

NURSING PATIENT CARE POLICY & PROCEDURE

 UW Health University of Wisconsin Hospital and Clinics	Effective Date: June 2, 2014	<input type="checkbox"/> Administrative Manual <input checked="" type="checkbox"/> Nursing Manual (Red) <input type="checkbox"/> Other _____	Policy #: 3.31AP
	<input checked="" type="checkbox"/> Original <input type="checkbox"/> Revision	Page <u>1</u> of <u>9</u>	Title: Insertion, Removal and Maintenance of an Indwelling Urinary Catheter (IUC) (Adult & Pediatric)

I. PURPOSE

Provide guidelines and the procedures for insertion, care and removal of an indwelling urinary catheter (IUC).

II. POLICY

- A. Indwelling catheter insertion and removal will be performed by a Registered Nurse (RN) or an emergency technician (ED tech).
- B. Indwelling catheters should only be inserted when necessary.
 1. Acute urinary retention or obstruction.
 2. Monitoring of urine output in critically ill patients.
 3. Post-operative requirements of specific procedures.
 4. To assist healing of open sacral or perineal wounds in incontinent patients.
 5. Patients requiring prolonged immobilization.
 6. End-of-life care.
 7. Physician judgment.
- C. The need for the catheter should be assessed daily.
- D. The smallest appropriate sized catheter should be used when inserting an IUC.
- E. Alternatives to an IUC may include intermittent catheterization, a toileting program, use of a condom or suprapubic catheter.
- F. IUCs should not be changed routinely.
 1. Exceptions:
 - a. Obstructed catheter
 - b. Catheter is leaking
 - c. Physician order to change catheter
- G. The IUC should be removed as soon as its use is no longer indicated.
- H. Catheter care is routinely performed twice daily, after a bowel movement (ensuring catheter is also cleaned), and as needed.

III. PROCEDURE FOR INSERTION

- A. Equipment
 1. Indwelling urinary catheter kit
 2. Organization-approved cleansing product (see Skin Care and Cleansing Product Descriptions on the Wound, Skin, Ostomy, and Continence Care website on U-Connect)
 3. Washcloths

4. Non-sterile gloves
5. Sheet to provide privacy
6. Blue pad/linen saver
7. Urinary catheter securing device
8. Specimen container (if collecting urine specimen)
9. Sterile water or Sterile Saline (ONLY if patient allergic to antiseptic cleanser in urinary catheter kit)
10. Checklist to be completed by observer RN

B. Procedure

1. Perform hand hygiene according to UWHC Hospital Administrative Policy 13.08, Hand Hygiene.
2. Observer: A second RN is needed for observation and completion of the insertion checklist. (Not required in emergent situations [i.e., codes] or in the operating room.)
3. Explain procedure to patient or caregiver as appropriate emphasizing the need to maintain a sterile field.
4. Verify patient allergies.
5. Provide privacy.
6. Don non-sterile gloves.
7. Raise bed to a comfortable working height. Lower side rails. Assist the patient into a dorsal recumbent or side lying position. Visualization of the urinary meatus is easiest when the female patient is in a dorsal recumbent position with legs widely separated and the knees flexed.
8. Place disposable blue pad/linen saver under patient's buttocks.
9. Provide light to allow better visualization.
10. Wash perineal area with approved cleansing product:
 - a. For female patients, open labia and cleanse entrance to urinary meatus with approved cleanser and washcloth wiping from front to back on each side with a downward stroke, using a new washcloth with each stroke. In side lying position, pull upward on upper labia minora.
 - b. For male patients, cleanse suprapubic and pubic area with approved cleanser and washcloth. Grasp the shaft of the penis firmly. Cleanse urinary meatus and glands with approved cleanser and washcloth beginning at the urethral opening. Retract foreskin on uncircumcised male patients. Cleanse in a circular motion moving from the meatus outward towards the shaft of the penis. For uncircumcised male patients, push foreskin back into place after cleansing.
11. Discard washcloths.
12. Remove and discard gloves. Perform hand hygiene. Don clean non-sterile gloves.
13. Drape patient so only perineum is exposed.
14. Set up sterile field:
 - a. Remove catheter kit from outer plastic package.
 - b. Place catheter kit between patient's knees (preferred). Carefully open outer edges opening first flap away from RN. If using side lying position, place kit about one (1) foot from perineal area near thighs.

