**Guide for Urinary Catheter Follow-Up Assessment**

**If assessment is conducted by phone**

Hello. My name is [First Name] and I’m calling from the [insert facility name]. May I please speak with [Patient First & Last Name]? This person is expecting my call.

***If patient isn’t available, ask for a good time to call back.*** [Enter time on tracking form] ***Or, automated system will re-try as per protocol***

Hello Mr./Ms. [Last Name]. My name is \_\_\_\_\_\_\_\_\_, I’m calling from the [insert facility name] as part of the catheter complications research study. I would like to talk with you about any symptoms or complications you may have experienced during the past 14 days that might be related to catheter use. This assessment will take less than 10 minutes to complete.

**Is this a good time for you to talk?**

YES 🡪 proceed with interview.

NO🡪 When would it be convenient for me to call you to complete the interview?

Schedule time for follow-up [enter scheduled time on tracking form]

**If assessment is conducted in-person**

Hello Mr./Ms. [Last Name]. My name is \_\_\_\_\_\_\_\_\_, I am a research assistant on the catheter complications research study. I would like to talk with you about any symptoms or complications you may have experienced during the past 14 days that might be related to catheter use. This assessment will take less than 10 minutes to complete.

*If conducted in-person, the research assistant will document current patient location. If conducted by phone, the automated system will prompt the patient to identify or confirm their current location, e.g.,*

1. Are you currently residing in [fill in discharge location or last location], and if no, where are you currently living?

|  |  |
| --- | --- |
|  | Own Home |
|  | Home of family member or friend |
|  | VA nursing home/community living center |
|  | Community based nursing home |
|  | VA domiciliary |
|  | Rehab facility |
|  | Hospital |
|  | Other |

Study ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time frame:\_\_\_\_\_\_\_\_

1. **Our records indicate that you had a urinary catheter during your hospital stay at the [insert facility name]. Is that correct?**

YES

NO [End Interview]

1. **Is that same catheter still in place?**

NO 🡪 When was it removed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [prompt to enter day/month]

2a. Are you currently using any other urinary management devices or products?

Foley Catheter

Intermittent Straight Catheter (ISC)

Condom Catheter

Suprapubic Catheter

Adult Incontinence Product

Urostomy Tube

Other Device

Yes 🡪 What device? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days have you used this device? \_\_\_\_\_\_

No

YES 🡪 How many days have you had the catheter? \_\_\_\_\_\_\_

**PLEASE NOTE:**

For 14 day follow ups, only ask the AUA Quality of Life question.

For 30 day follow-up:

|  |  |
| --- | --- |
| **AUA QOL ONLY** | **ALL AUA QUESTIONS** |
| **• If the catheter is still in place** | **• If the catheter has been removed and the patient is not using a subsequent device** |
| **• If the catheter has been removed and the patient is using any other subsequent device** | **• If the catheter has been removed and the patient is using an adult incontinence device** |

1. **American Urological Association (AUA) Symptom Index [asked at 30 days only. The automated system would prompt respondent to press the corresponding number on their touch tone phone key pad]**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Not at all**  **1** | **Less than 1 time in 5**  **2** | **Less than half the time**  **3** | **About half the time**  **4** | **More than half the time**  **5** | **Almost always**  **6** |
| Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating? |  |  |  |  |  |  |
| Over the past month, how often have you had to urinate again less than two hours after you finished urinating? |  |  |  |  |  |  |
| Over the past month, how often have you found you stopped and started again several times when you urinate? |  |  |  |  |  |  |
| Over the past month, how often have you found it difficult to postpone urination? |  |  |  |  |  |  |
| Over the past month, how often have you had a weak urinary stream? |  |  |  |  |  |  |
| Over the past month, how often have you had to push or strain to begin urination? |  |  |  |  |  |  |
|  | **None**  **0** | **1 time**  **1** | **2 times**  **2** | **3 times**  **3** | **4 times**  **4** | **5 or more times**  **5** |
| Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **QUALITY OF LIFE DUE TO URINARY SYMPTOMS** | **Delighted**  **1** | **Pleased**  **2** | **Mostly**  **Satisfied**  **3** | **Mixed**  **4** | **Mostly**  **Dissatisfied**  **5** | **Unhappy**  **6** | **Terrible**  **7** |
| If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that? |  |  |  |  |  |  |  |

