



POLICY AND PROCEDURE MANUAL

Department: NURSING	Division: IC	Policy:
Title: Prevention of Catheter-Associated Urinary Tract Infections (CAUTI)	Developed: 11/08	Supersedes:
Approved by:		Revised:

PURPOSE:

1. To identify urinary tract infection present on admission or after the insertion of a urinary catheter.
2. Urinary tract infection is the most common hospital acquired infection; 80% of these infections are attributable to an indwelling urethral catheter.
3. The duration of catheterization is the most important risk factor for development of infection this policy and procedure will promote early removal of invasive catheter.

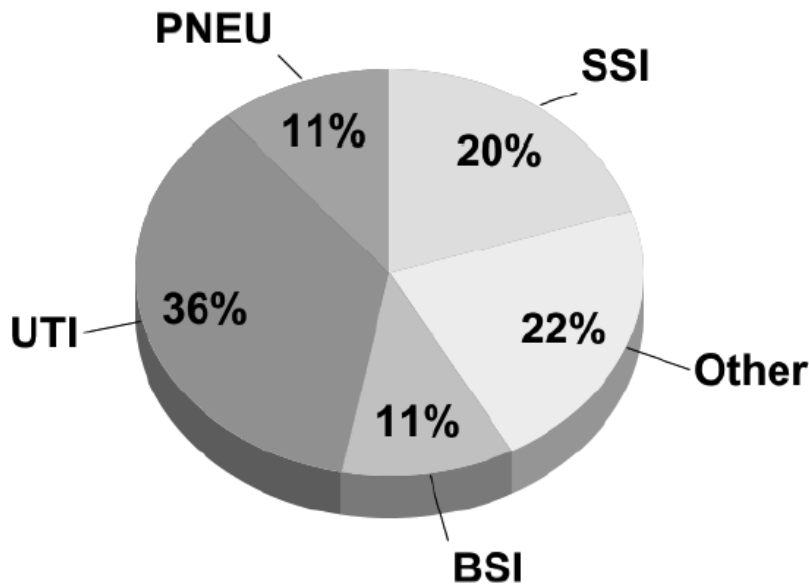


Figure 1 – Hospital Acquired Infections by Site

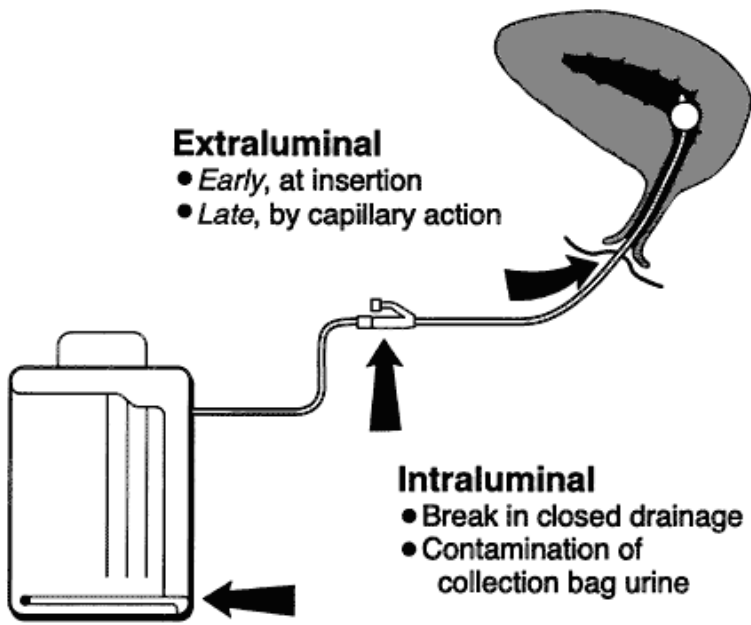
DEFINITIONS:

Catheter-Associated Urinary Tract Infections (CAUTI):

A urinary tract infection that occurs in a patient who had an indwelling urethral urinary catheter in place within the 7-day period before the onset of the UTI.

