Leamington Mennonite Home
Long Term Care

POLICY AND PROCEDURE

CATEGORY: **Nursing**	**SUBJECT:** **Catheterizations**	**SECTION:** **C** **POLICY:** **4**
DATE: **December 2004**	**Administrator:**	
REVISION DATES: **October 2016**	**Director of Care:** Cheryl Allick RN	

CATHETERIZATIONS

POLICY:

To provide continuous drainage of the urinary bladder to prevent retention and discomfort and to promote good skin integrity. Catheterizations may also be ordered to obtain a sterile urine sample for laboratory testing. Management of the catheter and its care is the responsibility of the Registered Staff. The process of emptying and changing the catheter bags can be delegated to the PSW's.

PROCEDURE:

- Gather all necessary equipment including the proper sized catheter as stated in the doctor's orders, catheterization tray, 5cc syringe, drainage bag and flashlight.
- Explain the procedure to the resident. Provide privacy.
- If the procedure is a catheter change, clamp the catheter 30 minutes prior to change (female). Remove the old catheter by removing the water from the balloon using the 5cc syringe (check order for the amount of water inserted into the balloon).

Catheterizations – Female

1. Position the resident on her back or side depending on the resident's ability to maintain the necessary position.
2. Position the flashlight on the bed to illuminate the area.
3. Wash hands.
4. Open the sterile dressing tray and create a sterile field.
5. Open the outer packaging of the catheter and position the sterile catheter on the sterile field.
6. Place sterile drape under resident.
7. Don sterile gloves.
8. Open the lubricant and dispense onto the side of the tray.
9. Remove the catheter from the sterile wrap. Using the sterile water in the syringe, test the catheter balloon to ensure it will inflate. Remove the water from the balloon. Lubricate the end of the catheter and place catheter in the tray.
10. Using the swabs provided, cleanse the labia from above downward making sure to use one swab per swipe.

11. Insert the catheter 1 ½ " into the urinary meatus until you receive urine return. Insert another ½ " and inflate the balloon. Gently pull back on the catheter once the balloon is inflated to make sure that the catheter is secure and in place.
12. Attach the other end of the catheter to the urinary drainage bag making sure that the bag is clamped shut. Secure the catheter to the resident 's thigh using the catheter strap.
13. Make sure the resident is comfortable and remove all supplies and waste from the resident's room.
14. Check the drainage bag in 30 minutes to ensure the catheter is draining properly.
15. Document the procedure in the resident's e- notes and on the TARS.

Catheterization – Male

1. Position the resident on his back.
2. Wash hands.
3. Open the sterile dressing tray and create a sterile field.
4. Open the outer packaging of the catheter and position the sterile catheter on the sterile field.
5. Place sterile drape under resident.
6. Don sterile gloves.
7. Open the lubricant and dispense onto the side of the tray.
8. Remove the catheter from the sterile wrap. Using the sterile water in the syringe, test the catheter balloon to ensure it will inflate. Remove the water from the balloon. Lubricate the end of the catheter and place catheter in the tray.
9. Using the swabs provided, cleanse the tip of the penis in circular motion using one swab per swipe. The last swab should be swiped directly over the urinary meatus.
10. The penis is held upright at a right angle to the resident's body to straighten the anterior urethra. Exert slight pressure to widen the opening. Insert the catheter into the urinary meatus approximately 6" until urine is returned. If resistance is felt and catheter is not able to pass, remove the catheter and attempt insertion again in 30 minutes. Inflate the balloon. Gently pull back on the catheter once the balloon is inflated to make sure that the catheter is secure and in place.
11. Attach the other end of the catheter to the urinary drainage bag making sure that the bag is clamped shut. Secure the catheter to the resident 's thigh using the catheter strap.
12. Make sure the resident is comfortable and remove all supplies and waste from the resident's room.
13. Check the drainage bag in 30 minutes to ensure the catheter is draining properly.
14. Document the procedure in the resident's e- notes and on the TARS.

