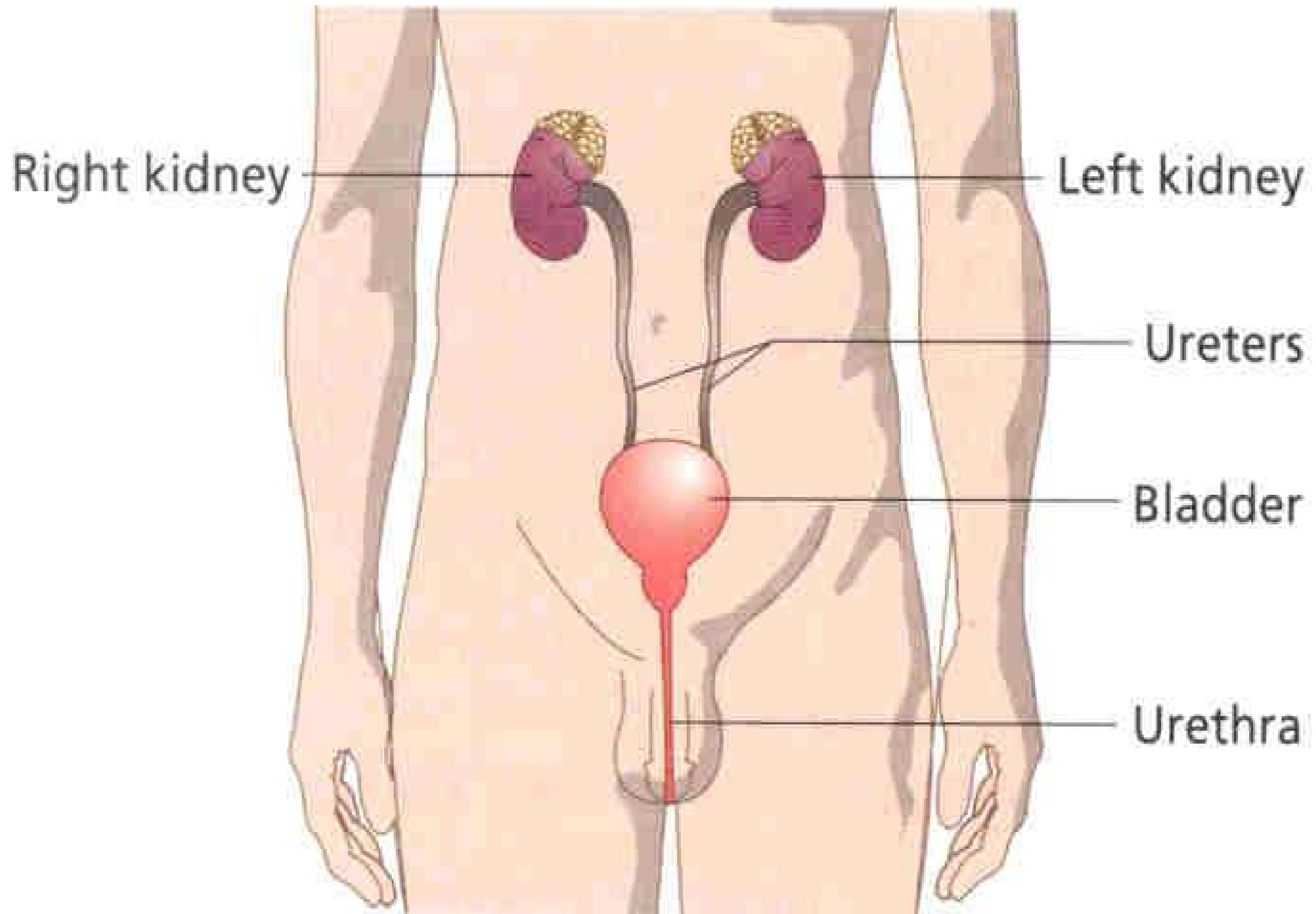
ASSISTING WITH

Anatomy of the Urinary System



VOCABULARY

- INCONTINENCE ---
- THE INABILITY TO CONTROL URINE OR FECES
- VOID ---
- TO URINATE.
- MICTURATE ---
- TO URINATE.
- DYSURIA---
- PAINFUL URINATION

RULES FOR NORMAL ELIMINATION

- DO NOT WITHHOLD FLUIDS
- FOLLOW THE PERSON'S ROUTINES
- ASSIST THE PERSON TO THE BATHROOM AS NEEDED. PROVIDE THE BEDPAN OR URINAL IF NEEDED
- ASSIST THE PERSON TO ASSUME A NORMAL VOIDING POSITION
- PROVIDE FOR PRIVACY
- ALLOW TIME TO VOID
- RUN WATER TO HELP START URINATION
- PROVIDE PERINEAL CARE IF NEEDED
- ALLOW PERSON TO WASH HANDS AFTER TOILITING

VOCABULARY

DYSURIA – PAINFUL OR DIFFICULT URINATION

HEMATURIA – BLOOD IN THE URINE

NOCTURIA – FREQUENT URINATION AT NIGHT

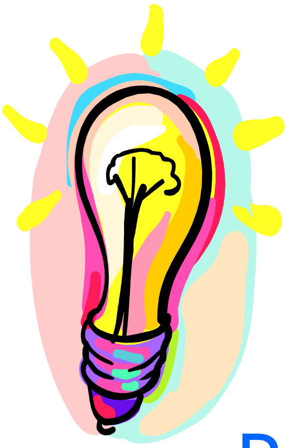
POLYURIA – LARGE AMOUNTS OF URINE

URINARY FREQUENCY – VOIDING AT FREQUENT INTERVALS

URINARY URGENCY – THE NEED TO VOID AT ONCE

FACTORS THAT AFFECT ELIMINATION

- LACK OF PRIVACY
- LACK OF PHYSICAL MOVEMENT
- MEDICATIONS
- USE OF BEDPAN



POINTS TO REMEMBER

- PATIENTS SHOULD BE SITTING UPRIGHT WHEN USING THE BEDPAN.
- GIVE THE PATIENT THE CALL BUTTON, PULL THE CURTAIN AND LEAVE THE ROOM.
- GLOVES SHOULD BE WORN WHEN YOU ARE ASSISTING WITH ELIMINATION.

RESTORATIVE MEASURES

- ALLOW THE PATIENT TO BE AS INDEPENDENT AS POSSIBLE
- PROVIDE ASSISTIVE EQUIPMENT IF NEEDED

BEDSIDE COMMODE

- MAY BE PLACED IN BATHROOM OVER THE TOLIET.
- MAY BE PLACED IN THE BEDROOM OR WHERE EVER THE PATIENT WILL BE LOCATED.
- SHOULD BE CLEANED AFTER EACH USE

ELIMINATION EQUIPMENT

BEDPAN

REGULAR BEDPAN

WOMEN USE THE BEDPAN FOR BOTH URINE AND B.M.

