

(Facility Name and Address)

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**(1A) Indwelling Urinary Catheter Use  
in the Long-Term Care Setting**

**Introduction:** Urinary tract infection (UTI) is a leading infection in long-term care facilities. The prevalence of UTIs is 15% to 50% in non-catherized residents and 90% to 100% in catherized residents. In residents with indwelling urinary catheters, the risk of developing a catheter-associated symptomatic urinary tract infection (CA-SUTI) increases at a rate of approximately 5% each day of use, reaching 100% prevalence at 30 days. Therefore, in those residents that require long-term indwelling catheters, the case for prevention interventions becomes crucial. Direct caregivers are responsible for insertion, care and maintenance of indwelling catheters, and the success of a prevention project occurs when those personnel are fully engaged and committed to this important resident safety initiative. Implementing a set of evidence-based interventions known as the CA-SUTI bundle has been correlated with reduction in complications associated with indwelling catheter use.

**Purpose:** To implement protocols that are evidence based for optimal prevention of CA-SUTIs and are bundled for maximized efforts toward these device-associated infections.

**Scope of Practice:** Nursing staff (RNs, LPNs, Aides, etc.), Infection Preventionist, Ancillary staff (Dietary, Physical Therapy, etc.), and Physicians (including Physician Extenders)

**Related Policy/Guidelines:** Surveillance of Urinary Tract Infections in the Long-Term Care Setting, Antibiotic Formulary Protocol, (also, reference your internal policies here)

**Policy and Procedure:**

**I. NHSN Definitions:**

**Indwelling catheter** is a drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a closed collection system; also called a Foley catheter. CA-SUTIs are captured if the resident had an indwelling urinary catheter at the time of or within 2 days before onset of the event.

**II. Insertion, Care and Maintenance of Urinary Catheters:**

**A. Insertion of Indwelling Urinary Catheters:**

Insertion of an indwelling urinary catheter occurs after medical necessity has been established. **ADDENDUM A** outlines the *CMS Standard Operating Manual for Long-Term Care* criteria for medical necessity. An order from the Medical Provider is required and the catheter is inserted by licensed personnel who have demonstrated insertion skills competency for males and females. Competency will be evaluated upon initial hire and yearly thereafter. **ADDENDUM B** is a skills check-off to assess urinary catheter insertion competency. All indwelling urinary catheters are inserted using aseptic techniques with sterile supplies to prevent extraluminal or external bacterial ascension creating a biofilm. Bacteria tend to be predisposed to ascend early after catheter insertion, suggesting a lack of asepsis during initial insertion.

**B. Care and Maintenance of Residents with Indwelling Urinary Catheters:**

**The CA-SUTI Prevention Bundle (ADDENDUM F)** consists of 7 interventions that are bundled together for implementation. Used individually, the impact of CA-SUTI prevention is unknown, used in tandem, they are proven strategies that reduce the risk of CA-SUTI.

**Daily Assessment of Catheter Necessity:**

Medical necessity and clinical appropriateness of indwelling urinary catheter is assessed and documented daily to prevent unnecessary use of the device. The following list of medical necessity is taken from the *CMS Standard Operations Manual for Long-Term Care* and is used to assess continued use beyond fourteen (14) days. The form for daily assessment of indwelling urinary catheters is provided as **ADDENDUM A**. Consider:

1. Urinary Retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by:
  - a. Documented post void residual (PVR) volumes in a range over 200 milliliters (ml);
  - b. Inability to manage the retention/incontinence with intermittent catheterization; and
  - c. Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction
2. Contamination of Stage III or IV pressure ulcers with urine which has impeded healing, despite appropriate personal care for the incontinence; and
3. Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.

