Competency Verification Record
UVA Health
Catheter Associated Urinary Tract Infection Prevention-RN

Employee Name:_____ **Employee ID #:**_____ **Date**:_____

Successful completion is documented on the Annual Competency Record (ACR) or Department Specific Competency Form using the following competency statement(s):

Competency Statement(s):

1. Demonstrate proper insertion of an indwelling urinary catheter
2. Demonstrate maintenance of an indwelling urinary catheter
3. Demonstrate proper application of sterile gloves

Evaluator(s): RNs are qualified to sign the competency statement on ACR or Department Specific Competency Forms

Method of validation (circle one):

DO	Direct Observation – Return demonstration or evidence of daily work.
T	Test: Written or oral assessments, surveys or worksheets, passing grade on a CBL test.
S	Simulation
C	Case Study/ Scenarios: Create/share a story of a situation then ask questions that capture the nature of the competency that is being referenced.
D	Discussion: Identify questions related to a competency and ask orientee to provide an example of their real-life experiences.
R	Reflection: A debriefing of an actual event or a discussion of a hypothetical situation.
QI	Quality Improvement Monitoring: Audits or compliance checks on actual work or documentation to ensure the competency is completed.
N/A	If the specific product or process step is not used in the respective area or by the respective role, then this step is deemed N/A.

Note: *This Competency Verification Record is* ***not*** *a required part of the permanent personnel record. This form is to be used as a guide for competency check off only;* ***the Annual Competency Record is used to document competency****. . (If competency validation occurs away from the unit, this form can be completed by the validator; the signed form can then be presented to the unit NEC or manager as evidence of competency. The Annual Competency Record is then signed indicating that the competency was validated).*

Instructions: Bolded steps are required critical elements for competency

Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	Evaluator's Initials
1. **Identify at least 2 indications** for insertion of indwelling urinary catheter (IUC) • Monitor urine output in select surgical procedures for up to 48 hours • Monitor urine output in critically ill patients • Monitor temp with induce hypo/normo-thermia protocol • Monitor patient managed by Urology • Perform continuous bladder irrigation for urologic patients; instillation of medications • Manage prolonged immobilization (e.g. unstable spine or pelvic injury) • Provide comfort at the end of life • Manage sacral/perineal wound or incision in incontinent patients • Manage acute urinary retention or obstruction	D	

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Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	Evaluator's Initials
2. **State at least 2 contraindications** to insertion of an IUC. • Incontinence (place on toileting routine, change frequently) • Prolonged postoperative use • Morbid obesity • Immobility (Rather manage by turning patient every 2 hours; up in chair) • Confusion or Dementia • Patient, family, and/or physician convenience	D	
3. Gather insertion supplies and *CAUTI Prevention Critical to Safety Standard Work* Standard Work: CAUTI-Critical to Safety-CAUTI Prevention (Adult) **4. Verbalizes the minimum number of personnel required for insertion** a) Two Team Members for **ALL** catheter insertions except for non-obese male patients	D	
5. Prepare patient for catheter insertion a. Explain procedure to patient b. Cleanse hands, don clean gloves, cleans the surface c. Removes gloves, cleanse hands d. Open kit to access aseptic wipes, don clean gloves e. Open aseptic wipes. **Cleanse perineum:** o If heavily soiled pre-clean with CHG wipes o Female: front to back direction; side/side/middle – **One wipe per swipe.** *Start with the opposite, inner labia furthest away from the operator; followed by the inner labia closest to the operator; then from the center, top to bottom)* o Male: in a circular direction, starting at penis head; urinary meatus/urinary meatus/up to glans; **One revolution per wipe.**	DO	
6. Insert IUC a. DIRECT assistant to hold and support patient as needed. b. REMOVE gloves and **CLEANSE hands** c. OPEN the rest of the kit using sterile technique. **d. DON sterile gloves- all staff are REQUIRED to demonstrate this skill correctly one time** e. POSITION the rectangle drape between legs of patient f. POSITION the fenestrated drape on patient g. OPEN the Betadine® **(povidone-iodine)** and pour over swabs. In a Patient with allergy to Betadine® **(providone-iodine),** sterile water should be used. h. ATTACH the water filled syringe to the inflation port of the catheter i. LUBRICATE the catheter and leave in the tray.	DO	

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Demonstrated Skill Behaviors for Competency (Critical Behaviors in Bold)	Method of Validation	Evaluator's Initials
j. Place sterile kit and field as close to patient as possible, ideally between legs k. **CLEANSE** the patient with the three pre-saturated betadine swabs. *(Side, side, middle for females* – **One swab per swipe.** *Start with the opposite, inner labia furthest away from the operator; followed by the inner labia closest to the operator; then the center top to bottom)*; urinary meatus/urinary meatus/up to glans for males) – **One revolution per swab**. l. **INSERT** the catheter. m. When urine is visible insert the catheter 2 more inches for adult females and to the hub in males. n. **INFLATE balloon** using amount indicated on catheter. Keep sterile hand on the sterile catheter until catheter balloon is inflated using non-sterile hand. o. **REMOVE syringe** from the catheter, keeping the plunger depressed until syringe is disconnected		
7. Secure device and position for optimal drainage a. **ATTACH StatLock® or securement device to catheter and place on patient (Male – upper thigh or lower abdomen; Female – upper thigh)** b. **POSITION the bag below bladder (waist) –** without dependent loops	DO	
DEMONSTRATE: CHG bathing treatment/perineal care using standard work SOP-CHG-bathing-treatment-102121 (1).pdf • Front to back cleansing for females • 1 CHG wipe for around and down catheter • 1 CHG wipe down tubing to drainage bag Verbalize how often pericare or CHG bathing treatment is performed on a patient with a IUC • Pericare every 24 hours, with CHG bath or when soiled	DO	
Verbalize management of IUC when patient is transported: • Drainage bag should be emptied before transporting patient • Collection container should be clean and used exclusively for urine a. Container should be discarded when routine rinsing does not adequately clean it • When emptying urinary drainage bag, do not allow spigot to touch inside of collection container • Keep drainage bag below bladder when moving the patient	D	

Critical Elements:

References:

Nursing Policy: Indwelling Urinary Catheter Insertion and Maintenance
Standard Work: CAUTI-Critical to Safety-CAUTI Prevention (Adult)

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Lippincott Procedures: Indwelling urinary catheter insertion, male
Lippincott Procedures: Indwelling urinary catheter insertion, female
Lippincott Procedures: Indwelling urinary catheter removal
Lippincott Procedures: Indwelling urinary catheter care and management

Competency Verified by:

_____ Date: _____

Evaluator's Name (printed) Evaluator's signature