MEN USE THE BEDPAN FOR B.M. ONLY

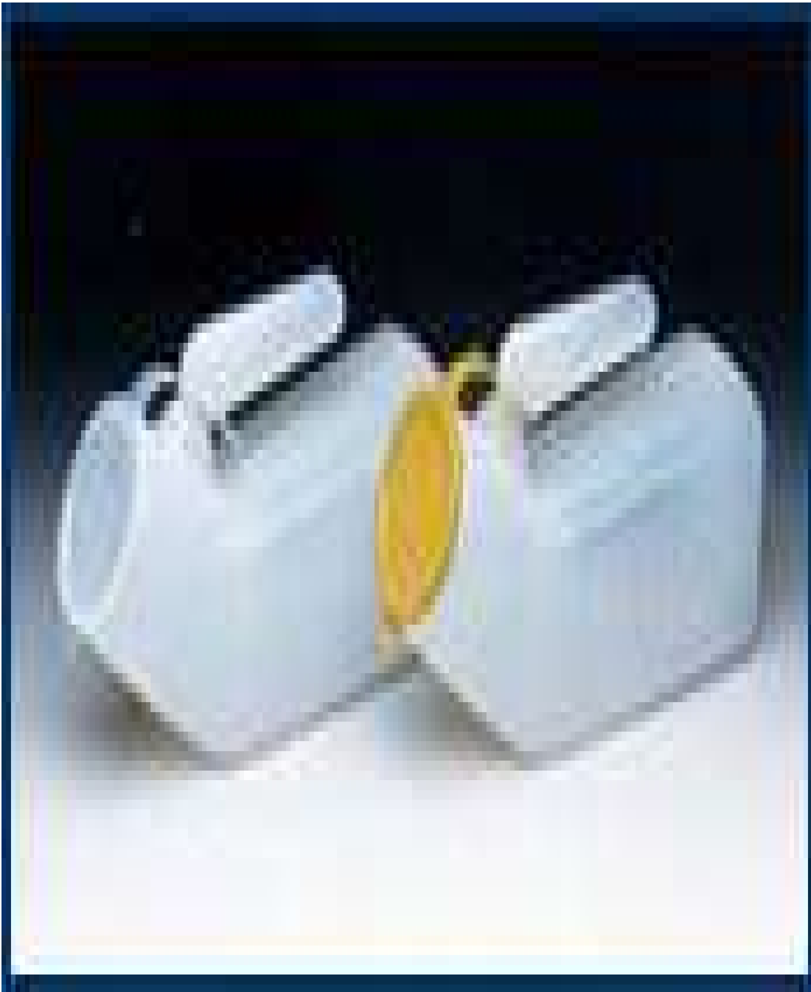
FRACTURE PAN

MORE COMFORTABLE

HOLDS LESS URINE

MORE EASILY SPILLED

ELIMINATION EQUIPMENT



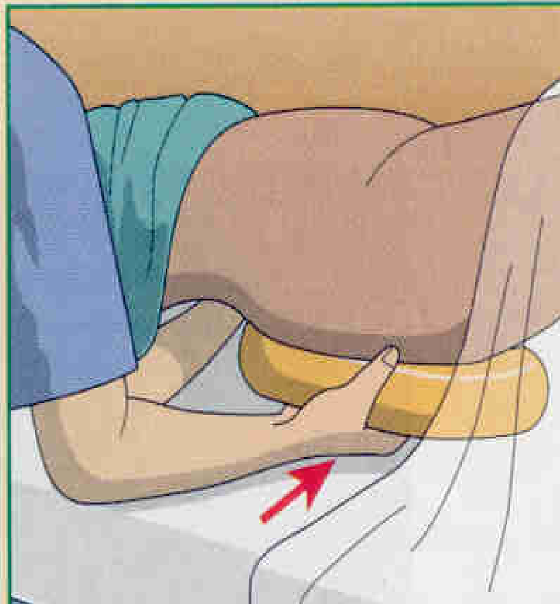
URINAL

USED BY MALE PATIENTS FOR URINATION

HAS A HANDLE TO HOLD ON TO

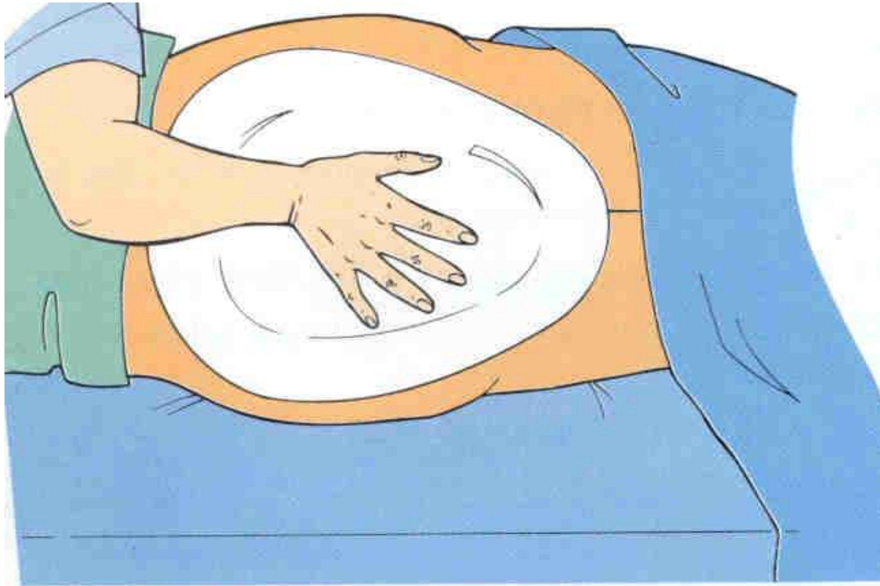
A LID WILL COVER THE TOP

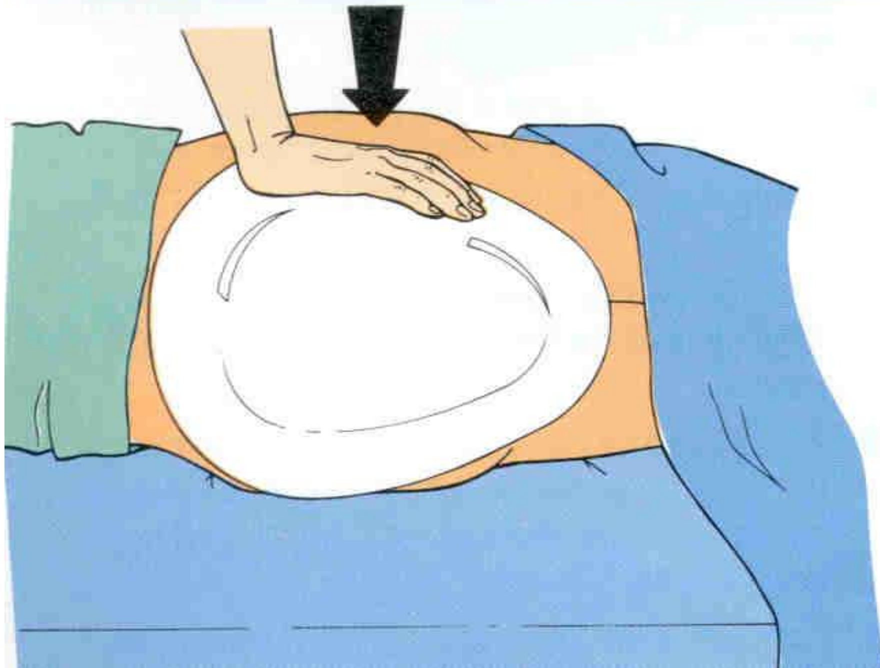
HAS CALIBRATIONS ON SIDE



GIVING A BEDPAN TO A PATIENT

- ✓ ASK THE PATIENT TO FLEX THE KNEES AND RAISE THE BUTTOCKS.
- ✓ YOU MAY NEED TO SLIDE YOUR HAND UNDER THE PATIENT'S BACK TO HELP RAISE THE BUTTOCKS.
- ✓ SLIDE THE BEDPAN UNDER THE PATIENT.
- ✓ MAKE SURE THE BEDPAN IS PROPERLY POSITIONED.