**PLEASE NOTE:**

If catheter is still in place, go to question 5

If catheter has been removed and patient is not using a subsequent device, go to question 4

If catheter has been removed and patient is using an adult incontinence device, go to question 4

If catheter has been removed and patient is using any other subsequent device, go to question 5

1. **If the catheter has been removed: During the past 14 days have you experienced any of the following?**

|  |  |  |
| --- | --- | --- |
| ***If patient answers yes to any questions below, please ask the patient to describe.*** | **YES**  **1** | **NO**  **2** |
| Fevers, chills, burning with urination, urinary frequency, urgency, or other symptoms suggestive of an infection that required you to see a doctor?  ☐Please check if patient reported symptoms but did not see a doctor. | Did the doctor indicate that the fever or symptoms might be due to an infection related to your urinary catheter?    Were you prescribed antibiotics for the infection?  Were you admitted to the hospital due to the infection? |  |
| Were you told you have a urinary tract infection? | Did the doctor indicate that the infection might be related to your urinary catheter?    Were you prescribed antibiotics for the infection?  Were you admitted to the hospital due to the infection? |  |
| Have you had pain or burning when you urinate? |  |  |
| ***If patient answers yes to any questions below, please ask the patient to describe.*** | **YES**  **1** | **NO**  **2** |
| A split stream of urine? |  |  |
| Spraying of urinary stream? |  |  |
| Leaking urine? |  |  |
| Bleeding from where the urinary catheter entered or was attached to your body? Or other discharge? |  |  |
| Skin problems in the genital area? |  |  |
| Pain or swelling in your scrotum? **MEN only** |  |  |
| Blood in your urine? |  |  |
| Difficulty with starting or stopping your urine stream? |  |  |
| A sense of urgency or bladder spasms? |  |  |
| Sexual problems? |  |  |
| New urinary tract symptoms? |  |  |
| ***If patient answers yes to any questions below, please ask the patient to describe.*** | **YES**  **1** | **NO**  **2** |
| Bladder/kidney stones? |  |  |
| Newly diagnosed urethral stricture disease? |  |  |
| Need for follow-up with a Urologist or had a urological procedure?  If yes, specify type of procedure. |  |  |
| Emergency Department visit or hospital admission for urinary issues? |  |  |
| Any other problem associated with having had the urinary catheter that we did not discuss? |  |  |

**5. If catheter is still in place: During the past 14 days have you experienced any of the following?**

|  |  |  |
| --- | --- | --- |
| ***If patient answers yes to any questions below, please ask the patient to describe.*** | **YES**  **1** | **NO**  **2** |
| Fevers, chills, burning with urination, urinary frequency, urgency or other symptoms suggestive of an infection that required you to see a doctor?  ☐Please check if patient reported symptoms but did not see a doctor. | Did the doctor indicate that the fever or symptoms might be due to an infection related to your urinary catheter?  Were you prescribed antibiotics for the infection?  Were you admitted to the hospital due to the infection? |  |
| Been told you have a urinary tract infection? | Did the doctor indicate that the infection might be related to your urinary catheter?    Were you prescribed antibiotics for the infection?  Were you admitted to the hospital due to the infection? |  |
| ***If patient answers yes to any questions below, please ask the patient to describe.*** | **YES**  **1** | **NO**  **2** |
| Blood in your urine? |  |  |
| Pain or discomfort? |  |  |
| A feeling of urgency or bladder spasms? |  |  |
| Trauma to your skin (related to securement or catheter placement)? |  |  |
| Restrictions in your activities of daily living related to having the catheter? |  |  |
| Restrictions in your social activities related to having the catheter? |  |  |
| Need for a follow-up with a Urologist or had a urological procedure?  If yes, specify type of procedure. |  |  |
| Emergency Department visit or hospital admission for urinary issues? |  |  |
| Any other problem associated with the urinary catheter that we did not discuss? |  |  |