# Foley Cath Audit

<table>
<thead>
<tr>
<th>Responsible RN:</th>
<th>Unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitting MD:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Care team members involved in audit:

<table>
<thead>
<tr>
<th>Observations</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is foley below bladder level?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Is there an un-obstructed flow of urine?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Is the drainage bag hanging at the foot of the bed?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Has the drainage bag been emptied?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Did employees wash their hands prior to handling the catheter, tubing or bag?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Is tubing secured w/a Stat Lock?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Is the red seal on the tubing intact?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Did the staff follow aseptic technique when collecting a specimen?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
</tbody>
</table>

**Staff Knowledge**

<table>
<thead>
<tr>
<th>Stated reason for the foley</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does this meet the criteria for insertion?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Can staff articulate the rationale for placement below the bladder &amp; how to accomplish this during pt transfers?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>Can staff articulate the importance of an un-obstructed flow?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
</tbody>
</table>

| Can staff articulate that foleys should be emptied prior to transport, based upon pt’s I&O, and pt status? | Yes | No | Comments |
| Can staff articulate that they need to wash their hands prior to manipulating the catheter, tubing or bag? | Yes | No | Comments |
| Can staff articulate the rationale for the Stat Lock? | Yes | No | Comments |
| Can staff articulate the policy for peri-care? | Yes | No | Comments |
| Has the patient and/or family been educated on peri-care? | Yes | No | Comments |
| Can staff articulate the importance of a closed system? | Yes | No | Comments |
| Can the staff articulate the correct technique for specimen collection? | Yes | No | Comments |

**Chart Review**

<table>
<thead>
<tr>
<th>Is there an MD order for insertion?</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an MD order for D/C of foley?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>When was peri-care last done?</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
</tbody>
</table>
TITLE: Catheter Insertion, Maintenance and Discontinuation of an Indwelling Urethral and/or Straight Catheter

Performed by: RN, LPN, SNE,CT, PSP-II, EMT-P

Purpose: To provide guidelines for insertion, maintenance and discontinuation of an indwelling or straight catheter.

Policy Statements:
1. Catheterization is a sterile procedure which will require a physician's order. This order can be written by a nursing order when patient’s needs meet Critical Care RN protocols. See NPP P-1HH, “Protocols for the Registered Nurse.”
2. Discontinuation of an indwelling bladder catheter inserted per nursing protocol can be performed without a physician’s order when patient no longer meets insertion criteria.
3. A physician’s order is required for discontinuation of an indwelling catheter placed by direct physician order.
4. Physician's order is required for open irrigation.
5. If the closed system must be opened, strict aseptic technique must be observed.
6. Indwelling catheters must be secured to the thigh for female or to the abdomen or thigh for male patients.
7. Obtain urinary specimens by aspiration using needleless system through port to maintain a closed system.
8. Indwelling urinary catheters are removed only after removal of the solution in the balloon.

General Information:

INSERTION
1. Insert urinary catheter only when necessary, and leave in place only for as long as necessary. Appropriate indications for insertion of an indwelling urinary tract catheter include:
   a. Any patient requiring strict I&O who is unable to cooperate with bathroom, bed pan or urinal usage.
   b. Any patient with an inability to void and intermittent catheterization is difficult, or volume by bladder scanner is >250ml.
   c. Any patient requiring monitoring of acute renal insufficiency, or failure, unless anuric (check with physician.)
   d. Any patient who is chemically paralyzed.
   e. Any patient post prolonged cardiac procedure with femoral arterial sheath.
   f. Any patient undergoing a urological procedure.
   g. Unable to avoid contamination of incision and or femoral central line.
   h. Management of a stage 3 or 4 pressure ulcer on the trunk or pelvis.

2. An indwelling urinary catheter is NOT indicated in the following instances:
   a. Patient is incontinent but none of the indications for insertion listed above are present.
   b. Patient has diarrhea but none of the appropriate indications for insertion listed above are present.
   c. Administration of a diuretic, unless strict I&O required.
   d. Any invasive cardiac procedure anticipated to be of average duration.
   e. Presence of decubitus ulcer, unless patient is in the post procedure period of a surgically repaired site at risk for urine soilage.
   f. Indwelling catheters, pads, and routine skin care are adequate.