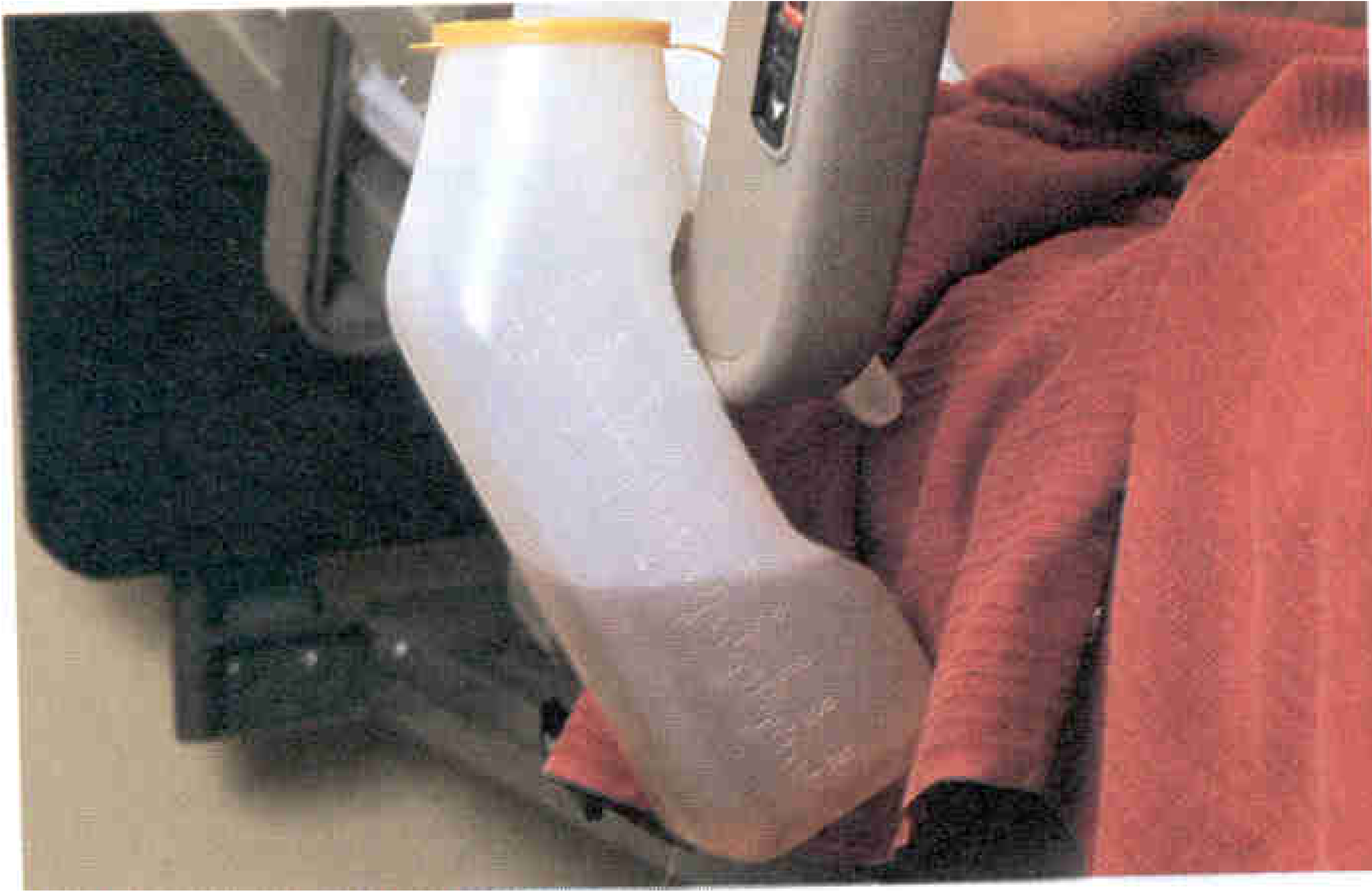


DO THE FOLLOWING IF

- ✓ TURN THE PERSON ONTO THEIR SIDE
- ✓ PLACE THE BEDPAN FIRMLY AGAINST THE BUTTOCKS
- ✓ PUSH THE BEDPAN DOWN AND TOWARD THE PATIENT
- ✓ HOLD THE BEDPAN AND TURN THE PERSON ONTO THEIR BACK

GUIDELINES FOR USING A URINAL

- DO NOT PUT THE URINAL ON THE OVERBED TABLE OR ON THE FLOOR
- EMPTY AND CLEAN THE URINAL PROMPTLY AFTER IT HAS BEEN USED



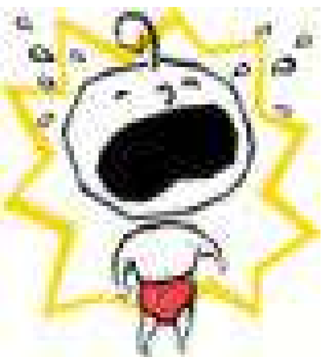
URINALS THAT ARE NOT EMPTIED PROMPTLY CAN BE TIPPED AND SPILLED.

ABNORMAL URINE REPORT TO NURSE IF:

- BLOOD OR MUCUS, STONES, GRAVEL, OR SEDIMENT IN THE URINE.
- DARK COLORED OR CONCENTRATED URINE
- UNUSUAL URINE ODOR
- COMPLAINTS OF PAIN, BURNING, OR ITCHING ON URINATION
- INABILITY TO VOID

NURSING MEASURES FOR PERSONS

- RECORD THE PERSONS VOIDINGS.
- ANSWER CALL LIGHTS PROMPTLY
- HAVE THE PERSON WEAR EASY TO REMOVE CLOTHING
- OBSERVE FOR SIGNS OF SKIN BREAKDOWN
- PROVIDE PERINEAL CARE AS NEEDED
- ALWAYS BE COURTEOUS AND POLITE



URINARY INCONTINENCE

- IS MORE COMMON IN ELDERLY PATIENTS
- CAUSED BY DISEASE, CONFUSION, MEDICATIONS, DECREASED MOBILITY, AND FAILURE TO TOLIET FREQUENTLY
- MAY CAUSE SKIN BREAKDOWN (WARM, MOIST ENVIRONMENT FOR PATHOGENS)
- IS NOT A NORMAL CHANGE OF AGING

GUIDELINES *for*

Caring for the Patient with Incontinence

Nursing assistant responsibilities include:

