

**Margaret H. Rollins School of Nursing**  
**Nursing 101 Foundations of Nursing**  
**Urinary Catheterization Procedure 2020**

**Pre-Procedure**

1. Verify the order to insert the urinary catheter on the electronic medical record (EMR).
2. Perform hand hygiene, enter patient room, identify patient, and explain procedure. Also verify any patient allergies, including latex and iodine.
3. Perform hand hygiene when leaving room to gather all necessary equipment/supplies to insert catheter (urinary catheterization kit, clean gloves, and supplies to perform perineal care).
4. Perform hand hygiene again upon entry into patient room. Identify patient and briefly explain procedure again. Ask to use bedside table. Clear bedside table and clean with disinfectant wipes.
5. Obtain the assistance of a coworker to help with patient positioning and to ensure that sterile technique is maintained during insertion. Provide privacy and ensure adequate lighting. Perform hand hygiene again and put on clean gloves. Using foot pedal, raise bed to appropriate working height.
6. Position patient:
  - a. *Female*: Supine, with knees flexed and separated, feet flat on bed.
  - b. *Male*: Supine with legs extended and flat on bed.
7. If needed, wash the perineum thoroughly with warm water and soap. Rinse and dry thoroughly.
8. Discard gloves and perform hand hygiene.
9. Open catheterization kit and catheter package, maintaining sterility. Place on bed between patient's legs.
10. Carefully put on sterile gloves from kit.
11. Remove sterile drape from kit and place under patient's hips, shiny side down. Also, place fenestrated drape over the genital area to create a sterile field. Take care not to contaminate your sterile gloves.
12. If necessary to visualize all items in the kit, lift the urine tray with catheter out of the kit and set onto the sterile drape, closest to the patient. Collection bag should be just distal to the urine tray.
13. Prepare equipment for use:
  - a. Open antiseptic cleansing swabs or pour antiseptic solution over cotton balls in tray.
  - b. Open lubricant package and squeeze contents onto sterile tray.
  - c. Remove catheter from package and attach balloon with sterile water to balloon inflation port. If required by manufacturer, inflate balloon to inspect for leaks and then deflate the balloon, keeping syringe attached to the catheter. Some manufacturers recommend *not* inflating the balloon – check instructions included with kit.
  - d. Place catheter in urine tray in the lubricant to keep sterile and prepared for insertion.

## Procedure

- 14-A. Cleansing for the *female* patient:
- With non-dominant hand, separate the labia as widely as possible with the thumb, middle, and index fingers. Keep the labia well separated throughout the procedure so as to not obscure the urinary meatus or contaminate the area after cleaning.
  - With dominant hand, use antiseptic swab or cotton ball to clean the perineal area:
    - Wipe the far side of the urinary meatus with a single downward motion from front to back. Discard applicator.
    - Wipe the near side with another sterile applicator. Discard.
    - Wipe directly over the meatus with a third applicator. Discard.
    - Take care not to contaminate your remaining sterile glove!
- 14-B. Cleansing for the *male* patient:
- Hold the penis with the non-dominant hand. If uncircumcised, retract the foreskin.
  - Gently straighten out the urethra - penis should be at a 60 to 90-degree angle.
  - With dominant hand, clean the glans with a sterile applicator or cotton ball, cleaning in a circular motion starting from the tip of the urinary meatus and moving outward. Repeat procedure using a total of 3 sterile applicators or cotton balls, discarding after each use.
  - Take care not to contaminate your remaining sterile glove!
15. With the dominant hand, hold the catheter 2-3 inches from the tip and prepare to insert into the urinary meatus. Keep the distal end of the catheter in the urine tray.
16. To relax the sphincter and facilitate insertion, ask the patient to take a deep breath and insert catheter slowly as patient exhales.
- 17-A. Catheter insertion for the *female*:
- Advance the catheter 2 - 3 inches until urine begins to flow.
  - When urine appears, advance catheter another 1-2 inches.
  - Inflate the balloon with designated volume from the water-filled syringe to secure the catheter inside the bladder. Remove syringe and set aside until procedure completed – then discard appropriately.
  - If the catheter is inadvertently inserted into the vagina, leave it there as a landmark and begin the procedure over with new supplies.
- 17-B. Catheter insertion for the *male*:
- Advance the catheter to the bifurcation and check for urine flow.
  - If the foreskin was retracted, replace it to prevent compromised circulation.
  - Once urine appears, inflate the balloon with designated volume from the water-filled syringe to secure the catheter inside the bladder. Remove syringe and set aside until procedure completed – then discard appropriately.
18. For a straight, single use catheter, allow urine to flow into collection device until bladder is empty then withdraw catheter slowly and smoothly. There is no balloon for inflation. Document output.