3. It is ideal to maintain the closed urinary drainage system.
4. Alternative methods of urinary drainage include condom catheter drainage and intermittent urethral catheterizations.
5. Coude catheters and non-latex catheters are also available in individual packages.
6. Refer to Corp. CLN: 2094HH, “Care and Management of Latex Sensitivity”, if patient has a latex allergy. Non-latex catheters and non-latex gloves are available.
7. Use a 14Fr preconnected kit, unless the physician orders a specific size. (Preconnected sets come in 14Fr, 16Fr and 18Fr). Use as small a catheter as possible, consistent with good drainage, to minimize urethral trauma.

8. Replacement of a non-functioning catheter is nursing judgment; however, consultation with a physician is recommended for patients with existing urologic problems.

9. Routine changing of urinary catheters is not recommended (this includes catheters that have been inserted at other facilities, for example, extended care facilities). An indwelling urinary catheter should only be changed if it is not functioning properly.

10. If the patient indicates an allergy to Iodine, use Para-chloro-meta-xylene (PCMX-Techni-Care) for cleaning during insertion.

11. Pretesting the balloon (prior to insertion) is not recommended since all catheters are 100% tested during the manufacturing process. Additionally, when the balloon is inflated just prior to insertion, “ridges” remain after deflation because the balloon will not fold up as tightly against the catheter shaft as it was prior to the test. These ridges can be uncomfortable for the patient during insertion and can cause urethral irritation thus increasing the chances of a urinary tract infection.

12. Refer to NPP# U-3HH, “Urine Specimens” for obtaining urine specimens.

13. When post-voided residual urine is ordered, measure the amount of voided urine and catheterize the patient within 20 minutes after voiding to obtain the remainder of urine in the bladder. Record both the amount of urine voided and the amount obtained by catheterization. Bladder scan may be used as a noninvasive alternative to determine residual.

14. Maintenance of the closed system is ideal; however, if it is necessary to change the bag only, sterility is to be maintained. Any violation of the closed system will increase the patient's risk of infection. Consider this extra risk before interrupting the closed system versus anchoring a new catheter. (Some indications for only changing the bag and tubing might be contamination of equipment, damage of equipment, or if equipment is not functioning properly.)

15. If the system is interrupted to attach a leg bag, see NPP: C-12HH, “Catheter Cleaning of Alternating Bag.”

16. To avoid reflux of urine, do not raise drainage bag above level of patient’s bladder.

DISCONTINUATION

1. Indications for the discontinuation of an indwelling bladder catheter:
   a. Upon discontinuation of strict I&O, or when patient is able to cooperate with strict I&O.
   b. When patient is able to resume usual voiding position.
   c. When surgical flap, or pressure ulcer is healed.
   d. Immediately upon return to unit post invasive cardiac or radiological procedure.
   e. Within 24 hours post procedure of an obstetrical-gynecologic procedure.
   f. When epidural catheter (for short-term pain management) is removed. NOTE: A physician's order is required for discontinuation of an indwelling catheter placed for the purpose of any pathology, or surgery, related to the genitourinary system.

Equipment:
1. Leg or abdomen securing device
2. Adult:
   a. Straight catheterization, use set with #15Fr catheter (set does not include a drainage bag).
   b. Indwelling insertion, use pre-connected sets with #14Fr catheter, unless otherwise ordered.