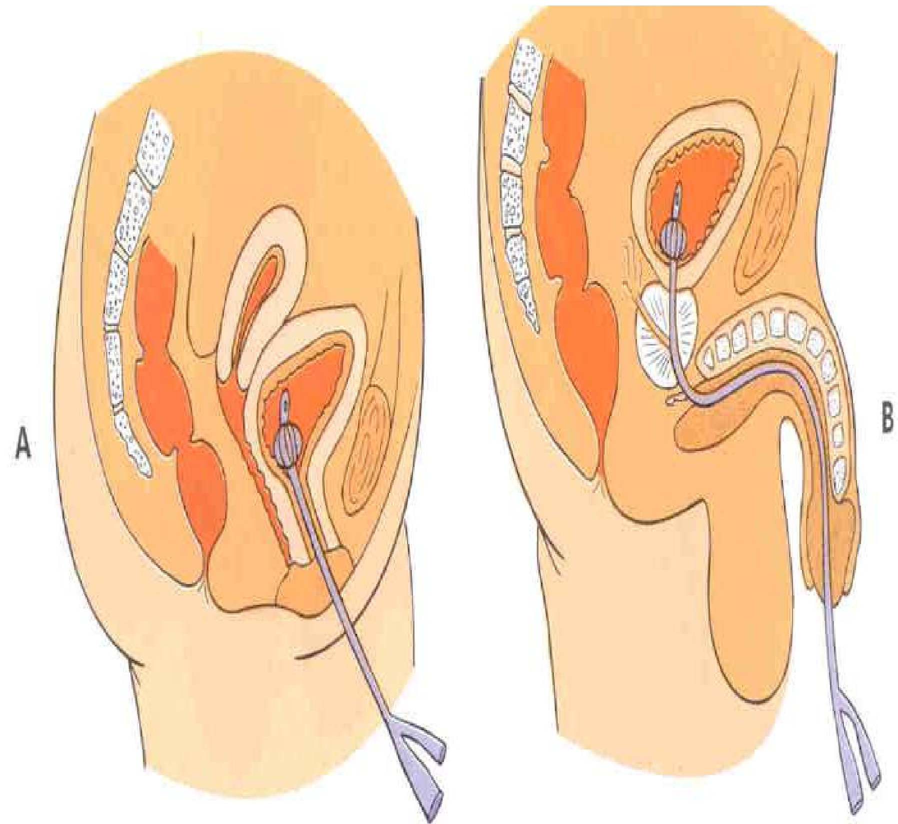
- Assisting patients who need help to toilet regularly.
- Answering call lights promptly.
- Always being courteous and patient when assisting patients with toileting.
- Maintaining a positive attitude when changing soiled garments and bed linen and never being critical.
- Performing good perineal care and being sure skin is clean and dry.
- Checking the skin for signs of irritation whenever toileting or bathing a patient or performing perineal care.
- Giving special attention to patients who are confused or forgetful, because they may be unable to clearly state their need for assistance.
- Changing wet linen immediately. This limits discomfort and embarrassment of the patient. Prolonged exposure of the skin to urine is a major cause of skin breakdown. In addition, pathogens grow rapidly on the warmth and moisture and can quickly move upward through the urinary tract, causing life-threatening infection.
- Helping the patient become continent. Little reference should be made to the temporary incontinence. Nursing assistants can do much to give emotional support and reassurance to patients who are incontinent.

PREVENTING INCONTINENCE

- OFFER TOLIETING AT REGULAR INTERVALS.
- ANSWER CALL SIGNALS PROMPTLY.
- REMIND CONFUSED PATIENTS TO USE THE BATHROOM ON A REGULAR BASIS.
- OBSERVE FOR SIGNS OF NEED FOR TOLIETING SUCH AS RESTLESSNESS, CRYING, OR HOLDING THE GENITALS.

URINARY CATHETERS

- CATHETER - A TUBE USED TO DRAIN OR INJECT FLUID THROUGH A BODY OPENING
- INSERTED THROUGH THE URETHRA, INTO THE BLADDER TO DRAIN THE URINE.
- CAN BE TEMPORARY OR LEFT IN PLACE
- A BALLON IS INFLATED TO HOLD THE CATHETER IN PLACE



WHICH PATIENT NEEDS A URINARY CATHETER

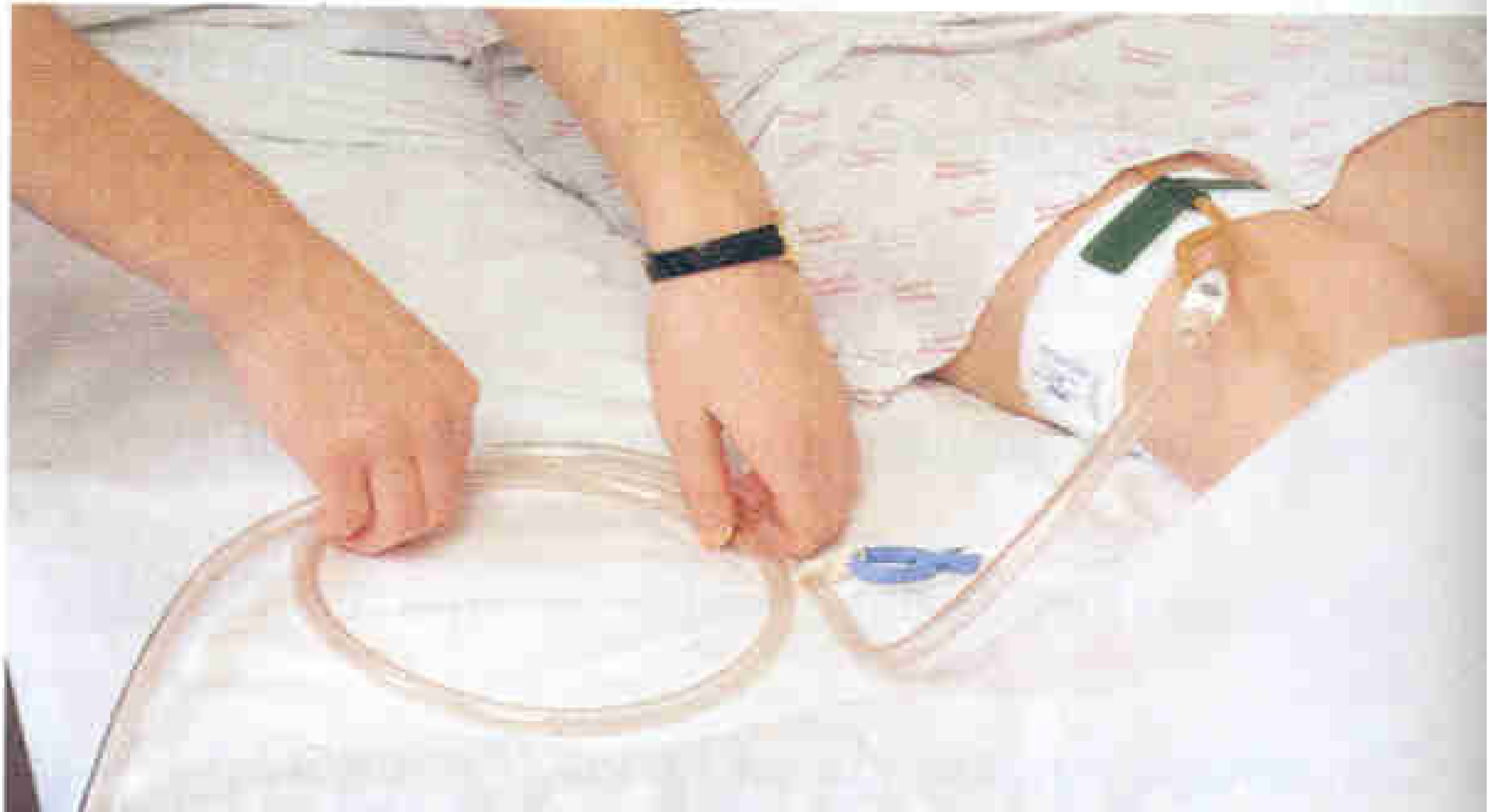
- TOO WEAK
- DISABLED
- POST SURGICAL
- PROTECT WOUNDS OR PRESSURE ULCERS
- FREQUENT URINARY MEASUREMENTS

