CAUTI Prevention, Bladder Scanning, & External Female Catheter

Related UCM Protocols:

- Urinary Catheterization
- Protocol for External Female Urinary Device

1. Urinary catheter alternatives

a. Remember No Foley = No CAUTI
b. Scheduled toileting: Commode/bedpan/urinal (male &female)
c. External female catheter **Must meet criteria for appropriate use (see protocol HERE)
d. Male external catheter
e. No diapers for adult unless up in chair/ambulating
f. Maintain good bowel regime; a common reason for urinary retention is full bowel

2. Urinary Catheter Insertion

What to do before putting in catheter:

a. Verify Order/Indication
    i. Does the patient really need the Foley? Remember No Foley = No CAUTI
b. Wash hands, clean patient with soap and water, gather supplies, explain to patient, provide education, 2nd person to assist
c. Review all contents of the insertion kit
d. Clean hands, clean patient again with the castile towelette, drape patient
e. Prepare all items sterilely, Lube catheter 3-4", no need to test balloon
f. Females: Spread labia/expose meatus: Betadine swab right, left and center: clean meatus with betadine, then wipe down toward vagina, don't let labia fall back on meatus
g. Males: Maintain penis **taut** at 90-degree angle, using a circular cleansing of the meatus and glans, use all three betadine sticks. Gentle ¼ turn at the prostate helps with elderly male insertion, insert catheter all the way to the bifurcation, before inflating balloon.

3. Maintenance processes:

a. Bag below bladder
b. Securement device in place, change every 7 days, when loose or soiled
c. No kinks, no dependent loops— be sure urine is free-flowing
d. Empty bag when half-full, before road trips, and at least every 4-6 hours
e. Be sure bag is not resting on the floor, must be hooked to bed or chair (maintaining below bladder level at all times)
f. Be sure to keep drainage spigot free of contamination- wash hands before handling, wear clean gloves, use a clean collection container when emptying
g. Keep CHG cap on the specimen port

4. Nurse-driven pediatric and adult standard pathway for urinary catheter removal

a. Review of daily BPA with appropriate indications
b. Extended urinary catheters

c. Removal of Urology placed catheter
d. Place order to maintain or discontinue, no need to call providers for additional orders, this is the protocol

5. Post Catheter Removal Protocol

a. Assist all pt to void, provide fluids unless contraindicated, up to commode, run water, hands in water, Credé maneuver (The Credé maneuver is executed by exerting manual pressure on the abdomen at the location of the bladder, just below the navel)
b. Pediatric notify providers of bladder scan volumes
c. Adult
   i. Bladder scan if >400ml. Straight cath per protocol…No need for provider order…
   ii. Avoid replacing Foley

6. Bladder Scanners

a. Use appropriate setting: Child, Male, Female, Female no uterus = Male
b. Warm the gel!
c. Scan 3 times and take the highest reading.
d. Concerns: patients with ascites, colorectal, bladder, uterine cancers
e. Notify providers of post void residuals per orders

7. Documentation

a. WALDO DOCUMENT at least every shift, indication, urinary catheter care at least every shift and prn
b. Removal Earlier removal prevents CAUTIs
c. Document urinary catheter care, not pericare, explain the difference!

8. Urinary Catheter Care

a. Soap and water, foam soap, Castile wipes, or meatal wipes if unit is using.
b. Provide urinary catheter care after all stools
c. Refer to Elsevier skills

9. Specimen Collection from Indwelling Urinary Catheter

a. Consult with provider regarding order to remove/replace urinary catheter prior to obtaining specimen
b. Clamp catheter tubing 12” below the specimen port for 30-60 minutes
c. Remove CHG cap from specimen port
d. Cleanse specimen port with CHG swab for 5 sec. and allow to dry
e. Attach sterile vacutainer to specimen port
f. Insert <u>gray urine culture tube</u> into vacutainer first, allow to fill
g. Insert yellow urine tube into vacutainer, allow to fill
h. Attach new sterile CHG cap to specimen port
i. Unclamp catheter tubing to allow urine to free-flow into drainage bag.

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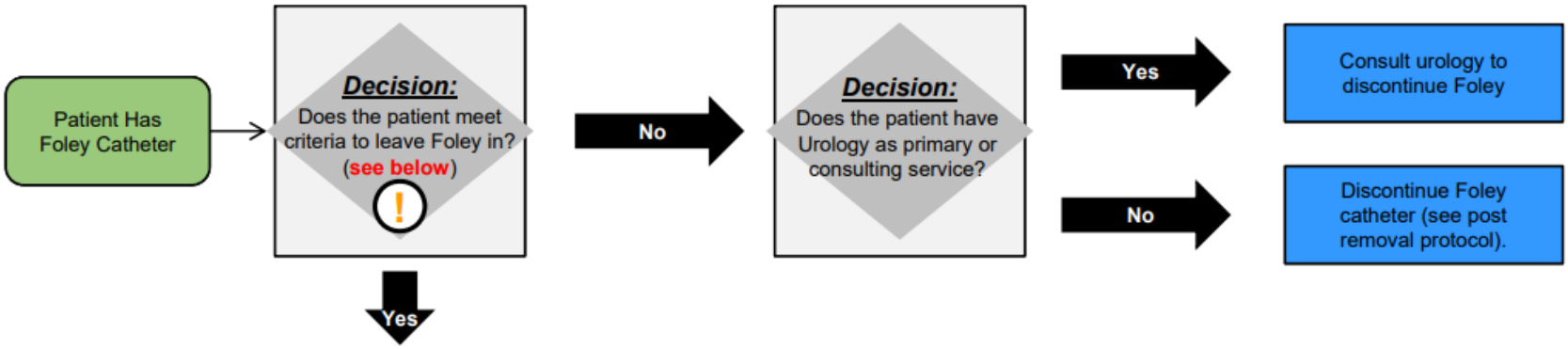
Standard Pathway for Prevention of Catheter-Associated Urinary Tract Infections



Maintain Foley Catheter:

1) Assess need for catheter daily
2) Perform Pericare Q shift and PRN
3) Use catheter securement device
4) Maintain drainage bag lower than level of the bladder
5) Maintain tubing free of kinks and loops
6) Provide patient education about indwelling urinary catheters

Examples of Surgery on a Contiguous Structure:

- **Urologic** – Prostatectomy, neobladder
- **Gynecologic** – Radical hysterectomy, modified radical hysterectomy, extensive dissection around the ureter/bladder, repair of cystostomy or oversew the bladder
- **Colorectal** – abdominoperineal resection, ileoanal procedure, coloanal anastomosis, proctocolectomy, repair of ileo-vesicle fistula, repair of colo-vesicle fistula, major abdominal surgery in a patient with symptomatic BPH
- **Transplant** – Post Renal Transplant

