Beebe Healthcare

Infection Control Manual

Indwelling Urinary Catheters: Insertion, Maintenance, Discontinuation	Date Issued: 1/78
Issued By: Infection Prevention, Patient Care Services Approved By: Steve Rhone, Patient Care Services	Revised: 2/80, 1/82, 10/85, 5/89, 2/99, 10/07, 11/09, 9/18
[X] Conditions of Participation 42 CFR 482.24(c)(2)(vi) 42 CFR 482.23(b)(5) 42 CFR 482.42(a) [X] Joint Commission Standard NPSG.07.06.01	Reviewed: 6/13, 8/16

PURPOSE

- To outline recommended practices for the insertion, care and maintenance of indwelling urinary catheters, along with the care of patients with these devices.
- To delineate responsibilities in the insertion, specimen collection, care and removal of indwelling urinary catheters.

SCOPE

This policy applies to all Beebe Healthcare personnel and providers involved in ordering, placing, caring for and/or removing indwelling urinary catheters. This policy also applies to any personnel involved in the care or transport of patients who have an indwelling catheter.

POLICY

1. General

1.1 Urinary catheters should be inserted *only* when medically necessary and should be evaluated at least daily for the need to continue use. **Under no circumstances should indwelling urinary catheters be used solely for the convenience of patient care providers.**

1.2 Urinary catheters are deemed medically necessary for specific evidence-based indications. See Appendix A for a current list of these indications adapted for use at Beebe.

1.2.1. Providers are expected to assess the continued need for an indwelling urinary catheter and document daily.

1.2.2. Nursing should assess the indications for continuing the catheter upon admission, each shift, with a change in caregiver and/or with a change in the level of care.

1.3 Alternatives to Indwelling Catheters

Consider using external catheters as an alternative to indwelling catheters in cooperative patients without urinary retention or bladder outlet obstruction.

Consider alternatives to chronic indwelling catheters, such as intermittent catheterization, especially in patients with bladder emptying dysfunction. See the related policy/protocol "Adult Urinary Catheter Management and Discontinuation Protocol"

A portable ultrasound device (bladder scanner) is suggested for use to assess urine volume and help reduce unnecessary catheter insertions. See the related policy/protocol "Adult Urinary Catheter Management and Discontinuation Protocol"

1.4 Indwelling urinary catheters should be placed and/or continued only under the direction of a physician order.

2. Insertion/Application

2.1 Indwelling, straight, and suprapubic urinary catheters should be inserted using aseptic technique and sterile equipment. If a catheter is contaminated during an unsuccessful attempt at placement, discard it and obtain a new insertion kit.

2.1.1. Two (2) licensed personnel are recommended to be present for every indwelling urinary catheter insertion. The second person is responsible to assure compliance with proper aseptic technique, and to stop the procedure if any breaks in aseptic technique are observed.

2.2 Patients with an allergy to betadine: In cases where the patient has an allergy to betadine, cleansing with soap and water or the patient wipes intended for urinary catheter care. Sterile saline may also be used.

2.3 The smallest bore catheter possible should be utilized to minimize urethral trauma and irritation.

2.4 Follow the manufacturer's instructions for use regarding pretesting of the catheter balloon. In most instances, e.g., most silicone catheters, pretesting the balloon is not recommended.

2.5 Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma. A securement device is recommended for use in patients admitted to the hospital, versus a leg strap or tape.

2.6 Patients who perform self-catheterization at home should be encouraged to continue performing this procedure while in the hospital.

2.6.1. Patients performing self-catheterization should utilize clean technique.

2.6.2. Nursing personnel should evaluate the patient's performance and reinforce positive behaviors.

3. Maintenance

3.1 Standard Precautions: Use gloves when manipulating the catheter site and drainage system and practice hand hygiene before and after.

3.2 A sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems.

3.3 If there are breaks in aseptic technique, disconnection of tubing, or leakage from the bag, or if the catheter becomes contaminated, the catheter should be replaced.

3.4 An unobstructed flow of urine should be maintained. In order to achieve a free flow of urine

3.4.1. Collection bags should always be kept below the level of the bladder, including during transport, ambulation, when transferring to a procedure table, etc.

3.4.2. The catheter and collection tubing should be free of obstructions, kinking and dependent loops.

3.5 Urinary drainage bags should not be allowed to touch or lay on the floor at any time.

3.6 Urine in drainage bags should be emptied at least once each shift using a container designated for that patient only. Care must be taken to keep the outlet valve from becoming contaminated. Use gloves and practice hand hygiene before and after handling the drainage device.

