Long-Term Care Survey Alert

Survey Compliance: Learn The In's And Out's Of Indwelling Catheter Use Under F315

Catheters require one of these medical rationales - and a care plan

If you routinely use indwelling catheters to manage urinary incontinence, your facility will be on the outs with surveyors.

The bottom line: If a resident has an indwelling catheter for more than 14 days, the facility better have a physician-documented rationale to explain why.

Document Reason for Catheter Use

The revised F315 tag spells out three scenarios where a resident might require a catheter for more than two weeks:

1. Urinary retention that cannot be treated or corrected medically or surgically (and where alternative therapy isn't feasible). The urinary retention is characterized by:

1. Documented post void residual (PVR) volumes in a range over 200 milliliters;
2. Inability to manage the retention/incontinence with intermittent catheterization; and
3. Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction.

Thus, a physician's documentation of a diagnosis of neurogenic bladder won't in itself suffice as a rationale for an indwelling catheter, cautions **Karen Merk, RN**, a clinical consultant with **Briggs Corp.** in Des Moines, IA.

2. Contamination of Stage 3 or 4 pressure ulcer with urine that has impeded healing, despite appropriate personal care for the incontinence.

Tip: Facilities shouldn't automatically use an indwelling catheter as an approach to treat Stage 3 or 4 pressure ulcers, cautions **Nancy Augustine, RN**, a consultant with **LTCQ Inc.** in Lexington, MA.

3. Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable or causes intractable pain. Even then, "facility staff should employ [individualized] pain management interventions ... to see if the person can achieve enough comfort to continue to use the bedpan or toilet," advises **Rena Shephard, RN, MHA, RAC-C, FACDONA**, president of **RRS Healthcare Consulting** in San Diego.

"If the person reaches the point when he can no longer use the toilet, bedpan or urinal - and incontinence is causing discomfort or skin breakdown, etc. - then a catheter might be an appropriate intervention," Shephard adds. "The decision to use a catheter should also reflect the resident's wishes or advance directive and care plan goals to promote comfort and dignity."

Preempt Catheter-Related Problems

Care plans for residents with indwelling catheters should include goals to promote optimal care, wellbeing and prevent catheter-related complications, advises **Cathy Sorgee, RN**, with **Broussard Group** in Lake Charles, LA. Make sure you're covering these bases:

4. **Assess and address leakage around the catheter.** Look for common reasons contributing to leakage, including irritation by a large balloon or catheter materials, excessive catheter diameter, fecal impaction and improper catheter positioning, advises the revised survey guidance. Don't try to remedy leakage by using increasingly large catheter sizes, unless "medically justified." The standard of care calls for facilities to use the "softest, narrowest tube to drain the patient's bladder."

   Leakage around the urinary catheter is a common problem - one usually caused by catheter-induced bladder spasms, says **Joseph Ouslander, MD**, chief medical officer at **Wesley Woods Center of Emory University** in Atlanta. To treat the bladder spasms, "the physician can prescribe a two-week trial of a bladder relaxant (the same medications used to treat urge incontinence or overactive bladder)," Ouslander tells Eli. If the medication doesn't do the trick, the patient may be a candidate for a suprapubic catheter, if he requires long-term use of a catheter, he adds.

5. **Develop a plan to address bowel incontinence.** "If you use a Foley and diaper to manage urinary and bowel incontinence, you're growing a culture," cautioned **Diane Newman, MSN, RN, CRNP, FAAN**, speaking on incontinence and the revised F315 tag at the **American Association of Nurse Assessment Coordinators** annual conference in March 2005. (For tips on managing chronic diarrhea, see p. 87.)

6. **Use best practices to prevent catheter-related complications, including UTI.** Consider adopting existing practice guidelines, such as the ones published by the **American Medical Directors Association** (AMDA), which include catheter care, advises **Gail Patry RN,C**, project manager for **Rhode Island Quality Partners**, the state's quality improvement organization. (AMDA will update the guidelines in Septem- ber, which are available at amda. com/info/cpg/incontinence.htm.)

   Also take steps to prevent UTI. For example, residents who perform their own intermittent catheterization can use clean technique, but nurses should use sterile technique when inserting an indwelling catheter, advises infection control expert **James Marx, RN, MS, CIC**, in San Diego, CA.

   Secure the indwelling urethral catheter in a way that prevents it from moving around the meatus, which can irritate the area and increase the risk for UTI, adds Ouslander. "The catheter can even drop down into incontinent stool, if it is not secured," he cautions.

   Clinical gem: To anchor the tubing in a way that prevents pull on the catheter, use a product that has an adhesive device that applies to the thigh with a swivel mechanism allowing the tubing room to move, suggests Marx. (See the related Clip 'N' Save on catheters, p. 94.)