Patient meets at least one of the following criteria:

- Need for accurate measurement of urinary output in a critically ill patients
- Epidural catheter and ONE or MORE of the following:
  - Known history of urinary retention
  - Lumbar epidural catheter
  - Male greater than 65 years of age
  - Benign Prostate Hypertrophy
- Surgery on a contiguous structure (urologic, gynecologic, colorectal)
- Urinary incontinence in a patient with full thickness wound on the trunk (including muscle or skin flaps/skin graft on the trunk)
- Post-surgical within 24 hours
- Acute urinary retention or bladder outlet obstruction
- Neurogenic bladder
- Prolonged immobilization
  - Potential unstable thoracic/lumbar spine
  - Multiple traumatic injuries such as pelvic fracture
- Hematuria with clots (for irrigation)
- To increase comfort at end of life if needed

Adult Patient Post-Catheter Removal Protocol

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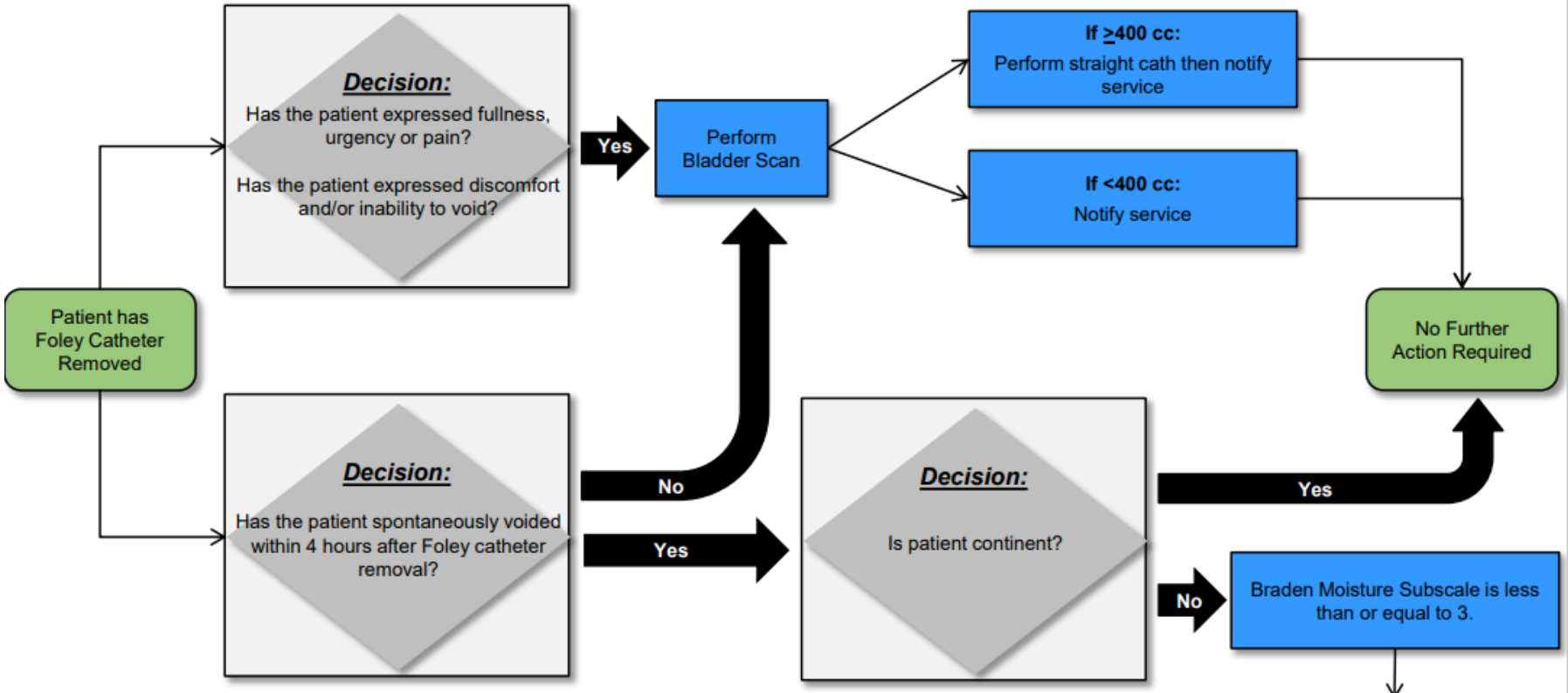

Male Patients:

Texas Catheters or Retracted Penis Pouches

- Patient should be measured for size prior to application of Texas Catheter
- Assess skin daily while in use
- Hair must be clipped prior to application of retracted penis pouch

Incontinence Pads / Diapers:

Should only be used:

- If patient is incontinent and in bed
- Only one incontinence pad should be used at a time
- Only use diapers in adult patients when up in chair or ambulating