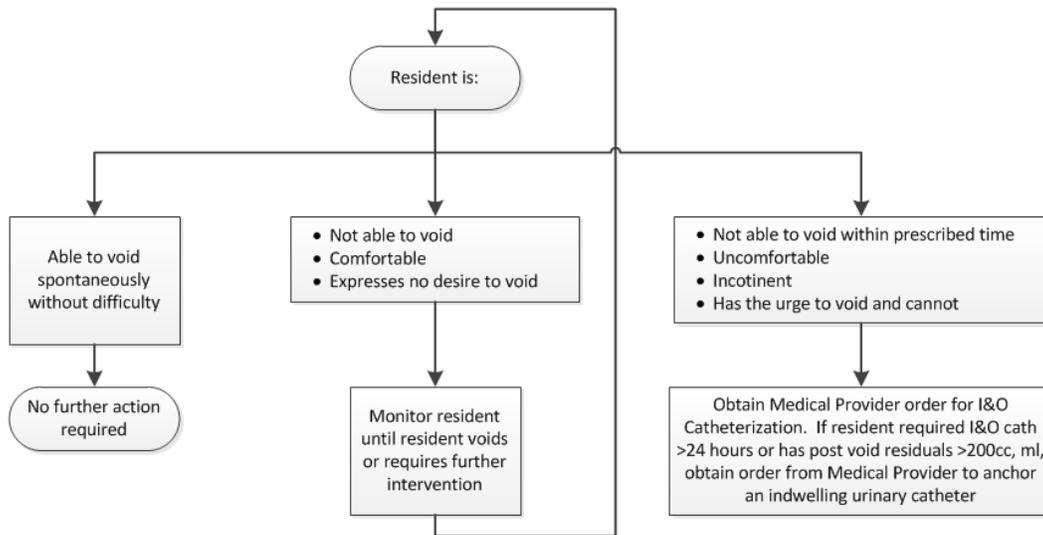
In the event a resident does not meet this criteria, an order will be obtained from the Medical Provider to discontinue the indwelling urinary catheter.

**C. Indwelling Catheter Removal:**

The following strategies and decision tree are to be utilized when indwelling urinary catheters are removed as a strategy to promote bladder emptying and avoidance of re-catheterization.

1. Early mobilization
2. Avoidance of prolonged horizontal positioning
3. Frequent toileting, offering use of toilet or bedside commode every two (2) hours with privacy
4. External catheter use for male residents
5. Use bladder scanner for assessment of retention
6. Use intermittent catheterization and obtain Medical Provider orders to implement

**ADDENDUM C** is a skills check-off to ensure indwelling catheter removal competency (catheter removed safely with no trauma to the resident).



**D. Hand Hygiene Before and After Touching Urinary Catheters:**

Multiple studies have shown hand hygiene as the primary intervention in preventing transmission of microorganisms. The World Health Organization (WHO) has developed the *5 Moments for Hand Hygiene in Healthcare* adopted by the Centers for Disease Control and Prevention (CDC). This practice ensures safety for the resident receiving care and for subsequent residents the healthcare provider interacts with, decreasing risk to the population and to themselves.

The 5 Moments for Hand Hygiene are:

1. Before touching a resident
2. Before clean/aseptic task
3. After body fluid exposure risk
4. After resident contact
5. After contact with resident surroundings

In order to facilitate hand hygiene, product(s) will be easily accessible throughout the resident’s surroundings (in his/her room or in common areas). Such products include soap and water with paper towels and adequate waste receptacles or waterless alcohol-based hand cleanser mounted throughout the facility. Products can be carried on staff’s person, placed on carts, or located in nursing stations.

**E. Catheter Secured:**

Indwelling catheters are to be secured using a leg strap or securement device to minimize urethral trauma, movement of the catheter within the urethra, and accidental dislodgment with associated urethral trauma.

**F. Tamper-Evident Seal Intact:**

Bacteria are introduced when the closed urinary drainage system is opened, leading to internal or intraluminal ascension of microorganisms and increasing the risk for CA-SUTI. Biofilm forms and can lead to mucosal damage within the bladder. Routine flushing of indwelling urinary systems is not supported or recommended. In the event a drainage system is not functioning properly, the best response is to obtain an order from the Medical Provider to discontinue the current catheter and replace it aseptically with a new one.

While routine drainage bag changing is not recommended, it is recognized that in the home setting, a resident may change from night time drainage bag to a leg drainage bag that will facilitate mobility, socialization, and participation of activities outside his/her room. When those bags are changed, it must be done aseptically to minimize any contamination or introduction of bacteria. **ADDENDUM D** is a skills check off for competency requirements for changing an overnight bag to daytime leg bag and vice versa.

