

Procedure for Clean Intermittent Catheterization—Female

Note: Family provides equipment and supplies.

1. Wash hands.
2. Assemble equipment:
 - Water-soluble lubricant (e.g., K-Y Jelly, Lubrifax, Surgilube)
 - Catheter
 - Wet wipes or cotton balls (nonsterile) plus mild soap and water or student-specific cleansing supplies
 - Storage receptacle for catheter, such as a sealed plastic bag
 - Toilet or container for urine
 - Non-latex gloves, if person other than student does procedure

If the student does the procedure unassisted, gloves may not be needed; however, the student should wash her hands with soap and water before and after performing the procedure.

3. Have another adult present for the procedure, if possible.

Having two adults present protects both the student and the caregiver.

4. Explain procedure using explanations the student can understand. Encourage her to do as much of the procedure as she is capable, so as to achieve maximum self-care skills.
5. Position the student.

The student may be catheterized lying down, standing, or sitting. If able, she may stand at or sit on the toilet. If unable to sit or stand, she may lie on her back. A receptacle to catch the flow of urine from the catheter is required.

6. Wash hands and put on non-latex gloves.
7. Lubricate the first 3 inches of the catheter with a water-soluble lubricant and place on clean surface.
8. Separate the labia and hold open with non-dominant hand. Cleanse, starting at the top of the labia and going down toward the rectum. Use a clean cotton ball each time. Wash three times: once down the middle and once down each side.

*Do **not** cleanse in a circular motion because doing so may move bacteria from the rectal area towards the urethra.*

9. Locate the urinary meatus (opening). Gently insert the catheter until there is urine.

The female urethra is short and straight. Keep the other end of the catheter over the toilet or the receptacle. If no urine is obtained, the catheter may have slipped into the vagina instead of the urethra.

10. When urine flow stops, insert catheter slightly more. If no more urine is obtained, withdraw it slightly and rotate catheter so that catheter openings have reached all areas of the bladder.

It may be helpful to have the student bear down a couple of times while the catheter is in place to ensure that all urine has been drained completely.

11. After bladder is completely empty, pinch catheter and withdraw.

This prevents urine still in catheter from flowing back into the bladder during withdrawal.

12. Wipe off any excess lubricant or urine.
13. Assist student in dressing, if needed.
14. Measure and record the urine volume, if ordered. Dispose of urine.
15. If using a one-time use catheter, wrap catheter around gloved palm, pull glove over catheter when degloving (to contain it) and dispose of according to school's infection control procedure.
16. If using a reusable catheter, wash, rinse, dry, and store the catheter in appropriate container according to student's IHP.

Examples of storage receptacles include a sealed plastic bag, a urine specimen container, and a clean pencil case. The reusable catheter(s) should be sent home with student to be cleaned. Dispose of catheters when they become brittle upon repeated use.

17. Remove gloves and wash hands.
18. Document on log sheet that the procedure was done. Report to the school nurse and family any changes such as cloudy urine, mucus, blood, foul odor, color changes, unusual wetting between catheterizations, which may be signs of infection.