Policy

Title	**Urinary Catheter - Insertion, Maintenance, And Removal**
Policy Number	NSOP-0028
PolicyType	Nursing
Category	Nursing Standards of Practice - General
Subcategory1	Catheters
Subcategory2	Catheter Care, Insertion and Equipment
Subcategory3	
Approval Date	5/19/2014
Contact	NRS.PNSSOP.Rush
Applies To	
Purpose	
Executive Summary	
Definitions	
Equipment	**Insertion equipment for Indwelling catheter:** Clean gloves Indwelling catheter tray that includes the following supplies: • Underpad • Pre-saturated towelettes with skin cleanser • Hand sanitizer • Sterile gloves • Fenestrated drape • Lubricant • Pre-saturated povidone iodine swabsticks • Syringe pre-filled with sterile water • Urinary catheter (appropriate size) • Stabilization device • Urine collection device Lamp/flashlight (optional) Lift equipment (optional) **Insertion equipment for intermittent catheter:** Clean gloves Hospital approved skin cleanser or soap and water Towel or washcloth

Disposable urethral catheter tray that includes the following supplies:

- Underpads
- Fenestrated drape
- Lubricant
- Povidone-iodine swabsticks
- Sterile gloves
- Urinary catheter (appropriate size)
- Specimen collection container
- Urine collection container

Lamp/Flashlight (optional)

Maintenance:
Clean gloves
Graduated cylinder
Soap and water or hospital approved skin cleanser
Towel or washcloth
Stabilization Device

Removal:
10cc syringe (for indwelling catheter)
Clean gloves
Water proof pad

Information

1. Nursing protocol for indications for indwelling urinary catheter:
    - Urinary retention/obstruction
    - Neurogenic bladder diagnosed pre-operatively
    - Accurate measurement for output in ICU patients
    - Uro/Gyne patient
    - Assist in healing of open sacral or perineal wounds in incontinent patients
    - Prolonged immobilization (unstable thoracic or lumbar spines)
    - Improve comfort at end of life
    - Movement intolerance (hemodynamic instability)
    - Patient less than or equal to 17 years of age
    - Kidney transplant this hospitalization
    - Core temperature monitoring
    - Urology patient
    - (ROPH Only) Chronic foley
    - (ROPH Only) Need for accurate I&O
    - Does not meet criteria for indwelling urinary catheter
2. Indications for straight (intermittent) catheterization
    - Urinary retention/obstruction/neurogenic bladder.
    - Alternative to indwelling urinary catheter.
3. Alternatives to indwelling urinary catheter include:
    - Use of bladder scanner to confirm urinary retention.
    - Condom catheter or retractable penis pouch for males, see NSOP-0022.
    - Intermittent urinary catheterization (straight catheter).
4. The usual adult size retention catheter is a 14 or 16 Fr.
    - Child size retention catheter: 8 or 10 Fr.
    - Infant size catheter: 5-8 Fr.
    - Neonates:
        - Less than1000 grams: 3-5 Fr. indwelling urinary catheter.
        - 1000 - 1800 grams: 5/6 Fr. Indwelling

catheter.
- Greater than 1800 grams: 8 Fr Indwelling catheter.

5. Stabilization device used for indwelling urinary catheter, pivots to allow repositioning of catheter and tubing when turning patient.
    - The stabilization device is changed every seven (7) days.

Policy

1. RNs and LPNs may insert urinary catheters per order.
2. Nursing personnel may discontinue an adult urinary catheter, as soon as possible, when no approved indications for its use exist.
3. Urinary catheterization is performed using sterile technique.
4. If attempt at urinary catheterization is unsuccessful and new catheter is needed, a new catheter tray is obtained and all steps in insertion procedure are repeated.
5. An indwelling catheter is connected to closed gravity drainage at all times.
6. The tubing is kept free of kinks and is not compressed by the patient's body.
7. The catheter and/or drainage system is kept below the level of the patient's bladder.
8. The urine collection device is kept off of the patient's bed or gurney.
9. The urine collection device is kept off of the floor.
10. Allergies should be verified prior to insertion of urinary catheter.
    - If latex allergy is confirmed, obtain a silicone urinary catheter tray.
    - If povidone-iodine allergy is confirmed, do not cleanse with povidone-iodine swabs.
11. Unless obstruction is anticipated, (typically after prostate or bladder surgery), bladder irrigation is not recommended.

