Guidance and responses were provided based on information known on 06.11.2026 and may become out of date. Guidance is being updated rapidly; users should look to CDC and NE DHHS guidance for updates.

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Long Term Care Webinar Series

June 11, 2026

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

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- Slides and a recording of this presentation will be available on the ICAP website: https://icap.nebraskamed.com/events/webinar-archive/
- Use the Q&A box in the webinar platform to type a question. Questions will be read aloud by the moderator. If your question is not answered during the webinar, please either e-mail NE ICAP or call during our office hours to speak with one of our IPs.

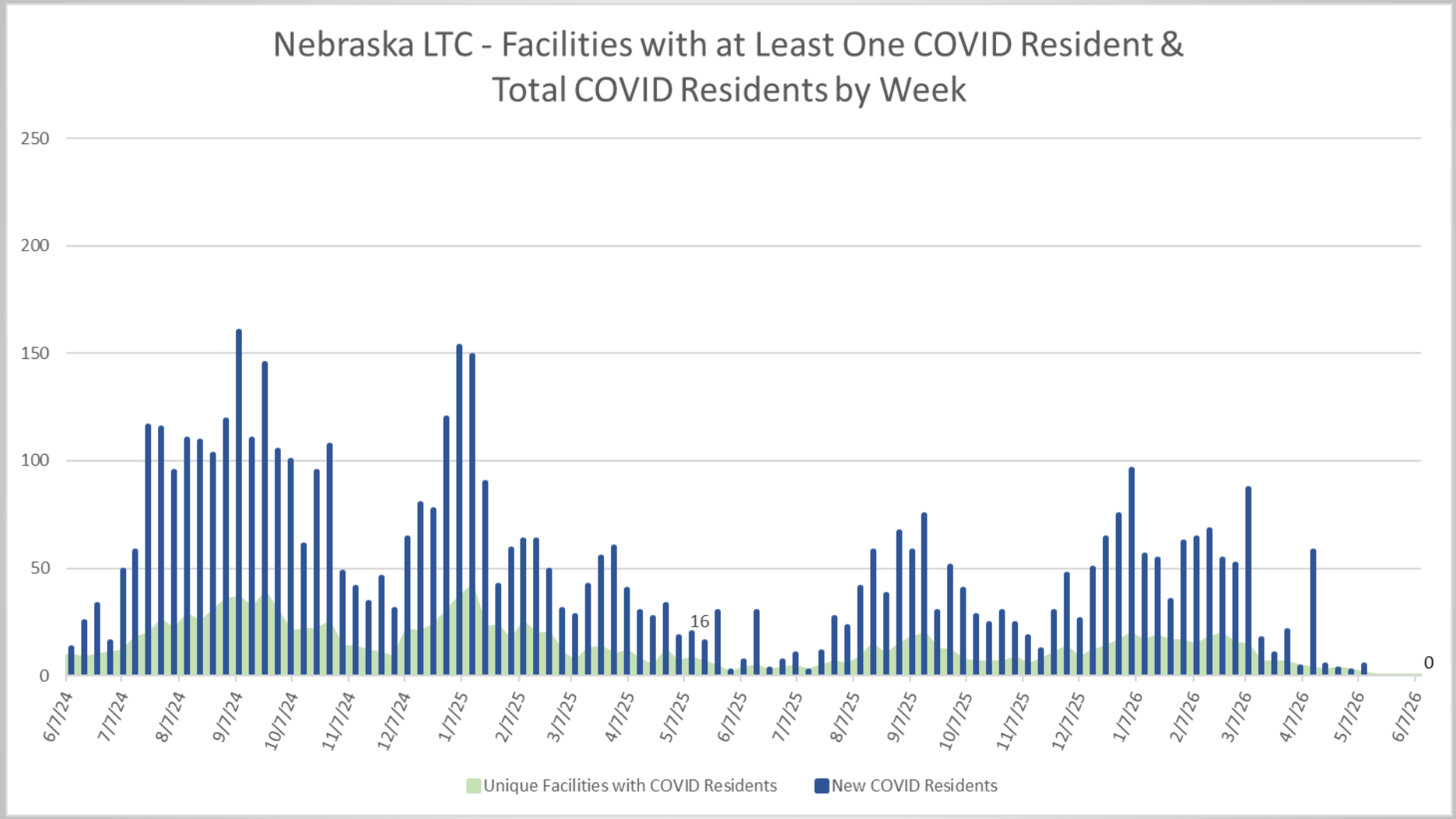
Continuing Education Disclosures

- 1.0 Nursing Contact Hour is awarded for the LIVE viewing of this webinar
- To obtain the nursing contact hour, you must attend the entire live activity and complete the post webinar survey
- No relevant financial relationships were identified for any member of the planning committee or any presenter/author of the program content
- This CE is hosted Nebraska ICAP along with Nebraska DHHS
- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by VTL Center for Professional Development, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Communicable Illness Update

NE ICAP

Nebraska LTC Facility COVID-19 Outbreaks



**Updated: 6/8/2026

Source: Unofficial Counts Compiled by Nebraska ICAP based on data reported by facilities and DHHS; Actual numbers may vary.

COVID-19 Wastewater Activity

Time Period: May 24, 2026 - May 30, 2026

Influenza A

Wastewater viral activity levels for influenza A are **very low**.

COVID-19

Wastewater viral activity levels for COVID-19 are **very low**.

RSV

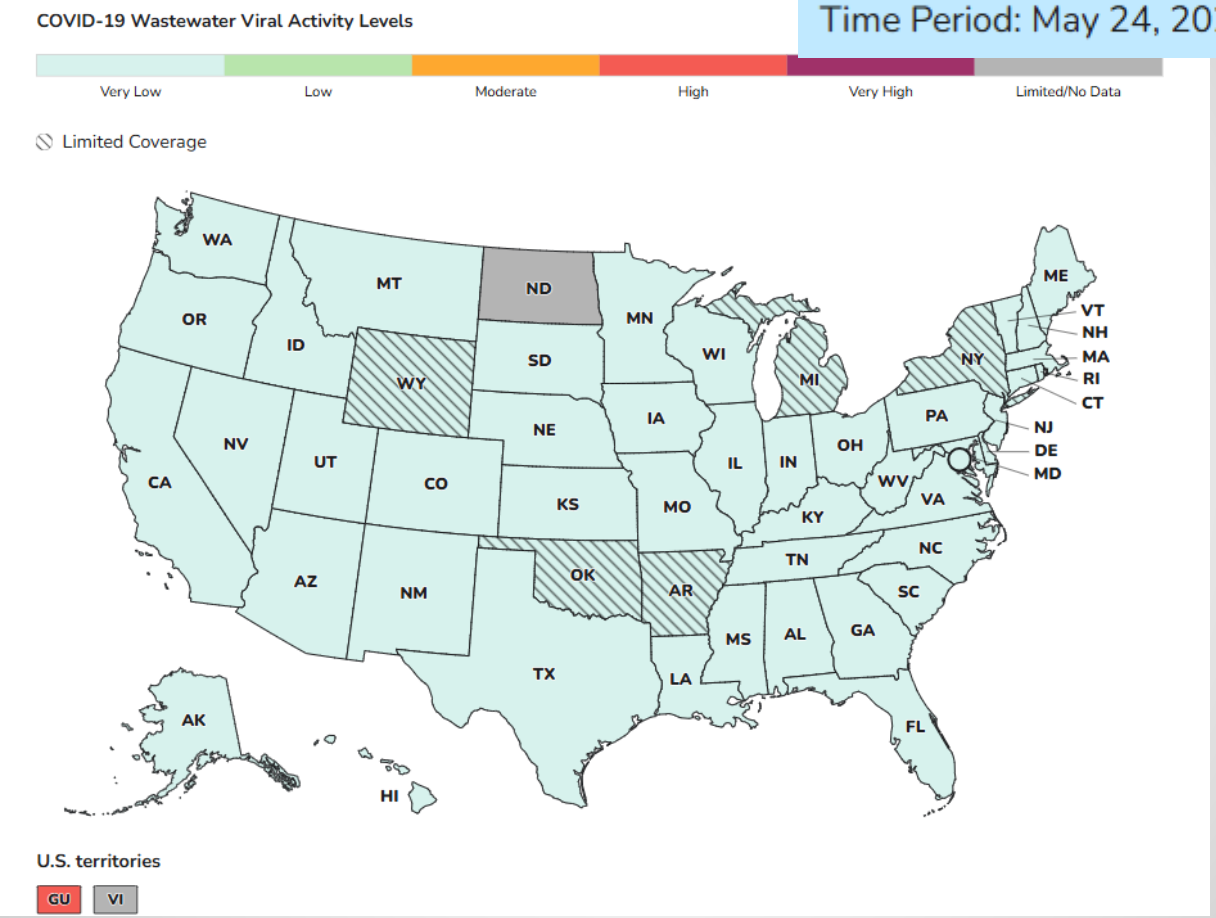
Wastewater viral activity levels for RSV are **very low**.

