TITLE: BLADDER CATHETERIZATION — INSERTION, CARE, MANAGEMENT, REMOVAL, ALTERNATIVES FOR PLACEMENT AND URINARY RETENTION MANAGEMENT—ADULT (FOLEY) (cat05)

DATE: 05/86
REVIEWED: 1/17
PAGES: 1 of 16

ISSUED FOR: Nursing

RESPONSIBILITY: RN, LPN, *(Patient Care Tech/Multi-skilled Tech – Foley care and removal only)

PURPOSE:
1. To remove urine from the bladder using sterile technique.
2. To provide continuous drainage of urine and treatment when necessary.
3. To prevent urinary tract infections.
4. To avoid unnecessary use of retention catheters.
5. To ensure necessary documentation.

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APPROPRIATE INDICATIONS/Criteria:

Appropriate Indications/Criteria for an indwelling urinary catheter (IUC) include:

1. **Acute urinary retention or obstruction**
   - without bladder outlet obstruction such as:
     1) Medication-related urinary retention
     2) Acute neurogenic bladder.
   - with bladder outlet obstruction such as:
     1) Exacerbation of benign prostatic hypertrophy
     2) Acute prostatitis and urethral trauma
     3) Gross hematuria with obstruction related to blood clots
     4) May be appropriate for **chronic** urinary retention with bladder outlet obstruction.

   **NOTE:** Patients with chronic urinary retention **without bladder outlet obstruction** such as neurogenic bladders or spinal cord injury are often best managed by non-indwelling methods such as intermittent straight catheterization.

   **NOTE:** Urology consultation should be considered for most appropriate catheter type and/or expert placement in cases with bladder outlet obstruction.

2. **Need for accurate measurement of urinary output in critically ill patients.**
   - To manage critical illness such as:
     1) Hemodynamic instability and frequent titration of life-supportive therapy (e.g., vasopressors or inotropes)
   - To measure *daily* urine output if *required* to provide medical treatment and cannot be assessed by alternative strategies

3. **Perioperative use for selected surgical procedures.**
   - For a surgery that it is anticipated:
     1) To be prolonged
     2) To require large-volume infusions or diuretics
     3) To need intraoperative urinary output monitoring
     4) To be performed on or in proximity of the genitourinary tract

4. **To assist in the healing of stage III or IV sacral or perineal wounds in incontinent patients.**
   - When there is concern that urinary incontinence is leading to worsening skin integrity in areas where skin breakdown already exists that cannot be kept clear of urinary incontinence despite wound care and other urinary management strategies.
Note: Urinary catheters should not be used as a substitute for the use of skin care, skin barriers, and other methods to manage incontinence and limit skin breakdown.

5. Patients with prolonged immobilization.
   a. An indwelling urinary catheter may be needed when:
      1) Turning causes hemodynamic or respiratory instability
      2) Weight exceeds 300 pounds and impairs nursing care
      3) Patients require strict temporary or prolonged immobilization following specific types of trauma or surgery. e.g.:
         • instability in the thoracic or lumbar spine
         • multiple traumatic injuries such as pelvic fractures, and
         • acute hip fracture when there is risk of displacement with movement prior to surgical repair

6. Hospice/comfort/palliative care
   a. When it facilitates meeting patient and family goals in a dying patient or helps with patient comfort.

INAPPROPRIATE INDICATIONS/Criteria:

Urinary catheters should not be placed in the following situations:

1. Urine output monitoring that can be obtained by means other than an indwelling urinary catheter.
   a. Alternatives to indwelling catheters should be prioritized including:
      1) Male external ("condom") catheters
      2) Urinals
      3) Graduated collection containers ("hats") in the commode
      4) Accurate daily weights.

2. Incontinence without a sacral or perineal pressure sore
   a. Urinary catheters should not be routinely placed for management of urinary incontinence.

3. Prolonged postoperative use
   a. Urinary catheters should be promptly discontinued after surgery unless there is an appropriate indication for continued postoperative catheter use. (e.g. specific physician’s order)

4. Patients who are being transferred within or from an acute care facility
   a. Any handoff transition when a patient moves from one unit to another is an opportunity for the off going and oncoming staff to review together whether the patient has an indication for continued use of an indwelling
5. **Confusion or dementia**  
a. Confusion or dementia is not an appropriate indication for urinary catheter placement.

6. **Patient and or family request**  
a. Patient and or family request is not a sufficient reason for placement of a urinary catheter.