DRAINAGE BAG

- THE END OF THE CATHETER IS ATTACHED TO A DRAINAGE BAG

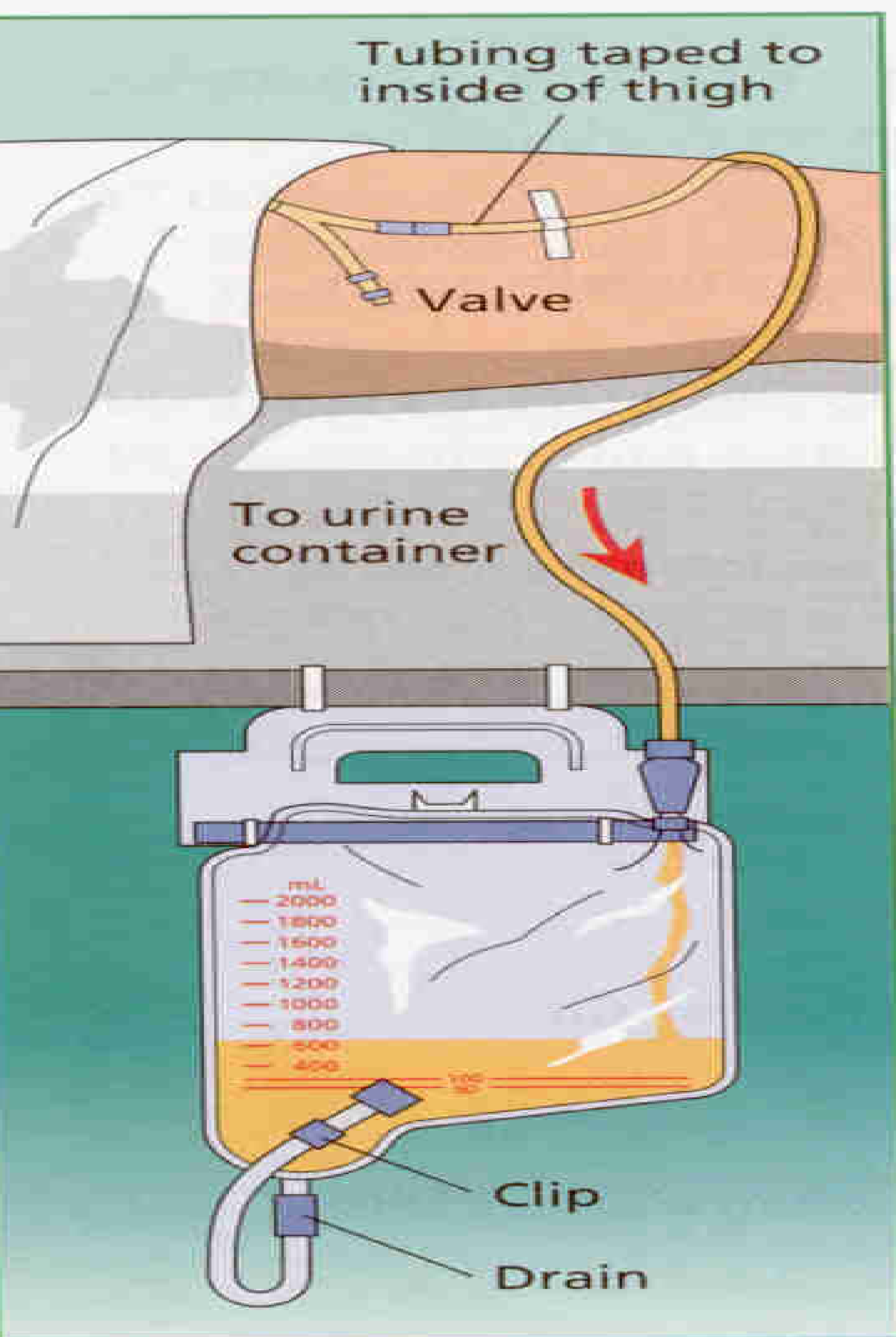
NURSING CARE FOR PATIENT WITH AN INDWELLING CATHETER

- LEAVE THE SYSTEM CLOSED AS MUCH AS POSSIBLE
- DO NOT ALLOW THE BAG OR TUBING TO TOUCH THE FLOOR
- ALWAYS KEEP THE DRAINAGE BAG BELOW THE LEVEL OF THE BLADDER
- KEEP THE CATHETER AND DRAINAGE TUBING FREE OF KINKS
- ATTACH THE DRAINAGE BAG TO THE BEDFRAME – NEVER THE SIDERAIL



THE DRAINAGE TUBING IS COILED ON THE BED AND CLAMPED TO THE BOTTOM LINEN TO PREVENT KINKING OF THE TUBING.

SLACK IS LEFT ON THE CATHETER TO PREVENT PULLING.



NOTICE THE

CATHETER TAPED TO

THE INNER THIGH.

NOTICE THE DRAINAGE

BAG HOOKED ON THE

BEDFRAME.

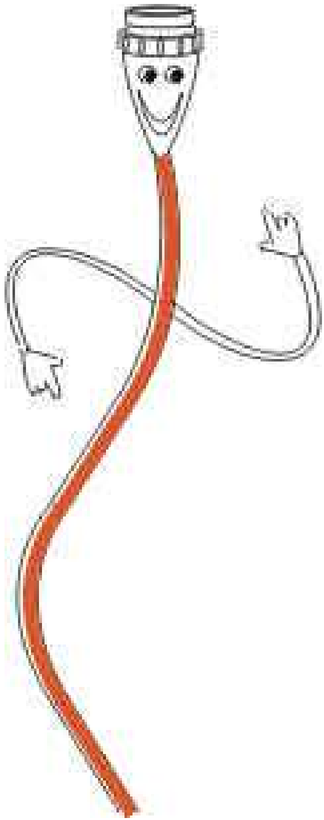
USE OF LEG BAG

- USE A LEG BAG ONLY WHEN THE PERSON IS AMBULATORY OR SITTING IN A CHAIR—NEVER WHEN IN BED
- A LEG BAG HOLDS ABOUT 1000 CC OF URINE, A DRAINAGE BAG HOLDS 2000 CC.

