SUBJECT: **BLADDER MANAGEMENT: INFECTION CONTROL PRACTICES**

Policy No.: C107
Effective Date: 03/1999

Purpose of Procedure: To identify methods of preventing infections in patients with indwelling, intermittent, external catheters or catheterization through a continent reservoir.

Performed By: RNs, LVNs, NAs, SNWs, Affiliating Nursing Students under RN supervision

Policy Statements

A. Provider order is required to insert, irrigate or remove indwelling catheters.
B. Need for an indwelling catheter to be assessed and documented by provider daily.
C. Routine changing indwelling catheters and drainage bags is not recommended, unless clinically indicated.
D. Routine hygiene is appropriate.
E. Bladder irrigation is a sterile procedure and only sterile irrigation sets and solutions are used.
F. Intermittent catheterization (IC) is a preferred alternative to indwelling catheters.
G. Leg bags are not recommended to be used for patients with indwelling catheters.
H. A portable ultrasound device is used to assess post-void residual, immediately (within 10 minutes) after voiding.

Procedure:

External Catheters for males

A. Change daily and prn
B. Remove external catheter.
C. Wash penis and surrounding area with soap and water. After area is dry, apply Cavilon prior to external catheter application.
D. Hold penis for 15 seconds to secure external catheter.
E. Connect external catheters to drainage bag. Use leg bag when the patient is up in a wheelchair .

External Catheter for Females (PureWick)

A. Connect canister to wall suction and set up to a minimum of 40mmHg continuous suction. Always use the minimum amount of suction.
B. Using standard suction tubing, connect the female external catheter to the collection canister.
C. Before applying the female external catheter, perform perineal care and assess skin integrity.
D. Separate legs, gluteus muscles, and labia. Palpate pubic bone as anatomical marker.
E. With soft gauze side facing the patient, align distal end at gluteal cleft. Gently tuck soft gauze side between separated gluteus and labia. Ensure that the top of the gauze is aligned with the pubic bone.
F. Slowly place legs back together.
G. To remove the external catheter, fully separate the legs, gluteus, and labia.
H. To avoid potential skin injury upon removal, gently pull the female external catheter directly outward. Ensure suction is maintained while removing.

I. Replace every 8-12 hours or if soiled with feces or blood. Assess skin for compromise and perform perineal care prior to replacement of a new female external catheter.
Key Points: To avoid potential skin injury, remove external catheter from patient prior to turning, can reapply same catheter once task is completed. Never pull or push the external catheter against the skin during placement or removal. Never insert the external catheter into the vagina, anal canal or other body cavities.

Indications for Use of Indwelling Catheters

A. Non- SCI patients (acute or chronic urinary retention)
B. SCI patients, when other bladder management measurements were not successful as inpatient.
C. Patient/family choice when patient is discharged home.
D. Temporarily assist with skin problem management (e.g. pressure injury)
E. Medical treatment measurement (e.g. strict intake and output)
F. Improvement in comfort for palliative care and dying patients.

Indwelling Catheters – Only RNs, LVNs, or Affiliating Nursing Students under the supervision of an RN

A. Insert indwelling catheter using sterile technique.
B. Properly secure catheter using securement device after insertion to prevent movement and urethral traction.
C. Maintain catheter as a sterile, closed system.
If leakage occurs, notify provider.. Investigate cause of leakage (e.g., hyperactive bladder). .
D. Use universal precautions during any catheter or drainage system manipulation.
F. Specimen collection, cleanse needleless port with alcohol pad then aspirate urine using a vacutainer and tube. Never obtain the specimen from the drainage bag.
G. Irrigation is a sterile procedure.
H. Keep collecting tubing and drainage bag below bladder level, free from blockage, or touching the floor.

Intermittent Catheterization (IC) – Only RNs, LVNs, or Affiliating Nursing Students under the supervision of an RN

A. IC is a sterile procedure as inpatient. Clean technique at home.
B. Perform IC according to patient's bladder management program e.g., IC every 4 or 6 hours. Urine volume should not exceed 500 mLs with every IC.