7. **Other inappropriate uses for indwelling urinary catheters, based on the Ann Arbor Criteria, include the following:**  
a. Attempting to reduce risk for falls by minimizing need to get up to urinate  
b. Post void residual urine volume assessment  
c. Random or 24-hour urine sample collection when collection by another strategy is feasible  
d. When patient is ordered for “bed rest” without a strict immobility requirement  
e. Attempting to prevent UTI in patients with fecal incontinence or diarrhea  
f. Management of frequent, painful urination in patients with UTI

**KNOWLEDGE BASE:**

1. A Catheter-Associated UTI Bundle (CAUTI Bundle) has been developed to promote best practices in regards to use of indwelling catheters.

2. **Optimize prompt removal of unnecessary urinary catheters by daily review of catheter necessity.**

3. **Nursing may generate a protocol in SCM (“Foley Catheter Insertion and Removal Protocol”) if the patient meets criteria for insertion or removal of an indwelling urinary catheter or contact the physician for orders.**  

**EXCEPTION: SCIP core measures guidelines:**

a. Foley catheter discontinued by post-op day 2  

1) **Nursing:**
   - Document Foley insertion date and time in SCM and GE  
   - Document Foley removal date and time in SCM and GE

2) **Physician:**
   - Document reason Foley catheter **not** removed when applicable

4. Utilize the SMHCS Urinary Retention Algorithm to govern nursing decisions if a patient is unable to void after an indwelling urinary catheter is removed.

5. Catheters are inserted using sterile technique and a new urinary catheter.
catheter kit must be used for each insertion/attempt.

6. In a surgical patient, the drainage bag and tubing should be kept on the non-operative side of the patient to minimize contamination of the surgical area.

7. When inserting a catheter, the balloon should not be inflated until urine flow is established assuring that the catheter is in the bladder, not the urethra. If urine flow is not obtained, determine if the bladder was empty at the time of insertion. Obtain a bladder scan to determine if bladder is empty, then make sure the catheter is advanced far enough before inflating the balloon to avoid injuring the urethra.

8. Catheters inserted in the hospital for long-term use, should be replaced after 30 days, if still clinically indicated.

9. Any patient admitted with a Foley catheter from outside SMH will have the catheter removed and replaced upon arrival to SMH if patient is assessed as still requiring it. EXCEPTION: Urology patients.

10. Urine culture stewardship: culture only when symptomatic.
   a. Do not culture because of odor, color, cloudiness or simply prolonged catheter use.
   b. If a urine culture is ordered on a patient that has had a Foley indwelling (non-urological patient) for 14 days or greater (due to the likelihood of bacterial colonization), remove the Foley and replace (if still clinically indicated) and then obtain a urine culture (physician order not required to change it).

11. Repeated attempts to catheterize the patient should be completed utilizing the following support system:
   a. The staff nurse first.
   b. If unable to catheterize patient, contact the intervention nurse for assistance.
   c. If still unsuccessful, contact the physician for a consult with a urologist.
   d. Once consult order obtained, contact the urologist to perform the catheterization.
   e. Obtain the Urology Cart which is kept in Sterile Processing as follows:
      - SPD can receive a requisition or a phone call from the unit needing the cart and SPD will have it ready for pick up and will sign it out to the department requesting it. We limit the in and out traffic of SPD staff, we do not make deliveries for House requests.
      - Once the GU cart has been used, cover the cart
with a plastic bag and attach a BIOHAZARD label to it prior to the transport of it back for decontamination as soon as possible after use (refer to SMH policy 00.IFC.16). Do NOT cover the GU cart with a red biohazard bag as they are to only be used for biomedical waste.

- Please return the Urology Cart to the Sterile Processing department where they will clean and restock the cart. If you have any concerns please bring it to the attention of Sterile Processing Manager, Suzin Vincent. On return to SPD the patient info on the inventory sheet that goes with the cart, (i.e. VID # or pt. sticker) as this cart is a patient charge. A flat fee is charged for the cart usage. SPD turns in the patient charge when restocked.

  f. If unable to catheterize patient, contact the intervention nurse for assistance.
  g. If still unsuccessful, contact the physician for a consult with a urologist.
  h. Once consult order obtained, contact the urologist to perform the catheterization
  i. Once the GU cart has been used, cover the cart with a plastic bag and attach a BIOHAZARD label to it prior to the transport of it back for decontamination as soon as possible after use (refer to SMH policy 00.IFC.16). Do NOT cover the GU cart with a red biohazard bag as they are to only be used for biomedical waste.