Pediatric Patient Post-Catheter Removal Protocol

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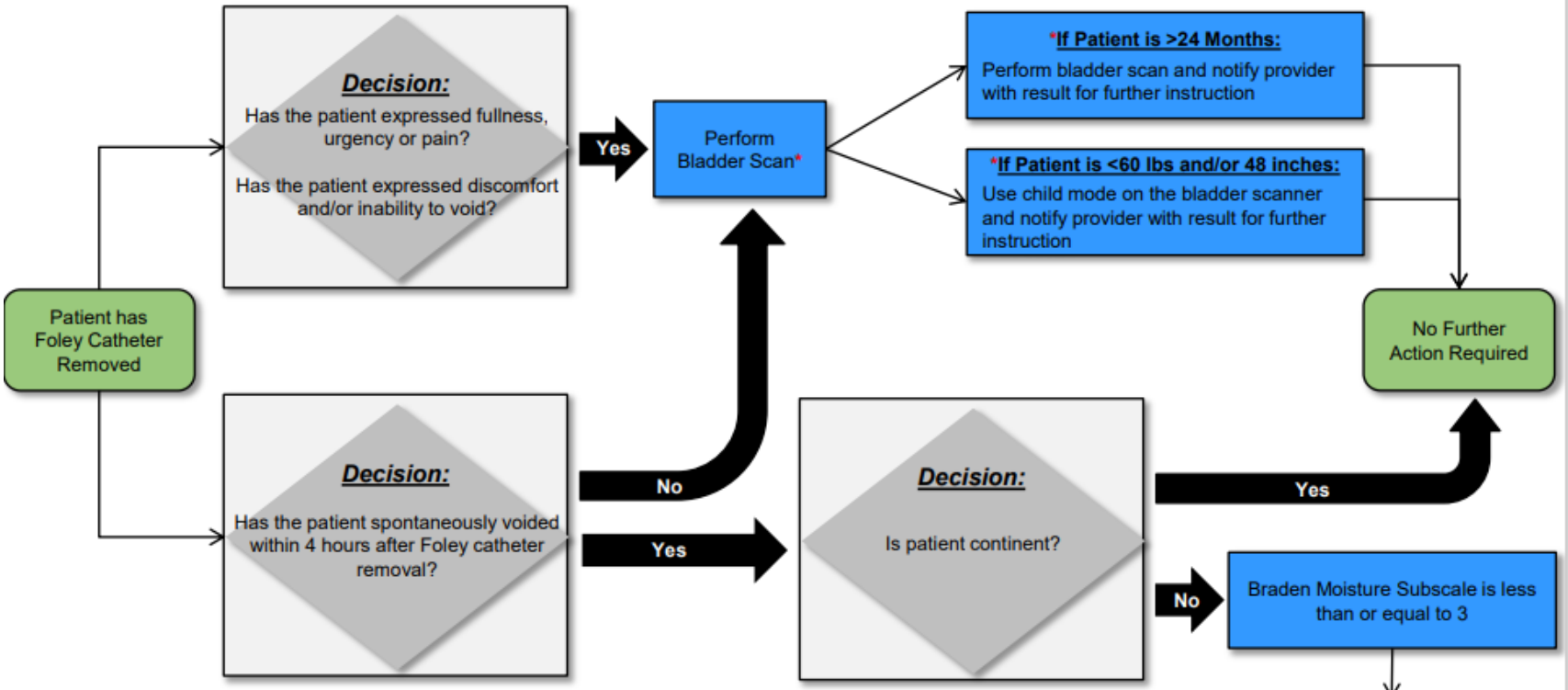


Adolescent Male Patients:

Texas Catheters or Retracted Penis Pouches

- Patient should be measured for size prior to application of Texas Catheter
- Assess skin daily while in use
- Hair must be clipped prior to application of retracted penis pouch

Incontinence Pads / Diapers:

Should only be used:

- If patient is incontinent and in bed
- Only one incontinence pad should be used at a time
- Only use diapers in adolescent patients when up in chair or ambulating
- Acceptable for use in non-potty trained patients

Bladder Scanner

Verathon Bladderscan i10. (If you are using the BVI 9400 model on your unit, please skip to pg. 11.)
Press the On/Off button; be sure that the machine has at least 20% power. (It will not perform an exam if connected to power outlet, FYI.)
Allow the system to start. When the system has started completely, the Home screen appears as shown in the following figure.

From this screen, review the following touchscreen icons:

ICON	FUNCTION
	Saved Exams—On the Home screen, view all exams that are saved to the console.
	Settings—On the Home screen, open the Settings screen.
	Tutorial—On the Home screen, view the onboard tutorial.
	Position—On the Home screen, select which side of the patient you are located on during the exam.
	Scan—Start scanning the patient.

OPTIONAL: Turn the BladderScan device on and view the "onboard tutorial." While the tutorial is playing, you can take these actions:

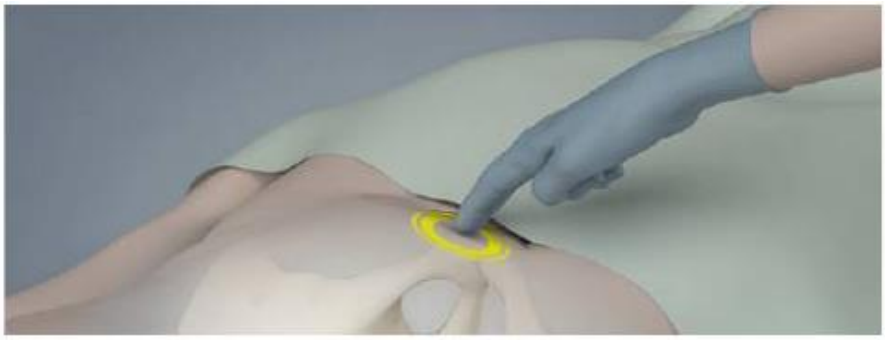
- View the previous frame of the tutorial (tap Previous)
- View the next frame of the tutorial (tap Next)
- Pause the tutorial (tap Pause) or continue the tutorial when paused (tap Play)
- When you are done viewing the tutorial, tap Exit.

**If you choose to skip the onboard tutorial during this training session, I would strongly encourage staff to view it on their own.

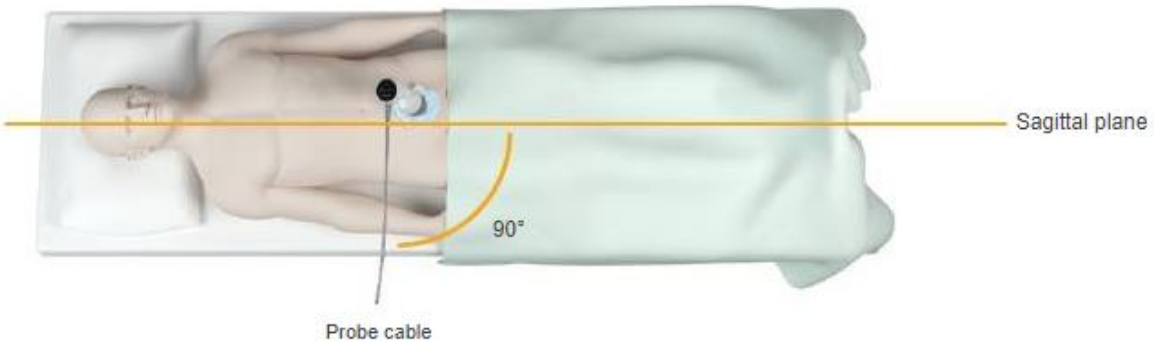
Steps for Measuring Bladder Volume

1. On the Home screen, select whether you are standing on the patient's left or right side by clicking on the correct "position" icon. (You do not need to specify the patient's age or sex to obtain an accurate result.)

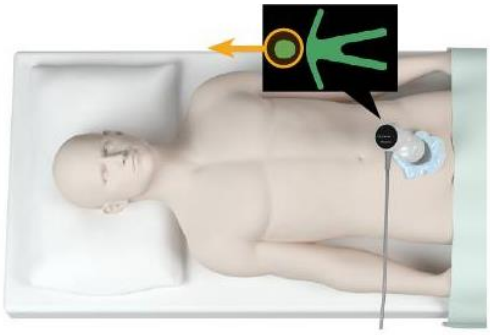
2. With the patient lying in a supine position and with the abdominal muscles relaxed, palpate the patient's pubic bone.