Outcome

Guidelines

Responsibility and Procedure

	Catheterization: Indwelling Urinary Catheters:

RN, LPN	1. Perform hand hygiene
	2. Explain procedure to patient/caregiver.
	3. Don clean gloves.
	4. Position patient exposing the genital area.
	5. Using aseptic technique, open the outer wrapping of the catheter kit.
	6. Place underpad under the patient.
	7. Cleanse the perineum with presaturated towelettes with skin cleanser.
	  o If cleanser is not provided, use soap and water or hospital approved skin cleanser.
	  o Female: Cleanse each side of meatus and down the middle using one towellete for each anterior to posterior stroke.
	  o Male: Retract the foreskin if applicable. Cleanse the glans penis beginning at the meatus and working outward.
	8. Remove gloves and perform hand hygiene with provided antiseptic hand sanitizer.
	9. Don sterile gloves.
	10. Position fenestrated drape on patient.
	11. Attach the water filled syringe to the inflation port.
	  o Do not pre-test the foley catheter balloon.
	12. Lubricate catheter
	13. Cleanse meatus/glans penis with packet of pre-saturated povidone-iodine swab sticks.
	  o Female: Separate labia with non-dominant hand, exposing meatus.
	    ▪ Maintain this separation throughout insertion procedure.
	    ▪ Cleanse each side of meatus and down the middle using one swab stick for each anterior to posterior stroke.
	  o Male: Retract the foreskin if applicable, holding the penis upright with the non-dominant hand.
	    ▪ NICU/PEDS: Retract foreskin on uncircumcised male only if needed to visualize.
	    ▪ Cleanse the glans penis three (3) times using a new swab stick for each circular stroke.
	14. Insert catheter for female patients.
	  o Insert lubricated catheter slowly into female urethral meatus in an upward and forward direction until urine begins to flow.
	    ▪ Insertion may only be around 2 cms in extremely low birth weight children.
	15. Insert catheter for male patients.
	  o Raise shaft of penis perpendicular body.
	    ▪ Pull outward gently to ensure straight line of entry into bladder
	    ▪ Insert catheter into male urethra, advancing until urine flows.
	    ▪ Instruct patient to take a deep breath, change angle of penis, and apply steady gentle pressure on the catheter if resistance is felt at the external

	sphincter. ▪ Return foreskin over glans penis on male patient. 16. Do not force catheter if unable to advance. Stop procedure, remove gloves, wash hands, and notify physician. 17. Inflate catheter balloon to volume per instructions on manufacturer's package for retention catheter. 18. Pull gently on balloon retention catheter to position catheter against bladder neck. 19. Apply stabilization device: o Conduct skin assessment prior to application. o Place catheter into retainer. o Initial and date stabilization device. o Identify proper site placement by placing stabilization device on front of thigh and then back up one inch towards insertion site (make sure leg is fully extended). o Degrease stabilization site with alcohol and allow to dry. o Apply skin protectant with both pads in directon of hair growth and allow to dry. o Hold the retainer to keep the pad in place, peel away paper backing one side at a time and place tension-free on skin. 20. Attach drainage bag to bed frame, positioning bag off floor and below bladder level. 21. Discard all soiled materials in appropriate waste containers. 22. Remove gloves. 23. Perform hand hygiene. 24. Document insertion procedure, catheter size,and the amount and characteristics of urine in Epic. 25. If catheter insertion attempt is unsuccessful, obtain new catheter tray and repeat procedure.
RN, LPN	**Catheterization: Intermittent (straight):** 1. Explain procedure to patient/caregiver. 2. Perform hand hygiene. 3. Don clean gloves. 4. Position patient exposing the genital area. 5. Using aseptic technique, open the outer wrapping of catheter kit. 6. Place underpad under the patient. 7. Cleanse the perineum with hospital approved skin cleanser or soap and water. o Female: Cleanse each side of meatus and down the middle using clean side of washcloth for each anterior to posterior stroke. o Male: Retract the foreskin if applicable. Cleanse the glans penis three times using clean side of washcloth for each circular stroke. NICU/PEDS: Retract foreskin only as far as to visualize the meatus. 8. Remove gloves and perform hand hygiene 9. Don sterile gloves. 10. Position fenestrated drape on patient. 11. Lubricate end of catheter.