PATIENT EDUCATION:

- Explain the procedure to the patient. Included in the catheter kit is a Patient/Family Education tool which should be reviewed with the patient.

EQUIPMENT FOR CATHETERIZATION PROCEDURES:

- For patients with Latex allergies:
  1. Sterile disposable closed system 16fr Catheter Kit
  2. Light source
  3. Sterile gloves
  4. Exam gloves
  5. TECHNI-CARE Prep (Chloroxylenol 3%) if allergic to povidone-iodine (Call #1367 Central Stores item #911050)
  6. Lidocaine Jelly 2% Urojet

  a. Requires MD order
  b. Refer to Nursing Procedure (cat10), “USE OF UROJET/LIDOCAINE HCL 2% JELLY”

PROCEDURES:

- FEMALE FOLEY CATHETER INSERTION: (RN, LPN)
For patients with Povidone Iodine allergies:

NOTE: If patient allergic to povidone-iodine, TECHNI-CARE prep (Chloroxylenol 3%) will be used with the same applicators and procedure as done with povidone-iodine.

1. Identify patient, ask if she has recently voided and explain procedure.
2. Perform hand hygiene.
3. Assist patient into a frog leg position with knees flexed and feet together. Modify position or provide support if needed using pillows behind knees. Ensure patient privacy and comfort.
4. It is preferred to have an assistant during insertion to help the patient stay in position, direct the light, perform the peri-care and if needed, don sterile gloves for better patient exposure during the insertion.
5. Perform hand hygiene and position yourself on the side of the bed that permits insertion using your dominant hand. Place tray on cleaned surface that can be brought close to the bed edge or use the Foley Catheter Insertion Cart surface. Remove tray from outer wrap (this can be set aside and used to discard used Castile wipes onto). Remove the label, directions for use brochure, and orange sticker sheet and set aside. Don clean gloves. Open the peri-care packet. Use the provided castile soap wipes to cleanse the patient’s peri-urethral area. Beginning with the outer perineum and the 1st cloth, cleanse with a gentle wiping motion top to bottom, discard away from the clean cloths and then with 2nd cloth, separate outer labia and wipe top to bottom. Lastly, separate inner labia and use 3rd cloth in the same way. Discard gloves.
6. Perform hand hygiene with the provided alcohol hand sanitizer gel. Using proper aseptic technique, open sterile wrap of the catheter pack. Open first layer of CSR wrap away from you. After all layers opened; don sterile gloves.
7. Set both drapes aside on sterile surface and prepare the tray.
8. Attach the water-filled syringe to the inflation port. NOTE: DO NOT TEST THE BALLOON.
9. Using the syringe with the green plunger, deposit lubricant into tray top compartment.
10. Remove the outer wrap from the catheter maintaining its position in the tray and place the tip in the lubricant.
11. Open the povidone-iodine packet and carefully pour enough solution onto swab stick ends to saturate them. If patient is allergic to povidone-iodine, discard the povidone-iodine packet and have assistant add Technicare prep to the prep section of the tray using aseptic technique.
12. Place the under-pad beneath the patient, plastic (or shiny side) down. Take caution not to contaminate sterile gloves. If so change gloves.
13. Position fenestrated drape on patient so only the genital area remains exposed. Transfer tray onto sterile drape between the patient's legs with the “prep” end of the tray toward the perineum.

14. Prepare the patient with the povidone-iodine or Technicare (if allergic) saturated foam swab-sticks. Gently twist the swabs to remove them from the tray. Remove excess prep to avoid dripping by pressing swabs onto the dry edge of the prep dish.

15. Separate inner labia as widely as possible with the thumb, middle and index fingers allowing a full view of the meatus. This hand is now considered contaminated and must not come in contact with the catheter until the Foley is inserted and draining.

16. Working top to bottom, cleanse the “far” labia minora and discard the swab. Do the same for the “near” labia minora. With the last swab-stick, cleanse the middle area between the labia minora.

17. With your sterile dominant hand and **keeping the labia well separated**, carefully insert lubricated tip into urinary meatus advancing about two to three inches until urine begins to flow. If the catheter is inadvertently inserted into the vagina, leave it there as a landmark and begin the procedure again using a new kit (Lippincott, page 379).

