Purpose

To ensure the safe, sterile placement and removal of an indwelling urinary catheter.

To provide guidelines for catheter care and specimen collection from the catheter.

To reduce the risk and occurrence of Urinary Tract Infection (UTI) and/or Catheter Associated Urinary Tract Infection (CAUTI).

Scope

This policy applies to all indwelling urinary catheter insertion performed in this facility and patients admitted with an indwelling catheter.

Policy

The somatic physician/physician's assistant are responsible for the insertion and removal of an indwelling urinary catheter by using aseptic techniques for site preparation, equipment, and supplies. The physician limits the use and duration of an indwelling urinary catheter according to situations necessary for patient care.

Indications for Use Include

Acute urinary retention or bladder outlet obstruction.

Need for accurate measurements of urinary output in critically ill patients.

Assistance with healing of Stage III or IV perineal and sacral wounds in an incontinent patient.

Post-surgical repair of penal wounds/injuries.

Nursing Responsibilities

The registered and licensed practical nurses are responsible for managing indwelling urinary catheters by:

- Securing catheters for unobstructed urine flow and drainage;
- Maintaining the sterility of the urine collection system;
- Collecting urine samples as needed;
- Assuring that no tension is exerted on the catheter during patient repositioning or movement; or when a leg bag is attached on an ambulatory patient; or during transfer;
- Following the infection control procedures outlined in the "Infection Control Considerations" section of this policy for collection containers used to measure the patient's urinary output;
- Educating the patient/family about the catheter (depending on patient's condition and family availability) and documenting same in the patient's medical record.
- Ensuring availability of replacement catheter supplies if needed.

Infection Control Responsibilities

The Infection Prevention and Control staff will:

- Measure and monitor catheter associated urinary tract infection (CAUTI) by surveillance.
- Monitor compliance with evidence-based best practices.
- Evaluate the effectiveness of prevention efforts.
- Generate reports and derive CAUTI rates in accord with applicable standards and/or regulations.

General Insertion Procedures

A. Patient Identification, Latex and Iodine Allergies/Sensitivities

- Identify the patient using the required two patient identifiers.
- Verify that the patient is not allergic to latex, iodine or betadine.
  1. If the patient is sensitive or allergic to latex, replace the catheter in the kit with a silicone catheter and obtain non-latex sterile gloves from the clinic (**do not use** the sterile latex gloves that come in the foley insertion kit).
  2. If the patient is allergic to iodine or betadine, obtain and use Theraworx cleansing wipe (available in the clinic).
- For any patient who is allergic to povidone or iodine, or who has a Latex allergy, notify the clinic ***immediately*** so that non-latex indwelling foley catheters, sterile non-Latex gloves, and/or Theraworx cleansing wipe can be obtained.
- If the area is grossly soiled, wash first with soap and water and **rinse all soap**

residue thoroughly before using any skin antiseptic or Theraworx cleansing wipe.

B. Gather Equipment

- Urinary catheter kit using the alternate non-latex and/or Theraworx cleansing wipe if indicated. Use the smallest size catheter appropriate.
- Explain the procedure to the patient and wash your hands or perform hand hygiene. Maintain the patient's privacy and dignity.
- Put on non-sterile gloves and wash the patient's genital area before the procedure if visibly soiled. Remove gloves, wash hands and put on clean unsterile gloves.
- Using aseptic technique, open the outer plastic wrap to form a sterile field and place the under pad beneath the patient, plastic (shiny) side down.
- Remove gloves and perform hand hygiene using the alcohol hand sanitizer gel (small packet in the kit).
- Put on sterile gloves and position the fenestrated drape on the patient.
- Remove the top tray and place next to the bottom tray on the sterile field.
- Remove the Foley catheter from wrap and lubricate using lubricate filled syringe in kit.
- Prepare patient with packet of three pre-saturated antiseptic swab sticks or three Theraworx cleansing wipes.
- Assistant to the MD/PA puts on non-sterile gloves or provides Theraworx cleansing wipes to MD/PA (use sterile forceps; give each of the three wipes into the MD/PA's gloved hand. Do not drop into sterile field).
- Use each swab stick/gauze for one swipe only.