Clean Intermittent Catheterization – Female

1. Ask resident to void. Record amount voided on the output sheet.
2. Gather a straight catheter, Betadine, 2 x 2's, lubricant, gloves and urinary hat or urinal.
3. Position the resident on her back or side depending on the resident's ability to maintain the necessary position.
4. Position the flashlight on the bed to illuminate the area.
5. Wash hands.
6. Don gloves.
7. Separate the labia and clean with Betadine.
8. Apply lubricant to end of straight catheter.
9. Insert catheter into the urinary meatus approximately 2 – 3 inches until urine returns.
10. Place opposite end of catheter into urinary hat or urinal and allow to drain.

11. Record amount of urine obtained on the output sheet.
12. Rinse the straight catheter with cold water, then wash the catheter with soap and hot water, rinse and allow to air dry.
13. Assist resident with getting dressed and to a comfortable position.
14. Place catheter into sterile package and label with resident's name and date, then place in a plastic bag. Place the catheter in the resident's bathroom inside the cupboard. If a resident's behaviour puts this at risk then a customized plan will be put in place.
15. Straight catheter may be reused by the same resident over a 24 hour day.
16. Document the procedure in the resident's e- notes and on the TARS

Clean Intermittent Catheterization – Male

1. Ask resident to void. Record amount voided on the output sheet.
2. Gather a straight catheter, Betadine, 2 x 2's, lubricant, gloves and urinary hat or urinal.
3. Position the resident on his back or side depending on the resident's ability to maintain the necessary position.
4. Position the flashlight on the bed to illuminate the area.
5. Wash hands.
6. Don gloves.
7. Clean tip of penis with Betadine.
8. Apply lubricant to end of straight catheter.
9. Insert catheter into the urinary meatus until urine returns.
10. Place opposite end of catheter into urinary hat or urinal and allow to drain.
11. Record amount of urine obtained on the output sheet.
12. Rinse the straight catheter with cold water, then wash the catheter with soap and hot water, rinse and allow to air dry.
13. Assist resident with getting dressed and to a comfortable position.
14. Place catheter into sterile package and label with resident's name and date. Place in a plastic bag. Place the catheter in the resident's bathroom inside the cupboard. If a resident's behaviour puts this at risk then a customized plan will be put in place.
15. Straight catheter may be reused by the same resident over a 24 hour day.
16. Document the procedure in the resident's e- notes and on the TARS

Suprapubic Catheter

1. Position the resident on their back.
2. Wash hands.
3. Open the sterile dressing tray and create a sterile field.
4. Open the outer packaging of the catheter and position the sterile catheter on the sterile field.
5. Place sterile drape beneath suprapubic catheter.
6. Remove the dressing. Deflate the balloon of the inserted catheter. ****Note: Next steps must be done quickly and efficiently to ensure the stoma site does not close.****
7. Remove the catheter.
8. Don sterile gloves.
9. Open the lubricant and dispense onto the side of the tray.
10. Remove the catheter from the sterile wrap. Using the sterile water in the syringe, test the catheter balloon to ensure it will inflate. Remove the water from the balloon. Lubricate the end of the catheter and place catheter in the tray.
11. Using the swabs provided, cleanse the stoma in circular motion using one swab per swipe.

12. Insert new catheter. It is normal to feel minor resistance at the stoma site and the catheter “pop” through the bladder wall. Inflate the balloon with 3 – 5 mls of sterile water. If resistance is felt, the catheter may need to be inserted further or pulled back slightly. Gently pull on the catheter to seat against the bladder wall and inflate with the remainder of the water.
13. Attach the other end of the catheter to the urinary drainage bag making sure that the bag is clamped shut.
14. Apply dressing to cystostomy site. Secure catheter to the abdomen with tape.
15. Make sure the resident is comfortable and remove all supplies and waste from the resident’s room.
16. Check the drainage bag in 30 minutes to ensure the catheter is draining properly.
17. Document the procedure in the resident’s e- notes and on the TARS.