18. When the urine starts flowing, advance a little farther to ensure catheter well into the bladder, then inflate the balloon with the water-filled syringe. **NOTE: Use the entire 10 ml of water as this is necessary to keep the balloon inflated and inhibit movement of the Foley in the urethra.**

19. After inflation, pull gently back on the catheter until resistance is met. Remove drape from patient, remove gloves and perform hand hygiene.

20. Remove the Foley bag from the tray keeping the Foley below the level of the bladder and place bag on the bed between the patient's legs. Remove tray and under drape to cart or table surface. Assist patient out of frog leg position. Pull gown down leaving leg that will wear the securement device exposed.

21. Open the StatLock® stabilization device included in the kit to secure the catheter to the thigh (apply alternate securement device per MD order if vascular surgery/other contraindication to the StatLock® device.) Place the catheter into the retainer with the directional arrow pointing toward the catheter tip and the balloon inflation arm next to the clamp hinge. Close lid. Measure the area for the StatLock® to be placed by laying the catheter onto the leg and allowing a **one inch slack** between the insertion site and the device. The device should be placed more anteriorly on the leg to avoid rubbing on the inner thigh. Cleanse and de-grease the skin with alcohol and allow
For patients with Povidone Iodine Allergies:

drying. Apply skin protectant using both pads and allow drying for 10-15 seconds. Hold the retainer to keep the pad in place, peel away paper backing (one side at a time), and place tension free on the skin.

22. Attach the bag to the bedrail where it should hang freely off the floor. Use the green sheeting clip to secure drainage tube to the sheet. Cover patient.

23. Indicate the time/date of the catheter insertion on the labels provided in the kit and place on the drainage system.

24. Fold the edges of the trap wrap together into a contained package and discard. Perform hand hygiene.

25. If cart used, wipe all surfaces of the cart with the disinfectant wipes provided in the cart.

MALE FOLEY CATHETER INSERTION: (RN, LPN)

NOTE: Consider the use of a condom catheter versus an indwelling catheter (refer to nursing procedure “Application of a Condom Catheter” (cat02).

1. Identify patient, ask if he has recently voided and explain procedure.
2. Perform hand hygiene.
3. Expose genitalia while ensuring patient privacy and comfort.
4. Have an assistant to help direct light etc. Assistant may use the Castile wipes while inserter prepares sterile tray.
5. Perform hand hygiene and position yourself on the side of the bed that permits insertion using your dominant hand. Place tray on a cleaned surface that can be brought close to the bed edge or use the Foley catheter Insertion cart surface. Remove tray from outer wrap (this may be set aside and used to discard used Castile wipes onto). Remove the label, directions for use brochure, and orange sticker sheet and set aside. Don clean gloves. Open the peri-care kit.
6. Open the Castile wipe packet. Use the provided castile soap wipes to cleanse the penis. Gently retract the foreskin and with the 1st cloth cleanse the entire head of the penis ensuring the removal of all exudative material. Wipe the shaft with the 2nd cloth and the scrotum with the 3rd cloth. Place the penis so it lies upward on the abdomen. Discard gloves.
7. Perform hand hygiene with the provided alcohol hand sanitizer gel. Using proper aseptic technique, open sterile wrap of the catheter pack. Open first layer of CSR wrap away from you. After all layers opened; don sterile gloves.
8. Set both drapes aside on the sterile surface and prepare

NOTE: If the patient is allergic to povidone-iodine, TECHNICARE prep (Chloroxylenol 3%) will be used with the same applicators and procedure as done with povidone-iodine.
9. Attach the water-filled syringe to the inflation port. NOTE: DO NOT TEST THE BALLOON.

10. Using the syringe with the green plunger, deposit lubricant into the tray top compartment.

11. Remove the outer wrap from the catheter maintaining its position in the tray and place the tip in the lubricant.

12. Open the povidone-iodine packet and carefully pour enough solution onto swab stick ends to saturate them. If the patient is allergic to povidone-iodine, discard the povidone-iodine packet and have assistant add Technicare prep to the prep section of the tray using aseptic technique.

13. Place the square drape onto the patient's upper legs and scrotum plastic (shiny side) down. Take caution not to contaminate sterile gloves. If so change them.

14. Fold the fenestrated drape in half and drape around the base of the penis. If contamination of the gloves occurs, change them. Transfer the tray onto the sterile drape with the prep end of the tray toward the perineum.

15. Prepare the patient with the povidone-iodine saturated foam swab-sticks or Technicare prep for allergic patients. Gently twist the swabs to remove them from the tray. Remove excess prep to avoid dripping by pressing swabs onto the dry edge of the prep dish.