[COVID-19 Wastewater Data – National Trends | NWSS | CDC]

CDC National Wastewater Surveillance System (NWSS)

COVID-19 Wastewater Activity

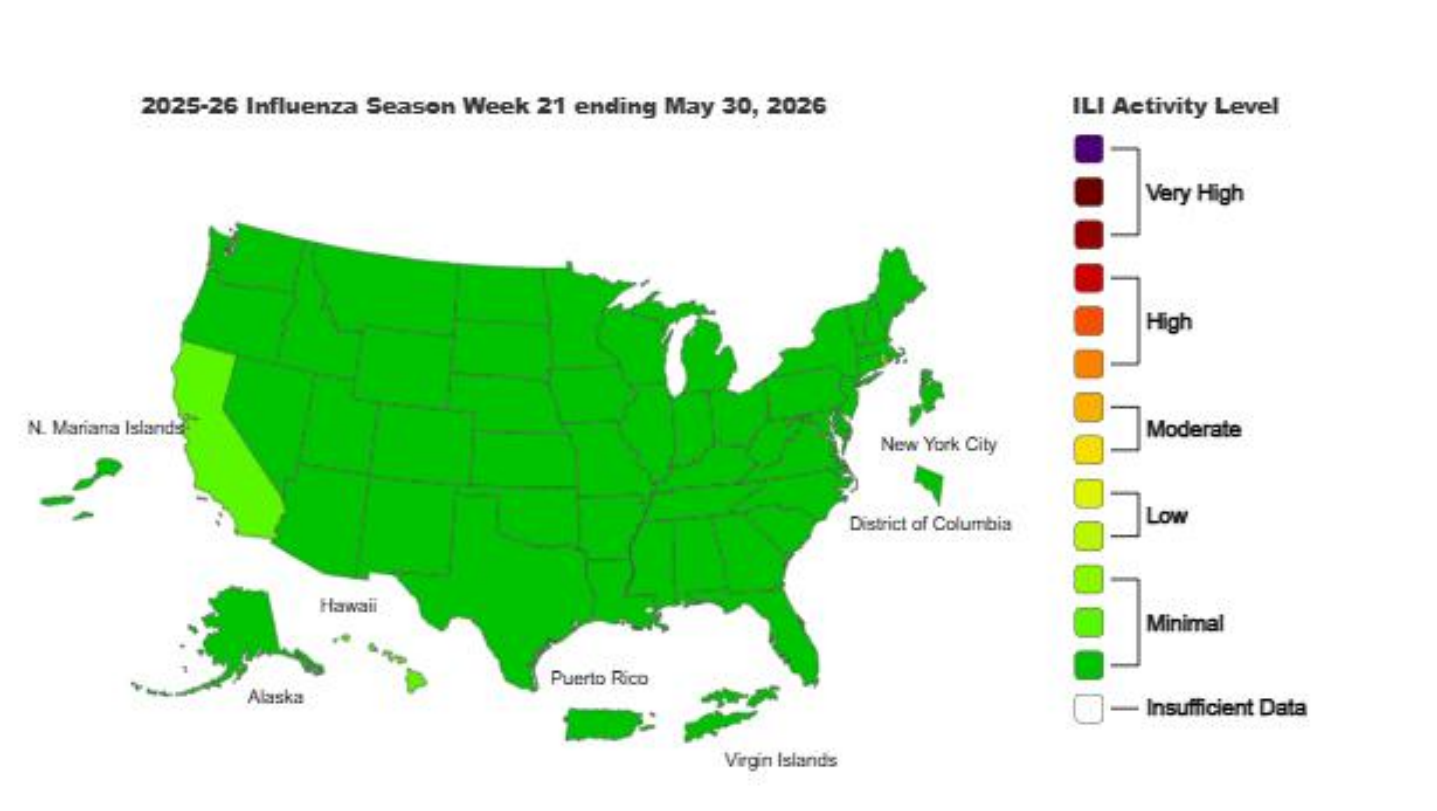
Time Period: May 24, 2026 - May 30, 2026



[COVID-19 Wastewater Data – National Trends | NWSS | CDC]

National Wastewater Surveillance System (NWSS)

CDC Weekly Influenza Surveillance



[Weekly US Map: Influenza Summary Update | FluView | CDC]

UTI and CAUTI Prevention

NE ICAP

Objectives:

- Describe the risk of healthcare-associated UTIs in nursing facilities
- Review evidence-based clinical practices shown to prevent UTIs and catheter associated UTIs (CAUTIs)
- Review available tools for training, audits, and surveillance

Urinary tract infections (UTIs) are one of the most common infections in nursing homes.

- Accounts for 20% - 30% of reported infections
- Approximately 1.5 per 10,000 resident days
- Frequently urinary catheter associated
  - 7% - 10% of residents have a urinary catheter

Definition Review

Symptomatic Urinary Tract Infection (SUTI)

- Signs and symptoms of infection are present (e.g., dysuria, urinary frequency, suprapubic tenderness) along with a positive urine culture

Asymptomatic Bacteremic Urinary Tract Infection (ABUTI).

- No signs or symptoms of a UTI but resident has urine and blood cultures positive for at least one common organism

Cystitis

- Urinary symptoms are usually confined to the bladder

Pyelonephritis

- Less common but more severe infection involving the renal parenchyma

Asymptomatic Bacteriuria

- Presence of bacteria in the urine without signs or symptoms of infection that localize to the urinary tract

Definition Review

Catheter-Associated Urinary Tract Infection (CAUTI)

- A UTI where an indwelling urinary catheter, inserted through the urethra, has been in place for more than two calendar days and the resident develops signs and symptoms localizing to the urinary tract

Most common UTI pathogens:

- *Escherichia coli* (E. coli)
- *Proteus* spp.
- *Klebsiella pneumoniae/oxytoca*
- *Enterococcus faecalis*
- *Pseudomonas aeruginosa*

The long-term care facility's role in UTI and CAUTI prevention:

- ❑ Ensure policies and procedures reflect current evidence-based recommendations

- ❑ Ensure staff competency upon hire and at least annually
  - Include hands-on training with return demonstration

- ❑ Establish an adherence monitoring program
  - Use standard tools to measure and document adherence

- ❑ Perform UTI/CAUTI surveillance

- ❑ Provide feedback to frontline staff and leaders
  - Present adherence results with UTI/CAUTI incidence

Recommended competency assessments related to UTI/CAUTI prevention:

- ❑ Resident fluid needs and promoting intake
- ❑ Resident mobility needs
- ❑ Perineal care procedures for both catheterized and non-catheterized residents
- ❑ Urinary catheter insertion and care
- ❑ Nursing assessment and SBAR Communication
  - ❑ Improving antibiotic stewardship efforts
- ❑ Urinary specimen collection
  - ❑ Clean catch
  - ❑ From catheter

General UTI Prevention Recommendations

- Empty bladder fully when urinating
- Urinate after sexual intercourse
- Wipe from front to back to prevent fecal flora from entering the urethra
- Drink plenty of water/fluids daily
- Avoid irritation of the vagina with feminine hygiene products such as douches or sprays, strong soaps, or scented pantyliners
- Do not delay urinating when the need arises
    - Consider timed and prompted voiding.

Alternatives to Indwelling Urinary Catheters

- Consider using external catheters as an alternative to indwelling urethral catheters in cooperative male patients without urinary retention or bladder outlet obstruction.
- Consider alternatives to chronic indwelling catheters, such as intermittent catheterization, in spinal cord injury patients.
- Intermittent catheterization is preferable to indwelling urethral or suprapubic catheters in patients with bladder emptying dysfunction.