Female Insertion Procedures

- Position female patient into a frog-leg position.
- Separate the labia using the non-dominant hand and visualize the meatus. Using downstrokes, cleanse the right labia and discard the swab/wipe away from the sterile field. Do the same for the left labia. Use the last swab stick/Theraworx cleansing wipe to cleanse the middle area between the labia.
- Check the balloon size and patency by inflating the balloon with the sterile water in the kit, then deflating and withdrawing the sterile water from the balloon. If the balloon inflates symmetrically with no leaks, it is patent. If it does not inflate symmetrically or has a leak, discard it. The assistant to the MD/PA will immediately retrieve another kit and the MD/PA will start the procedure again.
- Proceed with catheterization using strict sterile technique. Using the non-dominant hand, separate the labia and visualize the urethra. Using the dominant sterile hand, insert the catheter into the urethra until urine return is visible in the drainage tube. Insert the catheter two more inches and inflate the catheter balloon. Inflate the balloon slowly using the entire amount sterile water in the kit syringe. (Using less than the recommended volume can result in an asymmetrically inflated balloon).
- After the balloon is inflated, gently pull catheter until the inflated balloon is snug against the bladder neck.

Male Insertion Procedures

- Position male patients into a spine position.
- Cleanse the penis in a circular motion starting at the urethal meatus and working outward.
- Retract the foreskin, if present, and hold the shaft of the penis with the non-dominant hand.
- Prepare patient with packet of pre-saturated antiseptic swab sticks (or the alternative, Theraworx cleansing wipes.
- Assistant to the MD/PA puts on non-sterile gloves or provides Theraworx

cleansing wipes to MD/PA (use sterile forceps; give each of the three wipes into the MD/PA's gloved hand. Do not drop into sterile field

- Use each swab stick/Theraworx cleansing wipe for one swipe only.
- Grasp the penis in an upright position with the non-dominant hand and insert the lubricated catheter firmly into the meatus, using the dominant hand. Advance the catheter to the bifurcation at the "Y" of the catheter. A slight lean toward the umbilicus may be necessary to advance the catheter if resistance is met at the prostate.
- The return of urine does not assure that the catheter is placed correctly in males, since there is residual urine in the penis. Inserting the catheter to the bifurcation of the "Y" is the standard for assurance of proper placement.
- If the foreskin was retracted, reposition it after placement.
- Instruct the patient to inform the somatic physician/physician's assistant if any discomfort is felt with inflation of the balloon. If discomfort is felt, the catheter is most probably in the urethra and the balloon will need to be deflated so the catheter can be advanced. Withdraw the catheter slowly to the point of resistance at the bladder neck.
- If resistance is met do not attempt forceful catheter insertion. Apply continuous gentle pressure and ask the patient to take slow deep breaths to help relax or instruct the patient to try to void to open the sphincter and allow the catheter to pass.

Complete the Procedures

- Secure the catheter to the patient's thigh with hospital approved catheter securement device in the foley insertion kit to prevent movement, irritation, and decrease risk of infection.
- Position the bag on the bed rail at the foot of the bed or use the green sheeting clip to secure the drainage tube to the bed sheet, taking care that there is no tension on the drainage tube or foley catheter and no kinking in the tube.
- Position the bag to avoid urine reflux into the bladder, kinking, or gross contamination of the bag.
- Keep the bag below the level of the bladder at all times to prevent the backflow of urine and decrease the risk for infection.
- Never leave the catheter hanging unsecured to be pulled by the weight of the bag.
- Never leave the bag lying on the floor.
- Periodic observations of the system should be made to ensure that urine is flowing freely. If a standing column of urine is observed, check for correct positioning of the bag and then for a physical obstruction, such as a kink in the tubing.

Patient Care and Considerations

Always use sterile technique when inserting an indwelling urinary catheter and explain the procedure to the patient if appropriate (depending on patient's condition).