3. Squeeze a large amount (golf ball size) of ultrasound gel, with as few air bubbles as possible, midline on the patient's abdomen, approximately 3 cm (1 inch) above the pubic bone. **Must be ultrasound gel. Do not substitute with lubricant or other.
4. Hold the probe by grasping it with the probe cable running up your wrist and forearm.
5. Gently press the probe onto the lower abdomen through the gel. The probe cable should be oriented at 90 degrees to the sagittal plane of the patient.

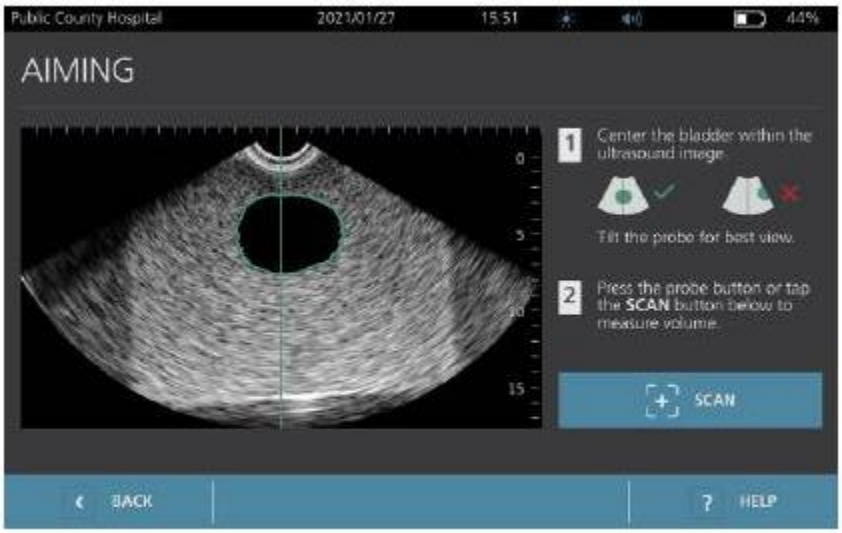


6. Look at the position indicator icons on the top of the probe. Make sure the head of the lighted directionindicator points in the same direction as the head of the patient.

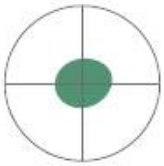
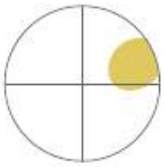


7. If you are scanning an obese patient, lift as much abdominal adipose tissue out of the way of the probe as possible. Apply more pressure to the probe to reduce the amount of adipose tissue through which the ultrasound must pass, but use no more pressure than necessary.
8. Make sure that there are no air gaps between the probe and the patient's skin, and that you are applying enough pressure to maintain adequate skin contact, until the scan is complete. If necessary, add more gel to ensure proper contact.

9. Angle the probe slowly from the patient's left to right until the dark (bladder) area is centered on the vertical green line on the aiming screen. Once the bladder is centered, angle the probe slightly up or down the patient's midline to obtain the largest possible dark area.



10. Once you are finished aiming the probe, press the probe button or tap Scan on the screen. The scanning process begins. (You do not need to hold the button down while the scan is taking place. Just hit once, and release.)
11. Hold the probe steady while the scan is in process. When you hear the end-scan tone, the scan is complete. Continue to the procedure “Review Exam Results.”
12. When the Results screen appears, check whether a yellow greater than (>) symbol appears next to the recorded volume and the bladder is shown in yellow. A greater than symbol (>) along with a yellow post scan result indicates that the bladder boundary may be outside the scan area or partially obstructed by the pubic bone. Actual volume may be underestimated. You should aim the probe again and rescan the patient. For guidance on improving the scan results, see table below:

RESULT	AIMING GUIDANCE	EXAMPLE
Successfully Centered	If the bladder is centered in the field of view, with all edges visible and no gray areas showing, then the scan was successful and the results are as accurate as possible.	
Not Centered	If the bladder is not centered in the field of view, you may move or angle the probe in the direction of the bladder on the display to optimize your results.	
EdgeScan	If one side of the bladder is not within the field of view, then a portion of the bladder was not included in the scan. The system displays a greater than symbol (>) before the measured result, indicating the actual bladder volume may exceed the displayed result. Move or angle the probe in the direction of the bladder on the display to optimize your results.	
Bladder larger than view	If more than one side of the bladder is not within the field of view, then multiple portions of the bladder were not included in the scan. The system displays a greater than symbol (>) before the measured result, indicating the actual bladder volume may exceed the displayed result. You may attempt to capture the entire bladder by rescanning while applying less pressure to the abdomen. However, the bladder may be larger than the field of view, and it may not be possible to capture the entire bladder within the view.	
Pubic bone interference	If a gray area appears, this indicates that the pubic bone is inside the field of view. Although the bladder may be centered and your measurement may be complete, there is a possibility the pubic bone is obscuring part of the bladder. The system displays a greater than symbol (>) before the measured result, indicating the actual bladder volume may exceed the displayed result. You may move or angle the probe to optimize your results.	

13. If you want to rescan the patient, on the Results screen, tap Scan. Repeat the scanning procedure as necessary to adjust your aim or confirm the initial measurement.
14. When you are satisfied with the results, record the exam results in the patient's chart and notify the nurse of results.

FYI-When you perform more than one scan, the Results screen displays the largest volume obtained. Above the largest volume measurement, the screen indicates the most recent scan volume.

Disinfecting the Bladder Scanner

1. If the system is on, press the On/Off button to turn it off.
2. Wipe any ultrasound gel completely off the probe with a paper towel and discard.
3. Using a germicidal wipe (Sani-Cloth-either purple or orange top, orange for c.diff patients) wipe the console, probe, and probe cable according to the directions on the cleaner. Repeat as needed to make sure that all visible contamination is removed.
4. Allow the probe to air dry completely before use to ensure disinfection.

Charging

1. Be sure the charging cable is securely attached to the console.
2. Plug the power adapter into a standard wall outlet.
3. If the battery indicator LED on the console remains unlit, press the On/Off button. The LED should light up to indicate that the battery is charging.

Important: The probe does not operate when the system is connected to an outlet. To scan patients, the console must have a charged battery and the system must be unplugged from external power

**Reference: © 2021 Verathon Inc, BladderScan i10, Verathon

For units still using BVI 9400 scanners- see quick reference below:

BladderScan®
Bladder Volume Instruments

BVI 9400 User's Quick Reference

Noninvasive, Accurate, Reliable, Easy to Use

1

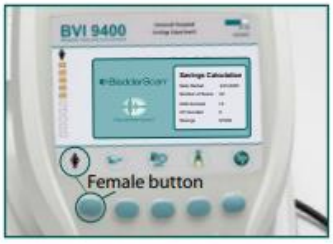
Turn on the BladderScan® BVI 9400 by pressing the POWER ON/OFF button.

