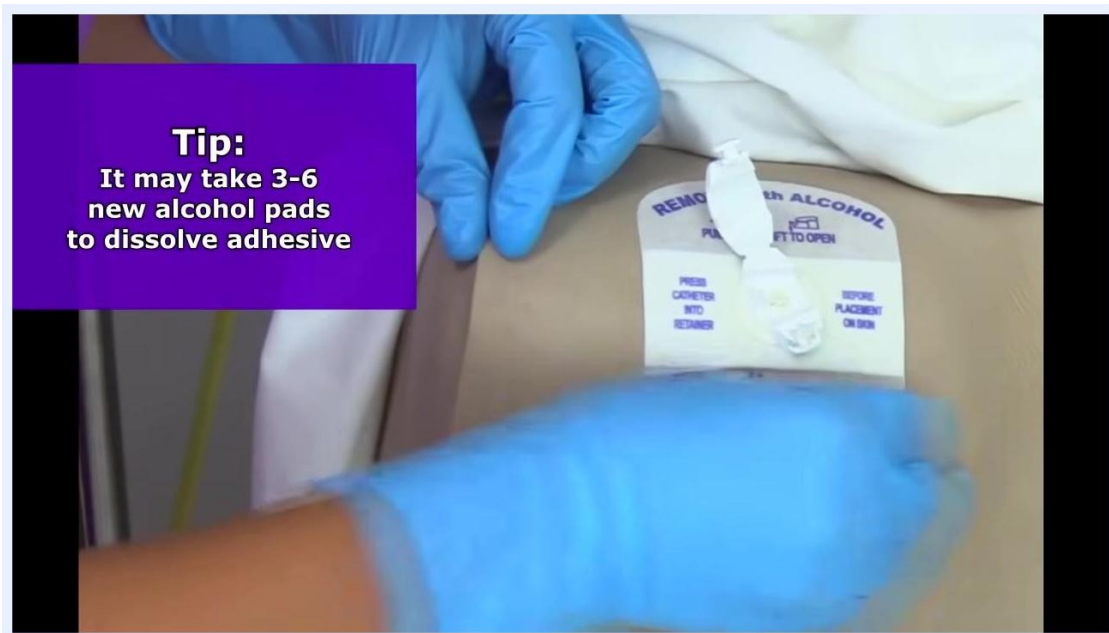


How to Remove a Foley Catheter (Female Patient): Patient Care Procedure

This procedure describes how to remove a Foley catheter from a female patient safely, in line with facility protocol and infection-control standards. It covers assessment before removal, the step-by-step removal technique, monitoring after removal, and the patient education needed to support a smooth recovery. Follow every step in sequence and use the exact supplies listed below.



Catheter released from the securement device, with the device still attached to the mannequin's thigh



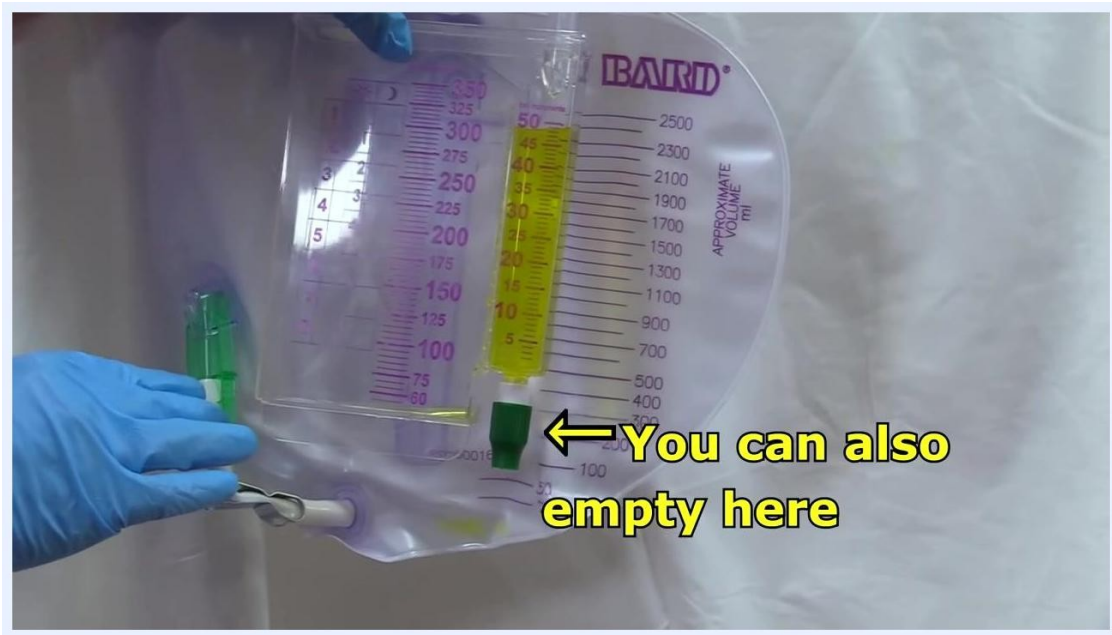
Patient Education:

