BARRIERS	POSSIBLE SOLUTIONS
ENGAGEMENT	
Some nurses may not to be on board with indwelling urinary catheter removal *[See section on Nurse Engagement: http://catheterout.org/?q=nurse-engagement]*	• Get buy in before implementation. For example, ask, "who do we have to convince on this floor?" Have that person help to develop the plan or participate in the education for that unit. • Listen to nurses' concerns and address them to nurses' satisfaction.
Lack of or problems with nurse champions *[See section on Nurse Engagement: http://catheterout.org/?q=nurse-engagement]* • Nurse managers tell your team that they are "too busy" to implement the new practice. • Individuals identified as champions do not go out on the unit and do not have direct contact with inpatients.	• Identify the types of champions that work in your organization. Not a one-size-fits-all strategy. For example: o Use nurse educators as champions. o Have more than one nurse champion, e.g., co-champions, all nurse managers and educators. o An LPN can be the champion if s/he is someone who others on the unit respect and go to for advice. • Recognize nurse champions via such mechanisms as certificates of recognition, annual evaluation appraisals, newsletters, notifying CNO.
Lack of physician buy-in to new practice or physician's are resistant to change in general *[See section on Physician Engagement: http://catheterout.org/?q=physician-engagement%20]* • Do not see indwelling urinary catheters as a risk. • "Way down on their priority list." • Can't get physicians to buy in to the new practice bundle because they do not want "to make waves".	• Provide data about urinary catheter use, feedback to physicians about monthly indwelling urinary catheter prevalence & CAUTI rates. • Provide one-on-one education (evidence-based and patient safety oriented). • Engage medical leadership support, e.g., chief of staff. • Involve physicians as much as possible in planning, education, and implementation; include physicians on your team. • Identify a physician champion who will: o Meet with other physicians to get them on board. o Back up nurses when there's a disagreement. o Conduct CME. Present evidence, e.g., highlight how often physicians have a patient with a indwelling urinary catheter and forget.
Lack of physician champion	• In some institutions, physicians may tend to go along with nurse recommendations so they rely heavily on nurse champions. The new practice could be seen as a "nursing initiative." • Also see Lack of physician buy-in above.
Leadership does not see CAUTI as a priority *[See section on Leadership & Policy Implications:*	• Prepare and present a business case to help convince leadership the time and cost factors for implementing the new practice would be worth it. Present a good business case.

BARRIERS	POSSIBLE SOLUTIONS
http://catheterout.org/?q=leadership-and-policy]	• Remind leadership about CMS non-payment rule. • Be sure leadership gets monthly CAUTI/catheter use data.
Large size hospital makes unit-to-unit roll-out difficult	• Create unit-based teams with stakeholders from different units/depts.
General guidance	• Get people on the team who feel CAUTI is worth working on. • Highlight staff who have adopted the new practice. • Know the system and how to get practice changes through relevant committees.
EDUCATION	
Gaps in knowledge of infectious and non-infectious consequences of CAUTI for patients *[See Sections on Infectious Complications: http://catheterout.org/?q=infectious-complications-general-background, and Noninfectious Complications: http://catheterout.org/?q=Non-infectious-complications-general-background%20]* • UTI not seen to be as serious as other infections • Belief that since the patient is going to be on bed rest the catheter is indicated. • Not thinking about an indwelling urinary catheter as an invasive device or as a less risky device compared to other devices, such as central venous catheters.	• Content o See Education Materials tab in toolkit *(hyperlink)* ▪ Distribute Signs and pocket guides with insertion/DC criteria o See Tab C – Preventive Practices *(hyperlink)* o Share safety and quality literature • Options on how educate staff o Create tailored educational materials. Different materials for IPs, nurses, physicians, clinical leadership, and perhaps for each unit, depending on what motivates staff in that unit (e.g., decrease length of stay, ambulate patient, decrease UTI risk). o Nurses: ▪ Education mandated by nurses' direct supervisor. ▪ Educate on the floor, in grand rounds, other venues. o If it's difficult to educate all staff, as in a large hospital, create computerized education modules.
Not knowing what to do to prevent CAUTI	HICPAC guidelines. *[See Section on General Prevention Practices: http://catheterout.org/?q=general-prevention-practices, and HICPAC guidelines: http://www.cdc.gov/hicpac/cauti/001_cauti.html]*
Nurses schedules are inflexible, so difficult to do education • Overtime not allowed. • No "dedicated" time away from patient care.	• Rather than having the nurses attend education sessions, bring the education to the bedside. E.g., doing competencies on the unit; talking with nurses one-to-one during the point prevalence assessments. • Incorporate education on CAUTI into annual competency testing (e.g., at

