# DAILY ASSESSMENT OF INDWELLING URINARY CATHETER NECESSITY

Instructions:

1. Perform this audit once daily
2. Turn this form into Infection Control at end of each week.

DATE (WK): _____

RESIDENT NAME: _____

RESIDENT ROOM: _____

| | Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
|---|---|---|---|---|---|---|---|
| 1. The resident is comatose. | | | | | | | |
| 2. The resident is terminal or in the end stages of a progressive debilitating disease. | | | | | | | |
| 3. The resident has a Stage III or IV pressure sore in an area affected by incontinence. | | | | | | | |
| 4. There is documented evidence of urinary retention that is causing persistent overflow incontinence, symptomatic infections and/or renal dysfunction and that cannot be managed surgically or practically with intermittent catheterization. | | | | | | | |
| 5. There is need for exact measurement of urinary output. | | | | | | | |
| 6. There is a documented history of resident being unable to void after a catheter was removed in the past. | | | | | | | |
| 7. The resident is a quad/paraplegia who failed a past attempt to remove a catheter. | | | | | | | |
| 8. There is documented evidence that a program has been attempted or considered to manage the incontinence. | | | | | | | |
| Staff initials: | | | | | | | |

The use of an indwelling catheter is medically/clinically necessary if any of the above conditions are present. If all answers are NO, the catheter is not medically/clinically necessary and should be removed. If medically or clinically unnecessary, obtain an order to discontinue the indwelling urinary catheter. If indwelling urinary catheter is deemed unnecessary and not discontinued, explain.

Further Comments/Summary:

DATE: _____ SIGNATURE: _____

(Infection Control)

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