Procedure-Insertion
1. Verify physician's order. Note if specimen collection is ordered.
2. Verify that patient is not allergic to Iodine or latex rubber.
3. Assist patient into a dorsal recumbent position, unless contraindicated by patient condition.
4. Maintain aseptic technique in preparing sterile field after opening outer wrap of catheter tray.
5. For female: open tray, then remove absorbent under pad, touching only the outer edges, and place under buttocks.
6. For male: open tray, then remove absorbent under pad and place under scrotum and penis with ends over thighs.
7. Put on sterile gloves.
8. Remove drape from tray and position over area around urinary meatus (optional for female).
9. Open cleansing solution and pour over rayon balls.
10. Open lubricant and squeeze lubricant onto plastic tray.
11. If urine specimen needed, remove cap of urine specimen container, and place both on sterile field.
12. Remove plastic tray and place on sterile field.
13. Remove plastic sleeve, (if present), from catheter, and discard.
14. Lubricate the tip of the catheter 6” for male patient, or 3”-4” for female patient.
15. Check drainage bag and tubing to be sure that all clamps are closed (for indwelling catheter only).
16. For female, separate inner labia and visualize the meatus. With cleansing solution, using forceps, cleanse one side of the inner labia and discard rayon ball in waste receptacle. Repeat on the other side of the inner labia and twice over the meatus, using a new rayon ball cleansing from front to back using a downward motion. Never go over an area with the same rayon ball.
17. For male, raise penis to 90-degree angle (this minimizes the number of curvatures in urethra). Retract the foreskin, if present, to expose meatus. Then, using forceps and rayon balls with cleansing solution, cleanse the meatus three times using a new rayon ball with each wipe. (Do not cleanse the same area more than once with the same rayon ball).
18. Discard forceps in waste receptacle.
19. Insert catheter until urine starts to flow. If resistance is met, wait 2-3 seconds, then continue advancing catheter. If no urine returns, question placement (on average 7-9 inches for male, or 2-3 inches for female into urinary bladder will be sufficient). DO NOT INFLATE BALLOON UNTIL URINE RETURNS.
   a. If straight catheter inserted and urine specimen is needed, obtain urine sample in urine specimen container in the kit. Do not utilize initial urine flow for specimen.
   b. If catheter is to be left indwelling, and specimen is required, aspirate specimen, see NPP# U-3HH, “Urine Specimens”.
20. In female patients, if the catheter is inadvertently placed into the vagina, it may be temporarily left as a landmark until a new sterile catheter is placed in the urethra.
21. For straight catheter, empty all urine from bladder, then remove catheter, provide perineal care as needed.
22. In an adult female, advance the indwelling catheter an additional 2 inches after urine is visualized in tubing before inflating balloon to ensure balloon is inside the urinary bladder, and not in the urethra.
23. In an adult male, advance the indwelling catheter to the beginning of the catheter's bifurcation (the point at which the balloon lumen separates from the rest of the catheter), before inflating balloon. This assures balloon is inside the bladder, and not in the urethra.
24. For indwelling catheter, attach pre-filled syringe to catheter, and inflate the balloon with 10 ml solution (pre-filled syringe holds 10 ml).
   Note: If patient complains of increasing pain while balloon is being inflated, deflate balloon immediately. Advance catheter and re-attempt inflation. If pain persists, remove catheter, and contact physician.
25. Tug gently on catheter to determine if balloon is inflated properly in bladder. For straight cath, remove catheter after bladder is drained and discard.
26. For male patient, return foreskin over exposed meatus.
27. Secure indwelling catheter to patient, using inner aspect of thigh for female or male, or lower aspect of abdomen for males. (Allow enough slack so that no tension is created on the catheter, avoiding mucosal damage. Securing the catheter prevents accidental traction that could result in injury to the bladder or urethra, which increases the risk of infection.) Patient shouldn’t be allowed to lie on tubing.
28. Position drainage tubing on top of thigh.
29. Secure drainage tubing to bottom sheet, and attach drainage bag to frame of bed. (Bag to be positioned toward foot end of side of bed without looping tubing to enhance gravity flow, prevent stasis of urine, and facilitate proper drainage.)
30. Instruct patient on placement of drainage tube below the level of the bladder and handling of drainage bag. Keep drainage bag off of floor. If necessary to raise the collection bag above the bladder for transfer purposes, temporarily pinch off the tubing.

Procedure-Maintenance
1. Avoid unnecessary manipulation of the catheter.
2. Assess continued need for catheter (based on insertion criteria).
3. Observe amount, character, and color of urine.
4. Verify:
   a. Closed drainage system maintained.
   b. Drainage bag kept below the level of the bladder.
   c. Drainage tubing is kink free, to gravity, and secured to the thigh or abdomen.
5. Empty the urinary drainage bag every 8 hours and prn.
   a. Use a separate collecting container for each patient.
   b. Do not allow the drainage spigot to come in contact with the non-sterile collecting container.
6. Cleanse the perineum daily with soap and water, or other appropriate perineal cleanser or wipe, and as needed after bowel movement.

