Voice-over narration script for Preventing CAUTI simulation video

1. Slide 1
   1. Hospital acquired catheter associated urinary tract infections, also known as “CAUTI”, is an important issue for patient care. CAUTIs are the most common type of healthcare associated infection and it is estimated that over a half-million hospital-acquired (or nosocomial) urinary tract infections occur each year, resulting in approximately 13,000 deaths each year. This issue is also estimated to cost the United States almost a half billion dollars annually. Therefore, it is critical for healthcare professionals to receive ongoing education and training on proper methods to prevent CAUTI.
2. Slide 2
   1. Over the course of this video, you will watch scenarios conducted in an academic nursing simulation lab. These scenarios were designed based on current, evidence-based guidelines for preventing hospital-acquired CAUTI. After viewing this video, you should be able to:
      1. Identify the CDC guidelines for appropriate indications for indwelling urinary catheter use \*\*highlight corresponding bullet when mentioned\*\*
      2. Demonstrate competency in the proper insertion of an indwelling catheter into a female and male patient as well as demonstrate proper removal of an indwelling urinary catheter \*\*highlight corresponding bullet when mentioned\*\*
      3. You should also be able to demonstrate competency in the proper assessment and care of an indwelling urinary catheter \*\*highlight corresponding bullet when mentioned\*\*
3. Slide 3
   1. In 2009, a clinical guideline for the prevention of CAUTI was developed by the Healthcare Infection Control Practices Advisory Committee, or “HICPAC”, and supported by the Centers for Disease Control and Prevention.
4. Slide 4
   1. This clinical guideline provides specific recommendations for individuals who would be considered appropriate for an in-dwelling catheter. It is important for those involved in patient care to carefully consider if an in-dwelling urinary catheter is medically necessary for a particular patient, rather than the catheter being placed for the convenience of those providing patient care.
   2. According to the guidelines, individuals who would be considered appropriate for placing an in-dwelling urinary catheter would be
      1. Individuals with acute urinary retention or some type of bladder outlet obstruction \*\*highlight corresponding bullet when mentioned\*\*
      2. A critically ill individual needing accurate measurements of urinary output \*\*highlight corresponding bullet when mentioned\*\*
      3. Peri-operative use of an indwelling urinary catheter for selected surgical procedures, such as urologic or GYN surgeries, prolonged surgeries, or close monitoring of urine output if many fluids, blood, or certain medications are administered during the perioperative period \*\*highlight corresponding bullet when mentioned\*\*
      4. Catheters would also be appropriate to use to allow healing of an open sacral or perineal wound in an incontinent patient, \*\*highlight corresponding bullet when mentioned\*\*
      5. For elimination in an individual requiring prolonged immobilization, such as a pelvic fracture or an unstable lumbar or thoracic spine, \*\*highlight corresponding bullet when mentioned\*\*
      6. And, if needed or requested by the individual, to provide comfort for end of life care. \*\*highlight corresponding bullet when mentioned\*\*
5. Slide 5
   1. Inappropriate uses of an indwelling urinary catheter would include
      1. Using the catheter as a substitute for quality nursing care of an individual \*\*highlight corresponding bullet when mentioned\*\*
         1. As an example, a nurse may not want to frequently change bed linens and clean a patient who has frequent incontinent episodes
      2. Using the catheter as a means for obtaining a urine culture or other diagnostic testing when a patient is able to void voluntarily, \*\*highlight corresponding bullet when mentioned\*\*
      3. And catheters should not be used for a prolonged period of time after surgery, unless an appropriate indication remains. \*\*highlight corresponding bullet when mentioned\*\*
6. Slide 6
   1. Due to the risks for infection and tissue trauma associated with urinary catheters, nurses must remember that only licensed staff, such as RN’s and LPN’s, may insert indwelling urinary catheters.
   2. Sterile or aseptic techniques must be followed during catheter insertion. This includes the use of sterile supplies that are typically included in pre-packaged catheter insertion kits. However, the contents included in catheter insertion kits may vary. Always know which supplies are included in the catheter kits used in your clinical area and which sterile items must be collected separately from your supply room.
