The Process of Embedding CAUTI Care Bundles in NHS Scotland

Debbie Waddell (PhD Student), Professor. Kay Currie, Professor. Jo Booth, Professor Jacqui Reilly

Institute of Applied Health Research, School of Health and Life Sciences, Glasgow Caledonian University

Introduction

- Catheter-associated urinary tract infection (CAUTI) are the most prevalent healthcare-associated infection globally and are one of the most common infections currently experienced in hospitals (Tambyah et al., 2012).
- The Scottish Patient Safety Programme (SPSP) developed a CAUTI care bundle in 2008, to tackle the problem of CAUTI and assist with infection reduction in Scotland.
- CAUTI remain one of the most problematic and costly yet preventable infections in healthcare.
- In 2013 SPSP acute adult safety programme revised its aims and CAUTI is now considered a patient harm.
- Each NHS Board in Scotland has introduced or is planning to introduce a programme of work to identify and reduce CAUTI rates.

Aim

The overall aim of the study was to apply a theoretical framework, Normalisation Process Theory (NPT) (May et al, 2009), to explore and explain those factors which lead to successful implementation and embedding of CAUTI care bundles in the acute care setting of NHS Scotland.

Methods

- A Systematic review of factors that influence the implementation of CAUTI care bundles in healthcare practice was undertaken.
- Using qualitative methodology, semi-structured interviews were conducted with 26 clinical leaders responsible for implementation, from 15 NHS Boards using NPT as a guiding framework.
- Framework analysis methods were applied to explore how clinical leaders make sense of the work of implementing the CAUTI care bundle (coherence); how they engage with it (cognitive participation); enact it (collective action); and appraise its effects (reflexive monitoring).

Results

Following analysis of the twenty-six clinical leaders there were five themes that were evident as facilitators for the successful implementation of the CAUTI care bundles (stakeholder engagement, early adopters, staff ‘buy-in’, education and collaborative working). Conversely, there were also barriers identified as posing challenges to the implementation of the CAUTI care bundle in everyday practice (definition of CAUTI, workload pressures, staff being ‘bundled-out’ and identifying the best outcome measure for CAUTI). However, education was highlighted throughout the interviews as being pivotal in meeting how effective the bundles were in practice. The higher the level of staff awareness and education around delivery of CAUTI care bundle the more receptive nursing staff were to their implementation, supporting the sustainability of the CAUTI care bundle in practice.

Conclusion

Either one of the NPT constructs (Figure 1) could be pivotal in determining the success of CAUTI care bundle implementation. If the CAUTI care bundle is perceived as adding more work for people then they may be less receptive to the new practice. Similarly, if people cannot trust nor have confidence in the new practice then this may result in people being less willing to participate in the implementation of the CAUTI care bundle. Organisational support is key for the success of implementation programmes, such as CAUTI care bundles, as it requires additional training, funding and ongoing support to sustain the implementation programme. For the programme to be successfully implemented and embedded, full and sustained support in all forms will be essential. Where good practice does exist it is crucial that this be shared at all levels.

References