PROCEDURE:

<p>1. Assemble needed equipment for peri-bath and foley catheterization.</p> <p><u>If patient arrives to facility with indwelling catheter. Obtain specimen from sampling port and then discontinue catheter and place a new catheter.</u></p>	<p><i>Use 14 Fr. Catheter as first choice Use as small a catheter as possible that is consistent with proper drainage, to minimize urethral trauma.</i></p> <p><i>Change Catheter at a minimum of every 28 days.</i></p>
<p>2. Explain procedure to patient</p>	<p><i>Introduces self, explains purpose and necessity of procedure, teach if able. Maintains patient privacy. Keep patient warm.</i></p>
<p>3. Perform Hand Hygiene. Don gloves. Perform peri-bath. Discard disposable peri-bath equipment.</p>	<p><i>Cleanse patient's peri area with soap & water (or bath cloths) to reduce bacterial contamination. Make sure to wipe basin with disinfectant wipe after use.</i></p>
<p>4. Perform Hand Hygiene</p>	<p><i>Use of Compulsive Handwashing prevents infection</i></p>
<p>5. Position patient.</p>	
<p>6. Open catheterization tray (maintain sterility of contents) and make a sterile field with the wrapper</p>	<p><i>Opens edges away</i></p>
<p>7. Place plastic-lined sheet/drape from catheterization kit under buttocks, by folding corners over hands</p>	
<p>8. Don sterile gloves.</p>	<p><i>Do not contaminate gloves</i></p>
<p>9. Place fenestrated drape over perineum</p>	
<p>10. Arrange tray contents for use:</p> <p><input type="checkbox"/> Pour Cleansing solution over cotton balls</p> <p><input type="checkbox"/> Lift top tray and place onto sterile field</p> <p><input type="checkbox"/> Dispense lubricant onto tray</p> <p><input type="checkbox"/> Remove plastic shield from catheter and lubricate end of catheter</p>	<p><i>Consider other methods for management, including condom catheters or straight catheterization after bladder scan.</i></p>
<p>11. Cleanse urethral meatus</p>	<p><i>Provide routine hygiene for meatal care at least daily and as needed.</i></p>
<p>12. Pick up catheter with dominant hand approximately 2-3 inches from catheter tip. Place distal end in sterile tray.</p>	<p><i>Guide forward until you observe urine in the tubing.</i></p>
<p>13. Gently insert the catheter into the meatus and advance to "Y" in catheter.</p>	
<p>14. Inflate balloon with 10ml sterile water in balloon port (or per manufacture direction).</p>	
<p>15. Gently pull back catheter to position balloon at neck of Bladder.</p>	<p><i>Replace system if a break in asepsis occurs. Maintain a sterile, continuously closed drainage system unless the catheter must be irrigated.</i></p>
<p>16. Place Foley bag below the level of the bladder.</p>	<p><i>Keep collection bag below the level of the bladder at all times. Keep collection bag off the floor.</i></p>
<p>18. Prep skin front mid-thigh adjacent to foley catheter Securment device</p>	
<p>19. Apply Securment device to front mid-thigh leaving ½ inch to 1 inch slack</p>	<p><i>Properly secure indwelling catheters after insertion to prevent movement and urethral traction.</i></p>

20. Discard disposable equipment in infectious waste trash.	
21. Document intervention and education in medical record. Document on the Catheter the date of Insertion.	<u>Date the foley bag with permanent marker with DATE of INSERTION of Urinary Catheter as a visual reminder to check necessity of foley.</u>
22. Obtain urine specimen on admission from any patient admitted with an existing urinary catheter, this must be completed before 48 hours from admission	<i>If urine culture is positive for organism, The Licenced Independent Practitioner will document in patient progress notes and/or history and physical.</i>
23. Obtain urine specimen upon insertion of an indwelling urinary catheter utilizing specimen access port.	<p><i>Do not use specimens from the collection bag.</i></p>  <p>Extraluminal</p> <ul style="list-style-type: none"> • Early, at insertion • Late, by capillary action <p>Intraluminal</p> <ul style="list-style-type: none"> • Break in closed drainage • Contamination of collection bag urine
24. Promptly transport urine samples to the laboratory for culture to prevent inaccurate culture results.	<i>Must be in the lab within 1 – 2 hours.</i>
25. Daily Nursing Staff will evaluate need for urinary catheter and document in medical record.	<p><i>Utilize Algorithym</i></p> <p><i>Empty collecting bag regularly, using a separate collecting container for each patient, and avoid allowing the draining spigot to touch the collecting container. Ensure the collection container is dated and has the patients Name on it.</i></p>
26. If patient no longer meets criteria for catheterization, Staff will notify Licenced Independed Practitioner and obtain an order to remove.	<p><u>Appropriate indications for the use of a indwelling urethral catheter are limited to include the following:</u></p> <ol style="list-style-type: none"> 1. Obstruction of the urinary tract distal to the bladder 2. Alteration in BP or volume status requiring accurate volume measure. 3. Preop catheter insertion for patient going to OR or procedure. 4. Continuous bladder irrigation for urinary tract hemorrhage/ TURP 5. Urinary incontinence posing a risk to the patient stage 3-4 perineal ulcer 6. Neurogenic bladder dysfunction and urinary retention not manageable by other means (intermittent catheterization) 7. Comfort Care at patient’s request or for terminally ill patients.