Document the following

- Indications for catheter insertion
- Procedure, including the size of the catheter placed; the color, amount, and clarity of urine returned after the initial placement, and patient response.
- Assess the patient for pain during and after procedure.
- Provide pain relief measures as indicated and document response

Directions for Foley Catheter Removal

- Deflate the catheter balloon: gently insert a Luer lock or slip tip syringe in the catheter valve. Never use more force than is required to make the syringe "stick" in the valve.
- Deflate the catheter balloon by negative pressure: allow the pressure within the balloon to force the plunger back and fill the syringe with water. If there is slow

or no deflation, re-seat the syringe gently.

- Use only gentle aspiration to encourage deflation if necessary. Vigorous aspiration may collapse the inflation lumen, preventing balloon deflation.
- If the balloon will not deflate, sever (cut) the valve arm to allow the water to drain out and deflate the balloon.
- Record urine output.
- Assess the patient for pain during and after procedure.
- Provide pain relief measures as indicated and document response.

Infection Control Considerations

- Ensure that only properly trained staff maintain/provide care for foley catheter patients.
- Wash hands or perform hand hygiene immediately before and after any manipulation of the catheter site, drainage bag tubing or bag.
- After hand hygiene, put on unsterile gloves to manipulate the catheter site, drainage tubing/bag.
- Routine meatal care is done daily with soap and water and anytime the site is visibly soiled (**do not use ReadyBath wipes**).
- Clean the perineal area with soap and water before proceeding with actual catherization.
- Clean the catheter tubing proximal to distal, with ready cleanse wipes daily and after every bowel movement.
- The meatus area should not be aggressively cleansed or cleansed with antiseptic solutions.
- The somatic physician/physician's assistant limit the use and duration of an indwelling catheter to situations necessary for patient care.
- Encourage fluid intake and use of the bedside commode or bathroom within 4-6 hours after the catheter is removed.
- To obtain a urine specimen, clean the sample port with alcohol and aspirate urine using a blunt needle (or leur lock syringe) and a 10 cc syringe.
- If there is a break in aseptic technique, disconnection, or leakage occurs, the physician/physician's assistant will replace the catheter and collection system using aseptic technique and sterile equipment, if in their clinical judgment, foley re-insertion is clinically indicated.
- Do not routinely irrigate the catheter.
- Maintain the integrity of the closed collection system.
- Be aware that there are multiple points of potential infection, e.g. catheter insertion, catheter care/maintenance, catheter removal, catheter re-insertion, etc.
- Empty the bag every 8 hours, or when the drainage bag is 2/3 full, to avoid traction on the catheter from the weight of the drainage bag and prevent infection. Take care not to contaminate the drainage port by touching the collection container or floor when emptying.
- Collection Container (to measure output):
    - Label the collection container with the patient's name and date using a black felt tipped pen.
    - Wash the collection container with soap and water, rinse and dry *on each shift.*
    - Replace the collection container weekly and label the container with the patient's name and date using black felt tipped pen. Document same on TARs.
    - Sit the collection container on the patient's dresser or nightstand when not in use. Do not leave it in the bathroom unless the patient is in a single room and never place it on the floor.

- Do not routinely change the catheter at fixed intervals.
- Change the indwelling urinary catheter before administering treatment for a CAUTI (catheter associated UTI)
- When transporting patient, transfer personnel must:
    - Wash their hands, put on unsterile gloves and empty the drainage bag.
    - Maintain position of drainage bag below the level of the patient's bladder to prevent reflux of contaminated urine from the bag to the bladder during transport.
    - Put on a pair of unsterile gloves if it is necessary to assist the patient to transfer from a stretcher/wheeler when he/she has arrived at their destination and/or when they return to the unit.
- To avoid potential contamination of the foley, do not handle or manipulate the foley or any part of the closed drainage system unless you have performed hand hygiene and are wearing unsterile gloves.
- If possible do not place more than one patient with a urinary catheter in the same room to prevent cross contamination.

Care of Suprapubic Catheter

- Care of a Suprapubic Catheter follows the same general guidelines as those for an indwelling Foley catheter relative to infection prevention and control. The physician or PA changes the suprapubic catheter when necessary.

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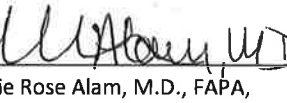

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Revised:12/3/19, 7/30/20, 9/6/20, 11/13/23