

## **Foley Catheter Removal**

Female1: We're going to take out a catheter today. What do we need to know about this?

Female2: We always have to think about why the catheter went in in the first place because that helps us to anticipate [if] we are going to have some issues later. So Charlie here had his catheter put in during surgery. They needed us to keep a close eye on his renal function and they anticipated maybe some urinary retention because of some opioids that we had given him. So I've informed him about what we're going to do and he's delighted to get rid of this tube. He's done his own peri care.

F1: So we can make this decision on our own, we don't need to have a direct order for that?

F2: That's a really good question. So again, it's within the nurse's scope of practice to do this independently without an order, but you need to make sure you have employer policy to support you. In our health authority they use a mnemonic called HOUDINI to help us make decisions about removing foley catheters. I'll leave a resource for the students so that they can refer to that. But one of the things [within that HOUDINI guideline] is you can't remove a Foley catheter on a patient post-operatively without an order. So in this case we definitely do have an order. So Wendy, I've got some clean gloves on and I've grabbed a 10 ml syringe.

F1: So you said that sometimes they [meaning balloons] can have up to 30 mls

F2: Yes it depends on the patient. So most--

F1: Does it say on here?

F2: It does, but even though might say that it's a 10 ml--

F1: It says 5 to 10,

F2: It might say that but that doesn't tell you how much the nurse [or surgeon] put in the balloon when it was inserted. So I'll just show you how you can ensure that the catheter balloon is deflated. Because it would be really difficult to pull out a catheter with the balloon inflated. It's possible. I've seen it.

F1: I've seen patients do that.

F2: Yeah, and it's not nice.

F1: I've seen nurses do that too, you know, when they accidentally put the catheter bag-- it gets wound up in the side rails and they pull the side rail down and it actually pulls out-- so it's really important to make sure-- that safety thing, that--

F2: Yes, urethral trauma, right. Okay, so all we do is we attach the syringe onto the pigtail and then the newer catheters they actually just start filling the syringe itself. So in this case, this is not a new catheter, because our equipment is not the latest and greatest. So I'm just going to keep pulling back. Now can the camera pick up how this tubing is collapsing on itself?

F1: Right here.

F2: Yes I know that that's empty. Now you can see, obviously, in the camera that we only have one ml and that's just the limitations of our anatomy [of the manikin] that we have going on.

F1: So normally there would be 10 or something.

F2: Probably 10 yes. That's going to go in the garbage. Usually I like to hold a little tissue or just put the garbage bag underneath the meatus. I say, 'Mr. Jones, take a

deep breath', and just pull the catheter until it's out.

F1: Okay.

F2: All right. So then this will make its way to the garbage and I'll empty the urine into the toilet or whatever system we have going on.

F1: Now what do we do if they have the stat lock on?

F2: The stat lock, it says right on it, remove with alcohol. So you're going to get an alcohol swab. You're going to rub it at the edge and you're going to slowly pull it back as it's coming off the skin.

F1: Okay.

F2: Yes. But some of the most important stuff that we have to think about [is] after catheter removal; it's the patient teaching. You need to tell Mr. Jones that it's probably going to burn the first few times that he urinates... to expect that. [And he needs to] drink extra water. So I've assessed him [and] there are no contraindications for him to not drink water, so I've asked him to drink two litres a day. I've given him a jug [aka urinal] and I'm going to measure at least the first void. So that's an interesting thing too, because some nurses have the habit of measuring the first three voids. Do you remember that?

F1: Yes.

F2: There's never been any literature to suggest that that is best practice. It's not wrong practice. I've found over the years with the quick turnover in acute care, oftentimes we'll just wait for the first void. If we're happy with the volume then we'll often discharge the patient.

F1: Is there any time from catheter removal to first void?

F2: That's a really good question too. So the textbooks will tell you six to eight hours, but I think you always have to go back and assess your patient. Are they hydrated? Are they drinking? Think about bladder capacity. So most of us have a bladder that at about the 400 ml mark will [make us] feel like we have to void. But there are people, I think from certain occupations that [can] hold their urine longer.

F1: Nurses?

F2: Nurses and truck drivers, yes. And they can sometimes have one litre bladders that they still don't feel any urge to void so-- going back, knowing your patient, palpating bladders, using bladder scanners if you're at all concerned that they're producing urine but they're not actually able to void. Yes.

F1: Okay.