Additionally, when urinary drainage bags are changed, new bags should be used. It is unreasonable, however, to mandate that a new bag must be used with every bag change in a resident's home. In some instances, this would require fourteen (14) bags a week, making this a costly and wasteful exercise. There is no evidence to suggest that a routinely cleaned bag used by only one resident increases the risk of infection. Guidelines for cleaning urinary drainage bags have been in place and utilized extensively in residential settings by wound and ostomy nurses. It is important in this setting to ensure hygiene of urinary bags and a procedural tree has been developed (**ADDENDUM G**). There are two (2) choices for cleaning, using a 1:10 bleach and water mixture or a 1:3 vinegar and water mixture.

**G. Drain Tube is Properly Positioned and Secured with No Dependent Loops:**

Urine drainage bags are to be positioned below the bladder utilizing gravity to facilitate drainage. Correct positioning of tubing using the securement clip facilitates drainage into the bag and prevents reflux of old urine into the bladder. Bags must never touch the floor to prevent contamination that can be a potential source for external biofilm formation.

**H. Drain Bag is Not Overfilled:**

Empty collection bag regularly with a separate, clean container for each resident. Avoid splashing and ensure the drainage spigot does not come into contact with the non-sterile collecting container. Staff that are responsible for this task must understand the importance of this concept in order to decrease risk of infection for residents.

**I. Minimum of Daily Catheter Hygiene:**

Catheter hygiene is performed daily and after any episode of incontinence/bowel movement. Staff that perform this task must demonstrate competency upon hire and yearly. **ADDENDUM E** is a skills check-off for catheter care competency.

**III. Prolonged Use of Indwelling Urinary Catheter:**

In the event that it has been determined that a resident will require long-term or chronic urinary diversion, other modalities that pose less risk to the individual must be considered, such as suprapubic catheters or intermittent catheterization.

# (Facility Name and Address)

## ADDENDUM A

### 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: \_\_\_\_\_

	<u>Sun</u>	<u>Mon</u>	<u>Tues</u>	<u>Wed</u>	<u>Thurs</u>	<u>Fri</u>	<u>Sat</u>
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)

**INDWELLING URINARY CATHETERIZATION PERFORMANCE CHECKLIST**

***FOR FEMALES***

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_  
UNIT: \_\_\_\_\_

The above named healthcare provider:

- HAS MET** all performance criteria (critical behaviors) identified below;
- HAS NOT MET** the performance criteria (critical behaviors) identified below with a checkmark (✓) in “NOT MET” box. **Refer to action plan.**

As of \_\_\_\_\_, validated by: \_\_\_\_\_  
(Date) (Signature of evaluator)

\_\_\_\_\_  
(Printed name)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
1. Assemble needed equipment for peri-bath and indwelling catheterization.			Use the smallest catheter as possible.
2. Explain the purpose and necessity of the procedure to the resident.			Introduce self. Maintain resident privacy. Keep resident warm.
3. Perform hand hygiene, don gloves. Perform peri-bath and discard disposable equipment.			Cleanse peri area with soap and water. Wipe basin with disinfectant wipe after use.
4. Hand Hygiene. Follow Standard Precautions.			
5. Position resident.			
6. Open catheterization tray (maintain content sterility). Use wrapper to make sterile field.			Open edges away.
7. Place plastic-lined sheet under buttocks, by folding corners over hands.			
8. Don sterile gloves.			
9. Place fenestrated drape over perineum.			Do not contaminate gloves.
10. Arrange tray contents for use: a. Pour iodine solution over cotton balls b. Lift top tray and place onto sterile field c. Dispense lubricant onto tray d. Remove plastic shield from indwelling catheter and lubricate end of catheter			No balloon check necessary before insertion.