2

Select scanning mode

The BladderScan BVI 9400 is designed to scan in three patient-specific modes. Select the proper exam mode to ensure the accuracy of your scan. Simply press the button repeatedly until the desired setting appears:

- Select to scan a male patient, or a female patient who has had a hysterectomy
- Select to scan a female patient who has not had a hysterectomy
- Select to scan a small child under 48 inches (122cm) tall and weighing less than 60 lbs (27kg)



3

With the patient supine, apply gel

Have the patient lie in the supine position with abdominal muscles relaxed.

Palpate the patient's symphysis pubis (pubic bone). Place an ample quantity of gel (with as few air bubbles as possible) midline on the patient's abdomen, approximately one inch (3 cm) above the symphysis pubis.

4

Aim toward the bladder

Standing at the patient's right side, place the Probe on the gel and aim toward the expected location of the bladder. For most patients, this means tilting the Probe slightly toward the patient's coccyx (tailbone) so the scan clears the pubic bone.

5

Press the SCAN button

Press the SCAN button, located on the underside of the Probe. As the scan progresses, sections of the bladder will appear on the console screen. When you hear the end-scan tone, the scan is complete.

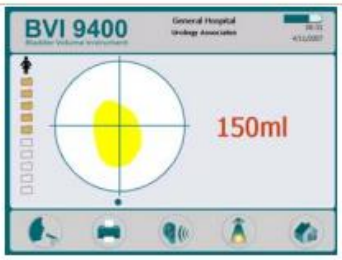
BladderScan®
Bladder Volume Instruments

BVI 9400 User's Quick Reference — Noninvasive, Accurate, Reliable, Easy to Use

6

Verify the scan

If the scan is **"on target"** all 8 arrows will flash on the Probe screen, and the bladder will be shown in the center of the crosshairs on the Console screen. Since no re-aiming is needed, no arrows will appear on the Console screen.



6a

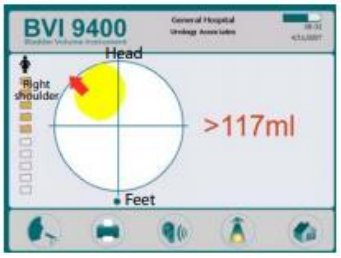
Re-aiming

If the scan is **"off target"** the Probe will show an arrow indicating the direction to move the Probe to be "on target." If the arrow is solid, it means you are slightly "off target." If the arrow is flashing, it means you are significantly "off target" and must re-aim and re-scan. On the Console, the bladder will not be on the crosshairs, and there will be an arrow pointing in the direction for re-aiming.

6b

To re-aim

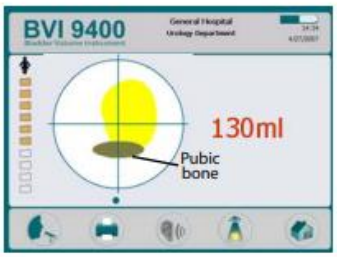
To **re-aim**, note that the small dot at "6 o'clock" on the Console target represents the feet of the patient. The "12 o'clock" position represents the head of the patient and the upper left quadrant (9-12 o'clock) represents the right shoulder of the patient. This orientation should help you in re-aiming the Probe to capture the complete bladder in the ultrasound "cone."



6c

Pubic Bone

You may also see a screen that indicates the pubic bone is "inside" the ultrasound cone. If this occurs, you may want to re-aim and re-scan. Although the bladder may be shown as centered in the ultrasound cone, and your measurement could be complete, there is a possibility that the pubic bone is obscuring some of the bladder. By re-aiming, you can ensure you have captured the bladder fully inside the ultrasound cone.



7

Save, review and print exam results

To save the exam, you must annotate it.

To annotate, press and release the RECORD button on the Console. When you see the RECORD button icon turn to a STOP button icon, record your patient information by speaking into the Probe microphone. Press the STOP button on the Console. When the hourglass icon disappears, press the LISTEN button to replay the annotation.

To review the images of your scan, press the REVIEW button (you must first save the exam before you can review it).

To print exam results via on-board printer, press the PRINT button.

To perform another exam, press the HOME button.

8

Finish exam

Once you have completed the scan, wipe the ultrasound gel off the patient and the Probe.

For ScanPoint® subscribers, logging on to ScanPoint® automatically transfers and saves your annotated exams.

To order additional rolls of paper (0800-0319) or batteries (0400-0066), contact Customer Care at 800.331.2313.

Reporting Values

- Alert the RN if your patient tells you they are experiencing any of the following:
    - Bladder feeling full
    - Urge to void, but cannot
    - Pain or discomfort
    - Patient has gone longer than four hours without voiding, especially after a Foley catheter was removed
- Alert the RN of any results of any bladder scans you complete
    - If bladder scan is over 400ml, immediately notify the RN- Treat anything over 400ml as a critical value.
    - If you are having difficulty obtaining an accurate result, consult the RN.

Contraindications

- The BladderScan i10 system is not intended for fetal use or for use on pregnant patients, patients with open skin or wounds in the suprapubic region, or patients with ascites (fluid in the abdomen).
- Patients under 24 months of age may have inaccurate bladder scan results.

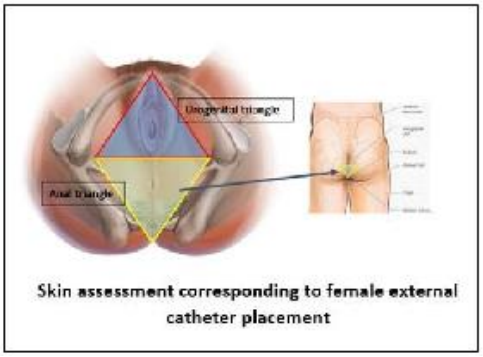
Key Points to Remember

- The BladderScan i10 system includes an onboard tutorial. It is recommended that you watch the tutorial prior to using the system. If you start the tutorial from the Home screen, the entire tutorial plays. If you start the tutorial from any other screen, the tutorial begins at the relevant section.
- It is recommended that you use ultrasound gel (not any other form of gel) to ensure accurate results. Additionally, the use of adequate ultrasound gel is very important. Scanning with the wrong gel, or without enough gel is likely to result in inaccurate readings. Place an ample quantity of ultrasound gel (2-3 cm thick/20 grams), with as few air bubbles as possible, midline on the patient's abdomen, approximately 3 cm (1 inch) above the pubic bone. Do not spread gel into a thin layer before scanning.
- Target the bladder by aiming the probe, first toward the feet, then slowly toward the head to find the widest diameter of the bladder. Angle the probe slowly side to side to center the vertical green line on the bladder. Press and release the green scan button once, or tap SCAN on the screen. The scanning process begins. Hold the probe steady while the scan is in process.
- After the scan is complete, a post scan result will appear on the touch screen display. If the post scan results indicate that the probe was not properly aimed (i.e., the bladder was not centered within the range of the ultrasound beam), re-aim and scan again as necessary
- If the screen displays a "greater than" symbol (>) next to the bladder volume measurement, then you do not have the bladder within full range of the probe and the patient's true bladder volume may be greater than the volume displayed on the screen.
- Press the print icon to print the largest volume measured during the exam.
- Alert the RN of any results of any bladder scans you complete
    - If bladder scan is over 400ml, immediately notify the RN- Treat anything over 400ml as a critical value.