Procedure – Discontinuation of Urethral Catheter
1. Verify physician’s order.
2. Expose catheter and place protective material underneath.
3. Attach syringe to the catheter valve. Allow the pressure within the balloon to force the plunger back and fill the syringe with water. Pull back on plunger to make sure all H2O is removed from balloon.
4. If unable to deflate balloon, perform the following:
   a. Re-attach the syringe to the catheter valve gently, and allow the balloon to deflate slowly on its own.
   b. Reposition the patient.
   c. Assess that the catheter is in the proper position by checking to see urine flowing freely.
   d. Check the patent of the valve by attempting to inject 3 ml of sterile water into the balloon. Gently aspirate contents of balloon. NOTE: Rapid or forceful aspiration may cause the lumen to collapse.
   e. If still unable to deflate balloon - contact physician.
5. Remove the catheter using gentle pulling. (Tell patient to cough during removal, unless contraindicated by the patient’s condition. This can facilitate comfortable removal of the catheter.)
6. Notify the physician if you are unable to remove the catheter.
7. Assist patients with cleansing the perineal area, as needed (females cleanse front to back).
8. Measure amount of urine in drainage bag. Note color and character of urine.
9. Place Foley catheter and empty drainage bag in trash receptacle.
10. Instruct patient, and initiate policy on DUE TO VOID procedure, NPP V-4HH, VOID, DUE TO.

Procedure – Discontinuation of Suprapubic Catheter
1. Verify physician’s order.
2. Ascertain if suprapubic catheter is stitched in place. Remove sutures if present.
3. If the suprapubic catheter has two ports, remove the sterile water from the balloon port.
4. Clamp the catheter and gently manipulate catheter to loosen, and then pull gently to remove.
5. Notify the physician if you are unable to remove the catheter.
6. Place a sterile dressing over the suprapubic site.
7. Measure the amount of urine in drainage bag. Note color and character of urine.
8. Place the catheter and empty drainage bag in the appropriate waste receptacle.
9. Instruct patient, and initiate policy on DUE TO VOID procedure, NPP V-4HH, VOID, DUE TO.

Documentation Guidelines:
Document in Multidisciplinary Notes or appropriate form the following:

Insertion:
1. Size of catheter and balloon (eg 14F, 10ml balloon).
2. Performance of procedure.
3. Reason for catheterization.
4. Amount, character, and color of urine.
5. Patient's response to procedure.
6. Instruction/information given to patient.
7. Patient response to teaching.

Maintenance:
1. Every 8 hours, document:
   a. Continued need for catheter
   b. Amount, character, and color of urine.
2. Performance of perineal care.

Discontinuation:
1. Performance of procedure (may chart “as stated in procedure”).
2. Amount, color, and character of urine.
3. Patient response to procedure.
4. Instruction/information given to patient.
5. Document amount of urine as output on appropriate intake and output form.

References:
TITLE: PROTOCOLS FOR THE REGISTERED NURSE

Performed By: RN who has successfully completed TIHH Competency Verification in Physical Assessment

Purpose: To provide protocols for the Registered Nurse (RN) providing patient care

Policy Statements:
1. The protocols listed in this policy may be initiated by the RN prior to physician notification as appropriate and as patient condition warrants but the attending physician is to be notified as soon as possible after initiating a protocol. These Protocols DO NOT APPLY TO THE EMERGENCY DEPARTMENT.
2. Each time a protocol that requires a medical order is initiated, an Physician Order Entry MUST be entered (Example: Stat ABG for severe respiratory distress per NPP Protocol/J. Doe RN)
3. The RN may delegate specific tasks to staff within their scope of practice.
4. The general RN protocols may be initiated by an RN who has successfully completed the orientation process and TIHH Competency Verification in Basic Physical Assessment-Adult.
5. The critical care specific protocols are additional protocols that may be initiated by the critical care prepared nurse (as evidenced by successful completion of the critical care orientation guide/orientation process). The progressive care prepared RN may initiate those components of the critical care protocols that are part of their orientation process as evidenced by successful completion of the orientation guide/orientation process. Both of these require successful completion of TIHH Competency Verification in Basic Physical Assessment-Adult.
6. Verify patient allergies prior to administering any medication

General Information:
1. If the attending physician or partner is unavailable or not accessible, the Family Practice resident, Emergency Department physician, or House physician (where available) may be notified.
2. The critical care consultation nurse may be called as needed to support clinical decision making in the non-critical care areas.
3. For hypoglycemic conditions, see NPP # D-002. Routine Care of the Person with Diabetes Mellitus
4. The critical care nurse who performs a consultation may initiate the critical care specific protocols in a non-critical care area.
5. The critical care nurse may transfer a patient to a higher level of monitored care monitored area as appropriate when performing a consultation.
6. Additional information pertaining to specific procedures may be obtained from those specific procedure policies.

