

Urinary Catheter Insertion

Student Name: _____

Student Signature: _____

Evaluator Signature: 1st attempt _____ Date: _____

Satisfactory*

Unsatisfactory^

Evaluator Signature: 2nd attempt _____ Date: _____

Satisfactory*

Unsatisfactory^

Evaluator Signature: 3rd attempt _____ Date: _____

Satisfactory*

Unsatisfactory^

**** Critical Behaviors that need to be stated or done in order to pass the skill.**

PERFORMANCE BEHAVIORS	S*	U^	COMMENTS
<u>Assessment</u>			
1. Avoid distractions			
2. Check physician's order			
3. **Check medical record for allergies, noting latex, betadine and povidone-iodine.			
<u>Planning</u>			
4. Identify expected outcomes.			
5. Gather equipment			
a. Indwelling catheter kit, using the smallest catheter if not specified. Determine what equipment is included in the kit (drainage bag etc.).			
1. Check expiration date.			
2. State average adult catheter size. (i.e. Female: 14-16Fr, Male: 16-18Fr)			
b. Extra catheter, clean wash cloth, basin with warm water and towel, blue pad, flashlight, etc			
6. Provide for privacy.			
<u>Implementation</u>			
7. Upon entering the room:			
a. **Perform hand hygiene			
b. Be aware of your spatial safety, have call light within reach			
c. Identify self			
d. **Identify patient using 2 forms of identification			
e. **Ask patient if he/she has allergies and check for identifying armbands.			
f. Explain what is about to occur.			
g. Allow for patient questions			
h. Ask the patient when last voided.			
i. Raise bed to comfortable height.			
j. Don clean gloves			
k. Adjust room for proper lighting			
8. Place a waterproof pad between legs and under hips. Place patient in lithotomy position. Use cleansing wipes to clean perineal area. Discard gloves. Wash hands.			
9. Open catheter kit.			
a. Remove kit, reserving plastic bag for garbage.			
b. Place kit between patient's legs.			
c. Open outer wrap, maintaining sterile technique.			
d. Remove sterile gloves from kit and don gloves.			
10. Organize equipment. Attach syringe containing sterile water attached to the balloon port. Do not inflate balloon.			

PERFORMANCE BEHAVIORS	*S	*U	COMMENTS
11. Male indwelling catheterization <ol style="list-style-type: none"> a. Lubricate catheter tip with water-soluble gel 2 inches. b. Open swab sticks. c. Cleanse urinary meatus from center out in circular fashion, repeat with clean swab. Keep non-sterile hand in place on penis. d. **Do not cross the sterile field with soiled cleaning materials. e. Hold catheter 2-3 inches and prepare for insertion. f. Ask patient to cough on insertion and then take deep breaths. g. Gently insert catheter into urinary meatus advancing catheter slowly to the bifurcation of the catheter. Stop if there is resistance and notify prescriber. **Do not break sterile technique. 			
12. Female indwelling catheter <ol style="list-style-type: none"> a. Lubricate catheter tip with water-soluble gel 1-2 inches. h. Open swab sticks. b. Cleanse urinary meatus with antiseptic solution. <ol style="list-style-type: none"> 1. Separate labia with fingers of non-dominant hand to fully expose urinary meatus. 2. Maintain position of non-dominant hand until catheter has been inserted, careful to keep labia apart. 3. **Clean the labia and urinary meatus from the clitoris toward the anus. Use one cotton ball or swab per stroke. 4. **Do not cross sterile field with soiled cleaning materials. c. Gently insert catheter into urinary meatus advancing catheter slowly 2-3 inches or until urine flows and then one additional inch. Stop if there is resistance and notify prescriber. **Do not break sterile technique. 			
13. Male or female completion of catheterization <ol style="list-style-type: none"> a. Hold the catheter securely at the meatus with your non-dominant hand. Use your dominant hand to inflate balloon. b. Allow bladder to empty fully, unless institution policy restricts maximum output, typically to 1000 ml. c. Secure catheter to upper thigh with Statlock, allowing slack to prevent tension. d. Position drainage bag lower than bladder by attaching it to non-moving part of patient's bed, not side rails. e. Ensure drainage bag is no more than one half full. 			
14. Before leaving room <ol style="list-style-type: none"> a. **Reposition patient for comfort and safety b. ** Lower bed c. **Raise appropriate side rails d. **Leave call light and belongings in reach e. ** Perform hand hygiene f. Dispose of used equipment 			
<u>Evaluation</u> 15. Observe urine in drainage bag for amount, color and clarity.			
16. Document catheterization, output, assessment findings, and patient's response to procedure in patient medical record.			

***S = Satisfactory, ^U = Unsatisfactory**

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