FOLEY CATHETER REMOVAL PROTOCOL

A. Criteria for Continuing Foley Catheter
1. Known or suspected urinary tract obstruction
2. Neurogenic bladder dysfunction
3. Recent urologic surgery, bladder injury, pelvic surgery, or recent surgery involving structures contiguous with the bladder or urinary tract, after pelvic surgery (i.e. GYN and Colorectal)
4. Urinary incontinence in a patient with Stage III or Stage IV pressure ulcers on the trunk, perineal wounds, necrotizing infections.
5. Need for accurate measurement of urinary output in a critically ill patient.
6. Gross hematuria in patients with potential clots (for irrigation)
7. Post surgical procedure, within 24 hrs
8. Epidural catheter still in place
9. Palliative care for terminally ill
10. Physician order to maintain catheter
RN can remove foley if none of the above are met, 7:00 AM is the most optimal time.

B. Criteria for Removal by RN (as applicable)
1. The patient is awake, alert, oriented; verbally express no trouble voiding before the catheter was placed.
2. Patient is able to resume their voiding position.
3. Order for strict I&O is discontinued or the patient is able to cooperate with strict I&O monitoring
4. If a foley is present post procedure, confer with physician to remove foley unless there is a clear reason for not discontinuing the foley.
5. Epidural catheter is removed
6. A physician order is required for discontinuing foley for patients who have had recent urologic surgery, bladder injury, pelvic surgery (i.e. GYN, colorectal surgery) and/or recent surgery involving structures contiguous with the bladder or urinary tract.
7. Document Order Sheet “Indwelling Catheter Discontinued per Protocol” RN sign/date/time
8. No need for a routine urine culture upon foley removal

C. Assessment Post-catheter Removal
After removal of the Foley catheter, the patient will be assessed by the RN for the following parameters:
1. Patient is spontaneously voiding
2. Patient is not voiding however is comfortable and expresses no desire to void. (do not do bladder scan)
3. A bladder scan should be done for any of the following:
   • patient is uncomfortable at anytime, whether voiding or not,
   • patient has an urge to void but is unable to do so
   • patient is incontinent at anytime
4. If the patient is uncomfortable or has the urge to void and if the bladder scan post void residual is > 400 cc, the RN will initiate straight catheterization every 6 hours and keep record of volume output with each catheterization and each void.
   • 0700–2100: RN should notify the physician and request an order for straight catheterization frequency
   • 2100 (9:00PM): RN may notify the physician the next morning
5. If the bladder scan volume is >600 cc, contact physician
6. Record output volume and time of day with each void and each/any catheterization

Remove Foley
No Action Needed