Equipment:
1. Physician order entry as needed for the protocol being initiated.

Procedure:
1. Based on assessment, the RN identifies a situation/patient condition that warrants initiation of a protocol.
2. An order for each protocol initiated is written on the physician’s order entry. (Example: Stat ABG for severe respiratory distress per NPP Protocol/J. Doe RN).
3. The physician is informed that the protocol was initiated and the patient status.
4. Patient is monitored based on the protocol initiated, response to MDN, Flowsheet, and Physician.
Documentation Guidelines:
1. Nursing assessment of patient which resulted in MDN
2. Patient response to intervention
3. Physician notification/attempt to contact physician
4. Physician order entry.

APPROVED BY: ____________________________  DATE: ______________________
1. May insert a peripheral well or keep open IV of normal saline for venous access.

2. May obtain stat chest x-ray to confirm placement of a central venous catheter.

3. For chest pain may:
   A. Obtain stat 12-lead EKG and report results to attending physician. In absence of a physician or inability to interpret EKG, may utilize the critical care consultation nurse accessed through the hospital operator and/or Tandem (Order Processing) system, or a Critical Care/Intensive Care Unit Care Manager.
   B. May initiate cardiac monitoring (e.g.: Lead II)
   C. May initiate O2 to keep saturation ≥ 92%.
   D. May administer SL Nitroglycerin 0.4 mg. every 5 minutes X 3.
   E. May administer 81 mg chewable aspirin x 4 (equivalent of 324 mg total in chewable form) if patient has not taken any ASA that day. EXCLUSION: true documented allergy to ASA.
   F. May monitor B/P-P-Resp. every 5 minutes and document.

4. For symptomatic SBP <70 or Symptomatic Relative Hypotension (≥40mm Hg drop in systolic baseline), call critical care consultation nurse stat; call physician stat and may:
   A. Utilize MODIFIED Trendelenburg position by elevating legs and leaving head flat. DO NOT use Trendelenburg position as it may increase respiratory distress and cause refractory bradycardia or hypotension.
   B. May initiate cardiac monitoring (e.g.: Lead II)
   C. May initiate O2 to keep saturation ≥92%.
   D. May administer SL Nitroglycerin 0.4 mg. every 5 minutes X 3.
   E. May administer 81 mg chewable aspirin x 4 (equivalent of 324 mg total in chewable form) if patient has not taken any ASA that day.
   F. May monitor B/P-P-Resp. every 5 minutes and document.

5. Hold oral antihypertensives until physician is consulted.

1. Constipation
   If patient complains of constipation or has not moved bowels in 3 days, may administer one of the following: EXCLUSION: current/recent colorectal surgery patients.
   A. Glycerin or Bisacodyl 10mg rectal suppository for patient with functioning rectal area.
   B. Bisacodyl 5 mg p.o. if patient on oral drugs.
   C. Docusate sodium 100 mg PO if patient is receiving opiate analgesics

2. Impaction
   May disimpact a patient under the following conditions:
   A. Patient complains of constipation or has not moved bowels for 3 days AND
   B. The administration of laxatives/suppositories and/or enemas has failed to cause a bowel movement AND
   C. Patient does not have any of the following contradictions:
      -rectal bleeding
      -reflexic sphincter muscle
      -increased intracranial pressure
      -spinal cord injury/autonomic dysreflexia
      -thrombocytopenia
      -neutropenia
   For patients at a risk, collaborate with physician regarding appropriateness of this procedure.

3. Antacids
   If patient complains of GI upset, may administer one dose of one of the following as long as patient does not have renal insufficiency (defined as creatine level >2.0) and that dose is not administered within 2 hours of patient receiving oral iron salts (Ferrous Sulfate products such as Feosol or Niferex), oral multivitamins, or oral quinolone therapy (Ciproflaxin, Levofloxacin).
   A. Maalox TC 15 cc p.o.
   B. Milk of Magnesia 30 cc p.o.

