NURSING STANDARDIZED PROCEDURE: Bladder Management

Population: INPATIENT WITH INDWELLING URINARY CATHETER (IUC)

Expected Outcome:

- Reduction in utilization of indwelling urinary catheters (IUC) and prevention of catheter associated urinary tract infections.

Nursing Assessment and Interventions:

- Assess patient every shift to determine if the patient continues to require an IUC:
    - Urinary retention
    - Urinary obstruction
    - Need for accurate measurement of urinary output in a critically ill patient; patient undergoing aggressive diuresis, or presence of renal impairment (unless patient is able to cooperate with strict I&O monitoring-can use a bed pan, urinal or commode)
    - Genitourinary tract surgery / Pelvic Surgery
    - Surgical patients (remove by post-op day 2)
    - Acute phase genitalia wounds
    - To aid in healing of Stage 3 and 4 pressure ulcers that cannot be kept dry utilizing standard protocol.
    - End of life comfort care orders in place for terminally ill patient
    - Epidural catheter in place

- If the patient fits one of these criteria document the appropriate justification in Cerner/IVIEW/Drains&Tubes/Foley /Justification

- If patient does not meet criteria for continuation of the IUC, remove IUC and enter a Cerner order for DC Foley "per Standardized Protocol." Consider other means of bladder management including an appropriate toileting plan, external male catheters, and peripads for incontinent women.

- Document in Cerner /IVIEW/Drains&Tubes /Foley Discontinuation / time that the IUC was discontinued.

- Assess voiding within 6 hours after removal of an IUC

    - If patient voids a total of ≥300 ml, no action is required.
    - If patient voids <300ml, bladder scan within 15 minutes of the void
        - If scan shows post void residual of >150 but ≤300ml, and patient is not uncomfortable, encourage voiding, encourage fluid intake, reposition the patient, and reassess 3hrs later. If scan shows >300 ml, straight cath patient and record volume.

            - Repeat process after 6 hrs, straight cath patient if indicated and record volume
            - Repeat for at least 3 periods of 6 hrs
            - Bladder scan patient whenever patient reports lower abdominal discomfort, has the urge to void but cannot, has frequent urination with small amounts, or becomes incontinent.
            - Review results with physician during daytime rounding regarding plans for an IUC and medications that may be causing retention.

ANURIC PATIENT

Patients who are identified as being anuric for >2 days should have their IUC discontinued.

- Bladder scans should be performed as needed based upon bedside nurse evaluation including assessment of the suprapubic area every shift for any fullness or lower abdominal discomfort or when the patient has the urge to void but cannot.

PATIENT DETERMINED TO HAVE URINARY RETENTION

If a patient is determined to have retention, the physician should be asked during daily rounds for a treatment plan (e.g. consideration of medications for retention, medications with the potential side effects of retention, bladder training, and Physical Therapy orders). Nursing should address this plan in their daily progress report. The plan should be reassessed with the physician at a minimum of every 7 days.

STANDARDIZED PROCEDURE FOR PERFORMANCE OF INTERDEPENDENT FUNCTION BY REGISTERED NURSES

1. Function(s): Perform assessment, interventions and interdependent functions in accordance with bladder management guidelines

2. Circumstances under which a Registered Nurse may perform function(s):

    a. Interdependent functions may be performed when competencies related to performance in accordance with this standardized procedure are assessed and documented.

    b. Setting: Practicing in accordance with this protocol is conducted by registered nurses in all inpatient nursing units.

    c. Supervision: Supervision in performance of interdependent functions outlined in this protocol is not required

3. Method of initial and continued evaluation of competence: All registered nurses will perform competencies specific to this protocol upon hire. Subsequent competencies will be performed during the annual nursing competency process. All competency assessments will be documented and maintained by the Education Department.

4. Review Schedule: This standardized procedure will be reviewed every two years or as designated by practice changes.

Responsible Position	Approval Date
Chief Nurse Officer	06/19/2014
Sponsoring Department or Committee	**Approval Date**
Committee on Interdisciplinary Practice	06/20/2014
	Approval Date
Medical Executive Committee	07/17/2014
Board of Trustees	