# VUMC Guidelines for Management of Indwelling Urinary Catheters

## Indications for insertion and continued use of indwelling urinary catheters include:
- Urinary retention or obstruction
  - An epidural catheter is not an absolute indication for continued use of a urinary catheter. Patients with epidural catheters should be assessed for urinary retention on an individual basis.
- Incontinence in patient with open perineal or sacral wounds
- Critical illness AND a need for accurate monitoring of urinary output
- Terminal illness receiving comfort care or withdrawal of care
- Perioperative use for selected surgical procedures
  - Surgeries of the GU tract or contiguous structures
  - Anticipated prolonged duration of surgery
  - Anticipated to receive large volume fluids/diuretics during surgery
  - Need for intraoperative monitoring of urinary output.

## Preparation & Procedure

### Perform hand hygiene before handling or accessing UC.

### Perform perineal/meatal care gently with soap & water or bath wipes at least every 12 hours, after bowel movements, and as needed.

### Keep the catheter anchored with a securement device at all times to prevent catheter movement.

### Keep drainage port clean and securely clamped. Do not allow drainage port to touch the receiving container when emptying the drainage device.

### Empty the collection bag q 6-8 hours and prior to transport to prevent overfilling and backflow.

### Small urine samples (urinalyses or cultures) are obtained from the access port closest to the patient.

### Do not send urine from the drainage bag or meter.

### Consider changing the catheter if the patient has a confirmed UTI. Routine catheter replacement is not recommended for prevention of CAUTI.

### An order is required for catheter placement. When a catheter is placed emergently, or when patients are admitted with a catheter in place, an order is obtained within 24 hours.

### Perform hand hygiene prior to insertion.

### Proceduralist(s) wears sterile gloves.

### Other PPE is necessary only if indicated by the patient’s condition or comorbidities, and per Standard Precautions.

### Maintain unobstructed urine flow:
- keep drainage systems free of kinking, above floor level and below bladder level for gravity drainage.

### Scrub to disinfect access port with antiseptic before aspirating a urine sample.

### After catheter removal, assess the patient to determine ability to void, to empty the bladder, & to maintain continence. If unable to void, notify provider.

### Educate Patient/Family about necessity for catheter and about CAUTI prevention.

### Do not inflate the balloon prior to insertion.

### After placement, do not inflate the balloon until urine flow is achieved.

### Minimize UC access; keep collection system connected unless disruption is required for patient care. (e.g., irrigation).

### Use aseptic technique when performing interventions, including obtaining specimens, emptying urine, and irrigation.

### If patient is unable to void, consider I/O catheterization x 2 before replacing indwelling catheter.

### Consider Urology consult for urinary retention of unknown etiology.

### If patient is at risk for difficult placement, a second person may assist with positioning and/or placement. Consider a Urology consult for patients with a history of difficult insertions or surgery.

### Aseptic technique is maintained during insertion.

### If the catheter is contaminated during an unsuccessful attempt at placement, discard it and obtain a new insertion kit.

### Do not routinely replace drainage systems. If bag becomes visibly soiled or integrity is breached, use aseptic technique to change.

### Do not culture asymptomatic patients (exceptions: patients who are pregnant or undergoing GU surgical procedures).

### The multidisciplinary team assesses continued need for the catheter daily.

### Patients are assessed by a nurse for clinical indications for continued use:
- Upon admission;
- Every shift or with a change in caregiver;
- With change in the level of care.

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**CAUTI** = Catheter-associated urinary tract infection; **UC** = urinary catheter

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**Monitor compliance with elements of insertion, care, access, and discontinuation.**

Every member of the team is obligated to identify and correct any deviation or potential deviation of these standards.