4. May order Clostridium difficile cultures on patient who has non-medically induced frequent, liquid stools and increased White Blood Cell and increased temperature with questionable etiology. Medically induced reasons include:
   -metoclopramide (Reglan®)
   -Alcohol-containing elixir
   -Antacid (especially containing magnesium)
   -Sorbitol/Sorbital-containing solutions
   -Lactulose (Chronulac®)
   -Chemotherapy agents
   -patient short bowel syndrome
   -patient with ileostomy
   -patient being treated for C-diff

5. May insert an orogastric tube (if unable to pass orogastric, may insert nasogastric tube) to low continuous suction for:
   A. Gastric distention, or
   B. Patient at risk for aspiration

6. May attach a clamped NG/OG/PEG tube to low continuous suction if patient:
   -has vomiting
   -has nausea
   -has residuals >100 cc for PEG or >200 cc for NG/OG
   -has noted distention with decreased bowel sounds

7. For suspected/active bleeding may:
   A. Draw 2 stat labs 1) CBC and send to lab 2) Type and screen and hold pending CBC results
   B. If Hgb <8, send type and screen to lab and set up 2 units packed cells
   C. Refer to Cardiovascular Section for IV access and hypotension protocols

8. Critical Care Prepared Nurses
   See Critical Care Specific Protocols for additional protocols that the Critical Care Prepared RN may initiate.
<table>
<thead>
<tr>
<th>MOBILITY</th>
<th>COMFORT</th>
<th>SKIN/WOUND</th>
<th>RESPIRATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In absence of any order restricting activity, may decide level of mobility and limit it to tolerance (Exception: neurological patient)</td>
<td>1. May administer 325-650 mg of acetaminophen (p.o. or PR) X 1 for patient complaint of mild pain (Exception: febrile neutropenia, liver dysfunction).</td>
<td>1. For patient who exhibits signs of skin fungal infection (evidenced by non-blanchable redness, conscious patient itching) in the areas of the groin, under breast tissue, or skin exposed to repeated moisture, may apply miconazole (Baza®) cream for comfort and prevention of further skin breakdown.</td>
<td>1. May start O₂ and titrate to saturation ≥92% (COPD patients to their documented baseline saturation).</td>
</tr>
<tr>
<td>2. May obtain walker from physical therapy for patient if he/she uses one at home unless mobility has been restricted by condition or physician order.</td>
<td>2. May institute cooling blanket for patient with temperature &gt;103ºF if physician is aware of elevated temperature and if patient is hemodynamically stable.</td>
<td>2. May order abdominal binder for surgical patient to support incision for comfort during mobility and or deep breathing. This protocol excludes continuous use.</td>
<td>2. May obtain O₂ saturation per pulse oximeter for change in respiratory status.</td>
</tr>
<tr>
<td>3. May temporarily interrupt plain primary IVF (NS, D5NS, D5 .45NS, D5 .225NS, LR, and D5LR) for patient to shower or ambulate providing vital signs are stable and a needleless system is present.</td>
<td>3. May order sterile ophthalmic lubricant, (solution or ointment) prn for decreased blink reflex or decreased tear formation. (Example: lacrilube, natural tears)</td>
<td>3. May order sterile ophthalmic lubricant, (solution or ointment) prn for decreased blink reflex or decreased tear formation. (Example: lacrilube, natural tears)</td>
<td>3. May obtain stat ABG’s for severe respiratory distress.</td>
</tr>
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<td>4. Patient may shower if able to ambulate in hall and in absence of shortness of breath, chest pain, or hemodynamic changes (Exception: Coronary Artery Bypass Graft, patient with sutures, staples, or wound edges not approximated)</td>
<td>4. May remove surgical dressing 72 hours post-op to inspect skin and wound healing. Avoid manipulation of any drains present. Re-dress with dry sterile dressing or per order of physician/wound/ostomy care nurse. May change any dressing that is saturated with bloody, serosanguinous, or purulent drainage. (Exceptions: plastic or Ear/Nose/Throat surgery)</td>
<td>4. For purulent drainage of wounds or at reddened/tender sites of intravascular devices, may obtain gram stain and culture and sensitivity. Cleanse wound areas only with normal saline (not intravascular device areas) prior to obtaining gram stain &amp; culture &amp; sensitivity specimen. (Exception: Sternal wounds in the CABG patient)</td>
<td>4. May obtain stat chest x-ray with reading for respiratory distress.</td>
</tr>
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<td>5. May order abdominal binder for surgical patient to support incision for comfort during mobility and or deep breathing. This protocol excludes continuous use.</td>
<td>5. For patient who exhibits signs of skin fungal infection (evidenced by non-blanchable redness, conscious patient itching) in the areas of the groin, under breast tissue, or skin exposed to repeated moisture, may apply miconazole (Baza®) cream for comfort and prevention of further skin breakdown.</td>
<td>5. For patient in respiratory distress whose previously ordered respiratory treatment has expired: may call Respiratory Therapy for previously ordered treatment stat X1. Must call physician for renewal/further orders (Resp. T will follow their policy pertaining to the 72-hour renewal reminder).</td>
<td>5. May decrease nasal O₂ if patient denies shortness of breath, and is acyanotic with O₂ saturation ≥ baseline on decreased setting. Notify Respiratory Therapy for Respiratory Care Assessment.</td>
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<td>6. For patient in respiratory distress whose previously ordered respiratory treatment has expired: may call Respiratory Therapy for previously ordered treatment stat X1. Must call physician for renewal/further orders (Resp. T will follow their policy pertaining to the 72-hour renewal reminder).</td>
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</table>