- c. Remove full drape from kit with fingertips and place plastic side down just under buttocks by having the patient lift their hips. Keep other side sterile as this will be the sterile work field.
15. Don sterile gloves.
16. Prepare items in kit for use during catheter insertion:
 - a. Pour antiseptic solution over applicators (i.e., cotton balls/swabs).
 - b. Lubricate catheter tip with gel (3 to 4 inches for females; 7 to 8 inches for males). Place it back into tray so catheter tip is secure in tray.
 - c. If drainage tubing is already attached to the catheter, place tubing and bag securely on sterile field, close to other equipment. Attach catheter to drainage bag if not already done.
 - d. Check clamp on collection bag to be sure it is closed.
 - e. Attach prefilled syringe to balloon port, but DO NOT test the balloon.
17. With sterile hand, move cleaning tray to end of the sterile field. Move catheter and collection bag closer to the patient.
 - a. Female:
 - i. Remove fenestrated drape from kit and drape perineum so labia are exposed.
 - ii. Separate labia minora with non-dominant hand (refer to step III, B, 10, a).
 - iii. With the dominant hand, cleanse meatus with the appropriate applicators.
 - For patients with sensitivity or allergy to the antiseptic solution provided in the urinary catheter kit, sterile saline or sterile water can be applied to applicator for meatal cleansing.
 - iv. Wipe downward once with each applicator and discard.
 - v. Begin at labium on side farther from you and move towards labium closer to you.
 - vi. Wipe once down the center of the meatus.
 - b. Male:
 - i. Remove fenestrated drape from kit and place penis through hole in drape with non-dominant hand. Keep dominant hand sterile.
 - ii. Pull penis up to a 90 degree angle to the patient's body.
 - iii. With the non-dominant hand, gently grasp the glans (tip) of the penis and retract foreskin, if necessary.
 - iv. With the dominant hand, cleanse the meatus and glans with antiseptic solution, beginning at urethral opening and moving toward the shaft of the penis. Make one complete circle around the penis with each applicator, discarding after each wipe.
 - For patients with sensitivity or allergy to the antiseptic solution provided in the urinary catheter

kit, sterile saline or sterile water can be applied to applicator for meatal cleansing

18. Using the sterile dominant hand, pick up the catheter about 1.5 to 2 inches from the tip with the thumb and first finger.
19. Carefully gather additional tubing into the dominant hand.
20. Ask patient to bear down and take slow, deep breaths. Encourage slow deep breathing until catheter is placed.
21. Insert tip of catheter slowly through the urethral opening
 - a. Female: To approximately 3 - 4 inches or until there is urine noted in tubing.
 - b. Male: To approximately 7 - 9 inches or until there is urine noted in tubing. Lower penis to about a 45 degree angle after catheter is inserted about halfway.
22. If resistance is met, verify position. **DO NOT FORCE** the catheter. If unable to advance catheter, remove catheter and notify provider.
23. After the catheter has been advanced successfully, advance another 1 to 1.5 inches.
24. Inflate balloon with the appropriate amount of sterile water (amount will be printed on catheter) and gently pull back on catheter until it stops.
25. Secure the catheter loosely to the thigh with an approved securement device on the side where the drainage bag will be hanging. In male patients, the catheter can be secured to the thigh or abdomen with an approved securement device. To prevent skin breakdown, securement devices must be removed and changed every seven (7) days according to manufacturer's instructions.
26. If there is an order for urinalysis and/or urine culture, remove gloves, perform hand hygiene and don new gloves prior to specimen collection.
 - a. Specimens should be collected aseptically from the sampling port. Specimens for urinalysis or culture should never be obtained from the urine in the collection bag.
27. Make certain tubing is not kinked, twisted, obstructed or caught on railing.
28. The drainage bag should always be below the level of the bladder to prevent reflux of urine.
29. Clear bed of all equipment.
30. Position patient for comfort and replace linens for privacy.
31. Raise side rails and put bed in lowest position.
32. Measure amount of urine in drainage bag.
33. Remove and discard gloves. Perform hand hygiene.
34. Document the following in the patient's electronic medical record (EMR):
 - a. Bladder scan results (if bladder scan performed)
 - b. Date and time of catheterization
 - c. Type and size of catheter
 - d. Amount of sterile water inserted into balloon
 - e. Insertion attempts

- f. Amount, color, consistency and/or odor of urine returned upon catheter insertion
 - g. Difficulties encountered during insertion of urinary catheter
 - h. Urine specimen collection (UA, urine culture, etc.)
35. Checklist must be completed and sent to “Scanner” at mail code 8340 on a monthly basis.