***Checklist continued on the next page...***

(Facility Name and Address)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
11. Cleanse urethral meatus: a. With less-dominant hand, separate labia and apply gentle traction upward. b. With dominant hand, use forceps to grasp iodine saturated cotton ball and cleanse the meatus wiping top to bottom of center, then outward using a new cotton ball with each wipe.			Must keep less-dominant hand in place for entire procedure and keep labia separated at all times.
12. Continue using less dominant hand to separate labia.			Have resident take slow, deep breaths to focus the mind and relax musculature.
13. Pick up catheter with dominant hand approximately 2-3 inches from catheter tip. Place distal end in sterile tray.			
14. Gently insert the catheter into the meatus and advance until you see urine flow, and then advance another ½ - 1 inch.			If the catheter is inserted into the vagina leave catheter in vagina and repeat steps 3-12. Remove catheter from vagina after proper placement of urethral catheter.
15. Release labia and hold catheter in place while dominant hand inflates balloon with 10ml sterile water into balloon port.			
16. Gently pull back catheter to position balloon at neck of bladder.			Stop once any resistance is felt.
17. Place indwelling catheter bag below the level of the bladder.			Do not curl tubing. Keep straight at all times.
18. Secure catheter with securement device.			If necessary, clip skin hair for adhesion. Allow sufficient time for alcohol prep and skin protectant to dry. Secure catheter with securement device, but not too tight.
19. Document date on securement device.			Must be replaced every 7 days.
20. Discard disposable equipment in Infectious Waste Trash.			
21. Doff gloves and perform hand hygiene.			
22. Document intervention.			Document size, resident tolerance, and description of urine. Document indwelling urinary catheter necessity on review form.

**ACTION PLAN**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date Action plan to be completed by: \_\_\_\_\_

Date Revalidation to be completed by: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Supervisor/Designee Signature: \_\_\_\_\_ Title: \_\_\_\_\_

INDWELLING URINARY CATHETERIZATION PERFORMANCE CHECKLIST

**FOR MALES**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

UNIT: \_\_\_\_\_

The above named healthcare provider:

- HAS MET all performance criteria (critical behaviors) identified below;
- HAS NOT MET the performance criteria (critical behaviors) identified below with a checkmark (✓) in "NOT MET" box. **Refer to action plan.**

As of \_\_\_\_\_, validated by: \_\_\_\_\_  
(Date) (Signature of evaluator)

\_\_\_\_\_  
(Printed name)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
1. Assemble needed equipment for peri-bath and indwelling catheterization.			Use the smallest catheter as possible.
2. Explain the purpose and necessity of the procedure to the resident.			Introduce self. Maintain resident privacy. Keep resident warm.
3. Perform hand hygiene, don gloves. Perform peri-bath and discard disposable equipment.			Cleanse peri area with soap and water. Wipe basin with disinfectant wipe after use.
4. Hand Hygiene. Follow Standard Precautions.			
5. Position resident.			
6. Open catheterization tray (maintain content sterility). Use wrapper to make sterile field.			Open edges away.
7. Place plastic-lined sheet over scrotum and upper thighs			
8. Don sterile gloves.			
9. Place fenestrated drape over penis			Do not contaminate gloves.
10. Arrange tray contents for use: a. Pour iodine solution over cotton balls b. Lift top tray and place onto sterile field c. Dispense lubricant onto tray d. Remove plastic shield from indwelling catheter and lubricate end of catheter			No balloon check necessary before insertion.
<b>Checklist continued on the next page...</b>			

(Facility Name and Address)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
11. Cleanse urethral meatus: a. With less-dominant hand, retract foreskin if resident is uncircumcised and grasp penis at shaft. b. With dominant hand, use forceps to grasp iodine saturated cotton ball, start at the opening to the meatus and cleanse in a circular motion using as many cotton balls as necessary to cleanse penis down to base of the glans.			Must keep less-dominant hand in place for entire procedure.
12. Lift penis to position perpendicular to the resident's body and apply light traction.			Changes in angle or traction may help. Have resident take slow, deep breaths to focus the mind and relax the musculature.
13. Pick up catheter with dominant hand approximately 2-3 inches from catheter tip. Place distal end in sterile tray.			Do not force catheter. If resistance is met, stop, remove indwelling catheter and notify physician.
14. Gently insert the catheter into the meatus and advance to "Y" in catheter.			Insert to "Y" to make sure that the balloon is past the prostate before inflating.
15. Inflate balloon with 10ml sterile water in balloon port.			
16. Gently pull back catheter to position balloon at neck of bladder.			Stop once any resistance is felt.
17. Place indwelling catheter bag below the level of the bladder.			Do not curl tubing. Keep straight at all times.
18. Secure catheter with securement device.			If necessary, clip skin hair for adhesion. Allow sufficient time for alcohol prep and skin protectant to dry. Secure catheter with securement device, but not too tight.
19. Document date on securement device.			Must be replaced every 7 days.
20. Discard disposable equipment in Infectious Waste Trash.			
21. Doff gloves and perform hand hygiene.			
22. Document intervention.			Document size, resident tolerance, and description of urine. Document indwelling urinary catheter necessity on review form.