	8. Or per Licensed Individual Provider order in the medical record with documentation supporting need for catheterization.
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Appendix 1 - Bladder Bundle

A	Active Surveillance of Health Care Providers Compliance with Bundle and Aseptic Technique
B	Barrier Protection to perineal area daily and as needed and Barrier or Isolation for Multi Drug Resistant Identified Organisms
C	Compulsive Hand washing when interacting with catheter. Change Catheter every 28 days
D	Daily Care / Cleaning of meatus daily and prn with soap and water and/or hospital bath cloths. DAILY review for appropriateness of use.
E	Education to patient, family, and health care providers about care of urinary catheter and prevention of infection.
F	Forward Thinking, Can this Catheter be removed?

FAQs

(frequently asked questions)

about “Catheter-Associated Urinary Tract Infection”

What is “catheter-associated urinary tract infection”?

A urinary tract infection (also called “UTI”) is an infection in the urinary system, which includes the bladder (which stores the urine) and the kidneys (which filter the blood to make urine). Germs (for example, bacteria or yeasts) do not normally live in these areas; but if germs are introduced, an infection can occur.

If you have a urinary catheter, germs can travel along the catheter and cause an infection in your bladder or your kidney; in that case it is called a catheter-associated urinary tract infection (or “CA-UTI”).

What is a urinary catheter?

A urinary catheter is a thin tube placed in the bladder to drain urine. Urine drains through the tube into a bag that collects the urine. A urinary catheter may be used:

- If you are not able to urinate on your own
- To measure the amount of urine that you make, for example, during intensive care
- During and after some types of surgery
- During some tests of the kidneys and bladder

People with urinary catheters have a much higher chance of getting a urinary tract infection than people who don’t have a catheter.

How do I get a catheter-associated urinary tract infection (CA-UTI)?

If germs enter the urinary tract, they may cause an infection. Many of the germs that cause a catheter-associated urinary tract infection are common germs found in your intestines that do not usually cause an infection there. Germs can enter the urinary tract when the catheter is being put in or while the catheter remains in the bladder.

What are the symptoms of a urinary tract infection?

Some of the common symptoms of a urinary tract infection are:

- Burning or pain in the lower abdomen (that is, below the stomach)
- Fever
- Bloody urine may be a sign of infection, but is also caused by other problems
- Burning during urination or an increase in the frequency of urination after the catheter is removed.

Sometimes people with catheter-associated urinary tract infections do not have these symptoms of infection.

Can catheter-associated urinary tract infections be treated?

Yes, most catheter-associated urinary tract infections can be treated with antibiotics and removal or change of the catheter. Your doctor will determine which antibiotic is best for you.

What are some of the things that hospitals are doing to prevent catheter-associated urinary tract infections?

To prevent urinary tract infections, doctors and nurses take the following actions.

Catheter insertion

- o Catheters are put in only when necessary and they are removed as soon as possible.
- o Only properly trained persons insert catheters using sterile (“clean”) technique.
- o The skin in the area where the catheter will be inserted is cleaned before inserting the catheter.
- o Other methods to drain the urine are sometimes used, such as
- External catheters in men (these look like condoms and are placed over the penis rather than into the penis)
- Putting a temporary catheter in to drain the urine and removing it right away. This is called intermittent urethral catheterization.

Catheter care

- o Healthcare providers clean their hands by washing them with soap and water or using an alcohol-based hand rub before and after touching your catheter.

If you do not see your providers clean their hands, please ask them to do so.

