INDWELLING BLADDER CATHETER

PURPOSE: To provide guidelines regarding the management of patients requiring indwelling bladder catheters.

SUPPORTIVE DATA: Indwelling catheters are utilized to keep the bladder empty of urine. Types include urethral and suprapubic.

A provider's order is required to catheterize a patient and to irrigate, remove, discontinue, reinsert, or change a catheter. However, once an RN has been trained and deemed competent to initiate the standardized procedure for discontinuation or deferral of placement of an indwelling catheter, the RN may discontinue it without a provider's order.

It is recommended that indwelling bladder catheters not be routinely changed (e.g., at set intervals).

Indwelling bladder catheters should be changed:

- Upon admission if it was inserted at an outside facility
- If catheter inserted during an emergency, when not done in a non-aseptic condition
- If the integrity of the catheter is impaired (e.g., clogged, leaking)
- If there are clinical issues such as bleeding
- Prior to obtaining a urine culture specimen if the catheter has been in place greater than 3 days.

*Refer to Inpatient Urine Culture Algorithm for urine culture specimen collection (attached)

If the patient has a urinary tract infection (UTI) that is being treated, the catheter does not need to be changed. However, if the UTI is recurrent, the catheter should be discontinued if possible. If the patient still needs the catheter (see list of indications below), the catheter should be changed because the catheter may be the continuing source of the infection.

A catheter should not be placed unless the patient has one of the following indications:

- Patient has acute urinary retention or bladder outlet obstruction
- Needed for accurate intake and output measurements in critically ill patients
- Needed for selected procedures, treatments or monitoring (e.g. bladder irrigations, intra-abdominal pressure monitoring, select surgeries)
- To assist in healing of open sacral or perineal wounds in incontinent patients
- Patient requires prolonged immobilization (e.g., for surgery or trauma)
- To improve comfort for end-of-life care
- Chronic catheter use on admission (use of alternatives should be assessed)

The catheter should be removed as soon as there is no longer an indication for it.

Alternatives to indwelling catheter include:

- External (condom) catheter
- External female catheter
- Urinals, bedpans, bedside commodes
- Intermittent straight catheterization
- Frequent toileting schedule
- Absorbent under pads

Catheters are inserted by trained personnel using the self-contained insertion tray and following the manufacturer's procedure. These step-by-step instructions are attached.

ASSESSMENT:

1. Assess a minimum of every 4 hours for:
   - Drainage system:
     - Catheter secured to skin
     - Drainage tubing with no dependent loops
     - Drainage bag below the level of the bladder, secured to bed frame and off of the floor
     - Tamper evident seal is intact
   - Bladder distention
   - Urine character and volume
   - Displaced fundus (postpartum patients)
   - Leakage and/or inflammation (i.e., around urinary meatus)
   - Signs and symptoms (S/S) of urinary tract infection, such as:
     - Fever/chills
     - Pain or tenderness [including suprapubic, pelvic, and costoverterbral angle (flank)]
     - Meatal discharge
     - Odor
     - Urine is cloudy or contains sediment or pus
2. Measure intake and output a minimum of every 8 hours (ICUs, every 2 hours; Pediatric, every hour).
3. Assess for the continuing need for the catheter every 24 hours and communicate with provider.

HYGIENE:

4. Clean insertion site and meatus/ perineal area with castile soap and water, castile towelette or approved designated pericare kit a minimum of every 12 hours and as needed (e.g., with each fecal incontinence).
   - Urethral catheter:
     - Cleanse meatus and perineum
     - Clean female from front to back in one motion
     - Clean male by cleaning around meatus, retracting and then replacing foreskin (if present)
     - Wash catheter from insertion site to connecting tubing
   - Suprapubic:
     - Cleanse close to insertion site, then moving outward
5. Perform hand hygiene before and after insertion of catheter and handling system and upon leaving the patient's room. Use standard precautions when handling the catheter system.

SYSTEM/ MAINTENANCE/ INFECTION CONTROL

6. Secure catheter properly using securement device after insertion to prevent urethral trauma/dislodgement: (except NICU)
   - Suprapubic: tape to abdomen
   - Urethral: Secure catheter to skin with securement device (e.g. with Statlock™)
     - Male - lower abdomen or anterior thigh
     - Female – thigh

     Exception: If skin condition such as burn or fragile skin exists, avoid use of adhesive
7. Attach collection bag to bed frame and maintain below level of bladder, preventing kinks and dependent loops in tubing, including during transport.
8. Ensure collection bag is kept below the level of the bladder and off the floor.
9. Label drainage bag with labels provided in catheter insertion tray. Write date and time of insertion and nurse's initials
10. Maintain a closed collection system. Ensure that the tamper-resistant seal is intact.
11. Scrub catheter/bag connection with Chloraprep™ (scrub for 15-30 seconds, allow to dry for 15seconds) before and after disconnection

    Note: Disconnect catheter from bag ONLY, if necessary, e.g. for intermittent bladder irrigation or intra-abdominal pressure monitoring.
12. Use needleless port to obtain urine specimens.
    - Scrub port with Chloraprep™ (scrub port for 15-30 seconds, allow to dry for 15 seconds) prior to obtaining specimen.