16. Grasp the penis with your non dominant hand, retract the foreskin on an uncircumcised male and gently lift and stretch the penis. Prep the head of the penis working from the meatus outward in a circle careful not to contaminate your dominant hand. Do this twice each time with a new applicator and then prep down the shaft to your hand.

17. Still grasping the penis, using your sterile dominant hand, insert lubricated tip into the urinary meatus advancing gently about six to seven inches until urine begins to flow. When the urine starts flowing, advance the catheter to the Y hub. If you are unsure if the catheter is all the way into the bladder let go of it. If it stays in place you are most likely in. If it pushes back out you are not in. Once you are in inflate the balloon with the water-filled syringe. NOTE: Use the entire 10 ml of water as this is needed to keep the balloon inflated and inhibit movement of the Foley in the urethra.

18. After inflation, pull gently back on the catheter until resistance is met. If foreskin retracted, replace it to prevent compromise of circulation/painful swelling. Remove drape from patient, remove gloves and perform hand hygiene.

19. Remove the Foley bag from the tray keeping the Foley below bladder and place bag on or to the side of patient’s legs. Remove tray and under drape to cart or table surface. Pull gown down leaving leg that will wear the securement device exposed.

20. Use the StatLock® stabilization device included in the kit to
secure the catheter to the thigh (apply alternate securement device per MD order if vascular surgery/other contraindication to the StatLock® device.) Place the catheter into the retainer with the directional arrow pointing toward the catheter tip and the balloon inflation arm should be next to the clamp hinge. Close lid. Measure the area for the StatLock® to be placed by laying the catheter onto the leg and allowing a one inch slack between the insertion site and the device. The device should be placed more anteriorly on the leg to avoid rubbing on the inner thigh. Cleanse and de-grease the skin with alcohol and allow drying. Apply skin protectant using both pads and allow drying for 10-15 seconds. Hold the retainer to keep the pad in place, peel away paper-backing (one side at a time), and place tension free on the skin.

21. Attach the bag to the bedrail where it should hang freely off the floor. Use the green sheeting clip to secure the drainage tube to the sheet. Cover patient.

22. Indicate the time and date of catheter insertion on the labels provided in the kit and place on the drainage system.

23. Fold the edges of the tray wrap together into a contained package and discard. Perform hand hygiene.

24. If cart used, wipe the surfaces of the cart with the disinfectant wipes provided in the cart.

**CATHETER CARE AND MANAGEMENT:** (RN/LPN, PCT/MST)

1. **Assess the need for the catheter, on a daily basis.**
2. Catheter care should be done on each shift and PRN (when catheter has encrusted material/drainage).
3. Inspect the urinary drainage for mucous shreds, blood clots, or sediment.
4. Perform hand hygiene. Apply gloves.
5. Inspect the outside of the catheter where it enters the urinary meatus for encrusted material or drainage. Inspect the tissue around the meatus for irritation.
6. Using a CHG compatible cleanser or cloth, cleanse visible drainage/stool.
7. Next, using 2% CHG cloth, cleanse around the meatus and 6” of the Foley nearest the patient wiping away from the meatus. In male patients, retract the foreskin before cleansing. Remove any encrusted materials which can be irritating. While cleansing with CHG, avoid pulling on the catheter to prevent contamination of the section that was inside the urethra which upon release re-enters the urethra and introduces organisms. Once cleansing is done, replace the foreskin of the male patient.

**NOTE:** If the patient is allergic to Chlorhexadine (CHG) or has an existing rash, redness or sensitivity to CHG wipes, use a Castile Wipe to cleanse around the meatus and 6” of the Foley.
nearest the patient wiping away from the meatus.

8. Remove gloves and perform hand hygiene.
9. Check the Foley StatLock® stabilization device site for redness or irritation. The securement device should be changed every 7 days and is removed with alcohol.
10. If a patient returns from surgery and has “traction” on the catheter, do not remove the “traction” to apply a securement device.
11. The Foley catheter should be emptied using a separate collection container for each patient. Avoid allowing the catheter spigot to touch the collection container. It is recommended to empty the urine when the drainage bag is approximately half full to prevent the weight of the bag pulling on the insertion site.
12. Avoid raising the drainage bag above bladder level, but try to keep the drainage bag off of the floor. This prevents reflux of urine, which can contain bacteria.
13. When the patient requires transport to another department/procedure, do not place the collection bag on top of the stretcher or bed—try to keep the bag lower than the bladder to avoid backflow of urine. It is recommended to empty the urine prior to transport to avoid urine reflux.
14. Try to maintain unobstructed urine flow. Remind the patient to keep the knee down (this includes the knee gatch) that has the catheter strap attached as that may impede the urine flow into the collection bag.
15. If the Foley catheter and/or the system is opened for any reason, change the entire system.