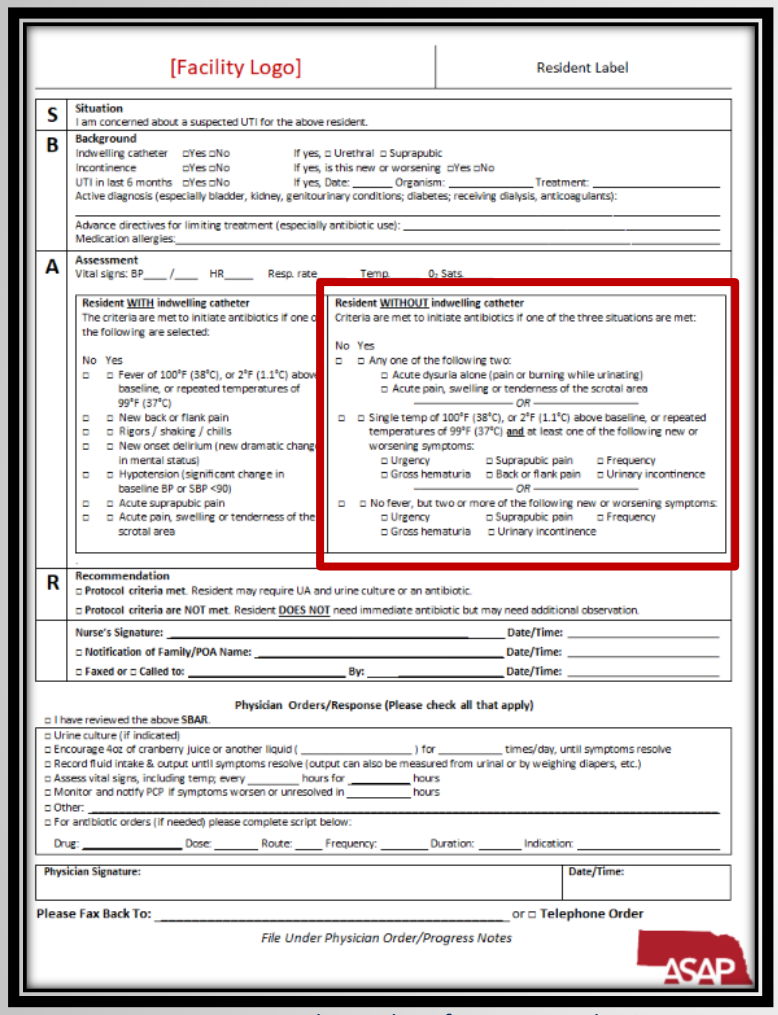
A standardized SBAR (Situation-Background-Assessment-Recommendation) Tool can be used to improve the evaluation and communication of clinical signs and symptoms when infection is first suspected.

- Almost half of the urine culture orders in nursing homes are due to inappropriate indications, like changes in mental status (32%) and in urine color, odor, or sediment (17%).

- Overuse and misuse of urine tests can lead to substantial overprescribing of antibiotics in nursing homes.

- Recommend the use of a diagnostic algorithm to promote antimicrobial stewardship.

- Education of healthcare personnel on appropriate criteria for requesting urine cultures should be a component of all interventions.



[Facility Logo] | Resident Label

S **Situation**
I am concerned about a suspected UTI for the above resident.

B **Background**
Indwelling catheter ☐Yes ☐No — If yes, ☐ Urethral ☐ Suprapubic
Incontinence ☐Yes ☐No — If yes, is this new or worsening ☐Yes ☐No
UTI in last 6 months ☐Yes ☐No — If yes, Date: _____ Organism: _____ Treatment: _____
Active diagnosis (especially bladder, kidney, genitourinary conditions; diabetes; receiving dialysis, anticoagulants):
Advance directives for limiting treatment (especially antibiotic use): _____
Medication allergies: _____

A **Assessment**
Vital signs: BP___/___ HR_____ Resp. rate_____ Temp_____ O_2 Sats_____

Resident WITH indwelling catheter
The criteria are met to initiate antibiotics if one o
the following are selected:

No Yes
☐ ☐ Fever of 100°F (38°C), or 2°F (1.1°C) abov
baseline, or repeated temperatures of
99°F (37°C)
☐ ☐ New back or flank pain
☐ ☐ Rigors / shaking / chills
☐ ☐ New onset delirium (new dramatic chang
in mental status)
☐ ☐ Hypotension (significant change in
baseline BP or SBP <90)
☐ ☐ Acute suprapubic pain
☐ ☐ Acute pain, swelling or tenderness of the
scrotal area

Resident WITHOUT indwelling catheter
Criteria are met to initiate antibiotics if one of the three situations are met:

No Yes
☐ ☐ Any one of the following two:
☐ Acute dysuria alone (pain or burning while urinating)
☐ Acute pain, swelling or tenderness of the scrotal area
— OR —
☐ ☐ Single temp of 100°F (38°C), or 2°F (1.1°C) above baseline, or repeated temperatures of 99°F (37°C) **and** at least one of the following new or worsening symptoms:
☐ Urgency ☐ Suprapubic pain ☐ Frequency
☐ Gross hematuria ☐ Back or flank pain ☐ Urinary incontinence
— OR —
☐ ☐ No fever, but two or more of the following new or worsening symptoms:
☐ Urgency ☐ Suprapubic pain ☐ Frequency
☐ Gross hematuria ☐ Urinary incontinence

R **Recommendation**
☐ **Protocol criteria met.** Resident may require UA and urine culture or an antibiotic.
☐ **Protocol criteria are NOT met.** Resident **DOES NOT** need immediate antibiotic but may need additional observation.

Nurse's Signature: _____ **Date/Time:** _____
☐ **Notification of Family/POA Name:** _____ **Date/Time:** _____
☐ **Faxed or ☐ Called to:** _____ **By:** _____ **Date/Time:** _____

Physician Orders/Response (Please check all that apply)
☐ I have reviewed the above **SBAR.**
☐ Urine culture (if indicated)
☐ Encourage 4oz of cranberry juice or another liquid (_____) for _____ times/day, until symptoms resolve
☐ Record fluid intake & output until symptoms resolve (output can also be measured from urinal or by weighing diapers, etc.)
☐ Assess vital signs, including temp, every _____ hours for _____ hours
☐ Monitor and notify PCP if symptoms worsen or unresolved in _____ hours
☐ Other: _____
☐ For antibiotic orders (if needed) please complete script below:
Drug: _____ Dose: _____ Route: ____ Frequency: _____ Duration: _____ Indication: _____

Physician Signature: | **Date/Time:**

Please Fax Back To: _____ or ☐ **Telephone Order**

File Under Physician Order/Progress Notes

ASAP

[SBAR-communication-tool-template-for-suspected-urinary-tract-infection.docx]

How to Use an SBAR for Antimicrobial Stewardship Activities

What is an SBAR?
SBAR is the acronym for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation. It is a communication technique originally developed by the US Navy and initially adopted into healthcare by Kaiser Permanente to facilitate prompt and accurate transfer of information.

Why use an SBAR?
SBAR outlines an easy-to-remember and structured format for communicating a standard set of information from one person/group to the next. Using this strategy, bedside nurses can communicate essential and relevant clinical information to clinicians as well as recommend protocol-driven actions. Using the provided information, a clinician can make management decision based on recommendations from the bedside nurse or provide an alternative management plan.

How to use an SBAR?
SBAR for antimicrobial stewardship activities are typically available as paper or electronic tools consisting of checkboxes or fill-in-the-blanks. Even though the format may be different, the procedure for using them remains similar.

[How-to-Use-an-SBAR-for-Antimicrobial-Stewardship-011419.pdf]

Implementation of SBAR for Antimicrobial Stewardship Activities

1. **What is an SBAR?**
SBAR is the acronym for **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation. It is a communication technique originally developed by the US Navy and initially adopted into healthcare by Kaiser Permanente to facilitate prompt and accurate transfer of information. It has gained increasing acceptance as a standard communication strategy in different areas of healthcare including in antimicrobial stewardship since its introduction.

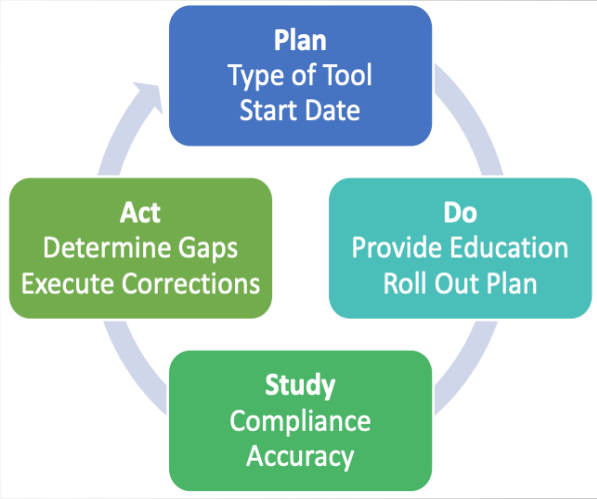
2. **Why use an SBAR?**
SBAR outlines an easy-to-remember and structured format for communicating a standard set of information from one person/group to the next. This strategy starts with a statement of why the communication is being initiated (Situation). It continues with providing relevant historical or current information that led up to the situation (Background). This is followed by evaluation of the situation using a standard set of criteria (Assessment). Finally, a course of suggested action is provided based on previously provided information (Recommendation).

