UCSF Health

FAQs for Nurse Driven Indwelling Urinary Catheter (IUC) Removal Protocol

Why is UCSF Health optimizing our nurse driven indwelling urinary catheter (IUC) removal protocol?
Regular attention to the presence of IUCs and prompt IUC removal is a key cornerstone to decreasing the risk of your patient developing a catheter-associated urinary tract infection (CAUTI). UCSF Health's CAUTI rates are higher than national benchmarks, and many other peer institutions use a similar nurse driven IUC removal protocol as one of their strategies to decrease the risk of CAUTI. IUCs also result in decreased patient mobility, which leads to increased patient risk of venous thromboembolism, pressure ulcers, and falls.

What is the nurse driven indwelling urinary catheter (IUC) removal protocol?
The bedside nurse will review the patient's clinical indication for a IUC every shift, and if a clear clinical indication is not met, they are authorized to remove the IUC. The first call provider will be informed via page or Voalte that the IUC was removed. All foley catheter orders will default to the nurse driven IUC removal protocol unless the ordering provider chooses to opt out by selecting one of the four provider-driven indications for an IUC.

What are the provider driven indications for placing and maintaining an IUC?
For patients with the following conditions, providers can opt-out of the RN-driven IUC removal protocol and place a provider-driven IUC order:

- GI, GU, Gyn, or OB surgery or pelvic trauma requiring IUC
- Chronic urinary obstruction and not a candidate for clean intermittent catheterization (CIC)
- Difficult IUC placed by provider (e.g. urology consultant)
- Undergoing continuous bladder irrigation, bladder pressure measurements, or medication administration via IUC

If one of the above indications is applicable to the patient and selected, the provider must place a "remove foley catheter" order prior to the foley being removed by the bedside nurse.

What are the clinically accepted indications for placing and maintaining an IUC?

- Need for accurate ***hourly*** I&O in *critically ill* patients (e.g. you are actively adjusting care on an hourly basis based on the I&Os)
- Acute urinary obstruction or retention
- Healing promotion for perineal/sacral wounds (stage III/IV) without alternative management strategy
- Required prolonged immobilization (e.g. unstable spine)
- Peri-operative fluid management up to 24 hours post-op
- Specific removal time indicated by order (e.g. "Remove catheter POD#1 at 6 am)
- Hazardous materials contained in urine (e.g. chemotherapy or radiation)

Per protocol, the bedside nurse will remove the IUC when any of the above clinical situations resolves or is no longer applicable to the patient.

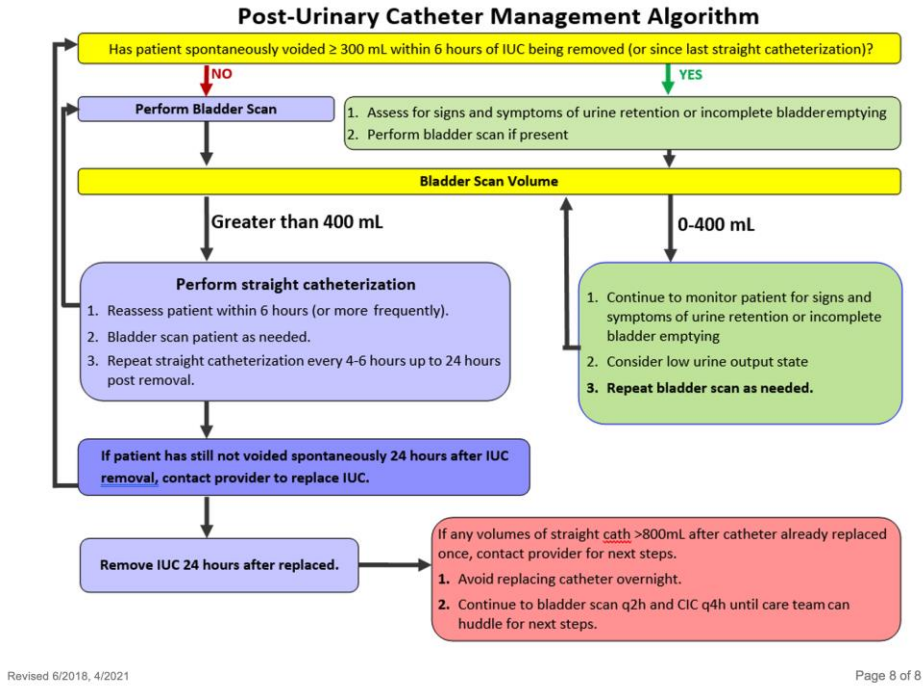
What are NOT clinically accepted indications for placing and maintaining an IUC?

- Substitute for urinary incontinence care
- Obtain diagnostic tests when patients can voluntarily void
- Prolonged postoperative use without appropriate indications (see above appropriate indications)
- Routine use for patients receiving epidural anesthesia/analgesia

These are some common examples where IUCs are not clinically indicated, and is not an exhaustive list. Per protocol, the bedside nurse will remove the IUC in any of the above clinical situations or those that are outside of the clinically accepted indications for placing and maintaining an IUC.

What happens if I need strict Ins and Outs to clinically manage my patient? Can I put the IUC back in?
There are other modalities for collecting strict Is and Os for your patient beyond an IUC, and nurses have training to collect accurate urine output measurements using urinals, bedside commodes, urinary hat collection devices, and/or clean intermittent catheterization. There are also external urinary collection devices that have been rolled out across all adult inpatient units. You may discuss the best option(s) for your patient with the bedside nurse.

What happens to a patient if they are unable to void after the IUC is removed?
Bedside nurses will follow a post-urinary catheter management algorithm as shown below.



Is there a higher risk for CAUTI if clean intermittent catheterization (CIC) is used?
CIC does NOT increase the risk of UTI and in fact places the patient at less risk for bacteriuria and UTI compared to an indwelling urinary catheter.

Is clean intermittent catheterization (CIC) uncomfortable for patients?
Nurses are trained in CIC and are encouraged to use liberal amounts of lubrication to ensure CIC is as comfortable for the patient as possible. CIC is well tolerated and patients with chronic urinary obstruction often perform CIC themselves as a part of their daily routine.

If there are further questions about the nurse driven IUC removal protocol, please contact:

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