- o Avoid disconnecting the catheter and drain tube. This helps to prevent germs from getting into the catheter tube.
- o The catheter is secured to the leg to prevent pulling on the catheter.
- o Avoid twisting or kinking the catheter.
- o Keep the bag lower than the bladder to prevent urine from backflowing to the bladder.
- o Empty the bag regularly. The drainage spout should not touch anything while emptying the bag.

What can I do to help prevent catheter-associated urinary tract infections if I have a catheter?

- Always clean your hands before and after doing catheter care.
- Always keep your urine bag below the level of your bladder.
- Do not tug or pull on the tubing.
- Do not twist or kink the catheter tubing.
- Ask your healthcare provider each day if you still need the catheter.

What do I need to do when I go home from the hospital?

- If you will be going home with a catheter, your doctor or nurse should explain everything you need to know about taking care of the catheter. Make sure you understand how to care for it before you leave the hospital.
- If you develop any of the symptoms of a urinary tract infection, such as burning or pain in the lower abdomen, fever, or an increase in the frequency of urination, contact your doctor or nurse immediately.
- Before you go home, make sure you know who to contact if you have questions or problems after you get home.

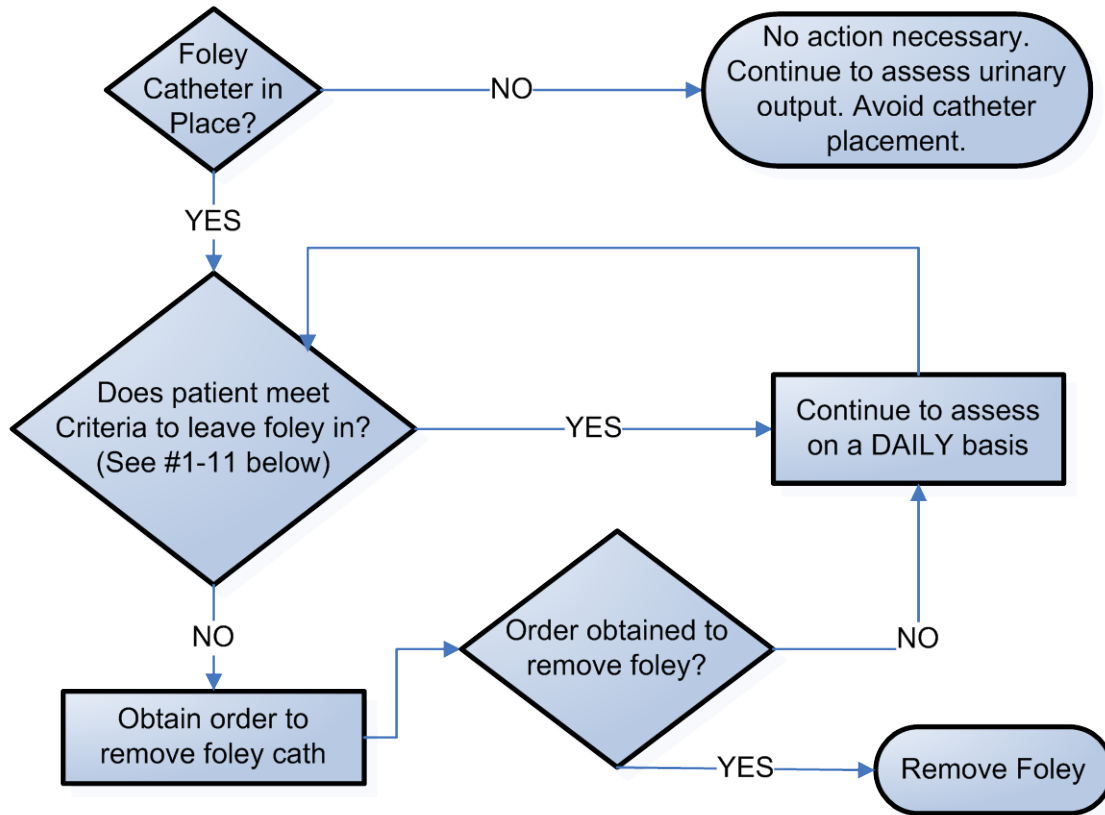
If you have questions, please ask your doctor or nurse.