[Implementation-of-SBAR-for-Antimicrobial-Stewardship-011419.pdf]

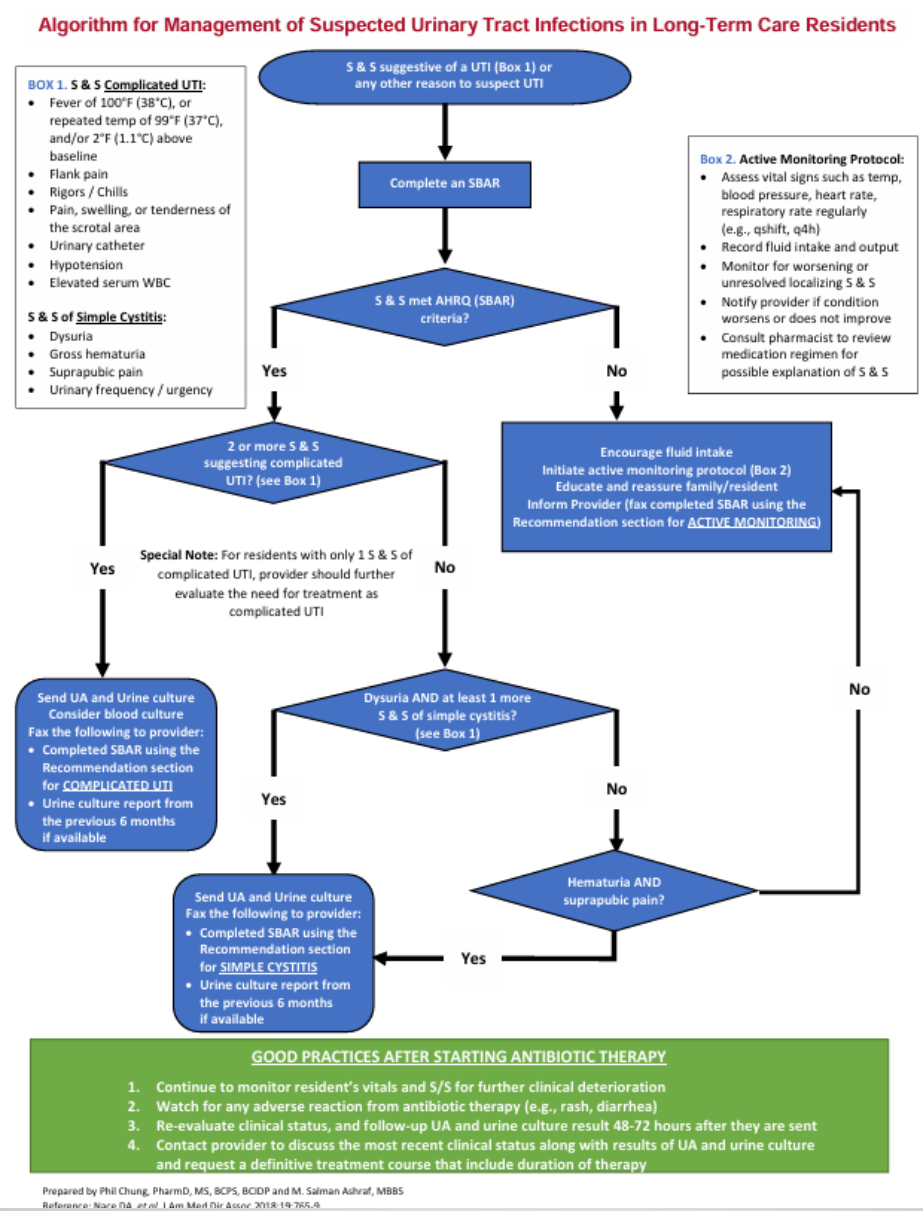
NE ICAP

Implementing SBARs

- Discuss as a stewardship committee how best to implement (paper vs. electronic, which infections, timeframe)
- Educate providers and staff on SBAR purpose and function, including detailed instructions for nursing staff
- Once implemented, assess SBAR compliance periodically
  - Share a report of compliance numbers with staff to encourage consistent use
- Identify and address barriers or gaps in compliance
  - Re-education, discussion with outlier staff members, revision of SBAR tool, etc.



Infographic for staff education



[Algorithm-for-management-of-suspected-UTI-in-LTC-Residents.pdf]

When a urinalysis and/or urine culture is indicated, a high-quality specimen is required to produce high-quality diagnostic results.

- Voided, clean-catch specimen
- Specimen obtained directly from urinary catheter

Clean Catch Specimen Collection

- Analysis of a voided specimen that is collected in a manner with as little contamination as possible is the most desirable sample.
- Many techniques have been attempted to obtain clean specimens, especially from females.
- In a "clean catch" sample the genital area is cleaned with a mild soap (wipe) beginning at the top of the labia washing downward toward the genitals to prevent bacteria from the genital area contaminating the specimen and causing confusion with the test results.
- As it is not uncommon for urine in healthy individuals to have low counts of bacteria, when possible, urine specimens should be collected as a "midstream" sample.
- All samples regardless of method of collection should be placed in a sterile collection container

Specimen Collection with a Urinary Catheter

When a catheter-associated urinary tract infection (CAUTI) is suspected:

- Residents with indwelling catheters should have the device changed prior to specimen collection if the urinary catheter has been in place more than 14 days.
  - This is done to prevent the influence of possible presence of biofilm on the device surfaces.

- Specimens obtained from drainage bags should never be submitted for analysis

- Consult the facility-contracted microbiology laboratory for the correct procedures for holding specimens for pickup
  - It is recommended that specimens be cultured within 2 hours. If that is not possible, use of refrigeration or chemical preservatives will be required.
  - Follow all requirements for biohazard labeling and preparation prior to transport

Evidence-based recommendations for the safe and effective management of indwelling urinary catheters

Essential practices
Infrastructure and resources
1. Perform a CAUTI risk assessment and implement an organization-wide program to identify and remove catheters that are no longer necessary using 1 or more methods documented to be effective.[34,35,51,52] (Quality of evidence: MODERATE)
a. Develop and implement institutional policy requiring periodic, usually daily, review of the necessity of continued catheterization.
b. Consider utilizing electronic or other types of reminders (see Supplementary Content, Appendices 2 and 3 online) of the presence of a catheter and required criteria for continued use.[63]
c. Conduct daily review during rounds of all patients with urinary catheters by nursing and physician staff to ascertain necessity of continuing catheter use.[64]
2. Provide appropriate infrastructure for preventing CAUTI.[56] (Quality of evidence: LOW)
a. Ensure that the supplies for following best practices for managing urinary issues are readily available to staff in each unit, including bladder scanners, non-catheter incontinence management supplies (urinals, garments, bed pads, skin products), male and female external urinary catheters, straight urinary catheters, and indwelling catheters including the option of catheters with coude tips.
b. Ensure that non-catheter urinary management supplies are as easy to obtain for bedside use as indwelling urinary catheters.
c. Ensure the physical capability for urinary catheters with tubes attached to patients (eg, indwelling urinary catheters, some external urinary catheters[EUCs]) to be positioned on beds, wheelchairs, at an appropriate height and without kinking for patients in their rooms and during transport.
3. Provide and implement evidence-based protocols to address multiple steps of the urinary catheter life cycle (Fig. 1): catheter appropriateness (step 0), insertion technique (step 1), maintenance care (step 2), and prompt removal (step 3) when no longer appropriate. (Quality of evidence: LOW)
a. Adapt and implement evidence-based criteria for acceptable indications for indwelling urethral catheter use, which may be embedded as standardized clinical-decision support tools within electronic medical record (EMR) ordering systems. Expert-consensus–derived indications for indwelling catheter use have been developed, although there is limited research that assesses the appropriateness of these uses.[34,65]
4. Ensure that only trained HCP insert urinary catheters and that competency is assessed regularly.[65] (Quality of evidence: LOW)
a. Require supervision by experienced HCP when trainees insert and remove catheters to reduce the risk of infectious and traumatic complications related to urinary catheter placement.[69–71]
5. Ensure that supplies necessary for aseptic technique for catheter insertion are available and conveniently located. (Quality of evidence: LOW)
6. Implement a system for documenting the following in the patient record: physician order for catheter placement, indications for catheter insertion, date and time of catheter insertion, name of individual who inserted catheter, nursing documentation of placement, daily presence of a catheter and maintenance care tasks, and date and time of catheter removal. Record criteria for removal and justification for continued use. (Quality of evidence: LOW)
a. Record in a standard format for data collection and quality improvement purposes and keep accessible documentation of catheter placement (including indication) and removal.
b. If available, utilize electronic documentation that is searchable.
c. Consider nurse-driven urinary catheter removal protocols for first trial of void without an indwelling catheter when the indication for placement has resolved (see Essential Practices, 3).
7. Ensure that sufficiently trained HCP and technology resources are available to support surveillance for catheter use and outcomes.[73] (Quality of evidence: LOW)
8. Perform surveillance for CAUTI if indicated based on facility risk assessment or regulatory requirements. as described in Section 5.[73] (Quality of evidence: LOW)
9. Standardize urine culturing by adapting an institutional protocol for appropriate indications for urine cultures in patients with and without indwelling catheters.[27,53,74–76] Consider incorporating these indications into the EMR, and review indications for ordering urine cultures in CAUTI risk assessment.[77] (Quality of evidence: LOW)

