**PROTOCOL: CARING FOR AN INDIVIDUAL WITH AN INDWELLING CATHETER**

1. **Purpose:**
   1. To ensure indwelling catheter is maintained to facilitate drainage of urine from bladder:
   2. To ensure appropriate catheter care to prevent infection.
   3. To measure urine output from an indwelling urinary catheter.
   4. To change an indwelling catheter collection bag to prevent infection.

Definitions: **Licensed Nurse:** A Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.), working under the direction of a registered nurse, who holds a current license issued by the State of Connecticut under Chapter 378 of the Connecticut General Statutes.

**II. Responsibility:**

1. Training: Training will be conducted by a licensed nurse.
2. Performance:
   1. Direct care staff who have completed:
      1. Baseline competency training checklist of DDS.
      2. Procedure task specific training.
   2. Trained staff will follow individual procedural guidelines including notifying the licensed nurse as indicated.
3. Monitoring:
   1. The licensed nurse.
   2. Trained staff performing the task under the clinical direction of the licensed nurse will notify the nurse of issues and/or outcomes as directed by the nurse.
4. Documentation:
   1. Individuals who perform the tasks will record all pertinent information as instructed by the licensed nurse.
   2. The licensed nurse will ensure agency compliance with required documentation.

**III. Training to Include:**

1. Initial: Overview of the procedure; its purpose. Demonstration of techniques by licensed nurse and return demonstration by the student.
2. Documentation of Training and Monitoring:
   1. Training: Licensed nurse completes training record of staff on “DDS Nursing Delegation Procedure Performance Evaluation Form”.
   2. Monitoring: Licensed nurse completes DDS “Nursing Delegation Task Competency Monitoring Form”.
3. Frequency of Monitoring Task and Performance:
   1. Staff will be monitored in their proficiency at this skill as determined by the licensed nurse but not to exceed 12 months.

**IV. Related Knowledge:**

1. Pertinent medical history of the person/rationale for the task.
2. Proper placement of urinary catheter.
3. Infection control practices.
4. When to communicate observations with Licensed Nurse.

**PROCEDURE: CARING FOR AN INDIVIDUAL WITH AN INDWELLING CATHETER**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Physician’s Order Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Dates Renewed: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (in pencil)

Physician’s Order (if applicable):

**I. Diagnosis**:

**II. Purpose of Procedure:** (why individual needs procedure)

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Signature of Delegating RN Date

## III. Procedure

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| **Task** | **Rationale** |
| **A. Gather Equipment:** |  |
| 1. Clean washcloths, 2 or more.  2. Basin with warm water for female or individual whose catheter care is not incorporated into bathing.  3. Soap.  4. Clean towel. | * Infection control. * Be prepared for task. |
| **B. Individual’s Preparation:** |  |
| 1. Explain to individual what you are going to do.  2.Provide privacy for individual.  3.Position female in bed on her back with legs separated. With male and/or individual who has suprapubic catheter, care may be done with bathing (showering) or when lying on his back. | * To promote understanding, comfort and cooperation of the individual. * To maintain individual privacy and dignity. * Provide easy access to perineal area. |
| **C. Perform Task:** |  |
| 1.Wash hands.  2. Put on disposable gloves.  3.**For a female:**  a. Clean suprapubic and pubic area with soapy washcloth. Then rinse washcloth.  b. Clean entrance to urinary meatus with soapy wash cloth moving in circular motion beginning from innermost point progressing outward.  c. Next, wash and rinse the inside of the labia. Use a clean unused portion of the washcloth for cleaning each side of labia; movement should be a single swipe of cloth from front to back for each side of labia.  d. Hold catheter firmly with one hand to prevent tugging on catheter. Using free hand wash the catheter tubing with clean portion of washcloth moving with single motion from point of catheter insertion towards juncture with foley tubing.  e. Rinse thoroughly all areas cleaned with soapy washcloth.  f. Gently dry areas of skin cleaned.  4.**For a male:**  a. Clean suprapubic and pubic area with soapy washcloth. Then rinse washcloth.  b. Hold shaft of penis while being careful not to tug on catheter. Wash penis with a clean, soapy washcloth starting at catheter insertion site and moving in a circular motion progressing outward.  c. Hold catheter firmly with one hand to prevent tugging on catheter. Using free hand wash the catheter tubing with clean portion of washcloth moving with single motion from point of catheter insertion towards juncture with foley tubing.  d. Rinse thoroughly all areas cleaned with soapy washcloth.  e. Gently dry areas of skin cleaned.  5.**For an individual with a suprapubic catheter:**  a.If gauze dressing maintained at catheter insertion site; remove gauze and discard in trash receptacle. Remove gloves, wash hands and put on new disposable gloves before next step.  b. Hold catheter near insertion site, being careful not to tug on catheter. Wash skin around stoma site with soapy washcloth starting at catheter insertion site and moving in a circular motion progressing outward.  c. Wash the catheter tubing with clean portion of washcloth moving with single motion from point of catheter insertion towards juncture with indwelling catheter. Hold catheter with other hand during this step as to prevent tugging.  d. Rinse thoroughly those areas cleaned with soapy washcloth.  e. Gently dry areas of skin cleaned.  f. If directed by delegating Nurse, a new gauze dressing should be placed at stoma site. Prior to replacing gauze dressing, remove old gloves, wash hands and then put on new disposable gloves.  6. Gather washcloths and towels used and place in appropriate receptacle for dirty linens.  7. Remove and dispose of gloves and wash hands. | * Infection control. * Reduces likelihood for recontamination of clean area. * Reduces likelihood for cross contamination from one side to the other. * Reduces likelihood of infectious organism being introduced to urinary tract system by moving from clean to dirty part of catheter. * Rinsing removes any potential irritants, e.g. soap, from skin. * Decreases microorganisms caused by moisture. * Reduces likelihood for recontamination of clean area. * Reduces likelihood of infectious organism being introduced to urinary tract system by moving from clean to dirty part of catheter. * Rinsing removes any potential irritants, e.g. soap, from skin. * Decreases microorganisms caused by moisture. * To facilitate cleaning of stoma site. * Reduces likelihood for recontamination of clean area. * Reduces likelihood of infectious organism being introduced to urinary tract system by moving from clean to dirty part of catheter. * Rinsing removes any potential irritants, e.g. soap, from skin. * Decreases microorganisms caused by moisture. * Protect skin at stoma site. * Infection control. |
| **D. Check Individual’s Status** |  |
| 1.Check to ensure that urine is flowing out of the catheter and into the urine collection bag. If urine not draining check to see if catheter kinked. If urine still not flowing after checking for kinks, notify Nurse immediately.  2.Notify Nurse immediately if individual exhibits following signs: elevated temperature, chills, complains ofback pain, urine with strong odor, bloody urine, no urine drainage, redness at catheter insertion site, fluid leaking around the catheter site, complains ofburning pain at the catheter site, if catheter falls out. | * To communicate any problems and/or change in status and receive appropriate direction. |
| **E.Care of Equipment** |  |
| 1. Gather washcloths and towels used and place in appropriate receptacle for dirty linens. | * Infection Control |
| **F.Documentation:** |  |
| 1. Follow agency procedure for documentation.  2.Document any problems encountered.  3.Document Nurse notification if applicable. | * To verify procedure completion * To accurately communicate problems and actions |

