# Foley Catheter Removal

## Purpose

The purpose of this procedure is to provide guidelines for the approved method of removing a foley catheter.

## Preparation

1. Verify that there is a physician's order for this procedure.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

## General Guidelines

1. Determine if the resident is on intake or output before discarding urine.
2. Culture indwelling catheter tips when changed or discontinued, as indicated by a physician's order.
3. Verify by the resident's medical record the size of the catheter balloon to ensure the aspiration of all fluid before removal of the catheter.

## Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Specimen container (if ordered);
2. Medication (if ordered);
3. Syringe (without needle); and
4. Personal protective equipment (e.g., gloves).

## Steps in the Procedure

1. Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached.
2. Wash and dry your hands thoroughly.
3. Assist the resident into the supine position.
4. Put on disposable gloves.
5. Fold the top covers down to the foot of the bed. Place a sheet (folded once) across the resident's chest. Avoid unnecessary exposure of the resident's body.
6. Obtain urine specimen, if ordered.
7. Remove tape or leg band used to secure tubing. Cleanse skin of any tape residue.
8. Insert the hub of a syringe in the intake lumen of the catheter and aspirate all of the fluid used to inflate the balloon.
9. Gently and slowly withdraw the catheter completely.
10. Clip the tip of the catheter tube, place it into the sterile specimen container, and close the container (with physician's order).
11. Measure urine and pour down commode. Flush the commode. Discard catheter, drainage tubing, and drainage bag into designated container.
12. Discard all disposable items into designated containers.
13. Remove gloves and discard in designated container. Wash and dry your hands thoroughly.
14. Clean the bedside stand and/or overbed table. Return the overbed table to its proper position.
15. Wash and dry your hands thoroughly.
16. Reposition the bed covers. Make the resident comfortable.
17. Place the call light within easy reach of the resident.

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**Steps in the Procedure (continued)**

18. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
19. Send catheter tip to lab for a routine culture (with physician's order).
20. Wash and dry your hands thoroughly.

**Documentation**

The following information should be recorded in the resident's medical record:

1. The date and time the procedure was performed.
2. The name and title of the individual(s) who performed the procedure.
3. All assessment data (e.g., character, color, clarity, etc.) obtained during the procedure.
4. How the resident tolerated the procedure.
5. If the resident refused the procedure, the reason(s) why and the intervention taken.
6. The signature and title of the person recording the data.

**Reporting**

1. Notify the Charge Nurse if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

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