IF A DRAINAGE SYSTEM IS ACCIDENTALLY DISCONNECTED:

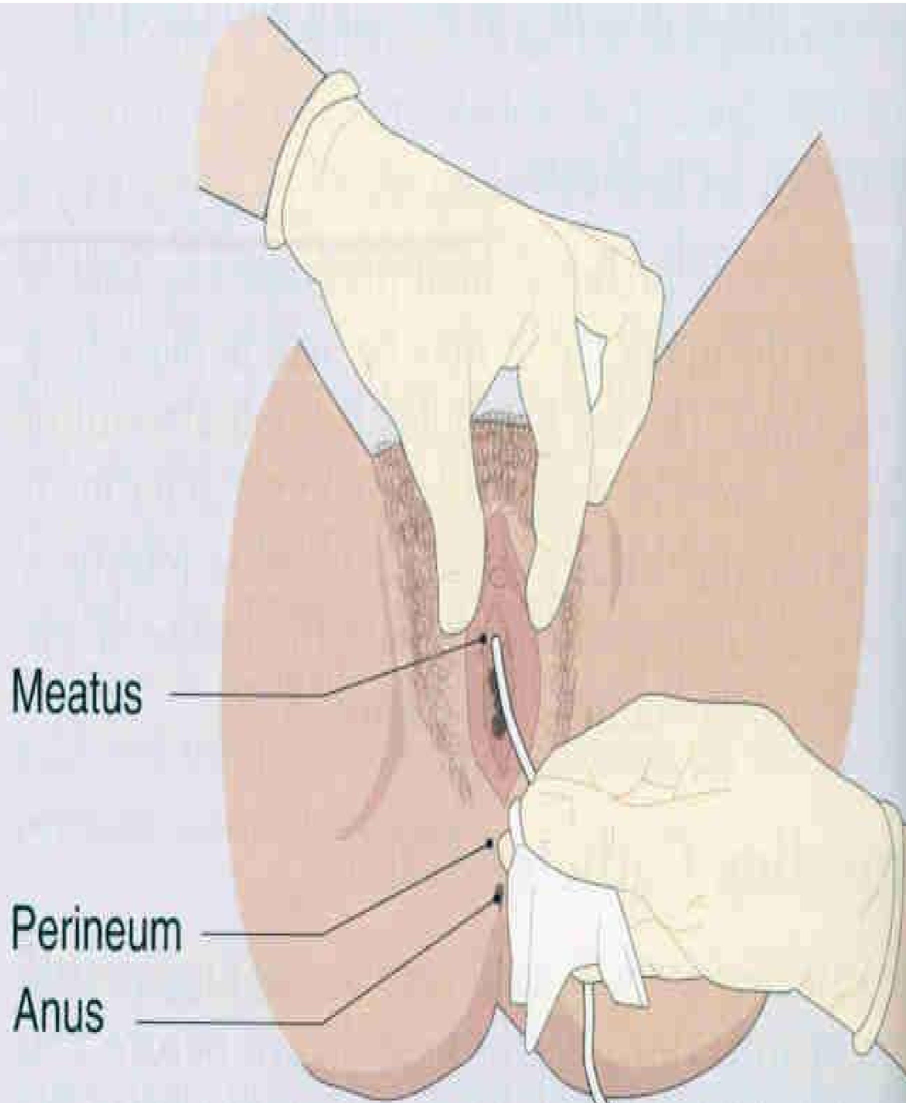
- Tell the nurse at once.
- Do not touch the ends of the catheter or tubing.
- Practice hand hygiene and put on gloves.
- Wipe the end of the tube with an antiseptic wipe.
- Wipe the end of the catheter with another antiseptic wipe.
- Do not put the ends down.
- Do not touch the ends after you clean them.
- Connect the tubing to the catheter.
- Discard the wipes into a biohazard bag.
- Remove the gloves and practice hand hygiene.

CATHETER CARE



- THE CATHETER SITE WILL NEED REGULAR CLEANING TO HELP PREVENT INFECTION
- WEAR GLOVES AND FOLLOW STANDARD PRECAUTIONS
- WASH AWAY FROM THE URINARY MEATUS
- CLEAN FOUR INCHES DOWN THE CATHETER
- USE A DIFFERENT PART OF THE WASHCLOTH OR A CLEAN ANTISEPTIC WIPE FOR EACH STROKE

CATHETER CARE



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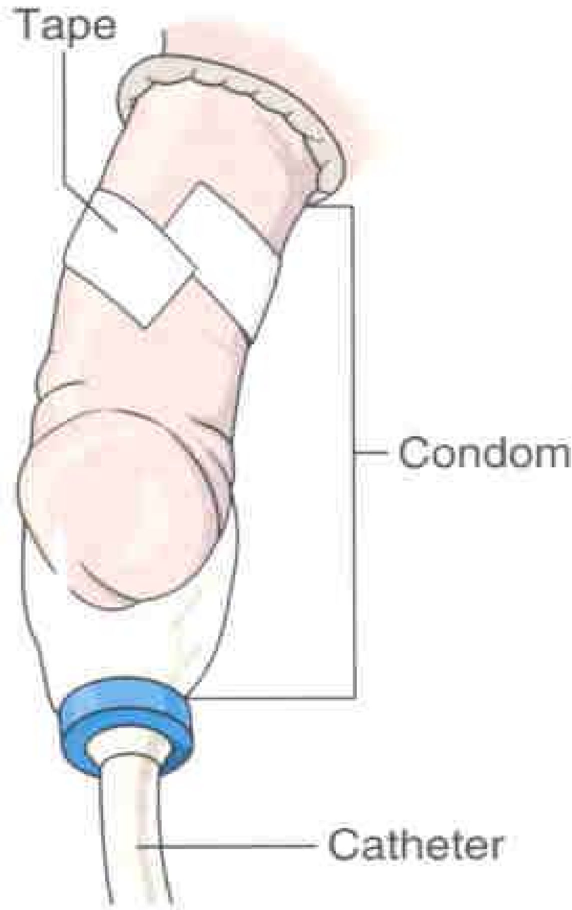
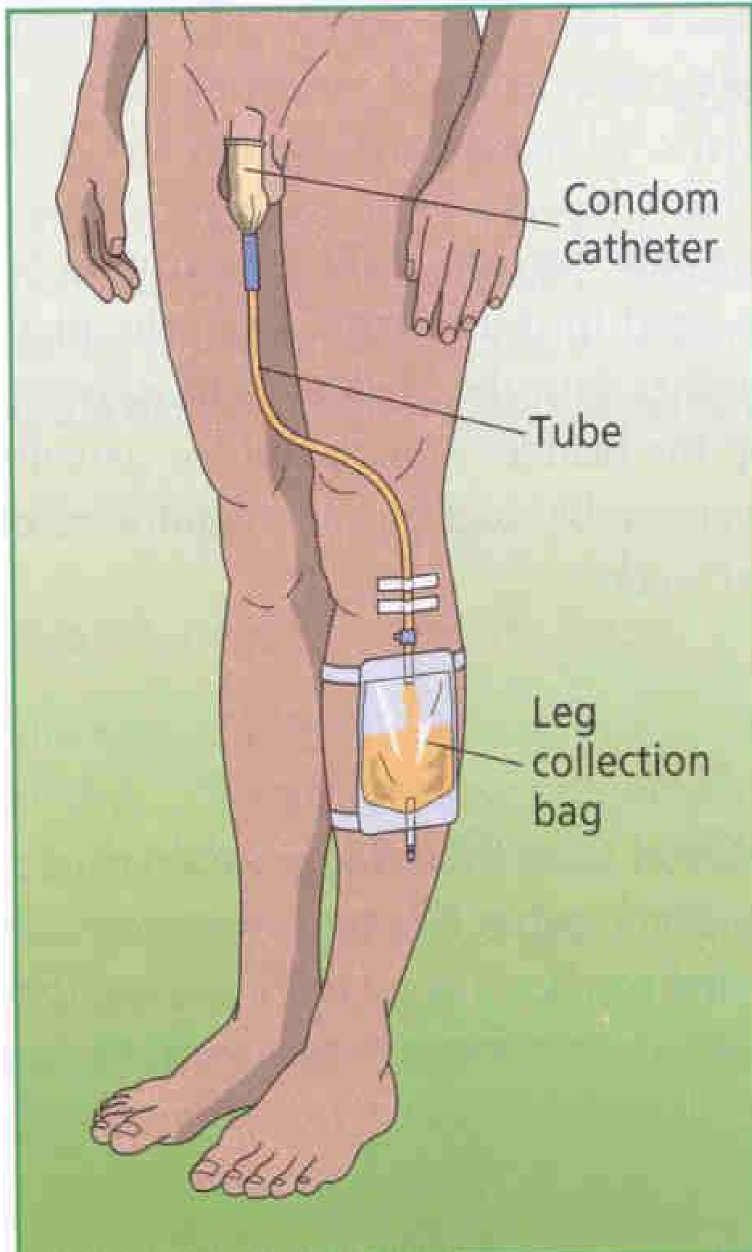
EXTERNAL CATHETER



