Urinary Catheter-Associated Infection Prevention Policy

Purpose: To provide Healthcare Workers regimens and practices related to urinary catheters that may decrease the incidence of urinary tract infections.

General Guidelines:
1. Limit the use of urinary catheters to carefully selected patients reduces the size of the population at risk. Generally, urinary catheterization is indicated for:
   - Known or suspected urinary tract obstruction (Benign prostatic hypertrophy, tumors, strictures, etc.)
   - Neurogenic bladder dysfunction
   - Urologic surgery, bladder injury, pelvic surgery, or surgery involving structures contiguous with the bladder or urinary tract
   - Continuous bladder irrigation
   - Post-surgical procedure, discontinue by POD 1 or POD 2.
   - Urine output monitoring in critically ill patients in ICU (Mechanically ventilated, hemodynamically unstable, unconscious or unable to cooperate with measurement of urine)
   - Assistance in stage III or stage IV pressure ulcer healing for incontinent patients
   - As an exception, to improve comfort with end of life care
2. Urinary catheterization is not indicated for:
   - Incontinence
   - Immobility
   - Patient and HCW’s convenience
   - Obtaining urine specimens
   - Diuresis
3. Intermittent catheterization is preferable to indwelling urethral catheterization in patients with bladder emptying dysfunction.
4. Provide education to patients who will have an indwelling catheter on ways to prevent infection. Give patient education provided in the catheter tray or go to F/data/bellin/home instructions/infection prevention/catheter associated urinary tract infection.

Alternative to urinary catheter use
1. External condom catheters for male patients without urinary retention or bladder outlet obstruction
2. Bladder scanning prior to insertion to determine urinary retention
3. Intermittent catheterization as per MD order
4. Every 2 hour toileting of the patient
5. Use of commodes, bedpans and urinals for aid in toileting.
6. Other considerations – peppermint spirits in the urinal or bedpan, running water.

Insertion
1. Verify physician order
2. Check patient’s medical history and ask if they have an artificial urinary sphincter (AUS). If the patient has an AUS do NOT insert catheter and inform MD (Refer to policy “AUS” BMH-PROC.117)
3. Catheters should be inserted by trained staff with documented competency.
4. Cleanse the perineal area thoroughly prior to catheter insertion
5. Perform hand hygiene and use aseptic technique when inserting a urinary catheter
6. If possible a catheter that is pre-connected to the drainage bag should be used.
7. Properly secure catheter to prevent movement and urethral traction
Maintenance
1. The indwelling catheter system should be maintained as a closed system. Avoid bladder irrigation unless obstruction has occurred. If necessary, bladder irrigation should be performed using aseptic technique.
2. Changing urinary catheter or drainage bags at routine intervals is not recommended. Change catheter and drainage system on indications such as obstruction or when the closed system is compromised.
3. Use Standard Precautions and hand hygiene before and after manipulation of the catheter and the drainage system.
4. Keep drainage bag lower than patient’s bladder at all times, including during transport. Avoid contact with the floor.
5. Obtain urine samples from a sampling port using aseptic technique.
6. Provide perineal care daily and after bowel movement, ensuring external catheter is also cleaned.
7. Maintain proper securement of the catheter for the duration of dwell.
8. Review catheter necessity and goal for discontinuation daily, and with each hand off.
9. Collaborate with the physician regarding catheter removal when patient no longer meets criteria.

Assessment Post catheter Removal
1. After removal of the foley catheter, interventions should be employed to encourage spontaneous voiding:
   - Early mobilization
   - Offering toileting with use of toilet or bedside commode to allow for upright position
   - Privacy
2. The patient will be assessed by the RN for the following parameters:
   - Patient is spontaneously voiding without difficulty
   - Patient is not voiding, however, is comfortable and expresses no desire to void
3. A bladder scan should be done for any of the following:
   - Patient is uncomfortable at any time, whether voiding or not
   - Patient has an urge to void but is unable to do so
   - Patient is incontinent at any time
   - Patient who has not voided within an appropriate time frame per nursing judgment (8-12 hours).
4. If the patient is uncomfortable or has the urge to void and if the bladder scan post residual is > 400 cc, the RN will contact physician to obtain order for straight catheterization. If a patient needs intermittent catheterization for a period longer than 24 hours, inform physician of inability to void.

Documentation
   a. Education of the patient on prevention of infection
   b. Insertion date, time, catheter size, material (silicone vs. latex)
   c. Indication for indwelling catheter with initial insertion and with genitourinary assessment every shift
   d. Discontinuation date and time.

References