# PROCEDURE: EMPTYING A URINARY CATHETER BAG

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Physician’s Order Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Dates Renewed: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (in pencil)

Physician’s Order (if applicable):

**I. Diagnosis**:

**II. Purpose of Procedure:** (why individual needs procedure)

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Signature of Delegating RN Date

## III. Procedure

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| **Task** | **Rationale** |
| **A. Gather Equipment:** |  |
| 1. Disposable gloves  2. Graduated urinal.  3. Alcohol prep pads. | * To be prepared to perform task * For accurate measurement of urine. * Infection control. |
| **B. Individual’s Preparation:** |  |
| 1.Explain to individual what you are going to do.  2.Provide privacy for individual. | * To promote understanding, comfort and cooperation of the individual. * Maintain individual privacy and dignity. |
| **C. Perform Task:** |  |
| 1. Wash hands. 2. Put on disposable gloves. 3. Position graduated urinal under urinary drainage collection bag, then open the valve to urinary drainage bag spout allowing urine to flow out of the bag into urinal. 4. Observe the urine to ensure that it is not bloody, tea-colored, very dark in appearance, cloudy or foul smelling--if present, report immediately to Nurse. 5. Once the bag is empty, wipe off the end of the drain spout with an alcohol prep pad, then close the valve. 6. Ensure that urine collection bag is below waist level at all times. 7. Never allow bag to drag or fall onto the floor. 8. Collection bag should be emptied when half to two-thirds full and as directed by the nurse. 9. Document amount of urine and empty urinal into toilet. 10. Remove and dispose of gloves when done. 11. Wash hands. | * Infection control.   .   * For accurate measurement of urine. * To communicate change in status and receive appropriate direction. * Infection control. * To prevent urine from back-flowing into bladder * Infection control. * Prevent bag from completely filling causing urine to back flow into bladder * For recording * Infection control. |
| **D.Check Individual’s Status** |  |
| 1.Check to ensure that urine is flowing out of the catheter and into the urine collection bag. If urine is not draining check to see if catheter is kinked. If urine still not flowing after checking for kinks, notify Nurse immediately.  2.Notify Nurse immediately if individual exhibits following signs: elevated temperature, chills, complaint of back pain, urine with strong odor, bloody urine, no urine drainage, redness at catheter insertion site, fluid leaking around the catheter site, complaint of burning pain at the catheter site, if catheter falls out. | * To communicate any problems and/or change in status and receive appropriate direction. |
| **Care of Equipment** |  |
| 1.Rinse out measuring container and return it to appropriate area. | * To ensure equipment is available for next use * Infection control |
| **Documentation:** |  |
| 1.Document the time and amount of urine removed from the bag (in cc’s) on appropriate flow sheet as directed by Nurse.  2.Document any additional interventions or observations.  3.Document Nurse notification if applicable. | * To monitor that client has proper output. * To verify procedure completion * To accurately communicate problems and actions |