**DISCHARGE PLAN**

1. May order the following for patient prior to discharge to an ECF:
   - A. PPD if one not done in last 3 months. **(EXCLUSION: Patient with history of positive PPD results)**
   - B. Chest x-ray if one not done in last 6 months.

2. May administer 325-650 mg of acetaminophen (p.o. or PR) X 1 for patient complaint of mild pain (Exception: febrile neutropenia, liver dysfunction).

3. May order sterile ophthalmic lubricant, (solution or ointment) prn for decreased blink reflex or decreased tear formation. (Example: lacrilube, natural tears)

4. May remove surgical dressing 72 hours post-op to inspect skin and wound healing. Avoid manipulation of any drains present. Re-dress with dry sterile dressing or per order of physician/wound/ostomy care nurse. May change any dressing that is saturated with bloody, serosanguinous, or purulent drainage. (Exceptions: plastic or Ear/Nose/Throat surgery)

5. For purulent drainage of wounds or at reddened/tender sites of intravascular devices, may obtain gram stain and culture and sensitivity. Cleanse wound areas only with normal saline (not intravascular device areas) prior to obtaining gram stain & culture & sensitivity specimen. (Exception: Sternal wounds in the CABG patient)

6. May start O₂ and titrate to saturation ≥92% (COPD patients to their documented baseline saturation).

7. May obtain O₂ saturation per pulse oximeter for change in respiratory status.

8. May obtain stat ABG’s for severe respiratory distress.

9. May obtain stat chest x-ray with reading for respiratory distress.

10. May decrease nasal O₂ if patient denies shortness of breath, and is acyanotic with O₂ saturation ≥ baseline on decreased setting. Notify Respiratory Therapy for Respiratory Care Assessment.

11. For patient in respiratory distress whose previously ordered respiratory treatment has expired: may call Respiratory Therapy for previously ordered treatment stat X1. Must call physician for renewal/further orders (Resp. T will follow their policy pertaining to the 72-hour renewal reminder).

12. Critical Care Prepared Nurses: See Critical Care Specific Protocols for additional protocols that the Critical Care Prepared RN may initiate.
# Critical Care Specific Protocols

