**PURPOSE:**

The purpose of urinary catheterization is to facilitate urinary drainage when medically necessary; i.e., when alternative methods such as programmed toileting have failed. Urinary catheters should be evaluated frequently for need and removed promptly when no longer necessary.

Urinary catheters may be deemed medically necessary for the following reasons:

1. Urinary retention including obstruction and neurogenic bladder: The resident is unable to pass urine because of an enlarged prostate, blood clots, or an edematous scrotum/penis or unable to empty the bladder because of neurologic disease or medication effect.
2. For urologic studies
3. Assistance with healing of perineal and sacral wounds in incontinent residents to avoid further deterioration of wound and skin when alternative methods are ineffective.
4. Hospice, comfort or palliative care, if requested by resident or healthcare representative.

**BACKGROUND:**

An indwelling urinary catheter (IUC) is a flexible hollow tube inserted into the urinary bladder via the urethra to drain urine that can be left in place for a long period of time.

**RESPONSIBILITY:**

The physician or nurse practitioner is responsible for giving the order for insertion of a Foley catheter. The physician (MD), nurse practitioner (NP) registered nurse (RN), and licensed practical nurse (LPN) is responsible for insertion of Foley catheter. The certified nursing assistant (CNA) may be involved with catheter handling and maintenance activities.

**POLICY**:

It is the policy of this facility to implement evidence-based infection prevention practices during the insertion, maintenance, and removal of indwelling urinary catheters to prevent the occurrence of catheter-associated urinary tract infections (CAUTIs). All staff will undergo training and education along with an assessment of competency upon hire and as needed.

**INSERTING A FOLEY CATHETER**

**EQUIPMENT**

Disposable catheterization tray with appropriate size foley catheter

Urinary drainage bag (bedside or leg)

Securement device (ex: foley thigh strap)

Drainage cover bag

Wash basin, soap, towels

**PREPARATION**

1. Confirm the order, including catheter and balloon size; use the smallest effective catheter size (if not specified) or the same size of previous catheter if replacing
2. Assemble and verify supplies. Consider bringing a second catheter to use if the first one is accidentally contaminated
3. Identify the resident and explain procedure to resident and/or family. Patients with dementia may not understand explanation but still explain in simple terms what you are going to do
4. Ensure adequate lighting
5. Position the resident correctly for the procedure; consider using an assistant to help resident stay in position and decrease potential contamination of sterile catheter
6. Perform hand hygiene; don clean gloves; if necessary, cleanse the perineal area with a washcloth, soap/perineal cleanser and warm water, moving from front to back (for females) and in a circular motion starting at the urethral meatus and working outward (for males)
7. Remove gloves and perform hand hygiene

**INSERTION**

1. Open the sterile catheterization kit on a clean bedside table, using sterile technique. Ensure all supplies are conveniently positioned
2. Don sterile gloves; place waterproof underpad beneath resident, “shiny” side down
3. Open the packet of the antiseptic swab. Open lubricant. Remove foley catheter from wrap and lubricate.
4. Attach normal saline syringe to the inflation port
5. Consider attaching catheter to the drainage system now and ensure the drainage bag emptying port is clamped
6. With nondominant (dirty) hand, identify meatus, and be prepared to keep this hand in this position until after the urine is flowing
7. With dominant (sterile) hand, clean the urinary meatus with the antiseptic solution
	1. Females: with a downward stroke cleanse the right labia minora and discard the swab. Repeat same for the left labia minora. Use the last swab stick to cleanse the area between the labia minora
	2. Males: Pull the foreskin back and clean the glans penis in a circular motion starting at the urethral meatus and work outward
8. With the dominant (sterile) hand, insert the catheter slowly into the urethra until there is a return of urine
	1. Females: advance catheter two more inches
		1. Leave the catheter in the vagina, if accidentally inserted, until after the new urinary catheter is inserted into the bladder
	2. Males: Advance catheter 6-10inches
		1. Do not force the catheter in the urethra (can result in urethral trauma)
9. Inflate catheter balloon using 10mL normal saline (Use of <10mL can result in improperly inflated balloon)
10. Gently tug/pull on catheter after balloon inflation to feel resistance

**AFTER INSERTION**

1. Remove used equipment and dispose of used supplies in trash/garbage bag
2. Secure catheter to the resident’s thigh with securement device (ex: thigh strap)
3. Remove gloves and perform hand hygiene
4. Assist resident to comfortable position
5. Ensure that the tubing is not kinked and the drainage bag is below the level of the bladder. Place drainage bag into drainage cover bag to maintain resident dignity
6. Perform hand hygiene
7. Document
	1. Type and size of catheter and balloon
	2. Amount of fluid inserted into balloon
	3. How the resident tolerated the procedure
	4. Amount of urine obtained and its characteristics (ex: color, clear/cloudy, odor)