## PLEASE NOTE: NO TASK IS CONSIDERED COMPLETED UNTIL DOCUMENTATION AND

**REQUIRED REPORTING OCCURS. ANY CHANGE OR VARIATION FROM THE**

**INDIVIDUAL’S BASELINE SHOULD BE REPORTED PROMPTLY TO THE NURSE.**

# PROCEDURE: CHANGING A URINARY CATHETER BAG

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Physician’s Order Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ Dates Renewed: \_\_\_\_ /\_\_\_\_ /\_\_\_\_ (in pencil)

Physician’s Order (if applicable):

**I. Diagnosis**:

**II. Purpose of Procedure:** (why individual needs procedure)

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Signature of Delegating RN Date

## III. Procedure

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| --- | --- |
| **Task** | **Rationale** |
| **A. Gather Equipment:** |  |
| 1. Disposable gloves  2. Graduated urinal.  3.Large overnight urinary collection bag  Or  Leg urinary collection bag for daytime use only.  4. Alcohol prep pads.  5. 50cc Syringe (to clean collection bag).  6. Clean urinary collection bag with solution as directed by Nurse. | * To be prepared to perform task * For accurate measurement of urine. * Overnight collection bag may be used if individual is not up and ambulating - able to contain large amounts of urine. * Leg urinary collection bag allows for independence and mobility– must be emptied frequently. Should not be worn while in bed given likelihood of urine back-flowing. * Infection control. |
| **B. Individual’s Preparation:** |  |
| 1.Explain to individual what you are going to do.  2.Provide privacy for individual. | * To promote understanding, comfort and cooperation of the individual. * Maintain individual privacy and dignity. |
| **C.Perform Task** |  |
| 1. Wash hands.  2. Put on disposable gloves.  3. Empty urine from drainage bag that is to be disconnected.  4. Disconnect the tubing to the drainage bag from the end of the catheter. Set bag aside if you intend to clean and reuse, otherwise dispose of bag.  5. Use alcohol pad to cleanse the end of the catheter and the end of the tubing going into the catheter.  6.Date each new collection bag upon removal from packing, before attaching to catheter.  7.If leg bag is being applied: Attach leg bag to individual’s thigh using straps provided with appliance. Ensure enough slack in tubing for individual’s comfort and to prevent tugging. Do not over-tighten straps; bag should be secure, but straps should not cause indentations or discoloration of skin.  8.If overnight bag is being applied: Attach overnight bag to secure area on bed frame with enough slack in tubing for individual’s comfort and to prevent tugging. If bed has rails, ensure collection bag and tubing won’t be in way of rails when raised or lowered.  9.Ensure that the collection bag and tubing is below waist levelat all times.  10.Do not allow bag to drag or fall onto the floor.  11. Collection bags should be changed as directed by nurseand replaced monthly at a minimum.  12. Remove and dispose of gloves.  13.Wash hands. | * Infection control.   .   * For accurate measurement of urine. * Infection control. * To keep track of date when replacement is due. * Securing leg bag will prevent tension on tubing that could cause injury. Leg straps that are too tight could interfere with blood circulation. * Prevents bag from falling on floor or catheter being dislodged. * To prevent urine from back-flowing into bladder. * Infection control. |
| **D.Check Individuals Status** | **Rationale** |
| 1.Check to ensure that urine is flowing out of the catheter and into the urine collection bag. If urine is not draining check to see if catheter is kinked. If urine still not flowing after checking for kinks, notify Nurse immediately.  2. Notify Nurse immediately if individual exhibits following signs: elevated temperature, chills, complaints of back pain, urine with strong odor, bloody urine, no urine drainage, redness at catheter insertion site, fluid leaking around the catheter site, complaints of burning pain at the catheter site, if catheter falls out. | * To communicate any problems and/or change in status and receive appropriate direction. |
| **E.Care of Equipment** |  |
| 1.Rinse out measuring container and return it to appropriate area.  **Cleaning urinary collection drainage bag**  1.Clean the bag that has been removed as follows:   * + 1. Use the 50cc syringe to flush the bag with tap water, draining water from bag’s drainage spout then close spout.     2. Using the syringe fill the bag with mixture of 1 cup vinegar and 1 cup water solution or commercially available cleaning solution. Leave solution in the closed bag for 30 minutes.     3. After 30 minutes drain solution from the urinary drainage bag.     4. Rinse the entire bag using tap water and then drain.     5. Use the syringe to push air into the bag and then hang the bag in a secure location to air dry. While drying the drainage spout should be left open; the bag’s other end--(connects to catheter)--should also be uncapped and open to air. This part of process should not be done in any shared / communal spaces.     6. When collection bag is completely dry, store in a clean, closed container.   2.Dispose of soiled urinary drainage collection bag when replaced.  3.Remove and dispose of gloves.  4.Wash hands. | * To ensure equipment is available for next use * Infection control |
| **F.Documentation:** |  |
| 1.Document the time and amount of urine removed from the bag (in cc’s) on appropriate flow sheet as directed by Nurse.  2.Document any additional interventions or observations.  3.Document Nurse notification if applicable. | * To monitor that client has proper output. |

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