Step 3: Train your team & Implement Toolkit

		Current Practice	**Activities Tracking:** Examples (not all-inclusive): Dates, meetings, materials developed, communications with multidisciplinary team members, any teaching done with staff/patients, meeting notes (or attach separately)	**Implementation Steps** **Barriers to Implementation**	**Revised/Final Practice -** specific ordersets examples, patient education, where element is implemented, how utilized **(Goal 3 - Care pathway)**
Training	**The Toolkit Slide Set** helps hospital teams get started using the SUCCESS toolkit components which are listed below.		**1/25:** SC/SCQR attended Surgery Quality meeting and shared the value proposition slides **1/30: kickoff meeting:** met with the multidisciplinary team to review slide set of tools to be implemented and QI project goals. Completed the GPS. Discussed initial plan to roll out to each inpatient unit, PACU and OR. **2/27: team meeting:** added periop services manager to the team who will roll out to PACU and OR	**1/30:** reviewed baseline data- most Retention is inpatient and bladder scanner not used consistently. Per unit manager - Bladder scanner not readily available on all units, all nurses not using them accurately OR/PACU has 1 bladder scanner and sometimes stuffed in storage closet **6/1:** still waiting on bladder scanners to arrive on all units	PACU/OR /inpatient training- SUCCESS toolkit (including all components and bladder scan/ catheterization, videos) added to training of new employees and with bi-annual inservice
Implement Catheter injury prevention **GOAL 2**	*Strategies for safe catheter insertion: safe Insertion booklet, difficult insertion training videos, difficult catheter insertion kit, catheter alternatives* *1. Identification and Flagging of Patients Difficult to Catheterize* *2. Difficult Catheter Insertion Tip Sheet* *3. Catheter Insertion Refresher Training Videos* *4. Coude Tip Catheter Insertion Training*	none of these tools are in place	4/18: reviewed prelim Q1 data with Surgical Quality Committee. 0 cases met criteria for trauma April-June:difficult catheter card given to 2 patients 7/18: reviewed prelim Q2 data with Surgical Quality Committee. 1 case had trauma in OR, patient had known BPH and was not recognized.	all nurses not trained to place coude, some nurses not comfortable. Pre-cath assessment of risk factors not done consistently	PACU/OR - these materials are available in a training binder and on the SUCCESS webpage, QR code posted in each OR at circulator desk and PACU desk. staff will communicate risk factors for trauma in report. inpatient - these materials are available in the unit training binder and on the SUCCESS webpage, QR code posted at each charge nurse station. Patient difficult insertion card are available at same location and will be given to patient at discharge, and also noted in EMR. volunteer nurses were trained on each unit to insert coude. 1 traveling SUCCESS kit is available on 2 of 3 postop units. staff will communicate risk factors for trauma in shift report.
Implement Urinary retention management protocols **GOAL 2**	Algorithm for standardized management of postoperative urinary retention 1. Inpatient 2. Ambulatory Surgery Center	we have a nurse driven foley protocol but it doesn't include monitoring/assessing/managing retention	4/18 - reviewed prelim Q1 data with Surgical Quality Committee. 2 of 100 cases had retention which was not managed appropriately. 2 cases were managed appropriately. April-June- rounded on inpatient units and PACU to talk to unit nurses about checking for signs of retention and the use of the algorithm. Reinforced the availability and use of algorithm	April-June - no resistance noted, surgeons and nurses are happy to have the tools available	OR - staff will pass off last void/catheter/output in OR details to PACU/ICU, along will conditions making patient at risk for retention PACU - these materials are available in a training binder and on the SUCCESS webpage, QR code posted in each OR at circulator desk and PACU desk. staff will pass off last void/catheter/output in OR details to inpatient/ICU, along will conditions making patient at risk for retention. If patient going home they will be informed of due to void. inpatient - these materials are available in the unit training binder and on the SUCCESS webpage, QR code posted at each charge nurse station
Michigan Appropriate Perioperative (MAP) criteria **GOAL 2**	MAP App, laminated cards, and/or MAP poster	this information is 'general knowledge' in OR. There no written policy and surgeons all have different practices for when they want a catheter placed/removed. Basically when the case is expected to take >2 hours OR nurses place a catheter	4/18- reviewed prelim Q1 data with Surgical Quality Committee. 5 cases had inappropriate catheter use, and 2 were not removed in the recommended time. Shared findings with unit managers.	Feb-April some surgeons refuse to follow the MAP guidance in OR for elective hernia repairs-they don't remove foley at end of case if placed. June - surgeon less resistant to remove foley end of case seeing that retention rate is not increasing	PACU/OR - these materials are available in a training binder and on the SUCCESS webpage, QR code posted in each OR at circulator desk and PACU desk. Laminated MAP card in OR. some surgeons downloaded the app. A policy was written and all surgeons follow the same MAP guidance now. inpatient - these materials are available in the unit training binder and on the SUCCESS webpage, QR code posted at each charge nurse station. nursing report includes catheter status and when it is due to be removed.