https://doi.org/10.1017/ice.2025.10252

1. Only personnel who have been trained in correct technique to insert catheters should perform a catheter insertion. If it is anticipated that the resident may present difficulties in the insertion procedure (e.g., the resident is having contractures and/or may be difficult to position or may be confused and try to grab equipment), an assistant may be needed.
2. Standard Precautions must be used.
3. Perform hand hygiene before gloving, and again when gloves are removed.
4. Use aseptic technique and sterile supplies for catheter insertion.
5. Use the smallest size catheter necessary to allow the free flow of urine to lessen the trauma of catherization.
6. Explain the urinary catheter insertion procedure to the resident and document their understanding. Document the use of sterile technique, the catheter size, and balloon size, toleration of procedure, if an assistant was needed, number of insertion attempts, urine character, and the connection to a collection bag that's positioned below the bladder for gravity drainage and above the floor.
7. Maintain a closed sterile urinary draining system.
8. Maintain an unobstructed urine flow. Keep the catheter and tubing free from kinking and secure the tubing per facility protocol.
9. Keep the collecting bag below the level of the bladder at all times. Do not place the bag on the floor.
10. Empty the collecting bag regularly using a separate, clean collecting container marked with the resident's name.

Infection Prevention Guide to Long-Term Care, 2nd edition |

Evidence-based recommendations for the safe and effective management of indwelling urinary catheters

- Only staff who have been trained in correct insertion technique should perform a catheter insertion
- Always use standard precautions
- Hand Hygiene should be done before gloving and again when gloves are removed
- Aseptic technique and sterile supplies must be used for catheter insertions
- To lessen the trauma of catheterization, use the smallest size of catheter to allow the free flow of urine
- For maximum safe catheter maintenance, maintain a closed sterile urinary drainage system.
- Maintain an unobstructed urine flow. Keep the catheter and tubing free from kinking and secure the tubing
- Keep the collecting bag below the level of the bladder at all times; do not place the bag on the floor
- Empty the collecting bag regularly using a separate, clean collecting container marked with the resident's name.

Long-Term Care: Indwelling Urinary Catheter Insertion Checklist

Resident Name (print) _____ Med Rec# _____ Unit _____ Date/Time _____
Inserting Clinician (print) _____ Signature _____
Technique Reviewer‡, if applicable (print) _____ Signature _____

I. BEFORE CATHETER INSERTION

1. Confirm order, to include catheter and balloon size; use the smallest effective catheter size.
2. Assemble and verify supplies. Consider bringing a second catheter to use if the first one is accidentally contaminated.
3. Identify the resident, per facility policy. Explain the procedure, its necessity, and its potential complications to the resident and/or family.
4. Ensure privacy and good lighting.
5. Position the resident correctly for the procedure; consider using an assistant to help resident stay in position and decrease potential contamination of sterile catheter.
6. Perform hand hygiene, don clean gloves, and cleanse the perineal area with a washcloth, skin cleanser, and warm water, moving from front to back.
7. Remove gloves and perform hand hygiene.

II. DURING INSERTION

1. Open the sterile catheterization kit on a clean bedside table, using sterile technique. Ensure all supplies are conveniently positioned.
2. Put on sterile gloves and drape the resident.
3. Prepare the antiseptic solution; ensure the resident is not allergic to iodine. Apply sterile lubricant to the catheter tip. Consider attaching catheter to drainage system now, if not already attached, and ensure the drainage bag emptying port is clamped.
4. With nondominant hand, identify meatus, and be prepared to keep this hand in this position until after the urine is flowing.
5. With dominant (sterile) hand, clean the meatus opening with the antiseptic solution, moving from top to bottom. Use a new wipe/swab each time. Allow the antiseptic to dry.
6. With the dominant (sterile) hand, insert the catheter slowly into the urethra until there is a return of urine. Then advance the catheter 2-3 inches more. (Do not force the catheter through the urethra). Leave the catheter in the vagina, if accidentally inserted, until after the new sterile urinary catheter is inserted into the bladder.
7. Hold the catheter with the nondominant hand; use the dominant hand to fully inflate the catheter balloon with the entire volume of supplied sterile water in the prefilled syringe.
8. Gently pull on catheter after balloon inflation to feel resistance.

III. AFTER INSERTION

1. Remove used equipment and dispose of used supplies in trash per facility policy. Place syringe in sharps container. If a bladder scanner was used, wipe it with appropriate disinfectant cleaner before storing for use with the next resident.
2. Secure catheter to the resident's leg with securement device. Remove gloves and perform hand hygiene
3. Cover the resident with linens and assist to a comfortable position.
4. Ensure the tubing in not kinked and the drainage bag is below the level of the bladder. Place a cover over the drainage bag to maintain resident dignity.
5. Perform hand hygiene.
6. Document—
   a. Type and size of catheter and balloon
   b. Amount of fluid inserted in the balloon
   c. How the resident tolerated the procedure
   d. Amount of urine obtained and its characteristics
   e. Name of person performing the insertion and the date it was completed.
7. Label a urine collection container with a resident identifier and date.

[Appendix G. Indwelling Urinary Catheter Insertion Checklist | Agency for Healthcare Research and Quality]

TAKE EVERY PRECAUTION
RIGHT PATIENT. RIGHT PRODUCT. RIGHT RESULT.

BARD® ADVANCE FOLEY TRAY SYSTEM
Insertion and Removal Skills Training Checklist

Objectives: 1. Clinician will demonstrate understanding of the device indications, contraindications, warnings and precautions. 2. Clinician will demonstrate understanding of proper insertion and removal of an indwelling urinary catheter. Supplies: BARD® ADVANCE Foley Catheter Tray	Task Completed	Trainer Initials
Foley Catheter Insertion		
1. Confirm patient meets the CDC Guidelines for Appropriate Indications for Indwelling Urethral Catheter Use:[1]		
• Patient has acute urinary retention or bladder outlet obstruction		
• Need for accurate urine output measurements		
• Use for selected surgical procedures		
• To assist in healing of open sacral or perineal wounds		
• Patient requires prolonged immobilization		
• To improve comfort for end of life care		
• Select the smallest Foley catheter possible, consistent with good drainage		
2. Preparation:		
• Conduct a 15-30 second antiseptic hand wash and don clean gloves		
• Open outer packaging, remove tray and open CSR wrap		
• Position patient		
• Place underpad beneath patient, plastic or "shiny" side down		
• Use provided castile soap wipes to cleanse patient's peri-urethral area using downward strokes from anterior to posterior		
• Discard gloves. Perform hand hygiene with provided alcohol hand sanitizer gel		
3. Insert Foley Catheter using aseptic technique and sterile equipment:		
• Maintain aseptic technique and don sterile gloves		
• Position fenestrated drape on patient appropriately		
• Use the syringe with the green plunger to deposit lubricant into tray-top for Foley catheter lubrication		
• Remove top tray and place next to bottom tray (keep on CSR wrap)		
• Attach the water-filled syringe to the inflation port ✓ Note: It is not necessary to pre-test the Foley catheter balloon		
• Remove Foley catheter from wrap and lubricate catheter		
• Prepare patient with packet of pre-saturated antiseptic swab sticks:		

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BARD | MEDICAL

[insertion_checklist.pdf (urotoday.com)]

Female urinary catheter insertion

Clinical competency checklist

Participant:
Facility:
Date:
Instruction provided by:

Instructions: Indicate your participation (verbal or skill demonstration) with a ✓ in the appropriate box.