**ACTION PLAN**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date Action plan to be completed by: \_\_\_\_\_

Date Revalidation to be completed by: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Supervisor/Designee Signature: \_\_\_\_\_ Title: \_\_\_\_\_

(Facility Name and Address)

**ADDENDUM C**

**INDWELLING URINARY CATHETER REMOVAL CHECKLIST**

**FOR MALES & FEMALES**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

UNIT: \_\_\_\_\_

The above named healthcare provider:

- HAS MET** all performance criteria (critical behaviors) identified below;
- HAS NOT MET** the performance criteria (critical behaviors) identified below with a checkmark (✓) in “NOT MET” box. **Refer to action plan.**

As of \_\_\_\_\_, validated by: \_\_\_\_\_  
(Date) (Signature of evaluator)

\_\_\_\_\_  
(Printed name)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
1. Close curtain or door to ensure resident privacy. Verify that discontinuation orders match resident information.			
2. Explain procedure to resident.			Introduce self, explain purpose and necessity of procedure, teach if able.
3. Perform hand hygiene and don gloves.			
4. Position bed to appropriate working height.			If side rails are raised, lower side rail on working side.
5. Organize equipment for catheter removal.			
6. Position resident.			Cover resident with bath blanket, exposing only perineal area.
7. Place waterproof pad under resident.			
8. Obtain sterile urine specimen if required.			
9. Remove adhesive tape or Velcro tube holder securing and anchoring catheter.			
10. Observe any discharge or redness around urethral meatus.			
<b>Checklist continued on the next page...</b>			

(Facility Name and Address)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
11. Insert hub of syringe into inflation valve (balloon port). Allow sterile water to return into syringe by gravity until the plunger stops moving and the amount instilled is removed.			
12. Pull catheter out slowly and gently while wrapping contaminated catheter in waterproof pad.			If resistance is met during catheter removal, catheter should be left in place and urologist should be consulted.
13. Unhook collection bag and drainage tubing from bed.			
14. Reposition resident as necessary to cleanse perineum.			
15. Readjust bed to initial position.			
16. Empty, measure, and record urine present in drainage bag.			
17. Discard used supplies.			
18. Doff gloves and perform hand hygiene.			
19. Document the procedure in the resident's record.			

# (Facility Name and Address)

## ADDENDUM D

### INDWELLING URINARY CATHETER – CHANGING URINARY DRAINAGE BAG CHECKLIST

#### **FOR MALES & FEMALES**

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

UNIT: \_\_\_\_\_

The above named healthcare provider:

- HAS MET all performance criteria (critical behaviors) identified below;
- HAS NOT MET the performance criteria (critical behaviors) identified below with a checkmark (✓) in “NOT MET” box. **Refer to action plan.**

As of \_\_\_\_\_, validated by: \_\_\_\_\_  
(Date) (Signature of evaluator)

\_\_\_\_\_  
(Printed name)

CRITICAL BEHAVIORS	MET	NOT MET	COMMENTS
1. Perform hand hygiene.			
2. Disconnect catheter from the drainage bag/leg bag tubing, careful not to tug the catheter end.			Avoid touching the tube or catheter ends as you disconnect them.
3. Clean the ends of the drainage bag tubing and catheter with rubbing alcohol.			Use either a gauze pad or cotton ball.
4. Pinch the catheter tubing to stop urine flow.			
5. Clean the tubing end of the replacement bag (if it is not a new, sterile bag).			
6. Connect the new/replacement bag tubing to the catheter snugly to prevent leaking.			
7. Clean the connection site again with alcohol.			
8. Cap the tubing end of the bag not in use.			
9. Return the bag to its desired location. Ensuring the drainage bag is below the level of the resident's bladder.			Strap the bag to the leg if applicable. Adjust straps so they are comfortable and not too tight. Leave a little slack to prevent the catheter from pulling when moving.
10. Perform hand hygiene.			