IV. PROCEDURE FOR CATHETER SITE CARE

A. Equipment

- 1. Non-Sterile gloves
- 2. Blue pad/linen saver
- 3. Organization-approved cleansing product (see Skin Care and Cleansing Product Descriptions on the Wound, Skin, Ostomy, and Continence Care website on U-Connect)
- 4. Washcloths
- 5. Approved securement device
- 6. Sheet for privacy

B. Procedure

- 1. Catheter care and perineal cleansing can be delegated to a nursing assistant after proper instruction and observation.
- 2. Gather supplies.
- 3. Perform hand hygiene according to UWHC Hospital Administrative Policy 13.08.
- 4. Explain procedure to patient/caregiver as appropriate, emphasizing the need to clean around the catheter and manipulate tubing.
- 5. Determine if patient is allergic to antiseptics or soaps.
- 6. Provide privacy with sheet.
- 7. Don non-sterile gloves.
- 8. Raise bed to a comfortable working height and lower side rails.
- 9. Drain Foley tubing.
- 10. Place blue pad under patient’s buttocks.
- 11. Remove tubing from securement device.
- 12. Position patient in supine, dorsal recumbent or side-lying position.
 - a. For male patients, cleanse suprapubic and pubic area with approved cleanser and washcloth. Grasp the shaft of the penis firmly. Cleanse urinary meatus and glans with approved cleanser and washcloth beginning at the urethral opening. Retract foreskin on uncircumcised male patients. Cleanse in a circular motion moving from the meatus downward and outward towards the shaft of the penis. For uncircumcised male patients, push foreskin back into place.
 - b. For female patients, open labia and cleanse entrance to urinary meatus with approved cleanser and washcloth wiping from front to back on each side with a downward stroke, using a new washcloth with each stroke, cleaning the innermost surface outward.
- 13. Remove gloves, perform hand hygiene and don a new pair of non-sterile gloves.

14. Assess catheter insertion site for redness or unusual drainage. Notify provider if irritation is noted or patient has discomfort.
15. Clean the catheter from the insertion site to approximately six (6) inches distally with hospital approved cleanser and washcloths.
16. Remove any dried secretions on the tube. Be sure not to pull on the catheter.
17. Discard washcloths.
18. Re-anchor catheter tubing with approved securement device.
 - a. For male patients, on the abdomen or thigh.
 - b. For female patients, on the thigh.
19. Remove all supplies/equipment from bed.
20. Position the patient for comfort.
21. Raise side rails and put bed in the lowest position.
22. Remove and discard gloves.
23. Perform hand hygiene.
24. Document in the patient's EMR.

C. Maintenance

1. Keep drainage bag below the level of bladder at all times.
2. Be sure tubing is not kinked, twisted, obstructed or caught on side rails.
3. Keep drainage bag off the floor.
4. Tubing should be secured with a securement device.
5. Empty bag prior to transport off of unit to another department.

V. PROCEDURE FOR REMOVAL OF AN IUC

A. Equipment

1. Syringe (appropriate size to remove water from balloon catheter)
2. Graduate container
3. Non-sterile gloves
4. Blue pad/linen saver
5. Organization-approved perineum cleanser (see Skin Care and Cleansing Product Descriptions on the Wound, Skin, Ostomy, and Continence Care website on U-Connect)
6. Washcloths
7. Specipan Urine Collection Device (optional) (Central Service Item Number 1219129)

B. Procedure

1. Verify provider order or authorization of protocol to remove indwelling urinary catheter. Refer to Protocol 25, Indwelling Urinary Catheter Removal – Inpatient – Adult (found on U-Connect).
2. Review medical records to check amount of sterile water inserted into balloon.
3. Explain procedure to patient/caregiver as appropriate.
4. Provide privacy.
5. Perform hand hygiene according to UWHC Hospital Administrative Policy 13.08. Don non-sterile gloves.
6. Raise bed to a comfortable working height and lower side rails.
7. Position patient in supine or side-lying position.