Skill	Verbal description	Skill demonstration
Confirm order: Review the patient's chart to ensure there is an order for catheterization based on appropriate indications.	☐	☐
Safety check: Check to see if the patient has any allergies such as iodine or latex and for pathological factors that may impede the passage of a catheter.	☐	☐
Catheter selection: Unless clinically indicated, use the smallest catheter French size possible consistent with good drainage to minimize bladder neck and urethral trauma.	☐	☐
Infection prevention: Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.	☐	☐
Materials: Begin by gathering your supplies: a Foley catheter closed system tray, perineal cleansing supplies in accordance with your facility's policy and procedure, and additional clean, non-sterile exam gloves.	☐	☐
Preparation and insertion setup		
1. Don non-sterile gloves.	☐	☐
2. Lower the head of the patient's bed to a flat position.	☐	☐
3. Have the patient bend their knees with legs spread and hips externally rotated.	☐	☐
4. Stand at the side of the bed in which your dominant hand is closest to the foot of the bed.	☐	☐
5. Remove the patient's bed covers, pajama bottoms or underwear.	☐	☐
6. Remove non-sterile gloves and perform hand hygiene.	☐	☐
7. Don a new pair of non-sterile exam gloves.	☐	☐
8. Open the plastic wrap and remove the Foley kit.	☐	☐
9. Place the tray between the patient's lower extremities.	☐	☐
10. Remove the castile soap and hand sanitizer. Set them aside.	☐	☐
11. Open the inner layer and remove the top drape, holding the back corners. Slide it under the patient's perineal and hip area.	☐	☐
12. Remove and dispose of non-sterile gloves, and perform hand hygiene using the provided hand sanitizer.	☐	☐

CardinalHealth
Essential to care®

- [Clinical competency checklist - Female urinary catheter insertion (cardinalhealth.com)]

No evidence that these practices prevent UTI:

- Complex urinary drainage systems
- Routinely changing catheters or drainage bags
- Routine antimicrobial prophylaxis
- Cleaning the periurethral area with antiseptics
- Unless obstruction is suspected, bladder irrigation is not recommended
- Antimicrobial irrigation of the bladder
- Antiseptic/antimicrobial solutions instilled into drainage bags
- Routine screening or culturing

Address the necessity of a urinary catheter upon insertion and on a consistent basis.

Appropriate Use	Inappropriate Use
Acute urinary retention or bladder outlet obstruction.	Convenience
Prolonged immobilization due to unstable spine or pelvic fracture	Alternative strategies are not utilized
Assist healing of perineal and sacral wounds in incontinent patients	Specimen collection for residents who can void
End-of-life comfort, comfort care, palliative care	Catheter is not removed when no longer necessary

CAUTI Prevention Bundle Examples

Insertion Bundle

- Verify need prior to insertion
- Insert urinary catheter using aseptic technique
- Maintain urinary catheter based on recommended guidelines

Maintenance Bundle

- Daily assessment of catheter need documented
- Tamper evident seal is intact
- Catheter securement device is used
- Hand hygiene performed before patient contact
- Daily meatal hygiene with soap and water
- Drainage bag emptied using a clean container
- Unobstructed flow maintained

Outcome Surveillance

- Looks at infections that can be considered the result of the LTC facility's practices
- Important to use standardized surveillance definitions, which may not be the same as a clinical diagnosis
- When calculating infection rates, the numerator is the number of residents with the specific infection and the denominator must accurately reflect the population being studied. For example, residents with indwelling urinary catheters will be the population or group who are at risk for catheter-associated urinary tract infections (CAUTIs).

Example:

Four people on a 10-resident unit develop new, symptomatic urinary tract infections during the month of March.
To calculate the incidence using a percentage:

$$\frac{\textbf{4 new UTI cases} \text{ occurring during a specific period of time}}{\text{10 people at risk for developing the disease during that period of time}} = 0.4 \times 100 = 40\% \text{ of residents}$$

To calculate the prevalence rate of UTI:

$$\frac{\textbf{4 new UTI cases} \text{ occurring during a specific period of time}}{\text{10 people at risk for developing the disease March (31 days)=310}} \frac{4}{310} = 0.013 \times 1000 = 12.9 \text{ UTI per 1000 resident days}$$

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Process Surveillance

- Looks at LTC facility-specific practices related to resident care

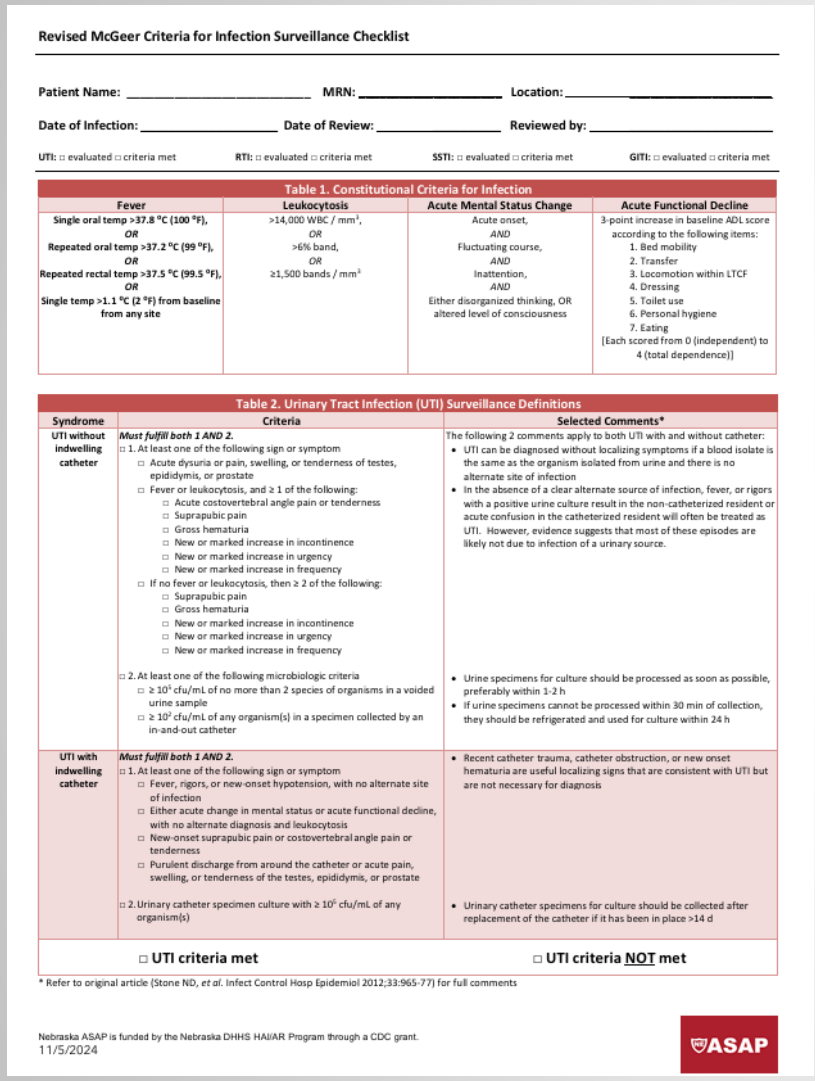
- Example, measure healthcare adherence to:
  - Hand hygiene
  - Use of checklists, such as SBAR
  - Documentation of catheter insertion and removal
  - Daily assessment of indwelling urinary catheter
  - Documentation of indications for use
  - Repository of monitoring tools: Monitoring Adherence to Healthcare Practices that Prevent Infection

- When combined with outcome surveillance, can provide cause/effect analysis

Use of Surveillance Activities

- Review and analyze the data
- Share results with leadership and frontline staff
  - Narrative summary
  - Graphs, charts, tables
- Identify areas for improvement and trend progress
- Report clusters/outbreaks to local health department

McGeer and Loeb Criteria



Revised McGeer Criteria for Infection Surveillance Checklist

Patient Name: _____ MRN: _____ Location: _____

Date of Infection: _____ Date of Review: _____ Reviewed by: _____

UTI: □ evaluated □ criteria met RTI: □ evaluated □ criteria met SSTI: □ evaluated □ criteria met GITI: □ evaluated □ criteria met

Table 1. Constitutional Criteria for Infection

Fever	Leukocytosis	Acute Mental Status Change	Acute Functional Decline
Single oral temp >37.8 °C (100 °F), *OR* Repeated oral temp >37.2 °C (99 °F), *OR* Repeated rectal temp >37.5 °C (99.5 °F), *OR* Single temp >1.1 °C (2 °F) from baseline from any site	>14,000 WBC / mm³, *OR* >6% band, *OR* ≥1,500 bands / mm³	Acute onset, *AND* Fluctuating course, *AND* Inattention, *AND* Either disorganized thinking, OR altered level of consciousness	3-point increase in baseline ADL score according to the following items: 1. Bed mobility 2. Transfer 3. Locomotion within LTCF 4. Dressing 5. Toilet use 6. Personal hygiene 7. Eating [Each scored from 0 (independent) to 4 (total dependence)]