**INDWELLING URINARY CATHETER CARE**  
**SKILL CHECK-OFF FOR CNA STAFF**

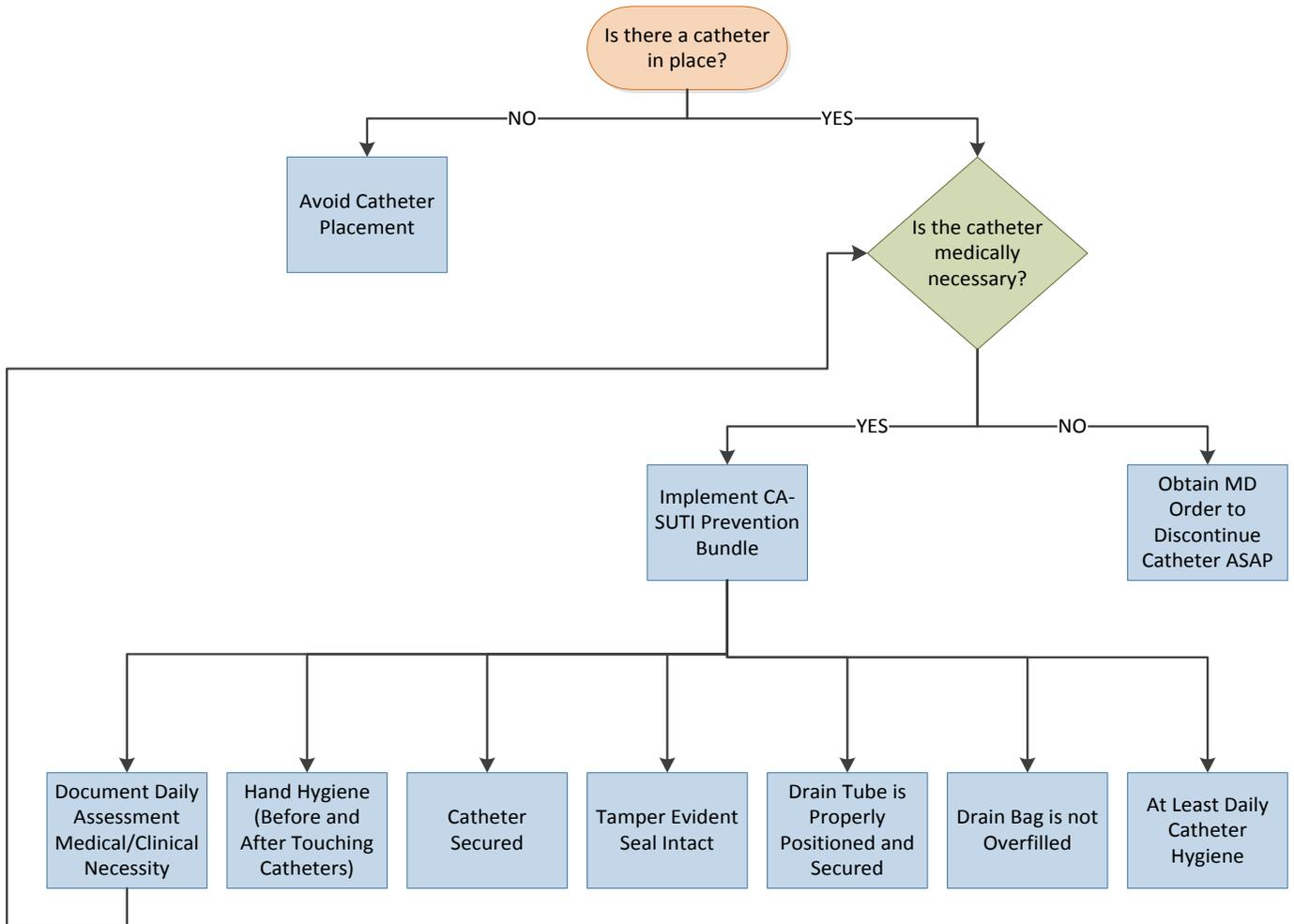
1. Perform hand hygiene and don gloves prior to handling the catheter, drainage system, or bag.
2. Check the perineum and urinary meatus during A.M. and P.M. care for any signs of inflammation.
3. Cleanse the perineum and urinary meatus with soap and water or a perineal rinse as part of A.M. and P.M. care and after each bowel movement or incontinence episode.
4. Cleanse the perineum from front to back and cleanse the catheter away from the meatus.
5. Be sure the catheter is properly anchored to prevent accidental tears of the urinary meatus.
6. Be sure the catheter, drainage system, and bag are properly positioned to maintain urine flow.
7. Doff gloves and perform hand hygiene.
8. Empty the collection bag each shift or more often as indicated. Use a separate container for each resident and avoid touching the spigot to the container.
9. Record urinary output.
10. Report the following to the nurse responsible for the resident's care:
  - a. Any sign or symptom of urinary tract infection (UTI): fever; change in urine, such as a foul odor or bloody/cloudy appearance; change in the resident's mental or physical status
  - b. No urine output or decreased urine output
  - c. Leakage of urine
  - d. Complaints of urinary-related pain
11. Exercise caution with mobility and positioning of the resident to prevent accidental removal.