EXCEPTION: Urology inserted

PROMPT CATHETER REMOVAL
1. Nurses and physicians should continually monitor the patient’s ongoing need for a catheter.
2. Nurses evaluating their patient’s catheter use and finding no current indication should contact the physician to promptly discontinue the catheter or independently remove it utilizing nurse driven protocol.

CATHETER REMOVAL PROCEDURE: (RN/LPN, PCT/MST)
1. ASSEMBLE THE FOLLOWING ITEMS:
   1. Towel or linen-saver pad
   2. 12-ml/35-ml syringe depending on catheter balloon size
   3. Non-sterile gloves
   4. Urinal, if appropriate
2. Remove the indwelling catheter when patient does not meet criteria to maintain the catheter. For Urology patients, an MD order is needed for the removal of a Foley catheter. If feasible, remove an indwelling catheter in the morning to avoid “after hour” issues with urinary retention. This procedure may be delegated to the Patient Care Tech or
multi-skilled tech by the nurse.
3. Explain the procedure to the patient. Tell the patient to save all voided specimens and explain urinary symptoms that may occur after the removal.
4. Have the patient lie down in supine position.
5. Perform hand hygiene.
6. Don gloves.
7. Place towel or linen-saver pad in appropriate position to prevent urine spillage. Insert syringe into valve opening and withdraw the fluid.

NOTE: Make sure all the fluid is withdrawn. There may be more fluid than the recommended amount.

8. When the fluid is withdrawn, steadily pull the catheter out catching the catheter in the towel or linen-saver pad at the same time to prevent spillage.
9. When done, measure and record the amount of urine.
10. Dispose of the urine and drainage bag according to Hospital policies.

Troubleshooting: (RN/LPN only, the PCT/MST is to notify the nurse of any difficulty; e.g. balloon deflates, but are unable to pull catheter out:
1. When the balloon is inflated, the balloon area stretches. This can cause a raised edge on the end of the catheter. It can “catch” on the inside of the urethra. You may need to pull a little harder. 
   STOP IF THE PATIENT COMPLAINS OF PAIN.
2. Have the patient lie in different positions, and then try to remove the catheter.
3. If none of the above works, call the physician.
4. Post indwelling catheter removal: follow the steps per the “Foley catheter Insertion and Removal Protocol” order set.

ACUTE URINARY RETENTION MANAGEMENT
1. Nursing may generate a protocol in SCM (“Foley Catheter Insertion and Removal Protocol”) if the patient meets criteria for insertion or removal of an indwelling urinary catheter or contact the physician for orders.
2. If patient unable to void within 4-6 hours post-operatively, after removal of an indwelling foley catheter or for other unknown reason, utilize the SMHCS Urinary Retention Algorithm. (located on Pulse)

EXCLUSIONS: Urology patients

3. If spontaneous urination does not return within 24 hours, contact physician (at appropriate time) to assess need for Foley catheter.

URINE SPECIMEN FROM INDWELLING CATHETER:
1. Refer to nursing procedure (cat09) Urine Specimen Collection for steps.

2. **NOTE:** Do not ask physicians for an order for a urine culture because the urine is cloudy or malodorous. It could be a bacteriuria and not a true UTI.

**DOCUMENTATION:**

**ELECTRONIC MEDICAL RECORD DOCUMENTATION**

1. Indication for foley or straight catheterization
2. Foley present on arrival to hospital
3. Foley or straight catheter insertion date and time
   a. How the patient tolerated the procedure. (RN, LPN)
4. Number of attempts
5. Interventions such as bladder scan, straight catheterization for post-void residual or placement of StatLock® stabilization device
6. Size and type of catheter
7. Describe the urine color, character and abnormalities
8. Foley catheter removal date and time (RN, LPN, Patient Care Tech, MST)
   a. Any problems encountered. (RN, LPN)
9. Urine output documentation:
   a. Initial catheterization
   b. The end of shift as appropriate
   c. Upon removal of catheter

**REFERENCE(s):**


AHRQ Pub No. 15-0073-2-EF


AHRQ Publication No. 13-0052-EF

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