- ALSO CALLED A:
  - ✓ CONDOM CATHETER
  - ✓ TEXAS CATHETER

- USED FOR THE INCONTINENT MALE PATIENT

- APPLY TAPE IN A SPIRAL MOTION



EXTERNAL CATHETER

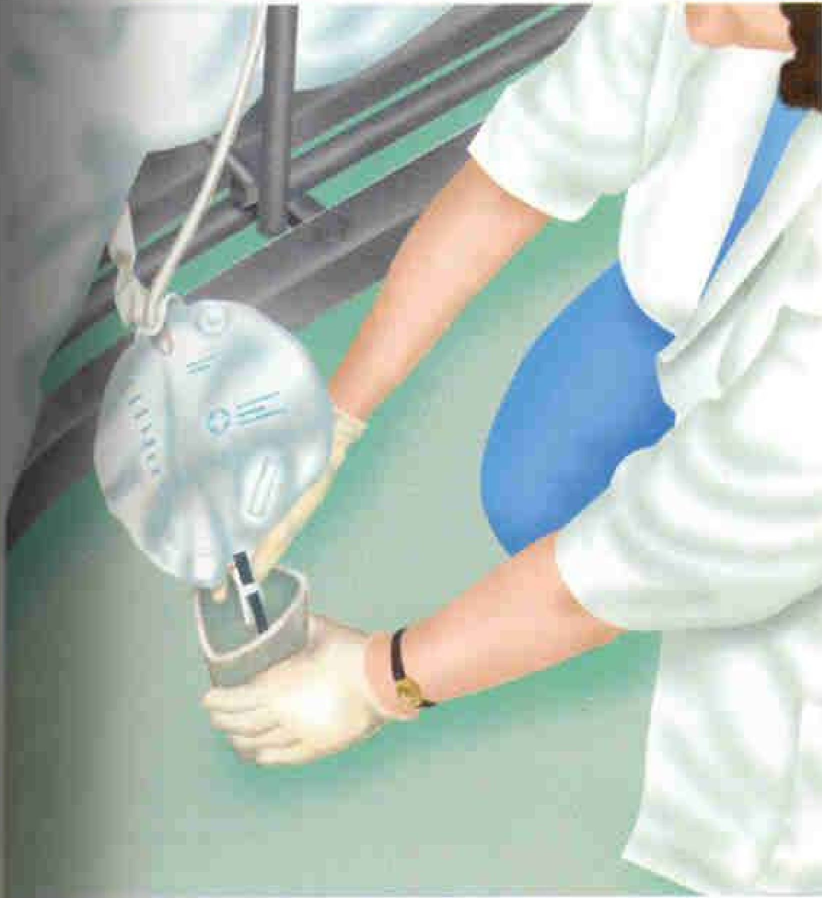
MOST FACILITIES CHANGE THE EXTERNAL CATHETER ON A DAILY BASIS.

PERFORM PERINEAL CARE BEFORE REAPPLYING THE EXTERNAL CATHETER

NOTE THAT THE CATHETER IS TAPED TO THE PERSON'S LEG TO KEEP IT FROM PULLING.

EMPTYING THE URINARY DRAINAGE BAG

- EMPTY THE BAG AT THE END OF EACH SHIFT
- MEASURE AND RECORD THE AMOUNT OF URINE PRESENT
- RECORD THE AMOUNT ON THE INTAKE AND OUTPUT SHEET
- USE A GRADUATE TO MEASURE THE AMOUNT OF URINE
- CHECK THE AMOUNT OF URINE IN THE BAG AT FREQUENT INTERVALS
- FOLLOW STANDARD PRECAUTIONS AND WEAR GLOVES



UNCLAMP THE SPOUT AND EMPTY THE DRAINAGE BAG INTO THE GRADUATE.

