Procedure: Clean Intermittent Catheterization, Female

Trainee Name: ______________________ Title: __________ Date: ________

Procedure steps	Rationale	Evaluator Initials/Date	Evaluator Initials/Date	Evaluator Initials/Date
1. Check orders.	Verify orders are current. CIC is usually ordered every 3-6 hours to prevent infection, leakage, and kidney damage.			
2. Wash hands.				
3. Prepare and set up supplies a. Catheter b. Water soluble lubricant c. Wipes d. Urine collector e. Gloves f. Mirror (if applicable)	Encourage participation by involving the student in checking and gathering necessary supplies. Open necessary products before beginning the procedure. Be mindful to have a clean and uncluttered work area.			
4. Explain procedure at student's level of understanding.	Use anatomical names for body parts. Talking to student about process will help them to recall steps. Encourage participation with supervision for student to achieve self-care skills.			
5. Position student.	CIC may be done lying down, sitting, or on toilet. A PT/OV evaluation may be helpful.			
6. Put on gloves.	CIC uses clean technique. If student is self-cathing or using a closed-system catheter, gloves may not be necessary.			
7. Lubricate tip of catheter.	Depending on the type/brand of catheter, lubricant may be packaged separately from or together with the catheter. (For example, a closed-system catheter may already contain a lubricated-tip catheter once cap is			

	removed.)			
8. Separate and hold the labia open. Use wipes or towelettes to clean around the urethra, once down each side and once down the middle of the labia from front to back.	Visualize and clean the area, moving bacteria away from the insertion site.			
9. Locate urethral opening. Gently insert catheter about 2-3 inches until urine begins to flow. Rotate catheter so that catheter openings have reached the bladder.	Encourage relaxation and deep breathing to relax the bladder as catheter is inserted. Some resistance may be felt prior to the catheter reaching the bladder as it passes the sphincter. Do not force catheter and report any unusual resistance. Once urine begins to flow, ask student to bear down or gently press on abdomen to help empty the bladder.			
10. When urine flow stops, pinch catheter as you withdraw catheter.	Pinch catheter and remove in a downward direction to prevent backflow of urine into the bladder.			
11. Assess urine output.	Note changes in color, odor, and amount. Note unusual leakage between catheter times.			
12. Remove gloves and wash hands.	Rinse supplies using warm water and mild soap, as appropriate. Air dry to prevent residue or bacteria. Store in clean area or refrigerate.			
13. Document.				

Evaluator Initials　　　Evaluator signature

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