Urinary Catheter Insertion, Indwelling - Male

Purpose: An indwelling Foley (or retention catheter) is used to remove urine from the bladder in situations when there is a mechanical obstruction in the urethra or retention of urine due to a nerve block (i.e. after surgery, with epidural administration), due to benign prostatic hypertrophy (BPH), or in cases where urine needs to be carefully measured. A catheter may also be used when a patient must be immobilized (such as with skeletal traction) and during many surgical procedures.

Nursing Considerations

Assessment:

Determine the indication for the indwelling catheter (Foley or retention catheter) and confirm the order.
Ask the patient if he has a history of urinary issues or has been catheterized before and for how long it may have been in place. If the patient has urethral strictures or an enlarged prostate (BPH), this can make catheterization more difficult.
Assess for latex allergy, depending on the catheter being used. Consider the use of a silicone catheter.
Assess for adhesive allergies.
Assess for shellfish allergy or iodine sensitivity.

Contraindications

Catheterization is contraindicated if there is suspected urethral trauma/tearing.

Risks:

The main risk is infection. Catheter-associated urinary tract infections are the most common nosocomial infections. 10-30% of patients develop bacteriuria and become symptomatic within 2-4 days after insertion of an indwelling catheter. Though catheters may be used for comfort at end of life, indwelling catheters are not indicated to manage incontinence or for convenience at any other time, and should always be removed as soon as possible.
Indwelling catheters may also lead to renal inflammation and pyelonephritis with prolonged use.

Patient Teaching:

Explain the procedure and what the patient can expect to feel during insertion (pressure, some temporary discomfort if there is an enlarged prostate, then relief as urine is released).
Due to expected concerns for modesty, offer to provide a bath blanket to cover the legs and close the curtain to provide privacy.

Procedure

Supplies:
Note: Catheters come in different sizes and materials. Catheters are sized in units called French, ranging from 12 FR (small) for pediatrics to 48 FR (extra large), and are usually silicone but may be latex or another material.
clean gloves
washcloth and warm water for perineal hygiene
waterproof pad
sterile Foley catheter kit
If you are not using a kit, also assemble the following supplies:
sterile catheter in the appropriate size
sterile gloves
sterile drapes, one with a fenestration (window)
antiseptic solution such as betadine (use castile soap or Hibiclens if the patient reported an iodine sensitivity)
stereile basin (the catheter kit tray may act as the basin)
stereile cotton balls
sterile forceps
prefilled syringe with WATER
lubricant (sterile)
disposable urine collection bag and tubing
paper tape or a leg strap

Steps:
Confirm the patient’s ID using two identifiers.
Close the curtain to provide for patient privacy and stand on the patient’s right side if you are right-handed or the left side of the bed if you are left-handed.
Ask the patient to lay back in the dorsal recumbent position; legs straight and slightly apart. Slip the waterproof pad under the patient’s penis and/or scrotum. Keep the patient covered while you set up your sterile field.
Set up the urine collection bag if a separate system is to be used, and attach it to the bed frame.
Open the sterile catheterization kit on the patient’s legs using sterile technique. If no kit is used, open a sterile drape and prepare sterile field with necessary supplies.
Dorn the sterile gloves included in the kit.
Apply the drapes: Lift the first sterile drape (with no window) and, using part of the drape to protect the sterile gloves, drape the thighs. If the gloves become contaminated, replace them with new gloves.
The second drape is fenestrated, and is placed over the patient’s groin area to expose the genitals through the window.
Open all the sterile supplies in the tray. Remove the plastic sheath covering the catheter, squirt the lubricant in the tray, and lay the catheter in the tray with the tip in the lubricant. Pour the antiseptic over the cotton balls, unwrap and attach the 10 mL syringe of water to the balloon port. (If no kit is used, ensure that the drainage end of the catheter is in the basin and this is within reach for urine drainage.)
Testing the balloon prior to insertion is not recommended. All catheters are tested during the manufacturing process. Also, inflation creates stress on the balloon that creates “ridges” and increases the surface area, causing higher incidences of urinary tract infections and more irritation upon insertion.
Clean the penis glans and urinary meatus: Using your nondominant hand as your working/nonsterile hand, pull back the foreskin, if applicable. Hold the penile shaft and glans and prepare to keep this hand in place until the catheter is in and urine is flowing.
Using your dominant hand and keeping it sterile, use the included sterile forceps to pick up an antiseptic-soaked cotton ball and clean the meatus and the surrounding penis glans in a circular motion starting at the tip, discarding the cotton ball after one pass. Pick up another cotton ball and repeat the process at least two more times.

Insert the catheter: Using your sterile, dominant hand, pick up the catheter a few inches from the tip ensure it is coated in the lubricant. Then insert the tip slowly into the urethra and advance it until you see the flow of urine, and then advance another 3 inches. Note: If you encounter pressure before you see any urinary flow, this may be due to a narrowing of the urethra from the prostate. Turn the catheter a little and advance further and it will slip past and into the bladder. Do NOT force the catheter if there is great resistance.

Inflate the balloon with the entire volume of sterile water (usually 10 mL). Do not inflate against great resistance. Try moving the catheter a little further before attempting to inflate again to avoid damage to the urethra.

Attach the urine drainage bag if no kit was used. Otherwise, attach the urine drainage bag to the bed frame now. Clean up supplies.

Use tape or a velcro leg strap to attach drainage tubing to leg, leaving some slack to allow for movement.

Remove gloves and perform hand hygiene.

Assist patient to a comfortable position.