External Female Catheters

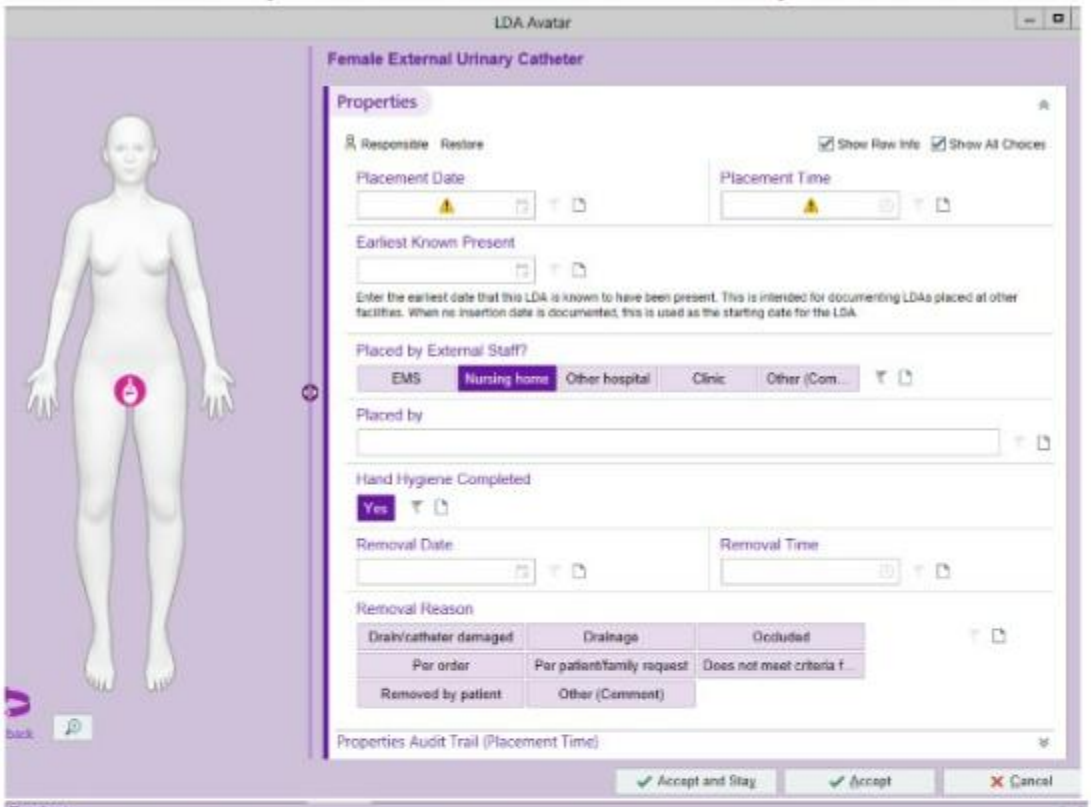
Intended for patients who require strict I&O and are unable to use bedpan, urinal or commode AND have limited mobility AND/OR require immobility and/or supine positioning.

1. **This device is not intended for incontinence management or to replace bedpan/commode/toilet use.**
    - Promote patient mobility: Assist patients to the bathroom toilet, bedside commode or use bedpan.
2. **Tip Do not use in patients who have contraindications:**
    - Incontinence and no medical necessity for accurate I&Os
    - Wounds (sacral, coccyx, lower abdomen, groin, perineum or inner thighs)
    - Ability to toilet with assistance (either bedpan, urinal or bedside commode)
    - Concern for fecal contamination (incontinent of stool, diarrhea)
    - Agitation/Delirium/Dementia
    - Pelvic/Trunk Sensory Deficits (paraplegia)
    - Sensory perception issues (inability to communicate pain/sensations)
    - Impaired coagulation (low platelet count, high risk for bleeding, bruising)
    - Suicide Precautions (ligature risk)
    - Age less than 18
    - Small or Large body habitus (improper fit, inability to assess skin integrity)
    - Prone positioning
    - Upright positioning, HOB>45 degrees
    - Pregnancy/Labor
    - Urinary retention
    - Rectal or Vaginal bleeding/Menstruation
    - Prolapses Uterus/Rectum
    - Trauma: Pelvic/Rectal/Vaginal/Perineal/Urological
    - Fistulas: Pelvic/Rectal/Vaginal/Perineal/Urological
    - Surgery: Pelvic/Rectal/Vaginal/Perineal/Urological
    - Anuria
    - Moisture associated skin damage
3. **Assess position of the device at least every 2 hours; assess for skin breakdown/pressure injury, especially perineum, urogenital triangle, anal triangle, intergluteal cleft at least every 2 hours and when repositioning.**



Skin assessment corresponding to female external catheter placement

4. Documentation Tip: Add an LDA and chart assessment/interventions in WALDO



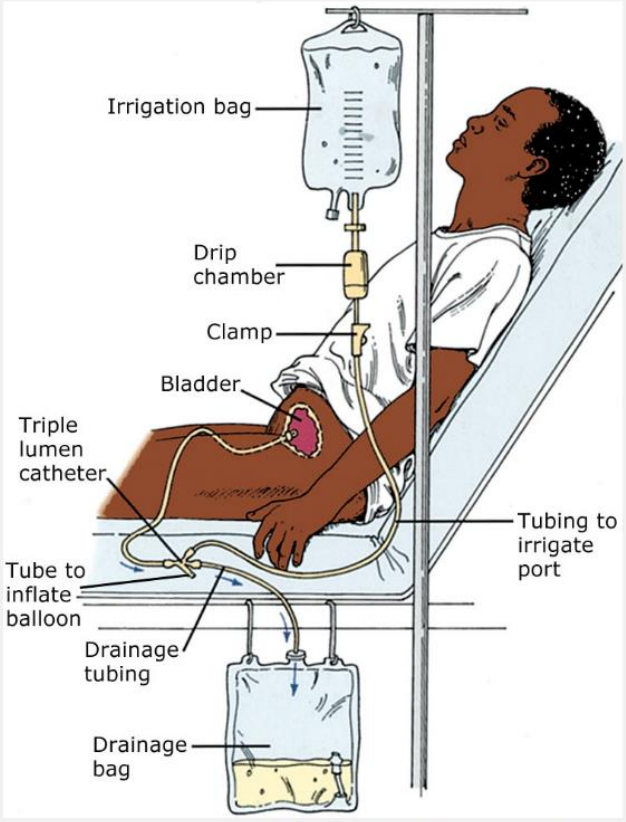
Continuous Bladder Irrigation (CBI) Guide