**REMOVAL OF FOLEY CATHETER**

**EQUIPMENT**

10mL normal saline STAT Lock syringe

Trash/garbage bag

**PROCEDURE**

1. Explain procedure to the resident and/or health care agent
2. Perform hand hygiene
3. Don clean gloves
4. Position resident and place waterproof pad under resident
5. Remove securement device (ex: Foley thigh strap)
6. Deflate catheter balloon
	1. Empty normal saline from syringe into trash/garbage bag
	2. Insert into Foley catheter inflation port
	3. Remove all 10mL of water (Do not use vigorous aspiration as this may cause the inflation lumen to collapse, preventing balloon deflation)
		1. Allow approximately 30 seconds for the pressure within the balloon to force the plunger back and volunteer its water into the syringe (via negative pressure)
	4. If there is slow or no deflation, re-seat the syringe gently
	5. Remove the catheter and discard in trash/garbage bag
7. Remove gloves and perform hand hygiene

**AFETR REMOVAL**

Document

* 1. Type and size of catheter removed
	2. Amount of fluid removed from balloon (should = 10mL)
	3. How the resident tolerated the procedure

**SPECIMEN COLLECTION**

1. Gather supplies
2. Check date IUC was last changed.
	* Per McGeer’s Criteria, urine catheter specimens for culture and sensitivity should be collected after replacement of the foley catheter if it has been placed ≥ 14 days. No stipulations made for suprapubic tubes, hence, do not change SPT prior to specimen collection
3. Clamp catheter just below collection port for 10-15 mins, but no longer than 20 minutes, before obtaining specimen (*rationale*: to allow for collection of urine in the bladder)
4. Perform hand hygiene
5. Thoroughly cleanse the sampling catheter port (see Fig 1) on the drainage bag with alcohol swab

 (≥ 15 seconds)

* If urinary catheter has no sampling port, then sample can be obtained from the urinary catheter. Cleanse catheter with alcohol swab, allow to air dry, then aspirate the urine sample using a small-bore needle and syringe.
1. Insert the Luer Slip Tip Syringe to the port (see Fig 2) and slowly withdraw/aspirate at least 60mL of urine
2. Remove syringe and transfer urine into labeled sterile specimen container.
3. Swab collection port with alcohol swab (≥ 15 seconds)
4. Remove the catheter clamp
5. Ensure catheter is properly secured to thigh
6. Discard soiled supplies in trash (garbage) bag
7. Perform hand hygiene

**MAINTAINING THE FOLEY CATHETER**

Maintain unobstructed urine flow by:

1. Keeping the catheter and tubing free of kinks
2. Secure catheter with leg/thigh strap (to be changed weekly or earlier if soiled) after insertion to prevent movement
3. Keep drainage bag below the level of the bladder at all times (*Rationale*: to prevent reflux of contaminated urine from the bag to the bladder).
	* Do not place the drainage bag on the floor (*Rationale*: to prevent contamination)
		1. May need to give special considerations for residents with urinary drainage bags who require their beds to be in the lowest position.
	* Place drainage bag in cover/privacy bag (to maintain resident’s dignity)
4. Do not allow bag to overfill. Empty at scheduled intervals (at least once per shift) and immediately if more than two-thirds full (*Rationale*: to avoid traction on the catheter from the weight of the drainage bag)
	* Don clean disposable gloves
	* Without touching the tip, remove the drain spout from its sleeve at the bottom of the drainage bag
	* Open the valve on the spout and let urine drain into urinal
	* After all urine has drained from drainage bag, close valve and replace spout in the sleeve
	* Perform hand hygiene
	* Document how much urine was drained from the bag (output)
5. May use urinary leg bag per resident’s preference
6. Perform perineal hygiene at least daily with soap and water for residents with indwelling catheter; be careful not to dislodge the catheter
7. Drainage bags should not be changed routinely or at fixed intervals (*rationale*: will compromise the closed system). Drainage bags will be changed based on clinical indications such as infection, obstruction, or when the closed system is compromised.
	* To change a drainage bag:
		1. Get new drainage bag and other supplies
		2. Perform hand hygiene
		3. Use alcohol prep wipe to clean urine drainage port (this is where the drainage tube on the drainage bag connects to the foley/suprapubic catheter)
		4. Clamp foley/suprapubic catheter just above bifurcation (“Y”)
		5. Remove old urinary drainage bag tubing and insert new
		6. Unclamp the tubing
		7. Perform hand hygiene
8. Indwelling catheters will be changes only when clinically indicated (not routinely), for example, when there is an infection, when there is urinary obstruction, or when the closed system is compromised.
9. **CNA**: report to unit nurse if resident’s bed and/or clothing is wet with urine; if urine is thick and cloudy or has blood clots or is blood-tinged; urine has a strong (bad) odor; no urine has drained from catheter in 6-8 hours; resident complains of pain or burning on urination; resident has chills
10. **RNS**: For new or readmission of residents with foley catheter in place:
	* Note size of catheter and balloon and check for patency and characteristics of urine
	* Review medical records (or ask resident [if alert] and/or family) for justification of foley catheter
	* Notify PMD of foley catheter along with reason for use
	* Document on 24-hr report that resident has a foley catheter in place
	* Place order in E-TAR and CNAAR for foley maintenance
	* Initiate CCP for foley catheter
11. **PMD/NP** will:
	* Assess resident within 48 hours and determine whether use of foley catheter is medically indicated
	* Provide medical diagnosis/justification for continued use or discontinuation of catheter
	* Order consults or diagnostic testing as necessary when indicated to justify continued use of catheter
	* Review catheter use on a monthly basis and document in medical record justification of use

