URINARY CATHETERIZATION

Purpose:
The purpose of urinary catheterization is to facilitate urinary drainage when medically necessary. Urinary catheters should be evaluated everyday for need and removed promptly when no longer necessary. See indications below.

Roles/Responsibilities:
Sanford USDMC SOP ICM 5-19
AHRQ toolkit “Nurse-Initiated Removal of Unnecessary Urinary Catheters in the Non-Intensive Care Units.” 7-2010

BACKGROUND
Urinary catheterization is the aseptic process of inserting a sterile hollow pliable tube into the urethra to facilitate urine drainage into a closed bag system. The urinary tract is the most common site of hospital acquired infections accounting for approximately 40% of hospital infections. The intent of this policy will not only give guidance for urinary catheter maintenance techniques, but also will assist in the prevention of catheter-associated urinary tract infections (CAUTI).

INDICATIONS
1. Urinary catheters are deemed medically necessary for the following reasons:
   1.1. Urinary retention including obstruction and neurogenic bladder: the patient is unable to pass urine because of an enlarged prostate, blood clots or an edematous scrotum/penis or unable to empty the bladder because of neurologic disease/medication effect.
   1.2. Required for a procedure- to be removed immediately after the procedure is completed.
   1.3. Prolonged effects (urinary retention of epidural anesthesia.
   1.4. Urological, gynecological or pelvic surgery (structural repair of the urethra, bladder repair, injury to the bladder, TURP, low anterior resection of the colon.)
   1.5. Assist healing of perineal and sacral wounds in incontinent patients to avoid further deterioration of wound and skin.
   1.6. Required immobilization for trauma or surgery.
   1.7. Hospice/comfort care or palliative to improve comfort for end of life cares.
   1.8. Need for accurate measurement of urinary output in hemodynamically unstable patients. This patient is usually in the ICU. Strict I&O is not an indication for a catheter.
   1.9. Chronic indwelling urinary catheter on admission.
   1.10. Catheter placed by urologist/gynecologist (difficult insertion).

POLICY
2. General:

2.1. Urinary catheters should be inserted only when medically necessary and should be evaluated every 12 hour shift for necessity. Urinary catheters should not be used solely for health care worker convenience. Document alternative methods for bladder elimination prior to insertion of indwelling catheter.

2.1.1. Alternative methods include:

2.1.1.1. Bladder training, which consists of placing the patient on the bedpan or commode every two hours.
2.1.1.2. Utilizing ultrasound bladder scanning for suspected urinary retention.

1.2 Urinary catheters should be placed only under the direction of a physician order. However, if the
patients nurse does not deem the urinary catheters meets the indications for placement, the patient’s nurse should question need.

3. **Insertion/Application:**

   2.1 Standard Precautions: se gloves when manipulating the catheter site and drainage system and practice hand hygiene before and after.

   2.2 Indwelling, straight, and suprapubic urinary catheters should be inserted using aseptic technique and sterile equipment.

      2.2.1 Sterile gloves, drape, and sponges; an appropriate antiseptic solution for periurethral cleaning and a single use packet of lubricant jelly should be used for insertion.

   2.3 The smallest bore catheter possible should be utilized to minimize urethral trauma and irritation.

   2.4 Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma.

   2.5 Patients who perform self catheterization at home should be encouraged to continue performing this procedure while in the hospital.

      2.5.1 Patients performing self catheterization should utilize a clean technique.

      2.5.2 Nursing personnel should evaluate the patient’s performance and reinforce positive behaviors.

4. **Maintenance:**

   4.1. Standard Precautions: Use gloves when manipulating the catheter site and drainage system and practice hand hygiene before and after.

   4.2. A sterile, continuously closed drainage system should be maintained for indwelling and suprapubic catheter systems.

   4.3. The catheter and drainage tubing should not be disconnected unless the catheter can only be irrigated manually or if new tubing needs to be attached.

   4.4. If there are breaks in aseptic technique, disconnection of tubing, or leakage from the bag; the drainage system should be replaced. The catheter tubing junction should be disinfected before connecting to the new drainage system. If the catheter becomes contaminated, the catheter should also be replaced.

   4.5. Drainage bags should always be placed below the level of the patients’ bladder to facilitate drainage and prevent stasis of fluid.

   4.6. Urine in drainage bags should be emptied at least once each shift using a container designated for that patient only. Care must be taken to keep the outlet valve from becoming contaminated. Use gloves and practice hand hygiene before and after handling the drainage device.

   4.7. Patients with urinary catheters will have intake and output recorded. However, urinary catheters are not to be inserted simply to monitor outputs except for the instance of intensive care patients awaiting transfer. Make use of other means to monitor outputs in the incontinent patient, such as daily weights.

5. **Catheter Change:**

   5.1. The interval between catheter changes should be determined by the individual patient’s needs. Indications for change may include: leaking, break in the integrity of the closed system, equipment deterioration, mechanical impediment and blockage.

   5.2. Catheters of post op urology patients should be changed by the urologist/ surgeon.

   5.3. Indwelling catheters should not be changed at arbitrary fixed intervals.
6. **Meatal Care:**
   6.1. Cleansing the meatal surface during daily bathing is appropriate. The periurethral area should not be cleaned with antiseptics in patients with indwelling urinary catheters.

7. **Specimen Collection:**
   7.1. Small volume urine specimens should be obtained by inserting a sterile needle/syringe into a disinfected sampling port and aspirating the urine.
   7.2. Regular bacteriologic monitoring of catheterized patients is not recommended.
   7.3. The patient with an indwelling catheter should be monitored for signs of catheter associated urinary tract infection such as fever, chills, or suprapubic pain.

8. **Irrigation:**
   8.1. Avoid irrigation unless there is an obstruction in the catheter.
   8.2. Closed continuous and/or manual irrigation should only be done if ordered by a physician.
   8.3. If irrigation is necessary to prevent obstruction due to bleeding, a manual method of irrigation should be utilized.
   8.4. The sampling port may be used to relieve an obstructed catheter. Using a sterile syringe and sterile irrigant enter the disinfected sampling port. Use gloves and practice hand hygiene before and after procedure.
   8.5. If clots are present, irrigate until clear using sterile normal saline (amount varies starting with 250ml for adult patients).
   8.6. Do not disconnect the closed system unless the sampling port cannot be used.

9. **Responsible Persons:**
   9.1. Only persons (e.g., nursing staff, family members, or patients themselves) who know the correct technique of aseptic insertion and maintenance of the catheter should handle catheters. Healthcare workers and others who take care of catheters should be given periodic education and training, stressing the correct techniques and potential complications of urinary catheterization.