

SAMPLE Policy and Procedure Insertion, Removal and Care of an Indwelling Foley Catheter

Approved by: Policy and Procedure Committee
Effective: x/xx
Revised: x/xx

Description: This policy provides the procedure to ensure the safe, sterile placement and removal of the Foley catheter. It also provides guidelines for catheter care and specimen collection from the catheter.

Accountability: The physician is responsible for writing the order for placement of the Foley catheter. The registered nurse, licensed practical nurse, advanced care partner, emergency medical technician or paramedic is responsible for placing an indwelling urinary catheter (Foley catheter). The above personnel must have demonstrated the knowledge and skills to perform this procedure as evidenced by verification on a competency checklist.

Instructions for Specialty Temperature Sensing Foley: **If temperature sensing foleys are clinically indicated, they are to be utilized in the Operating Room, Emergency Department and Critical Care Units only. Temperature sensing foleys are NOT MRI compatible. If a patient is to receive an MRI scan, the temperature sensing foley catheters MUST be removed and a non temperature sensing foley is to replace it prior to leaving the clinical area for the MRI scan.**

Policies/Procedures:

1. **Identify the patient using the required two patient identifiers.**
2. Verify that the patient is not allergic to latex, iodine or betadine. If the patient is sensitive or allergic to latex, replace the catheter in the kit with a silicone catheter. If the patient is allergic to iodine or betadine, use an alternate cleanser such as Hibiclens.
3. Gather equipment: Foley catheter kit (use non-latex for patients with latex allergies). Use the smallest size catheter that is appropriate.
4. Explain the procedure to the patient and wash your hands **or perform hand hygiene.** Maintain the patient's privacy and dignity.
5. **Consider washing the patient's genital area before the procedure if visibly soiled. Don non-sterile gloves, wash patient's genital area thoroughly with foam body cleanser (4:1 body cleanser) or Ready cleanse™ wipes Remove gloves and wash hands/hand hygiene.**
6. General Insertion Procedures
 - a. Visually inspect the product for any imperfections or surface deterioration prior to use. If any damage is noted or the package has been opened, do not use.
 - b. Don protective eye wear**
 - c. Using aseptic technique, open the outer plastic wrap to form a sterile field and place the underpad beneath the patient, plastic side down.**
 - d. Position the sterile fenestrated drape around the patient's genitalia.

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- e. **Apply sterile gloves and use strict sterile technique for the foley insertion procedure.**
 - f. Before insertion, dispense the lubricating gel into the kit tray, pour cleansing solution over three cotton balls, remove the plastic sleeve from the catheter and lock the sterile water syringe into the port. **DO NOT PRE-INFLATE THE BALLOON PRIOR TO INSERTION.**
 - g. Using the dominant, sterile hand to handle the catheter, cover the tip of the catheter with lubricant. Insert the foley through the urethra into the bladder.
 - h. Instruct the patient to inform the nurse if any discomfort is felt with inflation of the balloon. If discomfort is felt, the catheter is most probably in the urethra and will need to be deflated and advanced. Inflate the balloon slowly, using the entire 10 cc of sterile water. Withdraw the catheter slowly to the point of resistance at the bladder neck.
7. Female Insertion Procedure
- a. Position female patient into a frog-leg pose.
 - b. Separate the labia using the non-dominant hand and visualize the meatus. Grasp one cotton ball with the forceps, wipe one side of the labia from top to bottom and discard the cotton ball away from the sterile field. Repeat on the opposite side and then wipe down the middle using the third cotton ball. Then wipe the area with the dry cotton balls.
 - c. Insert the catheter approximately three inches, wait to see if urine flows, then advance another inch before inflating balloon.
 - d. For unconscious female patient's or those with decreased sensation (i.e. paralyzed), insert the catheter slightly further than three inches, to make certain the catheter is in the bladder.
8. Male Insertion Procedures
- a. Position male patients into a supine pose.
 - b. Retract the foreskin, if present, and hold the shaft of the penis with the non-dominant hand. Grasp one solution-soaked cotton ball with the forceps. Using a circular motion, wipe the glans from the meatus outward. Discard the cotton ball away from the sterile field. Repeat with two more cotton balls. Then wipe the area dry with the dry cotton balls.
 - c. Grasp the penis in an upright position and insert the lubricated catheter firmly into the meatus, advancing the catheter to the bifurcation at the 'Y' of the catheter. A slight lean toward the umbilicus may be necessary if resistance in advancing the catheter is met at the prostate.
 - d. The return of urine does not assure that the catheter is placed correctly in males, since there is residual urine in the penis. Inserting the catheter to the bifurcation of the Y is the standard for assurance of proper placement.
 - e. If the foreskin was retracted, reposition it after placement.
 - f. **If catheter placement is in question (i.e. no urine return or unable to fully insert the catheter) do not inflate the balloon and contact the physician.**
 - g. **If resistance is met do not attempt forceful catheter insertion; apply continuous gentle pressure and ask the patient to take slow deep breaths to help relax or instruct the patient to try to void to open the sphincter and allow the catheter to pass.**