Common Indications

- TURP
- Urinary retention with gross hematuria with significant clots

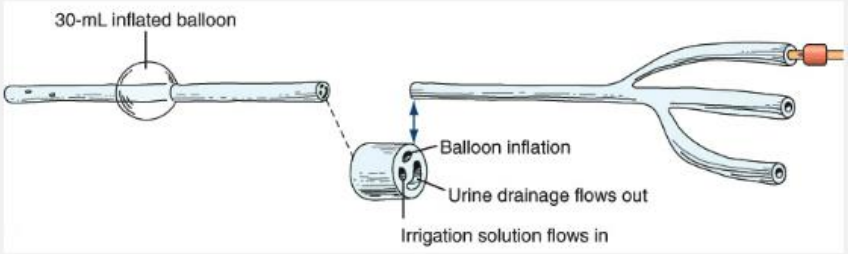
Images:

Figure 1



Closed continuous bladder irrigation. (From Perry, A.G. and others [Eds.]. [2022]. *Clinical nursing skills & techniques* [10th ed.]. St. Louis: Elsevier.)

Figure 2



Triple-lumen catheter for continuous closed irrigation (cross-section). (From Perry, A.G. and others [Eds.]. [2022]. *Clinical nursing skills & techniques* [10th ed.]. St. Louis: Elsevier.)

Nursing Interventions

There is a significant risk for a catheter-associated urinary tract infection (CAUTI) after the insertion of an indwelling catheter. The catheter should be removed as soon as possible once it is no longer needed.

Route tubes and catheters having different purposes in different, standardized directions (e.g., IV lines routed toward the head; enteric lines toward the feet).

1. Perform hand hygiene before patient contact. Don appropriate personal protective equipment (PPE) based on the patient's need for isolation precautions or the risk of exposure to bodily fluids.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Check the patient's record for the purpose of bladder irrigation, the practitioner's order for the type and amount of irrigation fluid, and the practitioner's order for a closed urinary drainage system and triple-lumen (three-way) catheter (one lumen to inflate the balloon, one to allow urinary drainage, and one to instill irrigation solution) (Figure 2).
5. Assess the color of the urine and look for mucus, clots, or sediment.
6. Assess the patient for bladder distention.
7. Assess the existing closed continuous irrigation system.
    a. Assess the ongoing urinary output and the amount of irrigating solution infused.
    b. Observe the amount of fluid remaining in the irrigating solution container.
8. Review the I&O record.
9. Assess the patient for abdominal pain or spasms, a sensation of bladder fullness, and urine leaking around the catheter.
10. Assess the patient's knowledge regarding the purpose of catheter irrigation.
11. Perform hand hygiene and don gloves. Don additional PPE based on the patient's need for isolation precautions or the risk of exposure to bodily fluids.
12. Explain the procedure and ensure that the patient agrees to treatment.
13. Raise the bed to an appropriate working height. If the side rails are raised, lower the one on the working side.
14. Provide privacy by pulling the curtains around the bed. Then fold back the covers to expose the connection of the catheter and the drainage tubing.
15. With the patient in the supine position, remove the catheter securement device anchoring the catheter to the patient. **Do not pull on the catheter.**
16. Close the clamp on the irrigation tubing. Then hang the bag of irrigating solution on the IV pole.
17. Use aseptic technique to insert the tip of the sterile irrigation tubing into the bag containing irrigation solution (Figure 3). Fill the drip chamber half full by squeezing the chamber.
18. Open the clamp and allow the solution to flow through the tubing, keeping the end of the tubing sterile. Close the clamp and recap the end of the tubing.
19. Swab the catheter port with an antiseptic and allow it to dry.

20. Use aseptic technique to connect the tubing securely to the irrigation port of the triple-lumen catheter. **Do not attach the irrigation tubing to the balloon inflation port because doing so causes the balloon to rupture.**
21. Adjust the clamp on the irrigation tubing to begin the flow of solution into the bladder. Be sure the clamp on the catheter drainage tubing is open and check the volume of drainage in the drainage bag (Figure 1).
22. Anchor the catheter to the patient's leg or thigh with a catheter securement device.
23. Label the tubing at the connection site closest to the patient and the source when there are multiple access sites or multiple solutions.
24. Assist the patient to a comfortable position.
25. Lower the bed to lowest position and position the side rails appropriately.
26. Assess, treat, and reassess pain.
27. Discard supplies, remove PPE, and perform hand hygiene.
28. Document the procedure in the patient's record.

