Mosby's Nursing Video Skills

Procedure Guideline for Removing an Indwelling Urinary Catheter

1. Verify the health care provider’s orders and previous documentation to determine how much fluid was used to fill the balloon on insertion.
2. Gather the necessary equipment and supplies.
3. Perform hand hygiene.
4. Close the door to the room, and pull the bedside curtain.
5. Introduce yourself to the patient and family, if present.
6. Identify the patient using two identifiers, such as name birth date, or name and account number, according to your agency’s policy.
7. Explain the procedure prior to proceeding.
8. Organize the equipment needed for perineal care and catheter removal.
9. Raise the bed to a comfortable working height. Lower the side rails on the working side.
10. Apply gloves and place a waterproof pad under the patient’s buttocks, and cover him or her with a bath blanket. Only the genital area and the catheter will be exposed.
   A. Help a female patient into the dorsal recumbent position.
   B. Help a male patient into the supine position.
11. Remove the catheter securement device while maintaining the catheter connection with the drainage tubing.
12. Perform catheter care and perineal hygiene. Refer to the Video Skills “Providing Catheter Care,” “Performing Perineal Care for the Female Patient,” and “Performing Perineal Care for the Male Patient.”
13. Removing the catheter on a female patient:
   A. Move the syringe plunger up and down to loosen it; then withdraw the plunger to 0.5 mL. Insert the hub of the syringe into the inflation valve or balloon port. Allow the balloon fluid to drain into the syringe by gravity. Make sure all fluid is removed by comparing the amount removed to the volume used for inflation.
   B. Pull the catheter out smoothly and slowly. It should slide out easily. Do not use force. If you notice resistance, reattach the syringe and make sure that all of the fluid is drained. Examine the catheter to make sure it is intact.
   C. Once the catheter is removed, wrap the contaminated catheter in a waterproof pad. Unhook the collection bag and drainage tubing from the bed.
14. Removing the catheter on a male patient:
   A. Place a washcloth between the penis and scrotum.
   B. Move the syringe plunger up and down to loosen it; then withdraw the plunger to 0.5 mL. Insert the hub of the syringe into the inflation valve or balloon port. Allow the balloon fluid to drain into the syringe by gravity. Make sure all fluid is removed by comparing the amount removed to the volume used for inflation.
   C. Pick up the shaft of the penis with your nondominant hand, and with your dominant hand pull the catheter out smoothly and slowly coiling the catheter around your finger. It should slide out easily. Do not use force. If you notice resistance, reattach the syringe and make sure that all of the fluid is drained. Examine the catheter to make sure it is intact.
D. Once the catheter is removed, wrap the contaminated catheter in a waterproof pad. Unhook the collection bag and drainage tubing from the bed.
15. Provide hygiene to the patient as needed. Help the patient into a comfortable position, and place toiletries and personal items within reach.
16. To ensure patient safety, raise the appropriate number of side rails and lower the bed to the lowest position.
17. Empty urine from the drainage bag, measure it, and record the amount.
18. Remove your gloves, and perform hand hygiene.
19. Unless contraindicated, encourage the patient to maintain or increase his or her fluid intake.
20. Initiate a voiding record or bladder diary. Instruct the patient to tell you when he or she needs to void, so that all urine can be measured. Make sure that the patient understands how to use the collection container.
21. Explain that many patients experience mild burning, discomfort, or small-volume voiding initially after catheter removal, and that these symptoms will subside soon.
22. Tell the patient to report any signs of complications, such as dysuria, hematuria, urgency, frequency, lower abdominal pain, change in mental status, lethargy, fever, chills, burning, flank pain, back pain, or blood in the urine.
23. Ensure that the patient has easy access to the commode, bedpan, or urinal. Place the urine hat on the toilet seat if the patient is using the toilet. Make sure to use gloves if touching any of the above and perform hand hygiene.
24. Place the call light within easy reach. Dispose of all contaminated supplies in the appropriate receptacle.
25. Leave the patient’s room tidy.