Suprapubic Catheter Care

1. Daily dressing changes are required for the cystostomy site.
2. Cleanse around catheter with normal saline. Monitor area for redness or any discharge. If discharge is present notify Physician.
3. Reapply clean dressing.
4. Ensure drainage bag is always below the waist to keep urine from flowing back into the bladder.
5. Try not to disconnect the catheter bag more than necessary. Keeping it connected ensures the efficiency of the catheter.
6. If catheter is not draining, check for kinks in the tubing. If irrigation order is present, irrigate to help dislodge any sediment from the opening.

Straight Catheterization for Urinary Lab Specimens

1. Use a straight catheter for this procedure.
2. Follow the above procedures to the point where urine is returned. At this point, place the end of the catheter into a sterile specimen bottle. Once the sample is obtained, remove the catheter.
3. Make sure the resident is comfortable and remove all supplies and waste from the resident’s room.
4. Document the procedure in the resident’s e- notes and on the TARS

Catheter Irrigation

1. Collect the necessary equipment: irrigation tray, sterile water, alcohol swabs and clean gloves.
2. Explain the procedure to the resident.
3. Position the resident on their back.
4. Open the irrigation tray. Drape the resident. Pour the sterile water into the container provided. Draw up sterile water into the syringe provided.
5. Disconnect the drainage bag from the catheter tubing. Clean the connection port with alcohol.
6. Insert the sterile water slowly into the catheter using the syringe. Remove the syringe and allow the water to drain into the tray, making sure to measure that the output is equal to the amount of water inserted. If resistance is felt when the water is inserted maneuver the catheter gently. If unsuccessful, the catheter will need to be changed.

7. Ensure that the resident is comfortable before leaving the room. Remove all equipment and waste.
8. Document the procedure in the resident's e - notes and the TARS.

For Catheter Care see following fact sheets.

Urinary Catheter Care Fact Sheet

Closed Urinary Catheter System: Recommended for Non-ambulatory Residents

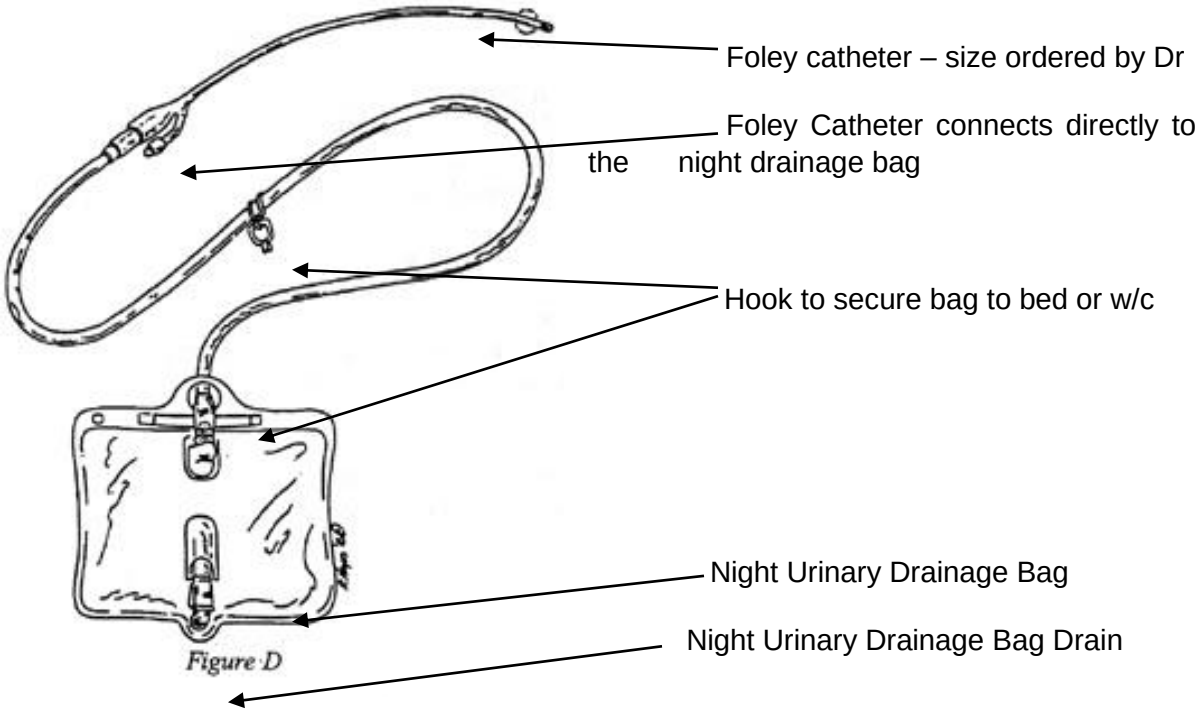


Figure D

It is essential that system remains closed to reduce chances for infection.