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9. Complete the procedure
 - a. **Secure the catheter to the patient's thigh with hospital approved catheter securement device (ie: Stat Lock) to prevent movement, irritation, and decrease risk of infection.** To improve urine flow, some men may need to have the catheter secured slightly upward. For males with long-term catheters, the catheter should be taped to the abdomen to prevent damage to the inferior urethra.
 - b. **Position the bag to avoid urine reflux into the bladder, kinking, or gross contamination of the bag.** For inpatient setting, position the bag hanger on the bed rail near the foot of the bed using the clip to secure the drainage tube to the sheet. **Keep the bag below the level of the bladder at all times to prevent the backflow of urine and decrease the risk for infection.** Never leave the catheter hanging to be pulled by the weight of the bag **Do not leave the bag laying on the floor unless necessary due to patient positioning (i.e. trendelenburg position in the Operating Room).**
 - c. Periodic observations of the system should be made to ensure that urine is flowing freely. If a standing column of urine is observed, check for correct positioning of the bag and then for a physical obstruction, such as a kink in the tubing.
 - d. If correct positioning of the bag or removal of physical obstruction does not allow free flow, the bag may have to be changed.
10. Directions for removal
 - a. Deflate the catheter balloon by negative pressure.. Exercise the plunger of a leur-tipped 10 ml syringe by moving up and down within the syringe barrel. Pull back 0.5 ml air in the syringe to prevent adherence of the plunger to the end of the syringe barrel, then insert the syringe into the balloon port. (This allows for automatic flow of instilled liquid and balloon deflation via negative pressure in the syringe.) Never use more force than is required to make the syringe "stick" in the valve. Use gentle aspiration, only if needed, to encourage deflation.
 - b. Allow the pressure within the balloon to push the plunger back and fill the syringe with water.
 - c. **NEVER FORCE THE WATER INTO THE SYRINGE.** Vigorous aspiration may collapse the inflation lumen, preventing balloon deflation. Allow 30 seconds for the balloon to deflate.
 - d. If there is slow or no deflation, re-seat the syringe gently.
 - e. If the retention balloon still does not deflate, reposition the patient to ensure catheter is not in traction or compressed within the bladder.
 - f. If this fails, contact the charge RN and the physician.
 - g. **Consider a bedside commode if the patient is not fully ambulatory.**
11. Directions for bladder scanning:
 - a. **If the patient does not void within 4-6 hours of removing the foley catheter, a bedside bladder scan ultrasound should be obtained.**
 - b. **If the bladder volume is less than 500mL, encourage the patient to void by using techniques to stimulate bladder reflex (cold water to abdomen, stroke inner thigh, run water, flush toilet). Continue to assess the patient and repeat the bladder scan in 2 hours if the patient has not voided.**
 - c. **If the bladder volume is greater than 500mL, catheterize for residual urine volume rather than place an indwelling foley catheter.**

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12. Patient care and considerations
 - a. **Always use sterile technique when inserting a foley catheter.**
 - b. Document the following:
 1. procedure, including the size of the catheter placed, the color, amount, and clarity of urine returned after the initial placement, and patient response.
 2. Catheter removal
 3. Use of the bladder scanner, amount of residual volume, need for intermittent catheterization.
 - c. Record urine output as ordered.
 - d. Assess the patient for pain during and after procedure. Provide pain relief measures as indicated and document response.
13. Infection control considerations
 - a. Wash hands or perform hand hygiene immediately before and after any manipulation of the catheter site or drainage bag.
 - b. **Clean the perineal area and catheter tubing proximal to distal, with foam body cleanser (4:1 body cleanser) or Ready cleanse™ wipes daily and after every bowel movement. The meatal area should not be aggressively cleansed or cleansed with antiseptic solutions as this can lead to meatal aggravation and increase the likelihood of infection.**
 - c. **If a foley catheter has been in place for 3 days or longer, the nurse should provide daily reminders to the physician recommending the removal of the foley catheter (unless the foley catheter is still indicated). Indications for continued foley usage include: unresolved urinary retention, urinary tract obstruction, critically ill patients, acute renal insufficiency fluid challenge, comfort care of the terminally ill, to promote healing on an area of skin breakdown, to provide medications directly to the bladder, and for the management of neurogenic bladder.**
 - d. **Provide patient and family education regarding the benefits of removing the foley. Encourage use of the bedside commode or bathroom within 4-6 hours after the foley is removed.**
 - e. **To obtain a urine specimen, clean the sample port with alcohol and aspirate urine using a blunt needle (or leur lock syringe) and a 10 cc syringe.**
 - f. A sterile, continuously closed drainage system should be maintained. If the catheter must be disconnected from the tubing, disinfect the catheter-tubing junction before separating.
 - g. **Empty the foley bag every 8 hours, or when the drainage bag is 2/3 full, to avoid traction on the catheter from the weight of the drainage bag and prevent infection. Take care not to contaminate the drainage port by touching the collection container or floor when emptying.**
 - h. **When transporting patient, maintain position of drainage bag below the level of the patient's bladder, to prevent reflux of contaminated urine from the bag to the bladder. Transport personal should be instructed to wash their hands prior to transporting a patient with a foley catheter. The catheter bag should be empty prior to transport to prevent reflux.**
 - i. **If possible do not place more than one patient with a urinary catheter in the same room to prevent cross contamination.**

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- j. If foley catheter is to remain indwelling for 30 days, obtain an order for foley catheter and bag change at 30 day intervals.
- k. Do not irrigate a foley catheter unless indicated for post urology /genitourinary trauma, surgery, or in the ICU to relieve obstruction.

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