   3. You should never use supplies that are not sterile or have become contaminated prior to using the supplies on your patient.
   4. Indwelling catheters should be in sterile packaging prior to use, either within the catheter insertion kit or packaged separately. Always select the smallest sized catheter possible to insert. Catheter sizes are usually categorized by the term “French”, and the larger the number, the larger the catheter diameter. For example, a 14 French urinary catheter is much smaller than an 18 French catheter. You may also see the diameter of the catheter measured in millimeters. Read the catheter packaging carefully to determine the size of catheter to select.
7. Slide 7
   1. For our first simulation scenario, let’s observe the process the registered nurse follows for placing an in-dwelling urinary catheter into a female patient
8. Begin video
   1. At 00:23
      1. Our nurse, Kelsey, had verified the order for the catheter prior to entering the patient’s room, and informed the patient of the rationale for placing the catheter. Since the patient’s bladder is not emptying, the nurse had verified an appropriate indication for placing an indwelling catheter. After washing her hands and verifying the patient’s identity, the nurse is ready to begin the procedure.
   2. At 01:02 – pause and insert next slide
9. Slide 8
   1. For this scenario, we are demonstrating the use of an additional person to assist with catheter placement. A second person may be used with a male or female catheter insertion procedure. If a second person is available to assist the nurse, the role of the second person is to help keep the patient’s legs properly positioned and to monitor and inform the nurse if there is any break in sterile field.
   2. If a second person is not available to assist during catheter placement, the nurse must still be mindful of potentially contaminating the sterile field. If this occurs, the nurse must stop the procedure, then start over with a new, sterile kit.
   3. The second person in this scenario is wearing sterile gloves, so that she may also assist with sterile components in the catheter kit, if necessary. If the second person is wearing sterile gloves, however, that individual must also ensure that he or she does not contaminate the sterile gloves then touch the sterile components of the catheter kit.
   4. It would be acceptable for the second person to wear non-sterile gloves. If this is the case, the second person would have to ensure that nothing in the sterile field is touched during the procedure.
10. Resume video at 01:03 and start narration
    1. Non-sterile gloves are used to open the catheter kit, then position the kit on the bed between the patient’s feet. The exterior covering of the kit is carefully opened by extending the corner fold of paper farthest away from the nurse, then the sides, then the corner closest to the nurse.
    2. The first drape in the kit is then carefully lifted out of the kit, still using non-sterile gloves, and carefully positioned and tucked under the patient.
    3. The kit used in this scenario contains cleansing wipes that may be used to clean the genital area for a male or female. If catheter insertion kits at your facility do not include these wipes, clean the genital area with soap and water prior to opening the catheter kit. This process will be demonstrated with the male catheter insertion scenario.
    4. At 02:22:
       1. Gloves are then removed and the hands are cleaned using either soap and water, alcohol-based hand cleaner, or using the hand cleaning gel included in some catheter insertion kits such as the one demonstrated here.
       2. Sterile gloves are then removed from the kit, placed on a clean bedside table, and donned being careful not to contaminate the gloves
    5. At 03:11:
       1. The fenestrated drape is then placed over the genitals using the sterile gloves.
    6. At 03:22:
       1. The rest of the kit is now positioned and prepped
    7. At 03: 41
       1. Place the lubricant into the tray
    8. At 3:51
       1. remove the catheter covering
       2. carefully place the catheter back in the sterile tray and submerge the end of the catheter in the lubricant
       3. next, connect the balloon inflation syringe to the catheter. Current literature and manufacturer recommendations do NOT recommend inflating the balloon prior to insertion to test the balloon due to potential urethral trauma and subsequent introduction of pathogens
       4. Now open the antimicrobial cleanser.
       5. Pause at 4:18
11. Insert slide 9
    1. Be sure to note if your patient has any allergy to iodine or any other component of the catheter kits available to use. Many catheter kits have betadine swabs to use for cleansing the genitals, and some kits use chlorhexidine. Likewise, some catheter kits contain latex components and some are latex free.