BARRIERS	POSSIBLE SOLUTIONS
	the same time that CPR is renewed).
EXECUTE: ELIMINATE UNNECESSARY USE OF INDWELLING URINARY CATHETERS	
Non-indicated indwelling urinary catheters inserted in the ED • Indwelling urinary catheter is inserted with no order written. When patient gets to the floor, nurses and physicians don't know the indwelling urinary catheter is there. • ED nurses think they are doing the floor nurses a favor by inserting the indwelling urinary catheter and assume that the patient might need it. • ED nurses using catheter for specimen collection and then leaving it in place. • Alternative practices (e.g., closed straight catheter system) eliminated due to cost.	• Involve ED medical and nursing directors as champions or supporters of practice change. • Work with ED to put a process in place that assures that an order was written and appropriate indications for use are followed. • Education about indications for insertion for the ED nurses and physicians. *[See section on Indications for indwelling urinary catheter use: http://catheterout.org/?q=Indications-for-indwelling-urinary-catheter-use]* • Re-implement alternative practice (e.g., closed straight catheter system). *[See section on Avoiding the Indwelling Urinary Catheter: http://catheterout.org/?q=avoiding-the-indwelling-urinary-catheter]*
No catheter policy in place	• Develop a policy on catheter insertion indications
Patient request *[See section on Patient & FamilyEducation Materials: http://catheterout.org/?q=patient-family-ed]* Clinicians give in to patient or family requests for indwelling urinary catheter, or believe that the patient wants the catheter in.	• Discuss risks of indwelling urinary catheters with patients and families. *[See section on Patient & Family Education Materials: http://catheterout.org/?q=patient-family-ed]* • Review documentation of the rationale for placement if indications are not met and reinforce use of appropriate indications.
Lack of physician buy-in once the new practice is initiated. See Lack of Physician Buy-in, above	
EXECUTE: ENSURE PROPER INSERTION TECHNIQUE	
Non-Aseptic Insertion Technique *[See section on Aseptic Insertion: http://catheterout.org/?q=aseptic-insertion]* • By nurses, aides, nursing care assistants.	• Develop competencies for those who insert catheters. • Restrict catheter insertion practice to RNs. • Develop a policy on catheter insertion techniques if none is in place.
EXECUTE: TIMELY DISCONTINUATION OF INDWELLING URINARY CATHETERS [*See section on Early Removal of Unnecessary Indwelling Urinary Catheters: http://catheterout.org/?q=early-removal]*	
Nursing workload • Nurses are concerned that they will have to spend more time cleaning up patients if the indwelling urinary	• Monitor o Catheter patrol: daytime charge nurses monitor which patients have indwelling urinary catheters, assisting with toileting, and assess

BARRIERS	POSSIBLE SOLUTIONS
catheter is removed. • General feeling of being overworked ("just trying to get through my shift"). • What you might see: o Nurses tell the physician or other nurses, "I do not want this catheter out" or that the physician doesn't want the catheter out (e.g., 'the physician needs I's and O's'). o Especially problematic on weekends—no one is monitoring catheter removal.	indications. If not indicated, talk with bedside nurse or ask physicians to DC. *[See section on Data Collection & Evaluation: http://catheterout.org/?q=data-collection]* o Daily assessment tool: bedside nurse assesses indications for continued use and if not indicated, nurses discuss removal with physician. • Feedback: o Data board in nurse units w/ monthly indwelling urinary catheter prevalence and CAUTI rates. • Education Workload reduction Nurse aides delegated to prioritize toileting activities over other activities (e.g. stocking supplies or cleaning equipment).
Shift schedules hamper communication among nurses 3 day, 12 hour shifts and block schedules can make it difficult to share information across shifts and departments.	• Identify a nurse champion on each shift.
No catheter policy on discontinuation in place	• Develop a policy on discontinuation.
Patient or family request *[See section on Patient & Family Education Materials: http://catheterout.org/?q=patient-family-ed]* • Nurses and/or physicians believe their patients want the catheter in. Some patients do (e.g., because they are incontinent or don't want to get out of bed), and will convince their nurses and physicians to keep it in even if it's not indicated.	• Discuss risks of indwelling urinary catheters with patients and families *[See section on Patient & Family Education Materials: http://catheterout.org/?q=patient-family-ed]* • Review documentation of the rationale for use and reinforce use of appropriate indications.
Patient Safety: Balancing risk of falls. • A fall is a "never event"	• Institute fall prevention strategies, for example: o Instruct the patient to request assistance. o Provide patient with non-skid footwear. o Ensure that path to restroom is free of obstacles. o Evaluate chair and bed height. o Ensure that assistive devices (if being used) are within patient reach o Engage patient and family in efforts to provide assistance as needed. o Other strategies as determined by nursing care plan and institutional policy.

BARRIERS	POSSIBLE SOLUTIONS
	• Incorporate urinary management (e.g., planned toileting) as part of broader fall prevention program.
Nurses are not confident speaking with physicians about removal.	• Find a physician champion to support nurse requests for removal. *[See section on Physician Engagement: http://catheterout.org/?q=physician-engagement%20]* • Nurse manager prompts nurses to speak with physicians. • Education on communication.
Physician resistance to nurses discontinuing indwelling urinary catheters using an automatic stop order	• Nurses prompt physicians for DC order as an initial strategy to build rapport. *[See section on Nurse-Initiated Removal: http://catheterout.org/?q=nurse-initiated-removal]* • Identify a physician champion who can act as an advocate.
Lack of physician Buy-in *[See section on Physician Engagement: http://catheterout.org/?q=physician-engagement%20]* See Lack of MD Buy-in, above	
Resistance to Early indwelling urinary catheter Removal -- Surgeons and Urologists	• Physician champion presents at med staff meeting about indwelling urinary catheter indications and non-indications. *[See section on Indiciations for Indwelling Urinary Catheter Use: http://catheterout.org/?q=Indications-for-indwelling-urinary-catheter-use] and Strategies for Physician Engagement: http://catheterout.org/drupal/Bladder%20Bundle/sites/webservices.itcs.umich.edu.drupal.Bladder%20Bundle/files/Section%20M%20Strategies%20for%20Physician%20Engagement_1.pdf]* • Work with the physician assistants to DC indwelling urinary catheters on day 2 after surgery. • Participate in SCIP initiative. • Engage a surgeon and/or urologist as a physician champion and work with them to establish conditions under which the catheter can be retained. Also see Lack of Physician Buy-in, above
Indwelling urinary catheters left in as when patient is transferred within the hospital (e.g., catheter placed in surgery, patient goes up to ICU, then to floor]	• Establish process to ensure that all lines and devices are reviewed and removed (if appropriate) prior to transfer. • Consider changes to transfer forms to include information about catheter presence, date of insertion, indication.