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12. Cleanse meatus/glans penis with pre-saturated povidone iodine swabs.
  o Female: Separate labia with non-dominant hand, exposing meatus.
    ▪ Maintain this separation throughout insertion procedure.
    ▪ Cleanse each side of meatus and down the middle using one swab stick for each anterior to posterior stroke.
  o Male: Retract the foreskin if applicable, holding the penis upright with the non-dominant hand.
    ▪ NICU/PEDS: Retract foreskin on uncircumcised male only if needed to visualize.
    ▪ Cleanse the glans penis three (3) times using a new swab stick for each circular stroke.
13. Insert catheter for female patients.
  o Insert lubricated catheter slowly into female urethral meatus in an upward and forward direction until urine begins to flow.
    ▪ Insertion may only be around 2 cms in extremely low birth weight children.
14. Insert catheter for male patients.
  o Raise shaft of penis perpendicular body.
    ▪ Pull outward gently to ensure straight line of entry into bladder.
  o Insert catheter into male urethra, advancing until urine flows.
    ▪ Instruct patient to take a deep breath, change angle of penis, and apply steady gently pressure on the catheter if resistance is felt at the external sphincter.
    ▪ Return foreskin over glans penis on male patient.
15. Do not force catheter if unable to advance. Stop procedure, remove gloves, wash hands and notify physician.
16. Place the distal end of the urinary catheter within the sterile basin collection tray. Allow urine to drain completely.
17. Slowly withdraw the catheter.
18. Discard all soiled materials in appropriate waste containers.
19. Remove gloves and perform hand hygiene.
20. Document catheterization procedure and the amount and characteristics of urine in Epic.
21. If catheterization attempt is unsuccessful, obtain new catheter tray and repeat procedure.
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<tr><td>RN, LPN</td><td>
Maintenance - Indwelling Urinary Catheter:

1. Review indwelling urinary catheter necessity daily and document in Epic .
  o If patient does not meet criteria to maintain catheter, place order to discontinue indwelling urinary catheter
  o A physician's order is not needed to
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	discontinue an adult indwelling catheter 2. Remove indwelling urinary catheter within 48 hours of surgical procedure, unless it meets one of the indications for continuation. 3. Cleanse perineum daily and if patient incontinent of stool. o Use soap and water or hospital-approved skin cleanser. o Inspect perineal skin integrity. o Document in Epic 4. Position drainage bag below level of bladder at all times. 5. Do not rest the drainage system on the floor. 6. Do not place the drainage system in the patient's bed. 7. Position drainage bag tubing over patient's leg or between legs to avoid kinks and compression to reduce bacterial stasis and migration of urine toward the patient and into the bladder. 8. Confirm use of catheter stabilization device. 9. Change stabilization device every seven (7) days. 10. Maintain a closed drainage system. 11. Prior to emptying drainage bag: o Perform hand hygiene and put on clean pair of exam gloves. o Empty drainage bag contents into graduated cylinder. o Record output in Epic. 12. Remove gloves and perform hand hygiene.
Nursing Personnel	**Indwelling Catheter – Removal:** 1. Perform hand hygiene and don exam gloves. 2. Place underpad under the patient. 3. Open stabilization device retainer by pressing the release button with thumb and lift to open. 4. Remove catheter from device. 5. Insert appropriate size syringe into balloon sleeve valve. 6. Allow the pressure within the balloon to force the plunger back and fill the syringe with water. o Ensure all 10cc's of fluid has been removed. o Use only gentle aspirationto encourage deflation if needed. 7. Withdraw catheter from the urethra. 8. Removal of the stabilization device: o Wipe edge of stabilization device with at least 5-6 alcohol pads until corner lifts. o Continue to stroke undersurface of pad in bath and forth motion by squeezing the alcohol out to dissolve the adhesive pad away from the skin. 9. Discard equipment. 10. Remove gloves then discard and perform hand hygiene. 11. Document amount of urine in Epic. 12. Document date and time of indwelling catheter removal in Epic. 13. Monitor patients ability to void within eight (8) hours of catheter removal or as specified by the

	physician. ◦ NICU/PEDS: Monitor patient ability to void within 4 hours of catheter removal.

Regulatory Elements	
Related Policies	
Reference	Grose S. & Schub T. (2012). Urinary Catheter – Care. *CINAHL Nursing Guide*. Glendale, CA: CINAHL Information Systems. Grose S. & Walsh K. (2012). Urinary Catheter, Indwelling (Foley) – Insertion in the Female Adult Patient. *CINAHL Nursing Guide*. Glendale, CA: CINAHL Information Systems. Caple C. (2012). Urinary Catheter, Intermittent (Straight) – Insertion in the Female Adult Patient. *CINAHL Nursing Guide*. Glendale, CA: CINAHL Information Systems. Potter P. A., Perry A. G. & Ochs G. (2009). Study Guide and Skills Performance Checklists for Fundamentals of Nursing. (7th ed.). St. Louis, MO: Mosby. HICPAC: Guideline for Prevention of Catheter-Associated Urinary Tract Infections, 2009. APIC Elimination Guide: Guide to the Elimination of Catheter-Associated Urinary Tract Infections (CAUTIs), 2008. http://bardmedical.com/Resources/Products/Documents/Brochures/Urology/StatLock%C2%AE%20Foley%20Tips.pdf
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