    2. Be sure not to use anything in the catheter insertion kit that may cause an allergic reaction in your patient.
12. Resume at 4:19
    1. When cleaning female genitals prior to inserting the catheter, be sure to wipe only once with each swab moving from the clitoral area toward the rectum. Wipe first along the right labia minora, then the left labia minora, then the last wipe down the middle over the urethral meatus.
    2. At this point, the hand holding the labia open is now contaminated, while the other hand is still sterile. Be careful not to cross contaminate the field or the catheter during this time.
    3. At 4:54
       1. Now carefully grab the end of the catheter with the sterile hand and ensure the catheter and connected drainage bag are positioned to allow insertion and advancement of the catheter without the risk of the catheter being accidentally pulled back out.
       2. Be sure there is a generous amount of lubricant on the end of the catheter.
       3. With the non-sterile hand, hold the labia as open as possible, then insert the catheter into the urethral meatus using the sterile hand. Do not reinsert the catheter if the catheter falls out or is otherwise contaminated. If so, you will need to begin the procedure again with a new sterile kit.
    4. At 5:32
       1. Once urine is visible in the drainage tube, advance the catheter 2 or more inches.
    5. At 5:51
       1. Now inflate the balloon with a full 10ml of sterile water, then disconnect the syringe. Less than 10ml in the balloon can result in improper inflation
       2. Gently pull back on the catheter until slight tension is detected. Do not forcefully pull on the catheter.
    6. At 6:13
       1. Place a catheter securing device on the leg then attach the catheter. Do not pull the catheter too tightly when securing in order to prevent tissue trauma.
       2. Keep the urine collection tubing and bag below the level of the bladder. Hang the bag on a stationary part of the bed, then secure the sheet clip to secure the drainage tube to the sheet.
       3. Label catheter collection bag with the date and time of catheter insertion.
       4. Reassess the catheter and tubing to ensure no kinks or dependent loops are present.
       5. Before leaving the patient, make sure the patient is covered and the bed and bed rails are returned to safe positions.
13. Insert slide 10
    1. The second simulation scenario is male catheter insertion. The majority of the steps from the female catheter insertion will also apply to this scenario. The focus of this simulation is male-specific techniques for catheter insertion and to demonstrate appropriate alternative techniques based on the type of catheter insertion kit you may have available at your facility.
14. Begin Male catheter video
    1. The nurse has already verified orders, validated an appropriate indication for an indwelling urinary catheter, introduced herself to the patient, cleaned hands, and verified the patient.
    2. Male and female genitals should always be cleaned prior to setting up the sterile field for catheter insertion. For this scenario, there are no cleaning wipes in the catheter kit as we saw with the female scenario. In this instance, soap and water should be used to gently clean the genital area. Non-sterile gloves, a basin with water, soap, towel, and washcloth are used.
    3. At 0:46
       1. When finished, clear the work area, remove dirty gloves, and wash hands. Position the patient and prepare your work area the same way as demonstrated with female catheterization.
    4. At 1:10
       1. Wearing non-sterile gloves, open the kit and place the drape under the patient.
    5. At 1:33
       1. It is important to ensure your work area is set up to reduce the risk of contamination, including moving tables and equipment that might be in the way.
       2. Remove the non-sterile gloves, clean your hands, then don sterile gloves using aseptic technique.
    6. At 2:18
       1. Position the sterile kit and place the fenestrated drape. Open the lubricant, remove the catheter covering and place the end of the catheter in the lubricant. Then connect the balloon inflation syringe to the catheter.
    7. At 3:05
       1. Open the antiseptic swabs. With your non-dominant hand, hold the penis upright. This hand is now contaminated. With your remaining sterile hand, take the first swab and clean the urethral meatus using a firm circular motion. With the second and third swabs, continue using a circular motion but continue working outward.
    8. At 3:37
       1. With your non-sterile hand, hold the penis upright. With your sterile hand, pick up the end of the catheter, ensure there is generous amount of lubricant on the end, then place the catheter into the urethral meatus.