8. Place disposable blue pad under patient's buttocks.
9. Insert syringe into balloon port valve.
10. Aspirate total amount of sterile water that was used to inflate the balloon. Once started the syringe should fill passively. If unsure the balloon is totally deflated, cut the inflation port and allow the water to drain.
11. Remove approved securement device
12. Instruct patient to relax and take slow deep breaths.
13. Slowly pull catheter out onto disposable blue pad.
14. Hold catheter up until all urine in tubing has drained into the drainage bag.
15. Measure the amount of urine in the drainage bag, noting color and odor.
16. Empty urine from drainage bag into graduated container.
17. Discard catheter and drainage bag by wrapping them in disposable blue pad.
18. Cleanse perineal area with approved cleanser.
 - a. For male patients, cleanse suprapubic and pubic area with approved cleanser and washcloth. Grasp the shaft of the penis firmly. Cleanse urinary meatus and glans with approved cleanser and washcloth beginning at the urethral opening. Retract foreskin on uncircumcised male patients. Cleanse in a circular motion moving from the meatus outward towards the shaft of the penis. For uncircumcised male patients, push foreskin back into place.
 - b. For female patients, open labia and cleanse entrance to urinary meatus with approved cleanser and washcloth wiping from front to back on each side with a downward stroke. Use a new washcloth with each stroke. In side lying position, pull upward on upper labia minora.
19. Position patient for comfort.
20. Raise side rails and put bed in lowest position.
21. Remove gloves and perform hand hygiene.
22. Instruct patient to notify nurse of need to void. If it is necessary for the patient to save urine, place a Specipan Urine Collection Device in the toilet in patient's room. For male patients, place urinal within reach.
23. Document the following in the patient's EMR:
 - a. Reason for removal
 - b. Date and time of catheter removal
 - c. Amount of urine, color, and odor of urine in collection bag
 - d. Difficulty with removal of catheter
 - e. Patient's tolerance of procedure
24. For patients with radioactive prostatic seed implants, catheter removal and disposal of urine is performed according to UWHC Surgical Services Policy 6.10, Radioactive Prostatic Seed Implants.

VI. UWHC CROSS REFERENCES

- A. CAUTI Toolbox (on U-Connect)
- B. Hospital Administrative Policy 13.08, Hand Hygiene

- C. Nursing Patient Care Policy 3.28, Collecting a Urine Specimen from an Indwelling Urinary Catheter
- D. Nursing Patient Care Policy 13.12A, Basic Care Standards (Inpatient Adult)
- E. Nursing Patient Care Policy 13.16, Basic Care – Inpatient Pediatrics (Birth-18 years of age)
- F. Nursing Practice Guideline: Catheter-Associated Urinary Tract Infection (CAUTI)
- G. Protocol 25, Indwelling Urinary Catheter Removal – Inpatient – Adult (on U-Connect)
- H. Skin Care and Cleansing Product Descriptions (on U-Connect)
- I. Surgical Services Policy 6.10, Radioactive Prostatic Seed Implants

VII. REFERENCES

- A. Center for Disease Control and Prevention (2009). Guideline for Prevention of Catheter-Associated Urinary Tract Infections. Retrieved from <http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIGuideline2009final.pdf>
- B. Lo, E., Nicolle, L., Classen, D., Arias, K. M., Podgorny, K., Anderson, D. J., Yokoe, D. S., & et al (2008). Strategies to prevent catheter-associated urinary tract infections in acute care hospitals. *Infection Control and Hospital Epidemiology*, 29, S41-S50.
- C. Smith-Temple, J., & Young Johnson, J. (2009). *Nurses' guide to clinical procedures (6th Ed.)*. Philadelphia, PA: Lippincott Williams & Wilkins.
- D. Wald, H. L., Fink, R. M., Flynn-Makic, M. B., & Oman, K. (2012). Catheter-associated urinary tract infection prevention. In Boltz, M., Capezuti, E., Fulmer, T., Zwicker, D. *Evidence-based geriatric nursing protocols for best practice (4th Ed.)* (pp. 388-408). New York, NY: Springer Publishing Company, LLC.
- E. Willson, M., Wilde, M., Webb, M. L., Thompson, D., Parker, D., Harwood, J., Gray, M., & et al (2009). Nursing intervention to reduce the risk of catheter-associated urinary tract infection. Part 2: Staff education, monitoring, and care techniques. *Journal of Wound, Ostomy, and Continence Nursing*, 36(2), 137-154.

VIII. WRITTEN BY

Clinical Nurse Specialist, Quality & Safety

IX. REVIEWED BY

Clinical Nurse Specialist, Transplant-General Surgery
 Clinical Nurse Specialist, Geriatrics
 Clinical Nurse Specialist, Gyn, Urol, Plastic & Otolaryn
 Clinical Nurse Specialist, Trauma Life Support Center
 Clinical Nurse Specialist, General Pediatrics
 Clinical Nurse Specialist, General Medicine and Geriatrics
 Infection Control Practitioner, Infection Control
 Nursing Patient Care Policy and Procedure Committee, May 2014

SIGNED BY

Beth Houlahan, MSN, RN, CENP
Senior Vice President Patient Care Services, Chief Nursing Officer