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Appendix 3 - Urinary Catheter Removal Protocol

Algorithm for Removal of Foley Catheter



Foley Catheter should be continued if any of the following criteria are met.

1. To provide relief of urinary tract obstruction not manageable by other means.
2. To permit drainage in patients with neurogenic bladder dysfunction and urinary retention not manageable by other means (i.e., with clean intermittent catheterization).
3. To obtain strict intake and output when patient is incontinent or a 24 hour urine collection when patient is incontinent.
4. Foley has been placed by physician due to difficult insertion or for special purposes.
5. Foley has been ordered by a urologist.
6. Management of urinary incontinence in persons with Stage III or IV pressure ulcers on trunk.
7. To aid in urologic surgery or other surgery in contiguous structures.
8. Patients with crush injury, pelvic fracture or who have had renal/urology surgery or other major surgery.
9. Patients who have had colorectal surgery or abdominal/ pelvic surgery (Check with physician after 72 hours for continued need of foley catheter).
10. Management of terminally ill patients.
11. Patients with epidural catheters in place.

* Key Point: Nursing will review appropriateness of Foley Catheter on a DAILY BASIS, using the above criteria.

Urinary Catheter Protocol/Order Set

Interventions

Insert _____ fr catheter under sterile technique and document in medical record. Change urinary catheter every 28 days. If Patient arrives to facility with catheter obtain UA C&S from sampling port and change out catheter.

Reason for Insertion

- Obstruction of the urinary tract distal to the bladder
- Alteration in BP or volume status requiring accurate volume measure.
- Preop catheter insertion for patient going to OR or procedure.
- Continuous bladder irrigation for urinary tract hemorrhage/ TURP
- Urinary incontinence posing a risk to the patient stage 3-4 perineal ulcer
- Neurogenic bladder dysfunction and urinary retention
- Comfort Care.
- Other: _____

Document Insertion in medical record.

Obtain Urine Specimen within 48 hours of admission and send for culture and sensitivity.

Write insertion date, time, unit placed, and initials on urine bag and urinary catheter with permanent marker.

Ensure system remains closed and verify seal at junction of catheter to bag (this will be exception if using a specialty catheter or urometer bag) Document seal intact or not intact daily.

Engage in proper hand hygiene and use of gloves when handling catheter.

Use cathetersecuring device.

EmptyFoley bag < **2/3 full** and empty prior to any transport

Label the emptying device with the patient's name and date and keep in patient's room.

Ensure perineum was cleansed with soap and water or bath cloths during hygiene q day and prn as needed for soiling.

Properly place collection bag on bed using dependent drainage. Drainage **BAG** attached to side of bed and **BELOW** the level of the **BLADDER**

Obtain any urinary specimen from the Catheter port with syringe and sterile needle. (Do Not Use from Bag)

Complete daily assessment of need and document in medical record.

- Enter Reminder "Sticker" to Physician Progress Note and/or Order Sheet requesting review and removal of urinary catheter every 7 days and /or when patient no longer meets criteria for urine catheter document in the medical record notification of the physician.

Urinary Catheter Removal Protocol

Obtain Medical Order From Licensed Individual Practitioner to remove catheter

Document Removal of the Catheter: Date and Time.

Document Post Catheter Void.

Bladder Scan if no voiding within 6 hours of removal and notify physician of urine > 250ml identified.

Date

Licensed Independent Practitioner Signature.

Appendix 4 – Order Set Renewal Label and /or MD progress note Label Identification

****URINARY CATHETER REMINDER****

DATE: __ / __ / ____

This patient has had an indwelling urethral catheter since __ / __ / ____

Please indicate below **EITHER** (1) that the catheter should be removed **OR** (2) that the catheter should be retained. If the catheter should be retained, please state **ALL** of the reasons that apply.

- Please discontinue indwelling urethral catheter; **OR**
- Please continue indwelling urethral catheter because patient requires indwelling catheterization for the following reasons (please check **all** that apply):
 - Urinary retention
 - Very close monitoring of urine output and patient unable to use urinal or bedpan
 - Open wound in sacral or perineal area and patient has urinary incontinence
 - Patient too ill or fatigued to use any other type of urinary collection strategy
 - Patient had recent surgery
 - Management of urinary incontinence on patient's request
 - Other—please specify

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