Table 2. Urinary Tract Infection (UTI) Surveillance Definitions

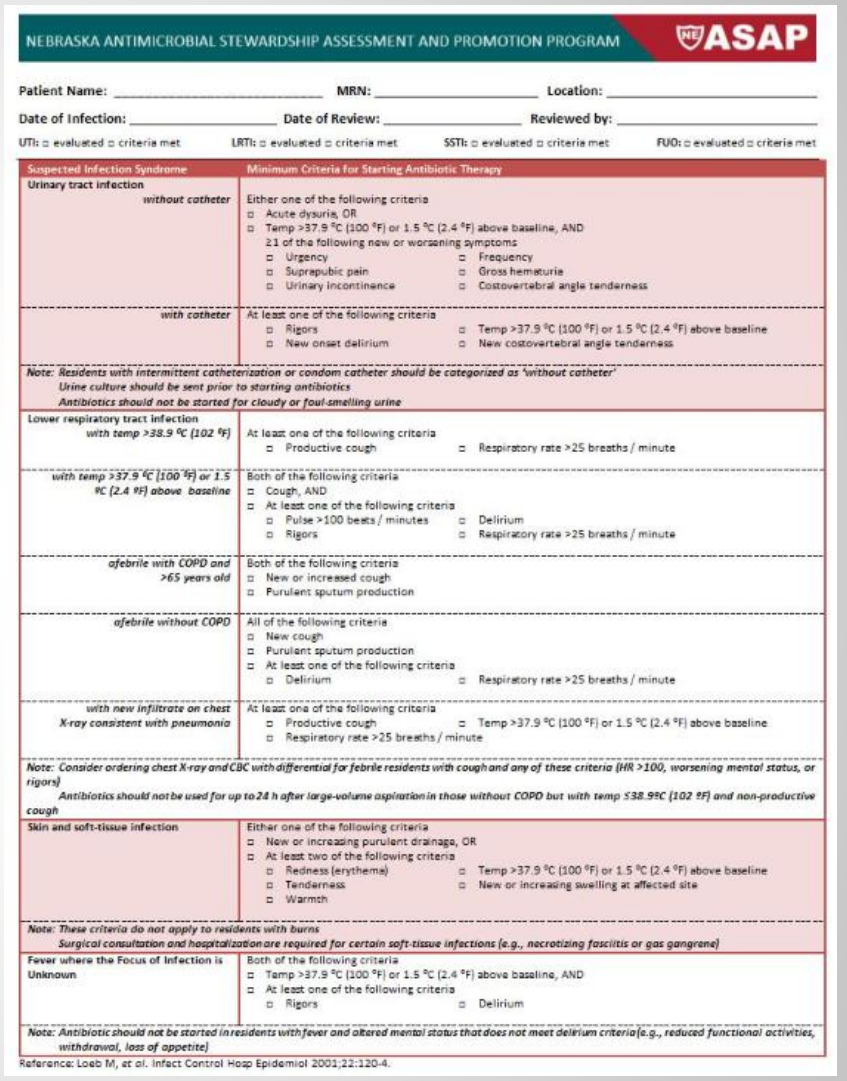
Syndrome	Criteria	Selected Comments*
UTI without indwelling catheter	***Must fulfill both 1 AND 2.*** □ 1. At least one of the following sign or symptom □ Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate □ Fever or leukocytosis, and ≥ 1 of the following: □ Acute costovertebral angle pain or tenderness □ Suprapubic pain □ Gross hematuria □ New or marked increase in incontinence □ New or marked increase in urgency □ New or marked increase in frequency □ If no fever or leukocytosis, then ≥ 2 of the following: □ Suprapubic pain □ Gross hematuria □ New or marked increase in incontinence □ New or marked increase in urgency □ New or marked increase in frequency □ 2. At least one of the following microbiologic criteria □ ≥ 10^5 cfu/mL of no more than 2 species of organisms in a voided urine sample □ ≥ 10^2 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter	The following 2 comments apply to both UTI with and without catheter: • UTI can be diagnosed without localizing symptoms if a blood isolate is the same as the organism isolated from urine and there is no alternate site of infection • In the absence of a clear alternate source of infection, fever, or rigors with a positive urine culture result in the non-catheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source. • Urine specimens for culture should be processed as soon as possible, preferably within 1-2 h • If urine specimens cannot be processed within 30 min of collection, they should be refrigerated and used for culture within 24 h
UTI with indwelling catheter	***Must fulfill both 1 AND 2.*** □ 1. At least one of the following sign or symptom □ Fever, rigors, or new-onset hypotension, with no alternate site of infection □ Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis □ New-onset suprapubic pain or costovertebral angle pain or tenderness □ Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate □ 2. Urinary catheter specimen culture with ≥ 10^5 cfu/mL of any organism(s)	• Recent catheter trauma, catheter obstruction, or new onset hematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis • Urinary catheter specimens for culture should be collected after replacement of the catheter if it has been in place >14 d

□ **UTI criteria met** □ **UTI criteria NOT met**

* Refer to original article (Stone ND, *et al.* Infect Control Hosp Epidemiol 2012;33:965-77) for full comments

Nebraska ASAP is funded by the Nebraska DHHS HAI/AR Program through a CDC grant.
11/5/2024

[Revised-McGeer-criteria-for-infection-surveillance-checklist.pdf]



NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM NE ASAP

Patient Name: _____ MRN: _____ Location: _____

Date of Infection: _____ Date of Review: _____ Reviewed by: _____

UTI: □ evaluated □ criteria met LRTI: □ evaluated □ criteria met SSTI: □ evaluated □ criteria met FUO: □ evaluated □ criteria met

Suspected Infection Syndrome	Minimum Criteria for Starting Antibiotic Therapy
Urinary tract infection ***without catheter***	Either one of the following criteria □ Acute dysuria, OR □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline, AND ≥1 of the following new or worsening symptoms □ Urgency □ Frequency □ Suprapubic pain □ Gross hematuria □ Urinary incontinence □ Costovertebral angle tenderness
with catheter	At least one of the following criteria □ Rigors □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline □ New onset delirium □ New costovertebral angle tenderness
Note: Residents with intermittent catheterization or condom catheter should be categorized as 'without catheter' ***Urine culture should be sent prior to starting antibiotics*** ***Antibiotics should not be started for cloudy or foul-smelling urine***	
Lower respiratory tract infection ***with temp >38.9 °C (102 °F)***	At least one of the following criteria □ Productive cough □ Respiratory rate >25 breaths / minute
with temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline	Both of the following criteria □ Cough, AND □ At least one of the following criteria □ Pulse >100 beats / minutes □ Delirium □ Rigors □ Respiratory rate >25 breaths / minute
afebrile with COPD and >65 years old	Both of the following criteria □ New or increased cough □ Purulent sputum production
afebrile without COPD	All of the following criteria □ New cough □ Purulent sputum production □ At least one of the following criteria □ Delirium □ Respiratory rate >25 breaths / minute
with new infiltrate on chest X-ray consistent with pneumonia	At least one of the following criteria □ Productive cough □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline □ Respiratory rate >25 breaths / minute
Note: Consider ordering chest X-ray and CBC with differential for febrile residents with cough and any of these criteria (HR >100, worsening mental status, or rigors) ***Antibiotics should not be used for up to 24 h after large-volume aspiration in those without COPD but with temp ≤38.9°C (102 °F) and non-productive cough***	
Skin and soft-tissue infection	Either one of the following criteria □ New or increasing purulent drainage, OR □ At least two of the following criteria □ Redness (erythema) □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline □ Tenderness □ New or increasing swelling at affected site □ Warmth
Note: These criteria do not apply to residents with burns ***Surgical consultation and hospitalization are required for certain soft-tissue infections (e.g., necrotizing fasciitis or gas gangrene)***	
Fever where the Focus of Infection is Unknown	Both of the following criteria □ Temp >37.9 °C (100 °F) or 1.5 °C (2.4 °F) above baseline, AND □ At least one of the following criteria □ Rigors □ Delirium
Note: Antibiotic should not be started in residents with fever and altered mental status that does not meet delirium criteria (e.g., reduced functional activities, withdrawal, loss of appetite)	

Reference: Loeb M, *et al.* Infect Control Hosp Epidemiol 2001;22:120-4.