To ensure proper flow of urine from the bladder to the bag, always position the drainage tubing and bag below the bladder level.

Position the tubing so that there are no kinks or loops to prevent flow of urine.

Hang the collection bag on the side of the bed on the bed frame never on the moveable side rails.

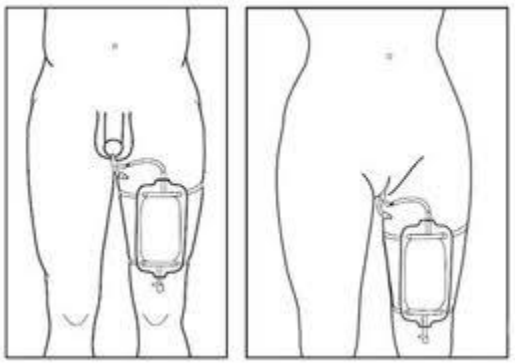
Use tape/leg strap to secure tubing to inner thigh.

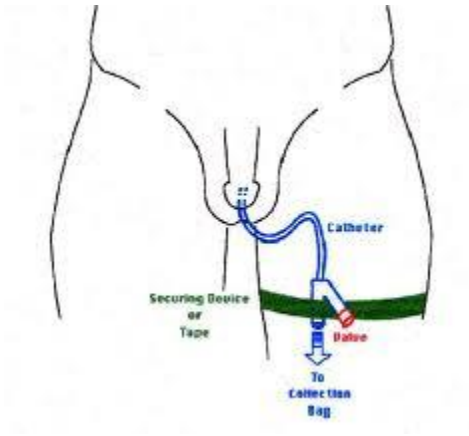
Always perform hand hygiene before & after task. Wear PPE's = gloves. Unclamp drainage spout/drain. Re-clamp – may wipe with alcohol swab to keep clean. Record the amount of urine drainage each shift (or as needed- bag is ½ full). Note the colour, odour, condition of the closed system in charting. Assess for the need to change catheter bag.

Personal hygiene: showers are recommended over tub baths. Keep skin/peri area clean. Keep tubing clean.

Urinary Catheter Care Fact Sheet

Leg Bag and Night Bag Urinary Catheter System: Acceptable for Ambulatory Residents





Positions for leg bags for male & female residents

If residents are uncomfortable with this position, a leg extension tube may be used. Ensure a proper fit with the connector is maintained to prevent leakage.

Leg Bag Drainage: for day used only – never to be left on overnight

Night Bag Drainage: larger for evening/night time use

Procedure for Care of Drainage Bags:

Equipment required: gloves, soap, alcohol swab, vinegar, measuring cup

Whenever a bag is disconnected it is to be cleaned right away.

Wash bag with soapy water: add a few drops of soap to connector site, flush with water running from tap at resident's washroom. Empty. Rinse with clear water. Fill and soak bag with vinegar solution 1 cup vinegar to 1 quart (1000ml) water. Leg bag may need to be ½ cup vinegar to 1 pint (500 ml) water. Soak a minimum of 30 minutes. Rinse. Hang/store in resident room with tip capped / drain clamped.

Discard gloves, perform hand hygiene.

Procedure for Changing the Drainage Bags:

Equipment required: gloves, alcohol swab, clean drainage bags

Perform hand hygiene, don gloves. Cleanse the clean bag's connecting tubing with alcohol and have ready to attach. Cleanse the connector area between the tubing and catheter with alcohol. Support the catheter and gently remove tubing immediate attach clean drainage bag. Clean drain bags as noted above.