*The ED Hospital Observation Report will be an* ***optional*** *tool that state leads can use when they visit EDs and/or their ED-inpatient pairs. State Leads can share a copy with the National Project Team if they wish. This tool may assist State Leads to understand the culture and processes specific to the ED participating in the CAUTI ED intervention project.*

Date:

1. Hospital Name:
2. Hospital Address:
   1. Street:
   2. City:
   3. State:
   4. Zip Code:
3. Do you have a team for CAUTI ED intervention activities?

* Yes
* No

1. Title and roles of team members:

1. Describe the decision making process for inserting catheters.
2. Describe the nurse-physician relationship in your ED.
3. Describe the process of hand-offs and transitions from the ED to inpatient units.
4. Describe the process of communication for catheter activities. (Why Foley was removed or left behind?)
5. Does your team use any alternative patient supplies and equipment other than catheters?

* Yes
* No

If yes, please describe the alternatives and rationale for the use.

1. What is your feedback loop process? How do care providers in ED and inpatient units communicate regarding CAUTI prevention activities?
2. How do you determine the effectiveness of your communication processes regarding the message of CAUTI reduction?

* Reduced CAUTI rates
* Reduced catheter utilization
* Increased compliance with written orders
* Increased compliance with documented appropriate use of catheters
* Return demonstration by staff for aseptic technique

1. Does your team utilize nurse educators for any training activities?

* Yes
* No

1. How often does Root Cause Analysis (RCA) occur when a CAUTI occurs?

* Never
* Rarely
* Sometimes
* Often
* Always

Who is responsible for the RCA process? (If applicable)

How is the learning from RCA meeting shared with other staff members? (If applicable)

1. Is there a process to address uncovered infections that are a result of an ED insertion?

* Yes
* No