[Loebs-Minimum-Criteria-for-Initiating-Antibiotic-Therapy-Checklist_new-template.docx]

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CDC Surveillance Criteria for SUTI

Criterion	*For residents **without** an indwelling catheter in place or removed >2 calendar days prior to the date of event, where day of catheter removal is equal to day 1:*
1	**Either** of the following (Signs & Symptoms): 1. Acute dysuria 2. Acute pain, swelling, or tenderness of the testes, epididymis, or prostate **AND** A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of ≥10^5 CFU/ml
2	**Either** of the following: 1. Fever+ [Single temperature ≥ 37.8°C (>100°F), or >37.2°C (> 99°F) on repeated occasions (more than once), or an increase of >1.1°C (>2°F) over baseline] 2. Leukocytosis [defined by NHSN as > 10,000 cells/mm^3, or Left shift (> 6% or 1,500 bands/mm^3)] **AND** **One or more** of the following (New and/or marked increase): 1. Costovertebral angle pain or tenderness 2. Suprapubic tenderness 3. Visible (Gross) hematuria 4. Incontinence 5. Urinary urgency 6. Urinary frequency **AND** A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of ≥10^5 CFU/ml
3	**Two or more** of the following (New and/or marked increase): 1. Costovertebral angle pain or tenderness 2. Incontinence 3. Urinary urgency 4. Urinary frequency 5. Suprapubic tenderness 6. Visible (gross) hematuria **AND** A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of ≥10^5 CFU/ml **Footnote:** +Since fever is a non-specific symptom, it should be used to meet SUTI criteria even if the resident has another possible cause for the fever (for example, pneumonia).

CDC Surveillance Criteria for CAUTI

Criterion	For residents **with** an indwelling catheter in place, or removed within 2 calendar days prior to event onset, where day of catheter removal is equal to day 1:
	One or more of the following (Signs and Symptoms and Laboratory and Diagnostic Testing): 1. Fever+[Single temperature ≥ 37.8°C (>100°F), or >37.2°C (> 99°F) on repeated occasions (more than once), or an increase of >1.1°C (>2°F) over baseline] 2. Rigors 3. New onset hypotension, with no alternate non-infectious cause 4. New onset confusion/functional decline with no alternate diagnosis **AND** Leukocytosis [defined by NHSN as > 10,000 cells/mm^3, or Left shift (> 6% or 1,500 bands/mm^3)] 5. New or marked increase in suprapubic tenderness 6. New or marked increase in costovertebral angle pain or tenderness 7. Acute pain, swelling, or tenderness of the testes, epididymis, or prostate 8. Purulent discharge from around the catheter insertion site 9. Acute Dysuria* **AND** A positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of ≥10^5 CFU/ml. **Footnote:** * Since fever is a non-specific symptom, it should be used to meet CA-SUTI criteria even if the resident has another possible cause for the fever (for example, pneumonia). *Only when "REMOVE" has been selected for catheter status will the system populate CA-SUTI for a selection of acute dysuria and a positive urine culture.

HAI Surveillance Protocol for UTI Events for LTCF

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NEBRASKA ANTIMICROBIAL STEWARDSHIP ASSESSMENT AND PROMOTION PROGRAM ASAP

Review of Antibiotic Prophylaxis in the Management of Recurrent Urinary Tract Infections (UTI) in Adults

Continuous antibiotic prophylaxis, while effective in the short-term, carries many risks including medication side effects in older patients[1], increased risk for multi-drug resistant organisms[2], and risk for *Clostridioides difficile* colitis[3].

Before considering antibiotic prophylaxis for recurrent UTIs, these non-antibiotic measures should be attempted first:

- Confirm the resident is experiencing true UTIs, not asymptomatic bacteriuria
- Maintain adequate hydration
- Encourage regular voiding. Holding in urine or not draining the bladder fully increases the risk of UTIs
- Ensure appropriate personal hygiene practices and proper care of urinary catheters
- Avoid sitting in wet or dirty undergarments for prolonged periods
- For post-menopausal women with risk factors such as atrophic vaginitis, prescribe topical vaginal estrogens
- Evaluate for underlying risk factors that may be the reason for recurrent UTIs and manage those accordingly
- Consider evaluation for kidney stones or a urology evaluation in functional patients

Non-Antibiotic Therapies & Supplements to Prevent UTIs

Local estrogen therapy

The use of vaginal estrogen therapy has been an underutilized tool for preventing UTIs. Estrogen therapy helps maintain vaginal pH levels and bacterial flora balance. Multiple studies have demonstrated a reduction in the frequency of UTIs among postmenopausal women using topical vaginal estrogen therapy.[4,5]

Methenamine hippurate (1 gram PO twice daily)

Methenamine is hydrolyzed to formaldehyde and ammonia in acidic environments which has a bactericidal effect by denaturing proteins and nucleic acid. Therefore, acidic urine increases efficacy, so patients are often advised to consume acidic foods to maintain an acidic urinary pH. While generally well-tolerated, common side effects include gastrointestinal upset and bladder irritation. It has been described as an antibiotic-sparing option for those patients with recurrent UTIs and trials indicate it may be helpful in female patients with no urinary tract abnormalities.[6,7]

Cranberry Supplements

Cranberry may decrease the adherence of uropathogens to the uroepithelial cells due to high concentrations of proanthocyanidins (PACs). Research on cranberry effectiveness has yielded mixed results; however, several studies suggest a potential benefit in reducing the frequency of UTIs[8]. Cranberry products are available in various formulations, including juice, liquid concentrates, tablets, capsules, and powder forms. The product chosen should be evaluated to ensure it contains PACs – some cranberry flavored supplements do not actually contain any PACs. It remains unclear what the optimal dose of cranberry should be, but studies suggest that the PAC dose be at least 36 mg/day[8]. Consideration should also be given to the amount of sugar consumed daily if utilizing cranberry juice.

D-mannose

D-mannose is a sugar that mimics the host's uroepithelial receptor and competitively binds to the uropathogen decreasing bacterial attachment to the mucosa. In a 2024 randomized clinical trial of 598 women, daily d-mannose did not reduce the proportion of women with recurrent UTI in primary care who experienced a subsequent clinically suspected UTI. D-Mannose should not be recommended for prophylaxis in this patient group.[9]

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Using Prophylactic Antibiotics

Use of any antibiotic for a prolonged period is associated with adverse effects and increased resistance.

If antibiotic prophylaxis is used, it should be after all other measures have failed.

Antibiotic prophylaxis is not recommended for patients with an indwelling urinary catheter.

No data has supported one agent over another for preventing UTIs, so antibiotic choice should be guided by recent culture results and sensitivities should be confirmed before initiating any prophylactic therapy. In addition, antibiotic allergies, medical comorbidities, and drug interactions should be considered. Fluoroquinolones should always be avoided due to risk for rare but catastrophic adverse events in the elderly. Therapeutic doses of antibiotics are not warranted. There is no strong evidence for or against the use of rotating antibiotics for prophylaxis of UTIs.

Some agents and doses that have been studied include:

Antibiotic	Dosing
Sulfamethoxazole-Trimethoprim	1 Single Strength tab PO once daily
Nitrofurantoin	50-100 mg PO once daily
Cephalexin	250 mg PO once daily
Trimethoprim	100 mg PO once daily

Counseling Points for Residents and Families:

- Antibiotic prophylaxis is not a lifelong treatment. The goal of a prolonged course of antibiotics is to allow time for the bladder wall to heal, making UTIs less likely. There is no evidence of additional benefit beyond 6-12 months. Therefore, antibiotic treatment should be stopped ideally after 6 months.
- Long-term antibiotic prophylaxis will cause antibiotic resistance and will limit future treatment options.

Managing Patients on Prolonged Antibiotic Prophylaxis

All patients initiated on antibiotic prophylaxis for recurrent UTIs should be reviewed at least every 3 months by the prescriber. During the review, a clinical decision should be made to stop or continue prophylactic antibiotic therapy. The decision should be documented in the patient's medical record.

If a resident develops a recurrent UTI after stopping prophylactic antibiotics, it is important to determine whether proper self-care measures are being followed. If they are, further investigation may include renal tract ultrasound, post void bladder residual volume scan, and referral to a urologist.

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- Module 5: Recognition & Management of UTI in Long-Term Care
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CNA Toolkit: Skin, Perineal, and Urinary Catheter Care: Maintaining the Body's First Lines of Defense Against Infections

Project Firstline: Skin, Perineal, and Urinary Catheter Care Activity Cards

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In Closing

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