POLICY NUMBER: 1-R-08 (b)

Section: Urological and Renal Care

P&P – **Foley Catheter Insertion and Care – Sterile Technique**

Policy:

Nurses will insert indwelling Foley catheters when ordered by a Physician. The frequency of catheter changes depends on the patient's physiology, the type of catheter, the presence of infection and the patient's fluid intake. Unless otherwise indicated for this agency catheters must be changed q4wks.

Special Information:

When removing a catheter, roll the catheter between your fingers. A crunching sound indicates a buildup of sediment and consideration should be given to the changing the catheter more frequently.

Generally, increasing the amount of water in the balloon or increasing the size of the catheter does not decrease bypassing of urine. The balloon should be inflated with 5 ml more sterile water than indicated on the balloon. It is important to realize that 10% of all urinary catheterizations result in a bladder infection. Catheters must be changes once a patient is started on antibiotics for a bladder infection.

Equipment:

- Sterile catheterization tray provided by the CCAC which contains all necessary supplies with the exception of:
    - * 2 sterile catheters
    - * Incontinent pad
    - * 10/20/30 cc syringe to remove water from balloon of existing catheter where applicable
    - * Soap and water
    - * Non-sterile gloves
    - * Urine receptacle
    - * Catheter leg strap/fixation device
    - * Sterile specimen container, if sample required

Procedure – Female:

1. Explain procedure to patient and caregiver.
2. Wash hands.

3. Assemble equipment. Ensure that there is adequate lighting. Open new drainage bag and ensure that all clamps are closed.
4. Assist patient to a supine position with knees flexed. Have patient relax thighs so as to externally rotate the hip joints. Legs must be supported with pillows to reduce muscle tension OR position in a side-lying position with the upper leg flexed at the knee and hip. This may be a more comfortable position for the patient.
5. Place incontinent pad under the patient.
6. Drape patient for privacy.
7. Don gloves and wash the perineal area with soap and water; dry.
8. If the patient has a catheter already in situ, using a syringe remove the water from the catheter balloon and remove the catheter. Discard.
9. Remove gloves.
10. Open catheter tray, using sterile technique.
11. Open the sterile wrap to provide a sterile technique.
12. Open foley catheter and place on sterile field.
13. Don sterile gloves.
14. Attach a sterile syringe (from the sterile catheter tray) to the sideport lumen of the new catheter, and inject 5-10 ml of sterile water to test the integrity of the catheter. Deflate the balloon before insertion.
15. Drape patient with the fenestrated towel (plastic side down) from the catheter tray.
16. Open antiseptic sticks, or pour antiseptic solution over cotton balls.
17. Lubricate the tip of the catheter. Place the other end into the basin or urine collection container.
18. With the non-dominant hand, separate the labia to expose the urethral meatus. Maintain this position throughout the procedure.
19. With the dominant hand, pick up an antiseptic stick/cotton ball (with forceps) and cleanse the perineal area, starting at the clitoris and progressing downward past the vagina.
20. Use a clean antiseptic stick/cotton ball for each stroke. Cleanse directly over the urethral meatus with the last antiseptic stick/cotton ball.
21. With your dominant hand, gently insert the catheter tip into the urethral meatus, approximately 2-3 inches, until urine flows. Instruct the patient to breathe deeply to relax the perineal muscles and to overcome resistance to entry.
22. ~~Obtain urine sample, if needed.~~
23. Attach a syringe to the sideport lumen of the catheter and slowly inject the appropriate amount of sterile water to inflate the balloon. If the patient complains of sudden pain, aspirate back the solution and advance the catheter further.
24. Gently pull the catheter to be sure the balloon is inflated and will hold the catheter in place.
25. Connect the end of the catheter to the drainage bag. Be careful not to contaminate the end of the catheter or the drainage tubing.
26. Secure the catheter and drainage tubing to prevent tugging. Secure to the inner thigh with a catheter leg strap/fixation device. Allow for slack so movement does not create tension on the catheter.

