

CATHERIZATIONS POLICY

Purpose:

To ensure correct and safe placement of an indwelling Foley Catheter.

Policy:

Catheterization shall be performed by a licensed Nurse or certified Patient Care Tech only upon a Physician's order to provide urinary drainage, prevent skin irritation and allow a wound of the sacrum to heal or as a diagnostic tool and to help patients to be active physically and socially without fear of embarrassment.

Procedure:

1. Insertion of Indwelling Foley Catheter

- A. Procedure shall be explained to patient prior to the insertion of the catheter and privacy must be provided.
- B. Sterile technique shall be used.
- C. If obstruction is encountered, procedure will be held until further instructions are obtained from the Physician. Never force the catheter when encountering an obstruction. A physician may have to insert the foley using a guide wire if there is an obstruction present.
- D. No greater than 600 mls of urine shall be allowed to initially drain from the bladder. Tubing will be clamped for 15-minutes and then opened to allow the bladder to drain. Draining a large amount of urine (greater than 750 ml) quickly could result in the patient going into shock.
- E. Tubing shall be secured to prevent accidental displacement of catheter position, or tautness on the line resulting in the balloon traumatizing the urethral opening and insure proper drainage.
- F. Procedure shall be documented in the Nurses notes to include:
 1. Date and time of insertion.
 2. Color and amount of urine obtained.
 3. Size of catheter inserted.
 4. Any specimens obtained.

- 5. Patient's tolerance of procedure.
- G. Date and time of catheter insertion and bag changes will be recorded in the medical record.
- H. All patients admitted from a nursing home with indwelling catheters will have the catheter changed within the first 24 hours or according to hospital policy.
- I. Intake and output should be recorded every 8 hours, unless otherwise specified by specific hospital policy or physician's order.
- J. Foley care with soap and water, and perineal cleansing twice daily and PRN.
- K. Closed system indwelling catheter system shall be maintained.
- L. Check for patency and dryness every 8 hours to make sure that the patient is not leaking around the catheter insertion site.
- M. Oral fluid intake shall be encouraged unless otherwise specified by a fluid restriction order.
- N. Follow Infection Control policy in regards to procedure for insertion and care of the catheter.
- O. Always keep level of drainage below the level of the bladder. Tubing is not to hang below the level of the drainage bag.
- P. If a patient is unable to void within 6 to 8 hours after removal of indwelling catheter, sooner if patient is distended or uncomfortable, notify the Physician. No patient is to be transferred to another facility or discharged after the catheter has been removed until he/she has voided.

II. **Straight Catheter Insertion**

- A. Procedure Shall be explained to patient prior to insertion of catheter and privacy provided.
- B. Sterile technique should be used.
- C. If obtaining residual urine specimen, patient shall void immediately prior to catheterization.
- D. Catheter shall be gently removed after procedure is completed.

- E. Procedure shall be documented in the Nurse's notes to include:
 - 1. Date and time of procedure.
 - 2. Amount and color of urine obtained.
 - 3. Size of catheter used.
 - 4. Any specimens that are sent to the lab.
 - 5. Patient's tolerance of procedure.

III. Condom Catheter

- A. Procedure shall be explained to patient prior to application of condom (Texas) catheter.
- B. perineal care shall be done prior to procedure.
- C. Condoms shall be applied securely without constriction.
- D. Condoms shall be checked for patency every 8 hours and PRN.
- E. Condoms shall be changed every 24 hours.
 - 1. Penis will be washed with soap and water and dried thoroughly.
 - 2. Skin will be inspected for redness, rash, and blisters.

Note: If present, the physician will be notified before the condom is applied.
- F. Gloves shall be worn by personnel for entire application procedure.

Patient Documentation:

Instruct patient to report any signs/symptoms of bladder fullness, burning or itching at the urethra opening.

Documentation:

Document in the medical record.

- 1. Date and time applied or changed.

2. Soap and water wash.
3. Assessment of the skin on the penis.
4. Intake and output every 8 hours or as specified by hospital policy.

Psychiatric Addendum:

Patients with a confirmed psychiatric diagnosis should have the procedure explained carefully especially if the patient is paranoid or has an altered body image. If the patient is agitated or potentially aggressive, make sure there is enough staff to deal with the patient. However, if the patient has to be held down during the procedure, make sure the procedure is absolutely necessary or an emergency before proceeding. The patient will feel as if they are being restrained as a form of “punishment”.