Appendix G.
Indwelling Urinary Catheter Insertion Checklist

Instructions for Use

Purpose

Use of a standardized indwelling urinary catheter (IUC) insertion checklist can ensure that residents are protected through application of nationally recognized evidence-based practices during this invasive procedure to reduce the risk of cross infection.

Rationale

The development of biofilms, bacteria colonization, asymptomatic bacteriuria, and symptomatic urinary tract infections are common to urinary catheter use. The risk of acquiring a catheter-associated urinary tract infection (CAUTI) due to urinary catheter insertion depends on aseptic technique during catheterization and on host susceptibility. Poor insertion technique can lead to the risk of cross transmission of microorganisms from the health care worker's hands and/or the equipment to the susceptible resident.

When Applicable

Anytime a new IUC is inserted. The results of the completed checklist provide the facility team with information on progress and barriers related to the processes involved in catheter insertion, such as use of aseptic techniques.

Next Steps

The completed checklist can be forwarded to the quality improvement team for review and potential improvement opportunities.

For All Indwelling Urinary Catheter Procedures:

- **Resident Name**. Identify the resident by completing the fields for resident full name, medical record number, unit/room, and the date and time that the IUC is being inserted.
- **Inserting Clinician**. Complete fields for inserting clinician's name, full signature, and title.
- **Technique Reviewer**. Complete fields for name of staff member present during insertion to ensure that correct procedural steps and aseptic technique are performed. Note that this person may also be assigned the task of completing the insertion checklist during the procedure.
- **Prior to, During, or After IUC Insertion:** Check the box next to each step when completed.
    - Use the comment section to list breaks in technique, if applicable, and corrective actions.
    - Check that the catheter is inserted based on the Centers for Disease Control and Prevention (CDC) appropriate indications for IUC use.[1]

References

1. Gould CV, Umscheid CA, Agarwal RK, et al. Guideline for prevention of catheter-associated urinary tract infections 2009. Infect Control Hosp Epidemiol. 2010 Apr;31(4):319-26. PMID: 20156062.

Additional Resources

Association for Professionals in Infection Control and Epidemiology. Guide to the Elimination of Catheter-Associated Urinary Tract Infections. 2008. http://www.apic.org/Resource_/EliminationGuideForm/c0790db8-2aca-4179-a7ae-676c27592de2/File/APIC-CAUTI-Guide.pdf.

Centers for Medicare & Medicaid Services. State Operations Manual. Appendix PP Revisions to Appendix PP—Section 483.25(d)-Urinary Incontinence, Tags F315 and F316. June 28, 2005. http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R8SOM.pdf.

Lippincott's Visual Encyclopedia of Clinical Skills. 2009. LWW; 257-60.

Lo E, Nicolle LE, Coffin SE, et al. Strategies to prevent catheter-associated urinary tract infections in acute care hospitals: 2014 update. *Infect Control Hosp Epidemiol.* 2014 May; 35(5): 464-79. PMID: 24709715.

Lynn P. Taylor's Clinical Nursing Skills. Third edition. 2011. Lippincott Williams & Wilkins; 617-32.

Long-Term Care: Indwelling Urinary Catheter Insertion Checklist

Resident Name (print)_____Med Rec#_____Unit_____Date/Time_____

Inserting Clinician (print)_____Signature_____

Technique Reviewer[1], if applicable (print) _____Signature_____

I. BEFORE CATHETER INSERTION	✓	COMMENTS
1. Confirm order, to include catheter and balloon size; use the smallest effective catheter size.		
2. Assemble and verify supplies. Consider bringing a second catheter to use if the first one is accidentally contaminated.		
3. Identify the resident, per facility policy. Explain the procedure, its necessity, and its potential complications to the resident and/or family.		
4. Ensure privacy and good lighting.		
5. Position the resident correctly for the procedure; consider using an assistant to help resident stay in position and decrease potential contamination of sterile catheter.		
6. Perform hand hygiene, don clean gloves, and cleanse the perineal area with a washcloth, skin cleanser, and warm water, moving from front to back.		
7. Remove gloves and perform hand hygiene.		
II. DURING INSERTION	**✓**	**COMMENTS**
1. Open the sterile catheterization kit on a clean bedside table, using sterile technique. Ensure all supplies are conveniently positioned.		
2. Put on sterile gloves and drape the resident.		
3. Prepare the antiseptic solution; ensure the resident is not allergic to iodine. Apply sterile lubricant to the catheter tip. Consider attaching catheter to drainage system now, if not already attached, and ensure the drainage bag emptying port is clamped.		
4. With nondominant hand, identify meatus, and be prepared to keep this hand in this position until after the urine is flowing.		
5. With dominant (sterile) hand, clean the meatus opening with the antiseptic solution, moving from top to bottom. Use a new		

[1] Licensed nursing staff member present during insertion to ensure that correct procedural steps/aseptic technique are performed.

wipe/swab each time. Allow the antiseptic to dry.		
6. With the dominant (sterile) hand, insert the catheter slowly into the urethra until there is a return of urine. Then advance the catheter 2-3 inches more. (Do not force the catheter through the urethra). Leave the catheter in the vagina, if accidentally inserted, until after the new sterile urinary catheter is inserted into the bladder.		
7. Hold the catheter with the nondominant hand; use the dominant hand to fully inflate the catheter balloon with the entire volume of supplied sterile water in the prefilled syringe.		
8. Gently pull on catheter after balloon inflation to feel resistance.		
III. AFTER INSERTION	✓	**COMMENTS**
1. Remove used equipment and dispose of used supplies in trash per facility policy. Place syringe in sharps container. If a bladder scanner was used, wipe it with appropriate disinfectant cleaner before storing for use with the next resident.		
2. Secure catheter to the resident's leg with securement device. Remove gloves and perform hand hygiene		
3. Cover the resident with linens and assist to a comfortable position.		
4. Ensure the tubing in not kinked and the drainage bag is below the level of the bladder. Place a cover over the drainage bag to maintain resident dignity.		
5. Perform hand hygiene.		
6. Document— a. Type and size of catheter and balloon b. Amount of fluid inserted in the balloon c. How the resident tolerated the procedure d. Amount of urine obtained and its characteristics e. Name of person performing the insertion and the date it was completed.		
7. Label a urine collection container with a resident identifier and date.		

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