Catheterization of Continent Reservoir

Equipment Needed: Gloves, 2X2 gauze/dressing (or 4x4), wash cloth, urinary catheter (MD will specify size), irrigation kit (if ordered), urinal (or other similar container), tape, lubricant.

Procedural Steps:

A. Explain procedure
B. Prepare supplies
C. Wash hands and don clean gloves
D. Remove stoma dressing and discard
E. Wipe off stoma with a washcloth or towelette
KEY POINT: This is a clean procedure as pouch is made from bowel and not considered sterile.
F. Lubricate the drainage catheter with water-soluble lubricant.

G. Place the large end of the catheter into a drainage container.
H. Slowly insert catheter into stoma with gentle pressure and a slight twisting motion into the stoma until urine begins to flow. Encourage patient to relax abdominal muscles.
KEY POINT: Push the catheter gently downward (the direction of insertion may vary depending on the patient).
I. Hold the catheter in place until urine stops flowing. Gently move it around, rotate or advance catheter to make sure pouch is empty, usually takes 5-10 minutes.
J. Follow with irrigation if ordered.
K. Remove catheter slowly after completing drainage.
L. Place the absorbent dressing over the stoma and secure with tape.
KEY POINT: Slow removal allows additional urine, if present, to drain. Pinch the catheter before removing the last inch to prevent urinary dripping.
M. Measure and observe urine output
N. Notify M.D. immediately if any signs and symptoms of complication or infection are noted (e.g., lack of urine output, bloody or foul-smelling urine, or difficulty with catheter insertion).

Types of Catheters:

A. Straight Catheters- This is a traditional simple catheter for indwelling catheterization of IC
B. Coudé Catheters- is particularly useful for men with prostatic enlargement or with obstructions/ blockage in the urethra. The curved tip allows the tubing to better navigate the upwards curvature between the bulbous urethra and prostatic urethra.
C. During placement of a Coudé catheter, the tip of the catheter should be facing pointed towards the ceiling **or** patient's face, assuming the patient is supine. Never force catheter.
D. 3 way Catheter- These catheters have an extra port for the instillation of irrigation fluid
KEY POINT: Any catheter can be either latex, or silicone. Silicone to be used for patients with latex allergies or sensitivities.

Documentation
A. Date, time, and catheter size upon insertion, replacement, and discontinuation in medical record.
B. All urine output.
C. Document significant information e.g., signs/symptoms of infection, hematuria, or difficulty inserting/applying catheters.
D. All patient/family education in medical record.

Revised by: Victoria Alvarenga, MSN, RN, CNS, CRRN

References:

American Urological Association; *Bladder Drainage. Different Catheter Types.* Retrieved July 2022: www.auanet.org/education/auauniversity/for-medical-student/medical-students-curriculum/medical-student-curriculum/bladder-drainage.

Ballstaed, L.; Woodbury, B. (2022). National Library of Medicine. *Bladder Post Void Residual Volume. Retrived July 2022: www.ncbi.nlm.nih.gov/books/NBK539839/*

C.R. Bard (2018). C.R.Bard, Inc. *PureWick, female External Catheter.* Covington, GA. Becton, Dickinson and Company

Lippincott Procedures. Continent Ileostomy Car. Retrieved July 2022. https://procedure.lww.com/lnp/view.do?pld=6607933

Lippincott Advisor Indwelling Urinary Catheter Management. Retrieved July 2022.

Lippincott Procedures - Indwelling urinary catheter (Foley) care and management (lww.com)

Newman, d.; Wilson, M. National Library of medicine. Review of Intermitte Catheterization and Current Best Practices. Retrieved July 2022: https://pubmed.ncbi.nlm.nihgov/21542441/

03/99 – Revised
07/03 – Revised (formerly a portion of C300)
12/06 – Revised
01/11 – Revised
12/13 – Revised
12/16 – Revised
09/17 – Revised
05/19- Revised
03/20- Revised
07/22 - Revised (combined with C107.10)