

SAMPLE NURSE DRIVEN FOLEY REMOVAL PROTOCOL

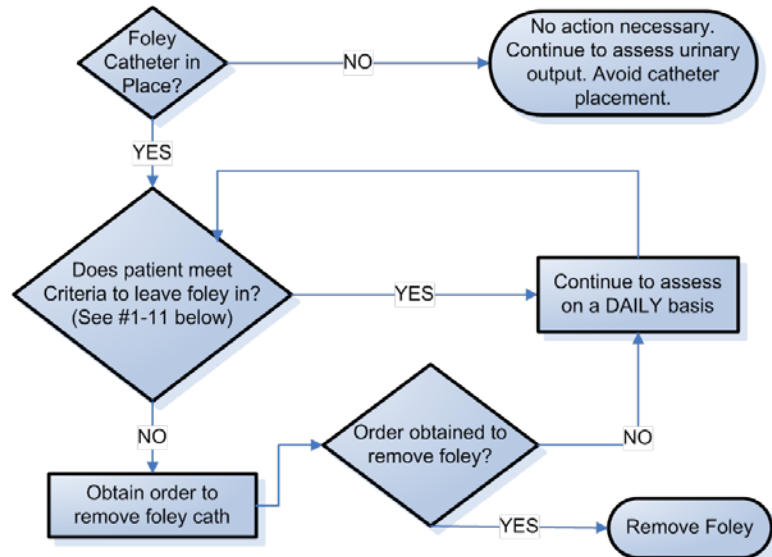
- Prevent Catheter-Associated Urinary Tract Infections •

Interventions

- Insert only when necessary-must have an order
- Write insertion date, time, unit placed, and initials on urine bag with permanent marker
- Engage in proper hand hygiene when handling catheter
- Use catheter-securing device
- Label the emptying device with the patient's name and date, and discard it after 24 hours
- Ensure perineum was cleansed with soap and water during morning care
- Properly place Foley bag on bed
- Ensure Foley tubing is free of obstructions and kink free
- Document insertion in medical record
- Complete daily assessment of need
- Empty bag routinely when 2/3 full

Nurse Driven Foley 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.



IMPROVING QUALITY
.....
REDUCING INFECTION

Documentation

- Catheter evaluation should be completed with every twenty-four hour shift assessment.
- Document insertion and discontinue date on nursing documentation form.

National Healthcare Safety Network CAUTI Criteria 1

Patient had an indwelling urinary catheter in place at the time of or within 48 hours prior to specimen collection

and
at least 1 of the following signs or symptoms with no other recognized cause: fever ($>38^{\circ}\text{C}$), suprapubic tenderness, or costovertebral angle pain or tenderness

and
a positive urine culture of $\geq 10^5$ colony-forming units (CFU)/ml with no more than 2 species of microorganisms.

National Healthcare Safety Network CAUTI Criteria 2

Patient had an indwelling urinary catheter in place at the time of or within 48 hours prior to specimen collection

and
has at least 1 of the following signs or symptoms with no other recognized cause: fever ($>38^{\circ}\text{C}$), suprapubic tenderness, or costovertebral angle pain or tenderness

and
positive urinalysis demonstrated by at least 1 of the following findings:

- a. positive dipstick for leukocyte esterase and/or nitrite
- b. pyuria (urine specimen with ≥ 10 white blood cells [WBC]/ mm^3 or ≥ 3 WBC/high power field of unspun urine)
- c. microorganisms seen on Gram stain of unspun urine

and
positive urine culture of $\geq 10^3$ and $< 10^5$ CFU/ml with no more than 2 species of microorganisms.