To be initiated only by the Critical Care Prepared RN

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>Cardiovascular</th>
<th>Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. May initiate apnea monitor</td>
<td>1. May obtain stat chest x-ray with reading to confirm placement of:</td>
<td>For SYMPTOMATIC DYSRHYTHMIAS** AND in the absence of orders to the contrary, **Symptoms may include, but are not limited to:</td>
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<tr>
<td>2. For patient in respiratory distress, contact Resp. T. for a Respiratory Care Assessment. May order respiratory treatment x 1 of 3 ml. solution containing 2.5 ml. of NS and 0.5 ml (2.5 mg) albuterol to be nebulized over 7-8 minutes and notify physician.</td>
<td>- Pulmonary Artery Catheter</td>
<td>--Lightheadedness</td>
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<td></td>
<td>- IABP</td>
<td>-- level of consciousness</td>
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<tr>
<td></td>
<td>- Chest Tube</td>
<td>-- Hypotension</td>
</tr>
<tr>
<td></td>
<td>- Triple Lumen Catheter</td>
<td>-- Nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td>- PICC</td>
<td>-- Diaphoresis</td>
</tr>
<tr>
<td></td>
<td>2. May use arterial stick to obtain labs</td>
<td>-- Cool Clammy Skin</td>
</tr>
<tr>
<td></td>
<td>3. IF ACLS PREPARED and experienced in technique, may start external jugular IV in emergency situation when other peripheral sites are unavailable or exhausted.</td>
<td>-- Mottling</td>
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<tr>
<td></td>
<td>4. For Acute Cardiac Arrhythmias may obtain stat:</td>
<td>A. Symptomatic Bradycardia either absolute (&lt;60), or relative</td>
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<tr>
<td></td>
<td>A. Plasma Potassium</td>
<td>Symptomatic Increasing 2(^{nd}) degree heart block</td>
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<tr>
<td></td>
<td>B. Serum Magnesium</td>
<td>Symptomatic 3(^{rd}) degree heart block</td>
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<tr>
<td></td>
<td>C. Ionized Calcium</td>
<td>1.) May give Atropine 0.5-1.0 mg IV Push</td>
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<tr>
<td>5. IN ADDITION TO GENERAL CHEST PAIN PROTOCOLS, for Chest Pain may:</td>
<td>2.) Repeat every 3-5 minutes to a maximum of 0.03-0.04 mg/kg.</td>
<td></td>
</tr>
<tr>
<td>A. Obtain stat CK-MB mass and Troponin-I</td>
<td>B. Symptomatic PVC’s &gt; 6 per minute</td>
<td></td>
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<tr>
<td>B. Give Morphine 1-2 mg IV every 5 minutes PRN until relief obtained. If &gt;10 mg required, notify physician stat.</td>
<td>Symptomatic frequent multifocal PVC’s</td>
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<tr>
<td>C. Obtain stat chest x-ray with reading</td>
<td>1.) May give Lidocaine 1 mg/kg and hang infusion of Lidocaine at 2 mg/min</td>
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<tr>
<td>6. IN ADDITION TO GENERAL HYPOTENSION PROTOCOLS, for Symptomatic (SBP &lt;70) or Symptomatic Relative Hypotension (≥40mm Hg drop in systolic baseline), may:</td>
<td>2.) If PVC’s not abolished with 1 mg/kg bolus and infusion at 2 mg/min, may give another bolus of lidocaine 0.5 mg/kg every 5-10 minutes to a maximum of 3 mg/kg and increase drip to 3 mg/min.</td>
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<tr>
<td>A. Hold all routes of antihypertensive medications and notify physician stat.</td>
<td>C. Symptomatic Ventricular Tachycardia, conscious and &gt;15 seconds</td>
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<tr>
<td>B. Give 250 cc NS bolus. May repeat bolus X1 in 15 minutes. If BP remains &lt;70 after a total of 500 cc NS, call physician stat.</td>
<td>1.) May initiate cough and Valsalva maneuver</td>
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<tr>
<td>C. Consider other causes of hypotension such as:</td>
<td>2.) May give amiodarone bolus 150 mg in 100 cc D5W over 10 min and start continuous infusion of amiodarone at 1 mg/min.</td>
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<tr>
<td>A. Narcotic administration</td>
<td>D. Symptomatic Ventricular Tachycardia (unconscious/pulseless) or Symptomatic Ventricular Fibrillation</td>
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<td>B. Diuretic administration</td>
<td>1.) Initiate CPR</td>
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<tr>
<td>C. Bleeding</td>
<td>2.) Call Code Blue and follow ACLS guidelines</td>
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<td>D. Benzodiazapines</td>
<td>E. For Asymptomatic VT of &gt;15 sec may:</td>
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<tr>
<td>7. May start Dopamine 800mg/250cc D5W) at 5mcg/kg/min and titrate to keep SBP≥90 to a maximum of 20 mcg/kg/min.</td>
<td>1.) Initiate cough and Valsalva maneuver. Notify physician stat.</td>
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### GI/GU

<table>
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<tr>
<th>GI/GU</th>
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<tbody>
<tr>
<td>1. May insert a Foley catheter:</td>
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<tr>
<td>A. For strict assessment of fluid status.</td>
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<tr>
<td>B. For inability to void if volume by bladder scanner is ≥ 250cc’s.</td>
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<tr>
<td>C. To avoid contamination of surgical or central line sites.</td>
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<tr>
<td>D. When an exdwelling catheter is ineffective for A, B, or C above.</td>
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<tr>
<td>E. Remove Foley when above issues resolved</td>
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