    Exception: Obtain 24-hour urine specimens from collection bag

    *Empty bag when ¾ full using a container designated for the patient.
13. Empty bag prior to patient transport.
14. Reposition patient and check tube for kinking if catheter is not draining properly.
15. Use drainage system with urine meter from the outset if hourly measurement is needed.

IRRIGATION:

16. Irrigate catheter gently via the needleless port as ordered by the provider with 30-50 mL normal saline if obstruction is suspected. Avoid routine irrigation.
    - Pediatric: less than 8 years use 5-10 mL, 8-17 years use 10-20 mL
    - If unable to clear obstruction via the port notify the provider

DISCONTINUATION:

17. Monitor intake and output a minimum of every 8 hours (ICU & Pediatric a minimum of every 2 hours) for 24 hours after catheter is discontinued.

REPORTABLE CONDITIONS:

18. Collaborate with provider daily regarding removing the catheter if there is no longer an indication for the catheter.
19. Notify Provider of:
    - Leakage or drainage of fluids around insertion site
    - Clots and/or bloody drainage
    - Urine output less than 30 mL/hour times 2 hours (Pediatric: less than 2 mL/kg/hr) or as ordered by physician
    - Dislodgement/obstruction of catheter
    - Bladder distention
    - Pain
    - Temperature greater than 38 degrees Celsius.
    - Abnormal urine odor, or discharge
    - Sediment or pus in the urine
    - Inability to clear obstruction by irrigation via the port

PATIENT/CAREGIVER EDUCATION

20. Provide patient/family with "Patient Education Information" (included in insertion kit)
21. Instruct on the following:
    - Regarding purpose of catheter
    - Regarding the risk of infection
    - Keep drainage bag below level of bladder and off the floor
    - Keep drainage tubing free of dependent loops
    - Adequate fluid intake
    - Notify nurse of pain, discomfort or feeling that bladder is full
    - Avoid tension on catheter
    - Maintain closed collection system
    - Encourage to ask about continued need for the catheter

ADDITIONAL STANDARD:

22. Refer to the following as indicated:
    - Intravenous Therapy

DOCUMENTATION:

23. Document in accordance with documentation standards.
24. Document applicable portions on iView including the following:
    - Catheter insertion
    - Catheter removal
    - catheter/perineal care
    - Irrigation

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REFERENCES:

Association for Professionals in Infection Control and Epidemiology (2014). Guide to Preventing Catheter-Associated Urinary Tract Infections. Retrieved from www.apic.org

CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (2009). Retrieved from www.cdc.gov/hicpac/cauti

Healthcare Infection Control Practices Advisory Committee (2009). Guideline for prevention of catheter associated urinary tract infections.Retrieved from www.cdc.gov

SHEA Compendium of Strategies to Prevent CAUTI (2014). Retrieved from https://www.shea-online.org

Society of Urologic Nurses and Associates (2015). Clinical Practice Guidelines "Care of the Patient with an Indwelling Catheter. Available at www.suna.org

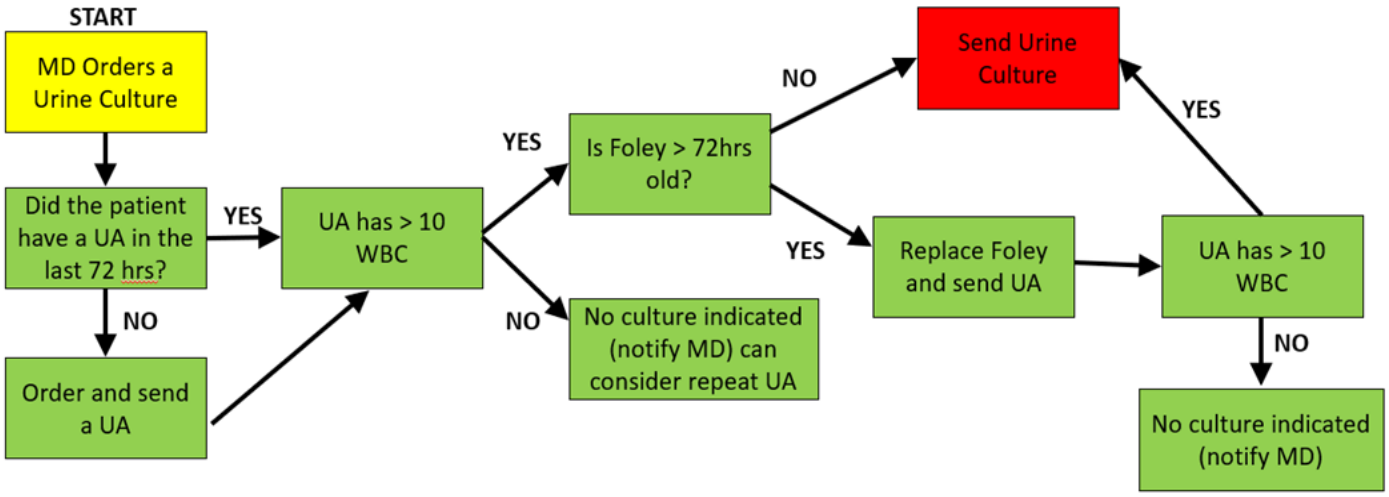
Consult: Los Angeles General Department of Epidemiology

