Collecting a Urine Specimen from a Closed Drainage System

Purpose
The purpose of this procedure is to obtain an uncontaminated urine specimen from a resident with a catheter.

Preparation
1. Verify that there is a physician’s order for this procedure.
2. Review the resident’s care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

General Guidelines
1. Do not touch the inside of the specimen container or the inside of the lid.
2. Place the lid on the specimen container as soon as the specimen is obtained.
3. Do not leave the bedside after you have clamped the catheter tubing.
4. Do not leave clamps on the catheter tube any longer than necessary to collect the specimen.
5. Use caution when handling needles to avoid needlestick injuries.

Equipment and Supplies
The following equipment and supplies will be necessary when collecting a urine specimen from a closed drainage system:

1. Alcohol swab;
2. Needle and syringe (capped);
3. Specimen container (with lid);
4. Label;
5. Pen or pencil;
6. Clear plastic specimen bag;
7. Plastic trash bag;
8. Paper towel;
9. Sharps container; and
10. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Note: In most facilities, a disposable collection kit is used to obtain this specimen. However, the equipment is listed to familiarize you with the equipment should a kit not be available.

Steps in the Procedure
1. Wash your hands thoroughly before beginning the procedure.
2. Place equipment on the bedside stand or overbed table. Arrange your supplies so that they can be easily reached.
3. Close the clamp on the drainage tube below the speci-port. (Note: Do not leave the resident after you have clamped the tube. Leave the clamp in place only long enough to collect the specimen.)
4. Cleanse the speci-port with the alcohol swab. Discard the swab into the designated container.
5. Remove the needle cover from the syringe.
6. Insert the needle into the speci-port. Pull gently back on the plunger to obtain the required amount of urine. (Note: Usually two [2] ccs are required.)
7. Remove the needle and syringe from the speci-port. Cleanse the speci-port with an alcohol swab.

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Steps in the Procedure (continued)

8. Open the clamp from drainage tubing. Be sure the urine is now running freely down the tubing into the collection bag.

9. Place the needle of the syringe into the specimen container. Push the plunger to expel the urine into the specimen container. Do not touch the inside of the specimen container.

10. Place the lid on the specimen container. Do not touch the inside of the lid.

11. Prepare the label for the container. Record the resident’s name, room number, and the date and time.

12. Place the label on the container.

13. Put the specimen container into the clear plastic bag. Seal the bag.

14. Discard the needle and syringe into designated sharps container. (Note: Do not recap the needle.)

15. Remove protective clothing, if worn. Discard into the designated container.

16. Wash and dry your hands thoroughly.

17. Reposition the bed covers. Make the resident comfortable.

18. Place the call light within easy reach of the resident.

19. If the resident desires, return the door and curtains to the open position.

20. Discard all used disposable supplies into designated containers. Remove from room and discard into designated containers.

21. Place soiled reusable equipment into a plastic trash bag. Tie the bag.

22. As you leave the room, take the trash bags with you to the soiled utility room.

23. If the resident desires and if visitors are waiting, tell them that they may now enter the room.

24. Give the specimen to the staff/charge nurse.

25. Wash and dry your hands thoroughly.

Documentation

The following information should be recorded in the resident’s medical record:

1. The date and time that the specimen was collected.
2. The name and title of the individual(s) who performed the procedure.
3. The character, clarity and color of urine.
4. All assessment data obtained during the procedure.
5. How the resident tolerated the procedure.
6. If the resident refused the procedure, the reason(s) why and the intervention taken.
7. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

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