3.7 Urine in drainage bags should be emptied prior to transporting/transferring the patient to another location, e.g., by stretcher or wheelchair, to prevent backflow.

3.8 Keep the catheter and the drainage system connected and the seal between the catheter and the drainage system intact, unless disruption is required for patient care (e.g., bladder irrigation).

3.9 Routine irrigation of an indwelling urinary catheter is not recommended, however, obstructions may occur that require irrigation. Refer to the Lippincott Procedure "Indwelling Urinary Catheter [Foley] Irrigation" for guidance. This is a sterile procedure.

4. Catheter Change

4.1 The interval between catheter changes should be determined by the individual patient's needs. Indications for change may include mechanical dysfunction or blockage of the urinary catheter system, and contamination of the closed system.

4.2 Indwelling catheters should not be changed at arbitrary fixed intervals.

5. Meatal Care

5.1 Meatal care should be performed as a clean procedure, and should be performed twice daily (e.g., once per 12 hour shift) using approved urinary catheter care wipes or soap and water. Care should also be performed as needed, e.g., if the area becomes soiled with fecal matter or other

contaminants. Ensure the external surface of the indwelling catheter, particularly the area at the meatal-catheter junction.

5.2 Catheter care performed on admitted patients should be documented using the Bard SureStep orange sticker system as well as in the electronic medical record.

6. Specimen Collection

6.1 The sampling port should be used for specimen collection. Cleanse the port with an appropriate disinfection solution prior to withdrawing a specimen.

6.2 Use aseptic technique to collect the specimen.

6.3 Do not collect urine specimens from the drainage bag – organisms cultured directly from the drainage bag have poor correlation with true urinary pathogens.

6.4 If a provider has ordered a specimen to be collected from a urostomy or ileal conduit, refer to the Lippincott Procedure titled "Urine Specimen Collection From a Urostomy, Ileal Conduit, or Colon Conduit."

7. Catheter Discontinuation

7.1 The catheter should be removed when the evidence-based indication(s) are no longer present.

7.2 If the Adult Urinary Catheter Discontinuation Protocol has been ordered, the nurse may remove the urinary catheter without a provider order.

7.3 In cases **where the Adult Urinary Catheter Management and Discontinuation Protocol is NOT ORDERED,** an order to discontinue the catheter must be obtained prior to removing the device.

7.4 Catheters placed by urology or other providers are typically not to be removed by the nurse, unless explicit instructions have been documented.

8. Patient and Family Education

8.1 Educate the patient and family about the necessity for the catheter

8.2 Educate the patient and family about measures they can take to minimize the risk of infection, including the importance of good hand hygiene, personal hygiene and avoiding catheter manipulation.

REFERENCES

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APPENDIX A.

PROTOCOL CATEGORY (CHORUS)	Specific Evidence-based Indication	Short Form (for EMR documentation)
C-COMFORT	Comfort at end-of-life/hospice	Comfort at end-of-life/hospice
C-COMFORT	Open perineal wound in incontinent pt	Open perineal wnd-incontinent
C-COMFORT	Open sacral wound (stage III or greater) in incontinent pt	Open sacral wnd (>stage II)-incontinent
H-HEMODYNAMIC	Strict I&O monitor in critically ill/postoperative pt not able to use alternatives	Strict I&O - critically ill/postop pt
H-HEMODYNAMIC	Hemodynamically unstable	Hemodynamically unstable
O-OBSTRUCTION	Gross hematuria/bladder irrigation	Gross hematuria/bladder irrigation
O-OBSTRUCTION	Urinary obstruction	Urinary obstruction
R-RETENTION	Acute urinary retention (confirmed w/ bladder scan) not manageable by alternatives	Acute urinary retention
U-UROLOGIC	Urologic procedure/study	Urologic procedure/study
U-UROLOGIC	Chronic indwelling (in place at time of admission)	Chronic indwelling
U-UROLOGIC	Neurogenic bladder	Neurogenic bladder
U-UROLOGIC	Placed by urologist or other physician	Placed by urologist/other physician
S-SURGERY	Monitor intraoperative urinary output/short term postop use (dc POD1)	Monitor intraop output/short term postop
S-SURGERY	Unstable orthopedic/spine pt	Unstable orthopedic/spine pt
S-SURGERY	Prolonged or strict immobilization	Prolonged or strict immobilization
S-SURGERY	Pelvic surgery (e.g., gynecol, colorectal)	Pelvic surgery (e.g., gynecol, colon)
S-SURGERY	Epidural/intrathecal catheter in place, or still in effect	Epidural/intrathecal catheter