe: Not documented

PROCEED TO SECTION F

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SECTION F: FINDINGS (complete for all catheters)	
1. The modifiable risk factors that contributed to this CAUTI event were♦:	
2. What measures should the unit implement to avoid a future CAUTIs event associated with the identified risk factor(s):	
3. Have the findings been reported back to the unit:	○NO ○YES
4. Have the findings been reported back to the treating team:	○NO ○YES

♦ In this context, **modifiable risk factors** are risk factors that can be eliminated or minimised by the clinicians or treating team and are independent of the individual patient. Modifiable risk factors are different to patient risk factors, which are those that are directly related to the individual patient (e.g. co-morbidities).

Investigator's name:

Investigator's signature: Date:

CLINICAL EXCELLENCE COMMISSION