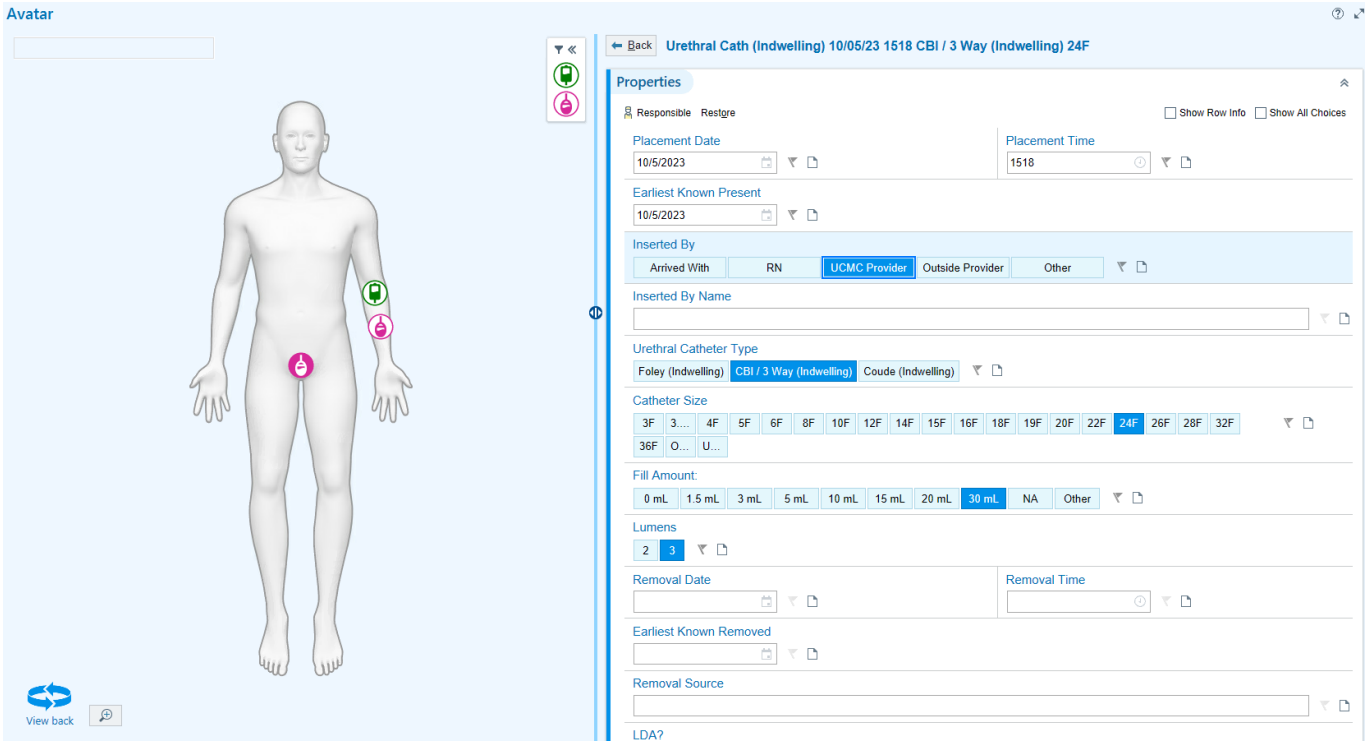
Troubleshooting:

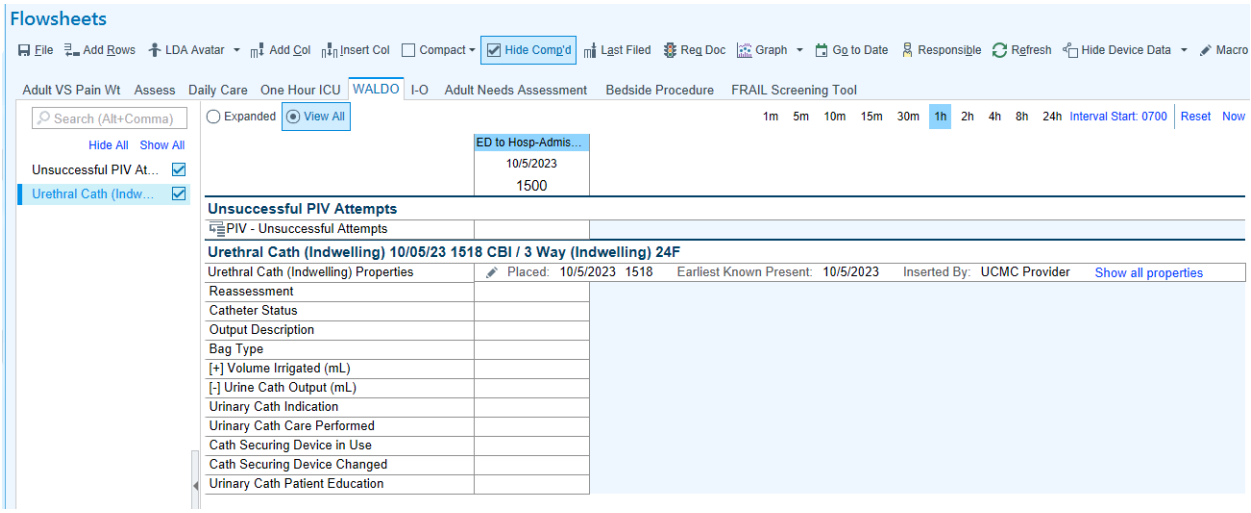
- Ensure no dependent loops
- Urinary collection bag below the bladder
- Titrate irrigation to urine "cool-aid" color and decrease in clots

Emergency:

- Sudden cessation of urinary output with significant increase in pain

Documentation





TIP SHEET: External Female Catheters

Intended for patients who require strict I&O and are unable to use bedpan, urinal or commode AND have limited mobility AND/OR require immobility and/or supine positioning.

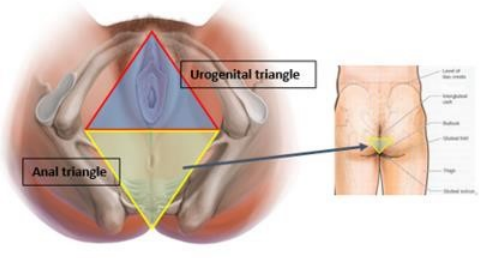
#1 Tip This device is not intended for incontinence management or to replace bedpan/commode/toilet use.

- Promote patient mobility: Assist patients to bathroom toilet, bedside commode or use bedpan.

#2 Tip Do not use in patients who have contraindications:

- Incontinence and no medical necessity for accurate I&Os
- Wounds (sacral, coccyx, lower abdomen, groin, perineum or inner thighs)
- Ability to toilet with assistance (either bedpan, urinal or bedside commode)
- Concern for fecal contamination (incontinent of stool, diarrhea)
- Agitation/Delirium/Dementia
- Pelvic/Trunk Sensory Deficits (paraplegia)
- Sensory perception issues (inability to communicate pain/sensations)
- Impaired coagulation (low platelet count, high risk for bleeding, bruising)
- Suicide Precautions (ligature risk)
- Age less than 18
- Small or Large body habitus (improper fit, inability to assess skin integrity)
- Prone positioning
- Upright positioning, HOB>45 degrees
- Pregnancy/Labor
- Urinary retention
- Rectal or Vaginal bleeding/Menstruation
- Prolapses Uterus/Rectum
- Trauma: Pelvic/Rectal/Vaginal/Perineal/Urological
- Fistulas: Pelvic/Rectal/Vaginal/Perineal/Urological
- Surgery: Pelvic/Rectal/Vaginal/Perineal/Urological
- Anuria
- Moisture associated skin damage

#3 Assess position of the device at least every 2 hours; assess for skin breakdown/pressure injury, especially perineum, urogenital triangle, anal triangle, intergluteal cleft at least every 2 hours and when repositioning.



Skin assessment corresponding to female external catheter placement

#4 Documentation Tip: Add an LDA and chart assessment/interventions in WALDO