PASSED: \_\_\_\_\_ FURTHER INSTRUCTION REQUIRED: \_\_\_\_\_

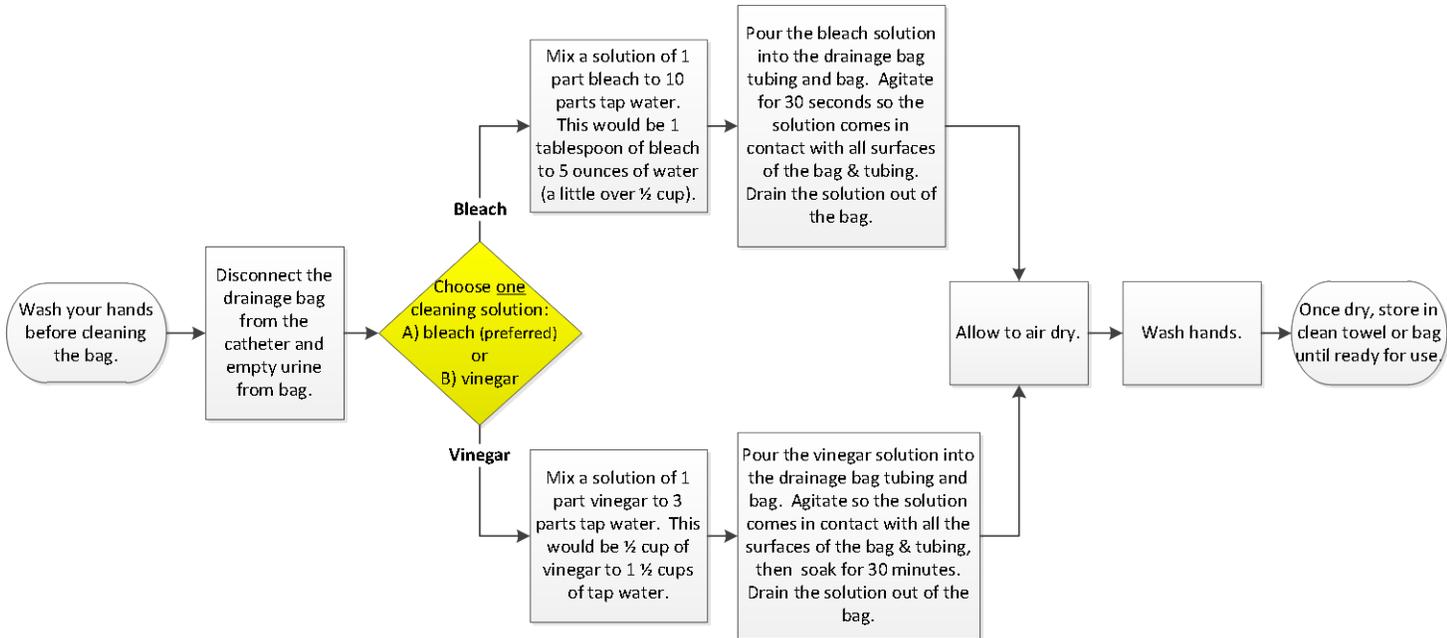
NEXT STEPS:

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**CA-SUTI Prevention Bundle**



**How to Clean a Drainage Bag**  
If you are using a leg bag during the day, the drainage bag should be cleaned in the morning when changing the leg bag, and the leg bag should be cleaned at night when changing back to the drainage bag.



## (Facility Name and Address)

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