## Post-Procedure (Indwelling Catheter)

19. Hang collection bag below the level of the bladder. Ensure there are no kinks, loops or obstructions in the tubing.
20. Apply catheter securement device (included in catheter kit) to secure the catheter to the patient thigh and avoid tension on the urinary meatus.

21. Dispose of all equipment and used supplies in regular trash receptacle. (Syringe in sharps.)
22. Wash and dry the perineal area, if needed.
23. Discard gloves and perform hand hygiene.
24. Assist the patient to a comfortable position. Instruct the patient how to position in bed with catheter over leg, and caution against pulling on catheter. Instruct to report any unusual or worrisome symptoms.
25. Lower the bed and ensure call bell in reach.
26. Document procedure. Include date/time of insertion, size, and type (indwelling, straight, coude, etc.) of catheter. Describe amount, color, and characteristics of urine. Note how procedure was tolerated and if chaperone was present.

### **Urine Specimen Collection:**

1. For straight (intermittent) catheterization:
  - a. Follow above procedure for catheter insertion using sterile technique.
  - b. Once access is obtained, hold the distal end of the catheter over the specimen container.
  - c. Collect 20-30 ml of urine in the specimen container.
2. For indwelling catheterization (catheter is already connected to drainage bag):
  - a. About 30 min before specimen collection, apply gloves and clamp tubing distal to the sampling port to collect urine.
  - b. Perform hand hygiene and put on clean gloves.
  - c. Disinfect sampling port with an alcohol pad and allow it to dry.
  - d. Access needle-less port with 10mL syringe and aspirate specimen into syringe.
  - e. Remove syringe and transfer urine into sterile specimen cup.
3. Properly scan & label urine specimen at bedside and place in biohazard bag. Follow procedure for sending to lab.
4. Discard gloves and perform hand hygiene.
5. Document procedure on EMR.

### **Discontinuing Indwelling Urinary Catheter**

1. Verify order for discontinuation on EMR (may be ordered under Urinary Catheter Discontinuation Protocol).
2. Gather Supplies:
  - a. Towel/absorbent pad
  - b. Empty 10 ml syringe
  - c. Non-sterile gloves
  - d. Optional: alcohol pads/gel
3. Perform hand hygiene when entering room, identify patient, explain procedure, provide privacy, perform hand hygiene again, apply clean gloves.

4. Empty urine from collection bag and tubing into graduated cylinder. Measure and empty into toilet.
5. Remove gloves and perform hand hygiene.
6. Apply new gloves and, using foot pedal, raise bed to comfortable working height. Position patient in supine position.
7. Place towel/absorbent pad under patient hips.
8. Remove leg strap/securement device from thigh (use alcohol wipes or handful of gel to loosen adhesive, prn).
9. Attach empty 10 mL syringe to balloon port and allow to passively deflate balloon.
10. When balloon is empty, gently pull catheter from urethra.
11. Use towel/absorbent pad to catch dribbles; dry & clean patient.
12. Dispose of catheter, tubing, and collection bag in regular trash.
13. Dispose of syringe in sharps.
14. Remove gloves and perform hand hygiene. Lower bed and ensure call bell in reach.
15. Document procedure on EMR: Date/time of removal and amount of urine emptied. Note how procedure was tolerated and if chaperone was present.
16. Instruct patient to notify RN when first void.

*Indwelling urinary catheter (Foley) insertion, female.* (2019). Lippincott Procedures.  
<https://procedures.lww.com/lnp/view.do?pId=2263042&hits=inserting,urinary,catheters,catheter,insertion,inserted,insert&a=true&ad=false>

*Indwelling urinary catheter (Foley) insertion, male.* (2019). Lippincott Procedures.  
<https://procedures.lww.com/lnp/view.do?pId=2263041>

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