URINARY CATHETER CARE

Student Reference Guide

WEST COAST UNIVERSITY

NPSG	Wash hands per CDC guidelines. ➢ Verbalize 20 seconds per CDC hand washing guidelines.
	Provide patient privacy. ➢ Verbalize and physically demonstrate.
NPSG	Introduce yourself.
NPSG	Identify patient correctly using two identifiers (check to chart). ➢ Patient's name and date of birth.
NPSG	Verify allergy status.
	Perform environmental safety check.
	Ensure proper body mechanics.
	Gather all supplies, equipment, and PPE as needed.

GENERAL SURVEY
Verify MD order ➢ ***MUST verbalize MD order and rationale for procedure***
Assess for procedure need, explain and educate the patient about the procedure. ➢ MUST verbalize rationale for urinary catheter insertion per CDC guidelines.

APPLYING A CONDOM CATHETER
Place supplies at bedside.
Position patient to optimize safety and privacy while allowing easy catheter placement.
Place bath Blanket over patient and pull top linens under blanket down to foot of bed.
Place a towel between the patient's legs. Push bath blanket up toward patient's abdomen.
Clean, rinse and dry penis with warm soapy water. If penis is uncircumcised, retract foreskin and clean between folds.
Open catheter equipment packages. Apply adhesive/skin protectant to penis (if applicable to type of catheter) and allow to dry.
Apply catheter to shaft of penis. Connect catheter to drainage tubing and bag. Attach leg strap to patient's thigh. Secure drainage tubing to leg strap.
Check that catheter is in place and will not come off easily. Check that blood supply to penis is adequate.
Hang drainage bag at bedside. Remove bath blanket and adjust gown and linens. Make sure patient is comfortable.
Gather and dispose of all supplies. Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach.
Wash hands per CDC guidelines

INSERTING AN INDWELLING RETENTION CATHETER – FEMALE (VALIDATE)
Place supplies at bedside.
Position patient to optimize safety and privacy while allowing easy catheter placement. ➢ MUST physically perform and verbalize proper positioning of female patient prior to insertion of urinary catheter.
Place bath Blanket over patient and pull top linens under blanket down to foot of bed. ➢ MUST provide patient privacy with bath blanket.

URINARY CATHETER CARE STUDENT REFERENCE GUIDE

Assess need for perineal cleaning. Have patient move ankles up and to side.
Open catheterization kit. Place drape between patient's legs. ☆ **Please remember the concepts of sterile technique and how to open a sterile package.** ☆ **If sterile technique is broken, please verbalize that you have broken sterile technique to restart the procedure.** ➢ ***For validation: The student is allowed to verbalize one break in sterile technique, granted the student recognized the mistake. Multiple and ongoing breaks in the sterile technique will result in failing to execute the procedure.***
Don sterile gloves. Open packet of antiseptic solution and pour on to cotton balls. Prepare lubricant. Attach prefilled syringe to catheter's balloon port. ☆ **For validation purposes, do not open iodine or lubricant packaging. Do not pre-test the balloon.**
With nondominant hand spread labia minora to expose urinary meatus. With dominant hand, clean mucosa with one downward stroke of each antiseptic-soaked cotton ball. ☆ **Please maintain sterility at all times. Do not cross contaminate with the cotton balls. Make sure you designate a "disposal area" to dispose of your trash.** ➢ ***MUST verbalize which hand will be clean and which hand will remain sterile.*** ➢ ***In a downward stroke:*** ○ ***Wipe the labia furthest from you*** ○ ***Wipe the labia closest to you*** ○ ***Wipe the urinary meatus***
Hold catheter with sterile dominant hand while stabilizing labia minora. Lubricate catheter. ➢ Lubricate catheter prior to insertion. In skills lab, we will not lubricate the catheter, please verbalize this step.
While patient bears down, insert catheter into urethra. Advance catheter until you see urine. Advance catheter an additional 1-2 inches. ➢ MUST verbalize the presence of urine ➢ VERBALIZE that you "will continue to insert the foley catheter 1-2 inches further into the urethra PRIOR to inflation of the balloon."
Release labia and hold onto catheter with nondominant hand. Inflate balloon and gently pull catheter. Secure catheter to patient's thigh. ➢ MUST verbalize on the use of a "stat-lock" and where it is to be placed.
Adjust gown. Attach drainage system below level of patient's bladder to bed. ☆ **Please be aware of CAUTI bundles.** ➢ ***MUST verbalize where to hang the drainage system.***
Remove drape. Adjust linens. Remove bath blanket. Make sure patient is comfortable.
Gather and dispose of all supplies. Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach.
NPSG Wash hands per CDC guidelines