       2. Continue holding the penis upright. This position facilitates easier passage of the catheter through the urethra.
       3. Advance the catheter 6-10 inches or until urine is seen draining from the catheter.
       4. Be sure to always use a new catheter if the catheter comes out or is otherwise contaminated during the insertion process.
    9. At 4:13
       1. Inflate the balloon using no less than 10ml, then remove the syringe.
       2. Gently tug on the catheter to confirm placement.
15. Insert slide 11
    1. Just as in the previous scenario, once the catheter is placed, discard used supplies, remove contaminated gloves, clean hands, and put on non-sterile gloves.
    2. Place the securing device on the leg being careful not to pull the catheter too tightly.
    3. Keep the catheter and drainage bag below the level of the bladder.
    4. Label the drainage bag, hang the bag on a fixed location on the bed, secure the sheet clip, and ensure there are no kinks or dependent loops.
    5. Before leaving the room, cover the patient and return the bed and bedrails to a safe position.
16. Insert slide 12 – scenario #3
    1. Proper maintenance and removal of indwelling urinary catheters is also an essential part of preventing CAUTI
17. Begin video 3
    1. Catheter drainage bags should be emptied every shift or sooner based on current orders for I’s/O’s for your patient. Drainage bags should also be regularly assessed throughout your shift and emptied to ensure no more than 400ml of urine is in the collection bag.
    2. There should be a labeled graduated container, dedicated to that patient and for the urinary catheter. A container should not be used to empty urine on another patient, such as a roommate in semi-private rooms, nor should the container be used to empty any other type of drainage.
    3. In preparation to empty the drainage bag, clean hands, put on non-sterile gloves, and locate the labeled, dedicated measuring container. It is also a good time to perform a quick assessment of the catheter to inspect for kinks, dependent loops, securing device, catheter and tubing connection, and any other abnormal findings.
18. At 1:07
    1. Carefully hold the container, or set the container on a towel on the floor, then open the drain. Be sure the drain opening does not come in contact with anything.
    2. Always inspect urine for color, consistency, and odor, and document the findings.
19. At 1:34
    1. After the bag is empty, close the drain and secure the drain in the holder.
20. At 1:44
    1. Regular cleaning of the genitals and urethral meatus are also important elements in preventing CAUTI. The urethral meatus should be inspected and cleaned with soap and water during daily bathing.
21. Stop at 1:53
22. Insert slide 13
    1. The catheter should not be pulled tightly to inspect part of the catheter that was inside the urethra. Instead, gently clean around the surface of the urethral meatus with a cleansing cloth and remove any debris that may have collected on the catheter and on the meatus. Be sure to also provide thorough hygienic cleaning of the remainder of the genitals. Use of antiseptic cleansers for daily periurethral care is not recommended.
23. Resume video
    1. If a specimen is needed for culture, the aspiration port of the catheter should be used. Do not disconnect the catheter from the drainage tubing to collect a specimen. Most catheters have a luer lock system for obtaining specimens.
    2. Wearing clean gloves, use an alcohol wipe or antiseptic swab to clean the access port. Open a sterile, packaged syringe and connect to the access port. Aspirate the syringe to obtain urine from the catheter.
24. At 2:23
    1. To remove an indwelling catheter, verify the order, wash your hands, then verify the patient.
    2. You will need to have 2-3 towels and an empty 10ml syringe. Put on non-sterile gloves and ensure the drainage collection bag has been emptied prior to removing the catheter.
    3. Position the patient and place one or two folded towels under the patient.
    4. Now remove the catheter from the securing device.
25. At 3:09
    1. Using the syringe, completely deflate the balloon. Use only gentle aspiration to encourage deflation, if needed. Ensure all fluid is removed from the balloon.
26. At 3:28
    1. Use a quick but gentle pulling motion to pull the catheter until it is completely removed.
    2. Dispose of the catheter, tubing, and drainage bag. Then remove the securing device from the leg.
    3. When finished, cover the patient and return the bed and side rails to a safe position.