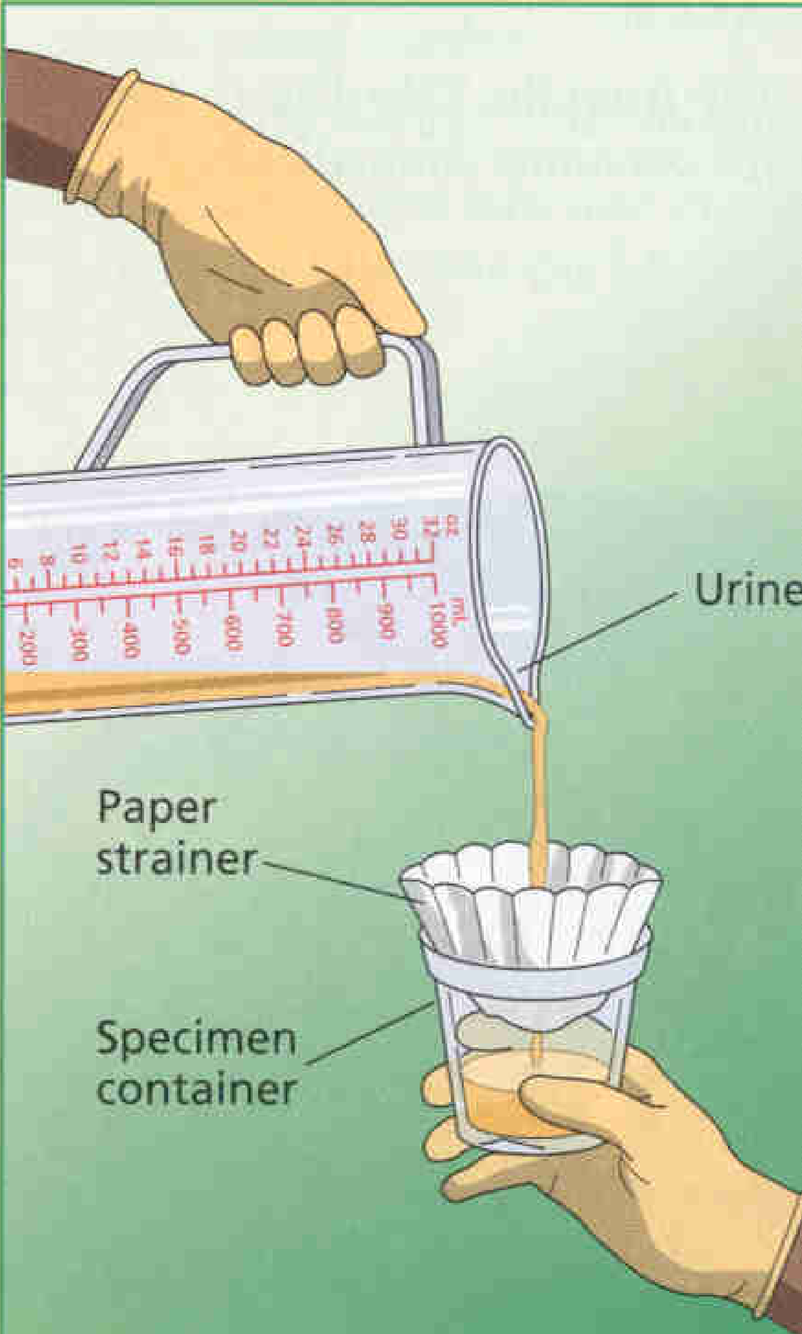
BLADDER TRAINING

THE GOAL IS TO RESTORE URINARY CONTINENCE

- SET UP A SCHEDULE TO ENCOURAGE VOIDING AT SCHEDULED INTERVALS
- BE CONSISTENT

CATHETERIZED PATIENTS

- INCREMENTS. START WITH 1 – 2 HOUR INTERVALS.
- EVENTUALLY CLAMP FOR 3 – 4 HOURS AT A TIME BEFORE REMOVING



STRAIN URINE

URINE IS STRAINED WHEN KIDNEY STONES ARE SUSPECTED.

IF ANY MATERIAL IS LEFT IN THE STRAINER IT IS SENT TO THE LAB FOR ANALYSIS.

URINE SPECIMENS

RULES FOR COLLECTING URINE SPECIMENS

- USE STANDARD PRECAUTIONS
- LABEL THE CONTAINER BEFORE COLLECTING THE SPECIMEN
- DO NOT TOUCH THE INSIDE OF THE CONTAINER
- IDENTIFY THE PATIENT
- THE SPECIMEN CAN NOT BE MIXED WITH BOWEL MOVEMENT
- DO NOT PUT TOLIET TISSUE IN WITH THE SPECIMEN
- TAKE THE SPECIMEN TO THE DESIGNATED PLACE

- WEAR GLOVES AND FOLLOW STANDARD PRECAUTIONS

•REMOVE SPECIMEN COLLECTOR FROM THE TOLIET

NOTE AMOUNT IF PATIENT IS ON INTAKE AND OUTPUT

- CAREFULLY POUR SPECIMEN

FROM COLLECTOR INTO THE

SPECIMEN CONTAINER

TYPES OF URINE SPECIMENS

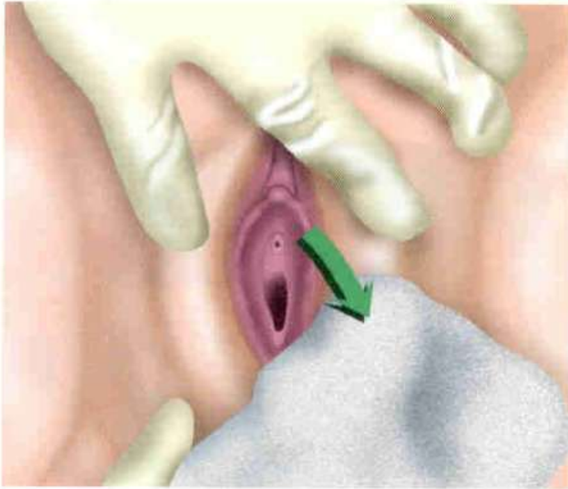
RANDOM URINE SPECIMEN

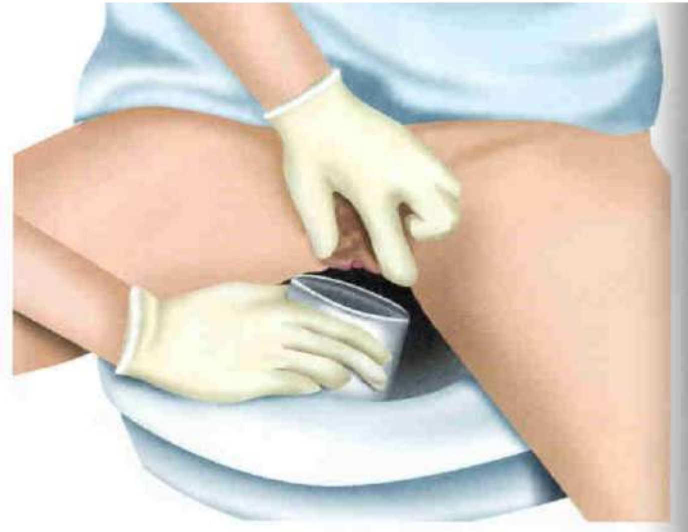
MIDSTREAM URINE SPECIMEN

24 – HOUR URINE SPECIMEN

DOUBLE VOIDED URINE SPECIMEN

MIDSTREAM URINE SPECIMEN
ALSO CALLED
CLEAN – CATCH URINE SPECIMEN





- CLEAN THE PERINEAL AREA BEFORE COLLECTING THE SPECIMEN

- HAVE PATIENT BEGIN VOIDING, STOP, PLACE THE SPECIMEN CONTAINER, THEN RESUME VOIDING

24 HOUR URINE SPECIMEN

- ALL URINE VOIDED DURING A 24 – HOUR PERIOD IS COLLECTED

- URINE IS KEPT CHILLED (ON ICE OR IN REFRIGERATOR)

- MAY NEED PRESERVATIVE ADDED

- VOID TO BEGIN TEST – DISCARD THIS URINE

- COLLECT FOR NEXT 24 HOURS

- VOID TO END TEST – COLLECT THIS URINE

DOUBLE VOIDED SPECIMEN

ALSO CALLED

FRESH – FRACTIONAL URINE

- USED FOR DIABETICS
- PERSON VOIDS TO EMPTY BLADDER OF "OLD" URINE
- IN 30 MINUTES THE PATIENT VOIDS AGAIN
- USED TO TEST FOR GLUCOSE AND KETONES
- GLUCOSURIA – SUGAR IN URINE
- KETONES (acetone) – PRODUCED BY THE BREAKDOWN OF FAT

SPUTUM SPECIMEN

MUCUS FROM THE RESPIRATORY SYSTEM

SPUTUM CHECKED FOR BLOOD, MICROBES, AND ABNORMAL CELLS

THE PERSON COUGHS UP SPUTUM FROM THE BRONCHI AND TRACHEA.

IT IS BEST TO COLLECT A SPECIMEN IN THE MORNING.

THE PERSON CAN RINSE HIS MOUTH WITH WATER BUT MAY NOT USE MOUTHWASH.