CATHETER CARE, INDWELLING URINARY

PURPOSE:
1. To prevent infection, odor and skin irritation
2. To maintain resident comfort

EQUIPMENT:
1. Waterproof bed pad
2. Mild soap and a basin of warm water or perineal cleanser/wash solution (no rinse)
3. Wash cloth (cloth or disposable) and towel
4. Disposable gloves

PROCEDURE:
1. Gather and assemble equipment
2. Identify the resident, introduce yourself and provide privacy (pull the privacy curtain)
3. Position the resident on back if possible
4. Put on disposable gloves, apply appropriate PPE, place waterproof bed pad under the resident.
5. Cover the resident with a sheet, and then draw up the cover/sheet to expose the perineal area and catheter.
6. Cleanse the genitalia by washing front to back with soap and water or the perineal wash on wash cloth.
    - For the Female Resident:
        - Separate the labia with the thumb and forefinger of the non-dominant hand and cleanse the area with the other hand, using the wash cloth in downward strokes around the catheter insertion site.
        - Fold or turn the wash cloth to allow for a clean surface for each stroke.
        - Next cleanse the catheter itself from the insertion site outward 3-4 inches from the insertion site. (Do not wipe the catheter down towards the genitalia, always away assuring a clean surface of the wash cloth with each stroke).
    - For the Male Resident:
        - Hold the penis with the non-dominant hand, retract the foreskin if needed and cleanse the area with a circular motion always cleaning away from the catheter insertion site using a clean surface of the wash cloth with each stroke.
        - Then cleanse the catheter tubing starting at the insertion site outward 3-4 inches from the insertion site. (Do not wipe the catheter tubing down towards the urethral opening).
7. If soap and water used, rinse the area and catheter using the same technique with a clean wash cloth and fresh water and dry the area gently.
8. Remove the bed pad, then remove gloves and wash hands before touching the resident or other objects in the room.
9. Observe for and report any irritation, redness, swelling, drainage or leaking around catheter entry site.

NOTE: Catheter care is done with AM/PM care and after each bowel movement for a resident with an indwelling catheter.

Always wash your hands before and after handling the catheter tube or bag and wear gloves following standard precautions.

CATHETER BAG DRAINING:

1. Empty the catheter bag at the end of every shift and when it is 2/3 full. Empty using standard precautions using a graduated cylinder placed beneath the catheter bag drainage port. Do not let the drainage tube touch anything. After the drainage valve is opened, the bag drained, close the valve, and replace the spout in the sleeve on the drainage bag.
2. Measure output and record in the medical record. Notify nurse if urine output is low, any problem with the catheter or unusual appearance of urine (e.g. blood, change in color, increased sediment).

NOTE: Check that there are no kinks in drainage tubing and that resident is not lying on tubing. Secure the catheter bag/tubing to bed or chair, making sure the catheter bag/tubing is not touching the floor.

Make sure catheter bag is below the level of the bladder and use a catheter bag with an attached covering or a catheter bag holder to protect the resident's dignity.

If resident's bed needs to be placed in lowest position for safety, remove gloves and lower bed. Then wash hands before touching the resident or other objects in the room.