**Figure 1**



**Figure 2**



**Revised:** 3/25/2021; 11/3/2021,2/17/22

**REFERENCES:**

AHRQ Safety Program for LTC: HAIs/CAUTI Implementation Guide

CDC HICPAC (2009). Guideline for Prevention of Catheter-Associated Urinary Tract Infections. <https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines-H.pdf>

CDC (Updated 11/5/2015). Catheter-Associated Urinary Tract Infections (CAUTI). <https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html>

Infection Control Policy and Procedure Manual, Revised June 2014

WHO (5/2018). Advanced Infection Prevention and Control Training: Prevention of Catheter-Associated Urinary Tract Infection (CAUTI) – Student Handbook. <https://www.who.int/infection-prevention/tools/core-components/CAUTI_student-handbook.pdf>

**EMPLOYEE’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_**

**EVALUATOR’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PASS/FAIL: \_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **BEFORE CATHETER INSERTION** | **TASK COMPLETED****(YES/NO)** | **COMMENTS** |
| 1. Confirm the order, including catheter and balloon size; use the smallest effective catheter size (if not specified) or the same size of previous catheter if replacing
 |  |  |
| 1. Assemble and verify supplies. Consider bringing a second catheter to use if the first one is accidentally contaminated
 |  |  |
| 1. Identify the resident and explain procedure to resident and/or family. Patients with dementia may not understand explanation but still explain in simple terms what you are going to do
 |  |  |
| 1. Ensure adequate lighting
 |  |  |
| 1. Position the resident correctly for the procedure; consider using an assistant to help resident stay in position and decrease potential contamination of sterile catheter
 |  |  |
| 1. Perform hand hygiene; don clean gloves; if necessary, cleanse the perineal area with a washcloth, soap/perineal cleanser and warm water, moving from front to back (for females) and in a circular motion starting at the urethral meatus and working outward (for males)
 |  |  |
| 1. Remove gloves and perform hand hygiene
 |  |  |

|  |  |  |
| --- | --- | --- |
| **DURING CATHETER INSERTION** | **TASK COMPLETED****(YES/NO)** | **COMMENTS** |
| 1. Open the sterile catheterization kit on a clean bedside table, using sterile technique. Ensure all supplies are conveniently positioned
 |  |  |
| 1. Don sterile gloves; place waterproof underpad beneath resident, “shiny” side down
 |  |  |
| 1. Open the packet of the antiseptic swab. Open lubricant. Remove foley catheter from wrap and lubricate.
 |  |  |
| 1. Attach normal saline syringe to the inflation port
 |  |  |
| 1. Consider attaching catheter to the drainage system now and ensure the drainage bag emptying port is clamped
 |  |  |
| 1. With nondominant (dirty) hand, identify meatus, and be prepared to keep this hand in this position until after the urine is flowing
 |  |  |
| 1. With dominant (sterile) hand, clean the urinary meatus with the antiseptic solution
	* Females: with a downward stroke cleanse the right labia minora and discard the swab. Repeat same for the left labia minora. Use the last swab stick to cleanse the area between the labia minora
	* Males: Pull the foreskin back and clean the glans penis in a circular motion starting at the urethral meatus and work outward
 |  |  |
| 1. With the dominant (sterile) hand, insert the catheter slowly into the urethra until there is a return of urine
	* Females: advance catheter two more inches
		1. Leave the catheter in the vagina, if accidentally inserted, until after the new urinary catheter is inserted into the bladder
	* Males: Advance catheter 6-10inches
		1. Do not force the catheter in the urethra (can result in urethral trauma)
 |  |  |
| 1. Inflate catheter balloon using 10mL normal saline (Use of <10mL can result in improperly inflated balloon)
 |  |  |
| 1. Gently tug/pull on catheter after balloon inflation to feel resistance
 |  |  |

|  |  |  |
| --- | --- | --- |
| **AFTER CATHETER INSERTION** | **TASK COMPLETED****(YES/NO)** | **COMMENTS** |
| 1. Remove used equipment and dispose of used supplies in trash/garbage bag
 |  |  |
| 1. Secure catheter to the resident’s thigh with securement device (ex: thigh strap)
 |  |  |
| 1. Remove gloves and perform hand hygiene
 |  |  |
| 1. Assist resident to comfortable position
 |  |  |
| 1. Ensure that the tubing is not kinked and the drainage bag is below the level of the bladder. Place a cover over the drainage bag to maintain resident dignity
 |  |  |
| 1. Perform hand hygiene
 |  |  |
| 1. Document
	1. Type and size of catheter and balloon
	2. Amount of fluid inserted into balloon
	3. How the resident tolerated the procedure
	4. Amount of urine obtained and its characteristics (ex: color, clear/cloudy, odor)
 |  |  |