27. Discard disposable items.
28. Remove gloves and wash hands.
29. Be sure there are no obstructions or kinks in the tubing, and ensure that tubing is checked after repositioning of patient.
30. Document the following on the patients Flow Sheet:

- The procedure and the patient's response
- Size of catheter inserted and capacity of balloon
- Amount of sterile water injected/ instilled into the catheter balloon
- Color, odor, amount of characteristics of patient's urine
- ~~Collection of urine sample, if appropriate~~
- Any patient/caregiver teaching

Procedure – Male:

1. Explain procedure to patient and caregiver.
2. Wash hands.
3. Assemble equipment. Ensure that there is adequate lighting. Open new drainage bag and ensure that all clamps are closed.
4. Assist the patient to a supine position with knees flexed and separated.
5. Place incontinent pad under the patient.
6. Drape patient for privacy.
7. Don gloves and wash the penis with soap and water. If the patient is uncircumcised, retract the foreskin and clean the meatus. Rinse and dry.
8. If the patient has a catheter already in situ, using a syringe remove the water from the catheter balloon and remove the catheter. Discard.
9. Remove gloves.
10. Open catheter tray, using sterile technique.
11. Open sterile wraps to provide a sterile field.
12. Open foley catheter and place on sterile field.
13. Don sterile gloves.
14. Attach a sterile syringe to the sideport lumen of the new catheter, and inject 5-10 ml of sterile water to test the integrity of the catheter. Deflate the balloon before insertion.
15. Drape patient with the fenestrated towel (plastic side down) from the catheter tray.
16. Open antiseptic sticks, or pour antiseptic solution over cotton balls.
17. Lubricate the tip of the catheter. Place the other end into the basin or urine collection container.
18. With the non-dominant hand, hold the penis upright at approximately a 90* angle to the patient's body. Retract the foreskin if the patient is not circumcised, and expose the meatus. Maintain this position throughout the procedure.
19. With the dominant hand, pick up an antiseptic stick/cotton ball (with forceps) and cleanse the glans with the antiseptic solution from the meatus outward. Use a clean antiseptic stick/cotton ball for each stroke.

20. Use a clean antiseptic stick/cotton ball for each stroke. Cleanse directly over the urethral meatus with the last antiseptic stick/cotton ball.
21. With your dominant hand, gently insert the catheter tip into the urethral meatus 6-7 inches, advancing approximately 2-3 inches until urine flows. Instruct the patient to breathe deeply to relax the perineal muscles and to overcome resistance to entry.
22. Obtain urine sample, if needed.
23. Attach a syringe to the sideport lumen of the catheter and slowly inject the appropriate amount of sterile water to inflate the balloon. If the patient complains of sudden pain, aspirate back the solution and advance the catheter further.
24. Gently pull the catheter to be sure the balloon is inflated and will hold the catheter in place.
25. If the patient is uncircumcised, place the foreskin back to its previous position to prevent swelling.
26. Connect the end of the catheter to the drainage bag. Be careful not to contaminate the end of the catheter or the drainage tubing.
27. Secure the catheter and drainage tubing to prevent tugging. Secure to the inner thigh with a catheter leg strap/fixation device. Allow for slack so movement does not create tension on the catheter.
28. Discard disposable items.
29. Remove gloves and wash hands.
30. Be sure there are no obstructions or kinks in the tubing, and ensure that tubing is checked after repositioning of patient.
31. Document the following on the patients flow sheet:

- The procedure and the patient's response
- Size of catheter inserted and capacity of balloon
- Amount of sterile water instilled into the catheter balloon
- Color, odor, amount of characteristics of patient's urine
- Collection of urine sample, if appropriate
- Any patient/caregiver teaching

Care of Catheter Drainage Bags:

Drainage bags may be used for 7 days at a time before being replaced with a new one.

The end of the catheter should always be cleansed with alcohol prior to reconnecting the catheter to the new tubing.

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