**Example B: Highlights for CAUTI Prevention Checklist**

**Highlights for CAUTI Prevention**

**Insertion**

• Patients must have an order for a foley (even if device was present on admission).

• The patient must have one or more of the following indications for a catheter:

o Urinary retention or obstruction. If the patient has a foley placed for this reason, a provider order is needed to remove it.

o Incontinence in patient with open perineal or sacral wounds. (e.g., Stage 3 or 4 pressure ulcer, surgical wound, wound vac)

o Critical illness **AND** a need for accurate monitoring of urinary output (does not apply outside the ICUs)

o Terminal illness receiving comfort care or withdrawal of care

o Perioperative use for selected surgical procedures—these should be removed as soon as possible after surgery

• If the patient has a foley and no order, evaluate for indications. If the foley is indicated, contact the provider to obtain an order. If not, *remove the catheter.*

• Foleys are placed aseptically

o A second person assists when placement may be difficult (e.g., obese, limited mobility, etc.) **AND** observer to STOP the procedure if they see sterility is compromised.

o If the first attempt fails, a new kit is obtained for the next attempt. Consider asking a second person to attempt the placement.

**Maintenance**

• While the foley is in, care is meticulous.

o BID and prn perineal / foley care—bath wipes or soap and water are acceptable, depending on patient needs

o Keep the catheter secured with Stat Lock

o Keep the bag below the bladder and off the floor—this means in transport, too.

• Don’t open the drainage system unless absolutely necessary. If you must open it, use aseptic technique.

**The Discontinuation Protocol**

• **Every patient with a catheter is on the discontinuation protocol unless the provider excludes the patient by order.**

• Remove the foley as soon as the patient no longer needs it (based on indications for use.) No order is needed to remove the foley unless the provider has written an order specifying so.

• If the order indicates a date and time for foley removal (4/1/14 @ 1400 or POD 2 at 0600), the patient is not on the protocol, and the foley is removed as specified.

• Once the catheter is removed, the patient is assessed at least every two hours for the need to urinate. Assistance is offered for toileting. If the patient is unable to void within six hours, assess bladder volume with the bladder scanner.

• Notify provider for next steps if

o Patient has suprapubic pain or the urge to void but is unable to do so.

o A volume of greater than 300 ml is identified with the bladder scanner, and the patient is unable to void.

o The patient has not voided and does not have significant volume in the bladder 6 hours after catheter removal.

For more information see MRMC Policies : Urinary Catheter: Insertion, Care and Removal; Urinary Catheter Removal: Nursing Clinical Practice Guidelines and Bladder Scanner: Nursing Clinical Practice Guidelines.