Emptying a Urinary Drainage Bag

Purpose

The purposes of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain a sterile specimen.

Preparation

1. Review the resident's care plan to assess for any special needs of the resident.
2. Assemble the equipment and supplies as needed.

General Guidelines

1. Empty the urinary drainage bag at least every eight (8) hours or more often if needed to keep the bag from becoming full.
2. Empty only one urinary drainage bag at a time using a clean and separate measuring container for each resident.
3. Do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (**Note:** If accidental contamination occurs, wipe the drain spout with an alcohol sponge or swab.)
4. Always check the tubing when emptying a urinary drainage bag to be sure there are no kinks and that the urine is draining freely.
5. Observe the character of the urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.
6. Always attach the drainage bag to the bedframe—never to the side rails.
7. Never disconnect the drainage bag from the catheter.
8. Keep the drainage bag below the level of the resident's bladder.
9. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure:

1. Measuring container (calibrated);
2. Alcohol sponge or swab;
3. Paper and pencil/pen;
4. Intake and output record;
5. Paper towels; and
6. Personal protective equipment (e.g., gloves).

Steps in the Procedure

1. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached.
2. Wash and dry your hands thoroughly.
3. Put on disposable gloves.
4. Place a paper towel on the floor beneath the drainage bag.
5. Position the measuring container under the drainage bag.
6. Remove the drain tube from its holder.
7. Open the drainage bag and let the urine flow into the measuring container.
8. After the drainage bag has emptied, close the drain.
9. Wipe the drain with an alcohol sponge or swab if accidental contamination occurs. Discard the sponge or swab into the designated container.
10. Replace the drain tube back into its holder.

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Steps in the Procedure (continued)

11. Measure and record the urinary output, if indicated.
12. Pour urine down the commode. Flush the commode.
13. Rinse out the measuring container and return to its designated storage area.
14. Discard all disposable items into designated containers.
15. Remove gloves and discard in designated container. Wash and dry your hands thoroughly.
16. Clean the bedside stand and/or overbed table. Return the overbed table to its proper position.
17. Wash and dry your hands thoroughly.
18. Reposition the bed covers. Make the resident comfortable.
19. Place the call light within easy reach of the resident.
20. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.

Documentation

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

1. The date and time the procedure was performed.
2. The amount of urine emptied from the drainage bag.
3. Kinks in the tubing that cannot be corrected by simple repositioning.
4. Leaking of urine from the tubing.
5. Lack of urine drainage through the tubing.
6. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.
7. How the resident tolerated the procedure.
8. If the resident refused the procedure, the reason(s) why and the intervention taken.
9. All assessment data obtained during the procedure.
10. The name and title of the individual(s) who performed the procedure.

Reporting

1. Notify the Charge Nurse if the resident refuses the procedure, or if there is leaking of urine from the tubing.
2. Notify the physician if there is any sediment in urine or if the urine has a strong odor.
3. Report other information in accordance with facility policy and professional standards of practice.