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|  URINARY CATHETER CARE | NO.  |
| PURPOSE: To provide Standard of Care for the care and maintenance of indwelling Catheters.STATEMENT OF POLICY: It is the policy of this facility that the catheter and perineal care will be provided in a manner that will promote and provide cleanliness, acceptable infection control, and provide dignity for the resident.1. Nursing Assistants must do catheter and perineal care with a.m. and p.m. care, and after each of the resident’s bowel movements.
2. Always wash your hands before and after handling the catheter, tube, or bag, and wear gloves. Follow standard precautions for infection control.
3. Clean the area where the catheter is inserted by wiping away from the insertion site, to prevent germs from being moved from the anus to the urethra.
4. Hold the end of the catheter tube to keep it from being pulled while cleaning.
5. Wash the catheter to remove any blood or other materials from the catheter, wiping downwards from the urethra.
6. Do not use powder around the catheter entry site.
7. Check for any irritation, redness, tenderness, swelling, drainage, or leakage, around the catheter entry site.
8. Catheter Tubing and Bag
9. Check frequently to be sure there are no kinks or loops in the tubing and that the resident is not lying on the tubing.
10. To prevent the catheter from being pulled out, secure the catheter tubing to the thigh without tension on the tubing.
11. Keep the bag below the level of the resident’s bladder at all times.
12. Use a catheter bag cover to protect the resident’s dignity.
13. Emptying the Catheter Bag
14. Empty the catheter bag at the end of every shift and also when it is 2/3 full.
15. Use a urinal or graduate to collect urine and measure amount.
16. Remove the drain spout from its sleeve at the bottom of the catheter bag without touching its tip, open the slide valve on the spout, and let the urine flow out of the bag into the container.
17. Do not let the drain tube touch anything.
18. Close the slide valve and put the drain spout into its sleeve at the bottom of the bag.
19. Measure the urinary output, and record it in the resident’s record.
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| 1. Notify the Unit Nurse if the output is low. This could mean the resident is dehydrated, has a urinary tract infection, there is a blockage preventing the urine from flowing out, or that the catheter is leaking. Urine will usually drain at a steady rate, filling the bag slowly.
2. Monitoring for problems.
3. All problems with the catheter, anything unusual about the resident’s urine, and signs of possible urinary tract infection should be reported to the Unit Nurse immediately.
4. If the bed or resident’s clothes are wet with urine, check to see if the catheter tubing is twisted or bent, or if the resident is lying on the catheter or tubing.
5. Healthy urine is clear and light yellow. Observe the urine for:
6. Dark or unusual color
7. Signs of blood
8. Mucus
9. Sediment
10. Foul odor
11. With all catheter care, check the skin around the catheter entry site for signs of irritation, redness, tenderness, swelling, or drainage.
12. Observe the resident for signs of possible urinary tract infection. A urinary tract infection can be very serious, leading to further infection, confusion, falls, and death. Signs and symptoms of a urinary tract infections include:
13. Increased confusion or sudden cognitive decline.
14. Fever.
15. Pain with urination, urgency or frequency.
16. Lower abdominal or flank pain.
17. Change in character of urine.

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