



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Nursing		
Document:	Internal Policy and Procedure		
Title:	Insertion of Urinary Catheter		
Applies To:	All Nursing Staff		
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1. PURPOSE:

- 1.1 To monitor urinary function, prevent or relieve bladder distension.
- 1.2 Provide continuous bladder drainage.
- 1.3 Obtain sterile urine specimens.
- 1.4 Measure residual urine.
- 1.5 Provide a means for irrigating the bladder with fluids or medication.
- 1.6 To maintain aseptic technique throughout the procedure.
- 1.7 To instil medication into the bladder.

2. DEFINITIONS:

- 2.1 **Insertion of Urinary Catheter** is an introduction of a rubber or plastic catheter through the urethra and into the bladder. It provides a continuous flow of urine in patients who are unable to micturate or in those with obstruction of urine flow.

3. POLICY:

- 3.1 All catheterization shall only be performed under the physician's order.
- 3.2 Catheterization is done under aseptic technique throughout the procedure.
- 3.3 If possible, male nurse will do catheterization for male patient only.
- 3.4 The urine bag should be hanged at all times.
- 3.5 Rubber indwelling catheter must be change every week.
- 3.6 Silicon indwelling catheter must be changed after 6 weeks.
- 3.7 During catheterization procedure, if any resistance is felt, do not use force against the resistance.
- 3.8 Remove catheter immediately and notify physician.
- 3.9 Assessment of patient includes:
 - 3.9.1 Reasons for catheterization
 - 3.9.2 Bladder distension
 - 3.9.3 Time of last urination
 - 3.9.4 Mobility and physical limitation of patient
 - 3.9.5 Patient's age and sex
- 3.10 Urinary bag must be changed every 24 hours.

4. PROCEDURE:

- 4.1 Male patients:
 - 4.1.1 Assess patient for the following:
 - 4.1.1.1 Time of last urination
 - 4.1.1.2 Level of awareness and knowledge of purpose of catheterization
 - 4.1.1.3 Mobility and physical limitation of patient
 - 4.1.1.4 Patient's age
 - 4.1.1.5 Pathological condition that may impair passage of catheter (e.g. enlarge prostate)

- 4.1.2 Verify the patient using 2 identifier (four names for Saudi or Complete name for Non-Saudi and Medical Record Number).
- 4.1.3 Explain the procedure to the patient.
- 4.1.4 Provide the patient with opportunity to perform personal hygiene (penile). Assist as necessary.
- 4.1.5 Wash hands.
- 4.1.6 Position the patient in supine with only the genitalia exposed.
- 4.1.7 Drape legs to mid-thigh with bed sheet.
- 4.1.8 Open catheterization tray.
- 4.1.9 Put on sterile gloves. Open all sterile equipment.
- 4.1.10 Drape the patient's genitalia.
- 4.1.11 With non-dominant hand, hold the penis at a 90° angle to the body. If the patient is not circumcised, pull back the foreskin to visualize urethral meatus.
- 4.1.12 Clean the urinary meatus with one downward stroke or use a circular motion from meatus to base of penis. Dry the meatus.
- 4.1.13 Lubricate catheter and gently insert into urethra (approximately 8 inches) until urine begins to drain.
- 4.1.14 Insert catheter an additional inch (2.5 cm) and inflate the balloon.
- 4.1.15 Check for placement by gently pulling on catheter.
- 4.1.16 Connect to drainage bag and tape catheter to the thigh.
- 4.1.17 Wash hands.
- 4.1.18 Record the time of completion of the procedure, amount, color of urine and time.
- 4.1.19 Notify the physician for any abnormalities noted.
- 4.2 Female patients:
 - 4.2.1 Assess patient for the following:
 - 4.2.1.1 Time of last urination
 - 4.2.1.2 Level of awareness and knowledge of purpose catheterization
 - 4.2.1.3 Mobility and physical limitation of patient.
 - 4.2.1.4 Patient's age
 - 4.2.2 Verify the patient using 2 identifier (four names for Saudi or Complete name for Non-Saudi and Medical Record Number).
 - 4.2.3 Explain the procedure to the patient
 - 4.2.4 Place the patient in supine position with knees bent, hips flexed, and feet resting on bed.
 - 4.2.5 Direct light for visualization of genital area.
 - 4.2.6 Apply moisture-proof pad under the patient's buttocks.
 - 4.2.7 Wash hands. Put on sterile gloves.
 - 4.2.8 Separate labia minora so that urethral meatus is visualize one hand to maintain separation of labia until catheterization is finished.
 - 4.2.9 Cleanse around the urethral meatus with a povidone iodine solution.
 - 4.2.10 Introduce a well lubricated catheter 5-7 cm (2-3 inches) into urethral meatus using strict aseptic technique.
 - 4.2.11 Allow some urine to flow through the catheter before collecting a specimen.
 - 4.2.12 Place the patient in a comfortable position.
 - 4.2.13 Wash hands.
 - 4.2.14 Record the time of completion of the procedure, amount and color of urine and time.
 - 4.2.15 Notify physician for any abnormalities noted.

5. MATERIAL AND EQUIPMENT:

- 5.1 Catheterization set- which includes cotton balls, lubricant forceps, specimen cup, gloves, drapes, drainage bag, foley catheter (5-16). Syringe with 10cc water, antiseptic solution (Povidone iodine)
- 5.2 Extra catheter and gloves
- 5.3 A light source (torch)

6. RESPONSIBILITIES:

6.1 Nurse




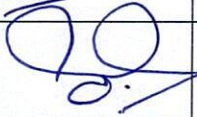
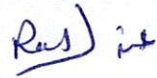
7. APPENDICES:

N/A

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration, Functions and Duties Policies and Procedures

9. APPROVALS:

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