Steps for Urinary Catheter Insertion

PREPARATION
Perform hand hygiene and don non sterile gloves
Position patient ensuring privacy is maintained
Open outer packaging of the urinary catheter tray and place between patient's legs (unless unable)
Remove directions for use, orange sticker label and patient education brochure, set aside
Open peri-care kit. Obtain additional castile soap wipes as needed. ***Use castile soap only***
Remove gloves and perform hand hygiene ***with provided alcohol sanitizer gel***
Orient kit towards the patient as indicated by the ***bold arrow*** located on catheter kit band if nurse is right-handed. (Arrow points away from patient if nurse is left-handed)
Remove band around catheter tray. Use proper aseptic technique to unwrap catheter kit
Use aseptic technique to don sterile gloves***, off the sterile field***
Place ***sterile pad*** (without hole) beneath patient (plastic or "shiny" side down)
Place ***fenestrated drape*** (drape with hole) appropriately over peri urethral area
URINARY CATHETER INSERTION USING ASEPTIC TECHNIQUE
STEP 1: Open povidone iodine packet
STEP 2: Pour solution onto 3 foam swab sticks to saturate them
STEP 3: Attach water-filled syringe to inflation port
STEP 4: Use green plunger to deposit lubricant in tray. Unwrap catheter and place in lubricant
STEP 5: With ***sterile non dominant*** hand **FEMALE PATIENT**: Separate labia visualize meatus **MALE PATIENT:** Retract foreskin, hold penis at base visualize meatus
STEP 6: With ***sterile dominant*** hand: **FEMALE PATIENT**: With a single downward stroke of povidone iodine: **A) Swab One:** Clean right labia minora and discard swab off the sterile field **B) Swab Two:** Clean left labia minora and discard swab off the sterile field **C) Swab Three:** Clean middle area between the labia minora from front to back and discard swab off the sterile field **MALE PATIENT**: With an outward circular motion of povidone iodine: **A) Swab:** Use all 3 swabs to clean penis in a circular motion starting at the urethral meatus and work outward, discard swab off the sterile field
STEP 7: With ***sterile dominant*** hand: **FEMALE PATIENT**: Insert catheter approximately three inches, wait to see urine flow, advance catheter another inch before inflating balloon **MALE PATIENT** Insert catheter firmly into the meatus, advance the catheter to the bifurcation at the "Y" of the catheter**.**
STEP 8: Inflate balloon with entire pre-filled catheter kit syringe (10mL). Gently pull catheter back until taut. ***Must use sterile water: normal saline may not be used***
- ***When procedure is complete, if indicated retract foreskin to original position***
SECURE CATHETER
STEP 1: Prep thigh with included skin prep pads. Secure catheter to anterior aspect of upper thigh with securement device to prevent movement, irritation, and decrease risk of infection.
STEP 2: Use green clamps to coil and secure tubing on top of bed. Ensure urine bag is below bladder, off floor, free of dependent loops
LABELING
STEP 3: Label bag with 2 orange stickers: • Insertion time, date and initials • CDC guidelines for placement indications and acknowledgment of provider order
PATIENT EDUCATION
Provide patient with included patient education information

Inpatient Urine Culture Algorithm For Patient with Foley Catheter

*Does not apply to pediatric or pregnant patients and patients with GU injury or in which urology/surgery services placed catheter



Description of Above: Please do not send a urine culture from a foley catheter that has been in for >72 hrs as literature indicates it will almost certainly be colonized. If you are concerned your patient has a catheter associated UTI, please first send a urinalysis (UA). If the UA is negative, please do not send a culture. If the UA is positive and the foley is >72hrs old, replace the foley and repeat the UA on the new foley catheter. If it continues to be positive, ok to send a urine culture.

Please call department of patient safety or infection control for questions: 323-409-3156 or 323-409-6645