REMOVING AN INDWELLING RETENTION CATHETER – FEMALE

Place supplies at bedside and position patient to optimize safety and privacy while allowing easy catheter placement.
Move top linens to foot of bed. Place waterproof pad under patient, if not already in place.
Lift gown to expose catheter. Drain residual urine into bag. Remove tape or band securing catheter to leg. Place paper drape or towel under patient's perineum.
Attach syringe to balloon port of catheter and remove air or fluid from retention balloon. ➢ MUST attach the appropriate syringe the correct port. ➢ MUST physically remove air/fluid from port and verbalize how much air/fluid is removed.
With towel or drape in nondominant hand, slowly and gently remove catheter as patient exhales. ➢ MUST educate the patient on when to exhale.
Using towel or drape to collect drainage, observe catheter for any blood, mucus, or signs of infection. ➢ MUST verbalize assessment of catheter.
Prepare catheter or tip for culture if indicated.
Cleanse and dry perineal area. Adjust linens. Make sure patient is comfortable.
Gather and dispose of all supplies. Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach.
NPSG Wash hands per CDC guidelines

INSERTING AND REMOVING STRAIGHT CATHETER – MALE

Place supplies at bedside and position patient to optimize safety and privacy while allowing easy catheter placement. ➢ MUST provide patient privacy with bath blanket. ➢ MUST physically perform and verbalize proper positioning of male patient prior to insertion/removal of urinary catheter.
Place bath Blanket over patient and pull top linens under blanket down to foot of bed.

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Revision: Colletti, Costea & Nguyen, 2020

URINARY CATHETER CARE STUDENT REFERENCE GUIDE

Place a towel between the patient's legs. Push bath blanket up toward patient's abdomen.
Open catheter kit. Place drape over patient's upper thighs.
Don sterile gloves. Discard specimen cup, unless needed. Place fenestrated drape over penis. Open antiseptic swab package and prepare lubricant. Bring basin and supplies close to patient. ☆ **If sterile technique is broken, please verbalize that you have broken sterile technique to restart the procedure.** ➢ ***For validation: The student is allowed to verbalize one break in sterile technique, granted the student recognized the mistake. Multiple and ongoing breaks in the sterile technique will result in failing to execute the procedure.***
Grasp penis and cleanse urethral meatus and head of penis with antiseptic swabs. Use sterile gloved hand to hold catheter and nonsterile gloved hand to hold penis. Retract foreskin if necessary. ☆ Please maintain sterility at all times. Do not cross contaminate with the cotton balls. Make sure you designate a "disposal area" to dispose of your trash. Also, do not break sterility when doing this step. ➢ MUST physically perform and verbalize which hand will be clean and remain sterile.
Apply lubricant to catheter. Insert catheter into urethra. Release foreskin if retracted. Advance catheter until you see urine. Hold catheter in place until all urine has drained into basin.
Remove catheter slowly. Remove drape. Adjust gown and linens. Remove bath blanket. Make sure patient is comfortable.
Gather and dispose of all supplies. Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach.
NPSG Wash hands per CDC guidelines

PERINEAL CARE – FEMALE

Place supplies at bedside.
Assist patient to a comfortable position that allows you to visualize perineal area. ➢ MUST provide patient privacy with bath blanket. ➢ MUST physically perform and verbalize proper positioning of perineal care.
Place bath blanket over patient and pull top linens under blanket down to foot of bed while patient holds top of blanket.
Have patient bend knees and spread legs. Place waterproof pad underneath patient if not already in place. Lift bath blanket and gown toward patient's abdomen.
Stabilize external genitalia with nondominant hand and expose by holding back labia.
Wash labia majora and perineal area from front to back with warm washcloth and approved perineal wash and using a different area of washcloth for each side. Wash labia minor from front to back. Rinse labia major from front to back. Rinse labia minora from front to back. Gently pat dry. ➢ MUST physically perform and verbalize these steps.
Clean first 4 inches of external portion of catheter closest to patient. Dry catheter.
Remove waterproof pad. Adjust gown and blanket. Reattach catheter to leg band. Assess catheter for patency. Adjust gown and linens. Remove bath blanket. Make sure patient is comfortable.
Gather and dispose of all supplies. Ensure safe environment: bed to appropriate height, brakes locked, appropriate side rails up and call light within reach.
NPSG Wash hands per CDC guidelines

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