- Instruct patient to notify you before voiding (urinating)
- Patient should typically void within next 6 hours (if not, notify physician)
- Void should be a complete stream
- If patient isn't voiding, Dr may order bladder scan
- Measure & document 1st void (output, color, smell)

Nurse assisting an older patient with an IV pole in a hospital room, monitor in the background, next to Patient Education notes

Purpose & scope

This procedure applies to female patients with an indwelling Foley catheter who have a physician's order for catheter removal. It is intended for use on a hospital ward or comparable inpatient care setting where a nurse performs catheter removal, monitors the patient's first void, and provides post-removal patient education.



Close-up of a Foley catheter urine collection bag with measurement markings, a gloved hand pointing to the drainage port, and the on-screen note: You can also empty here

Patient assessment

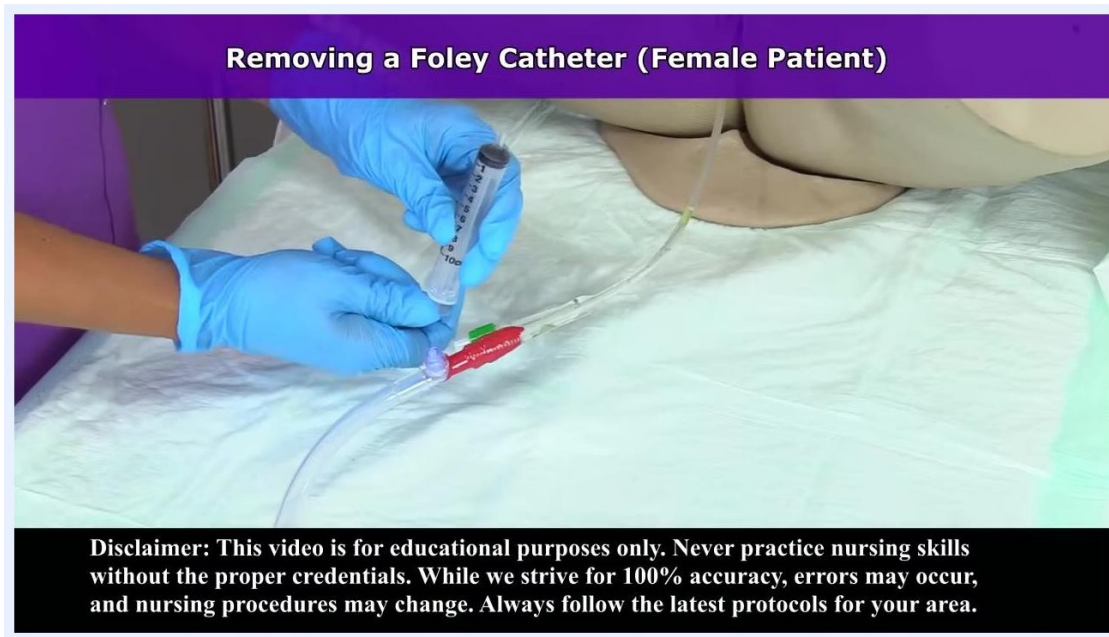
Before touching any equipment, complete the following checklist.

1. Obtain a doctor's order confirming that catheter removal is authorized.
2. Verify the patient by confirming you have the correct patient.
3. Explain the procedure to the patient, letting her know that removal is a simpler procedure than insertion, and obtain her verbal consent. Reassure her and answer any questions.

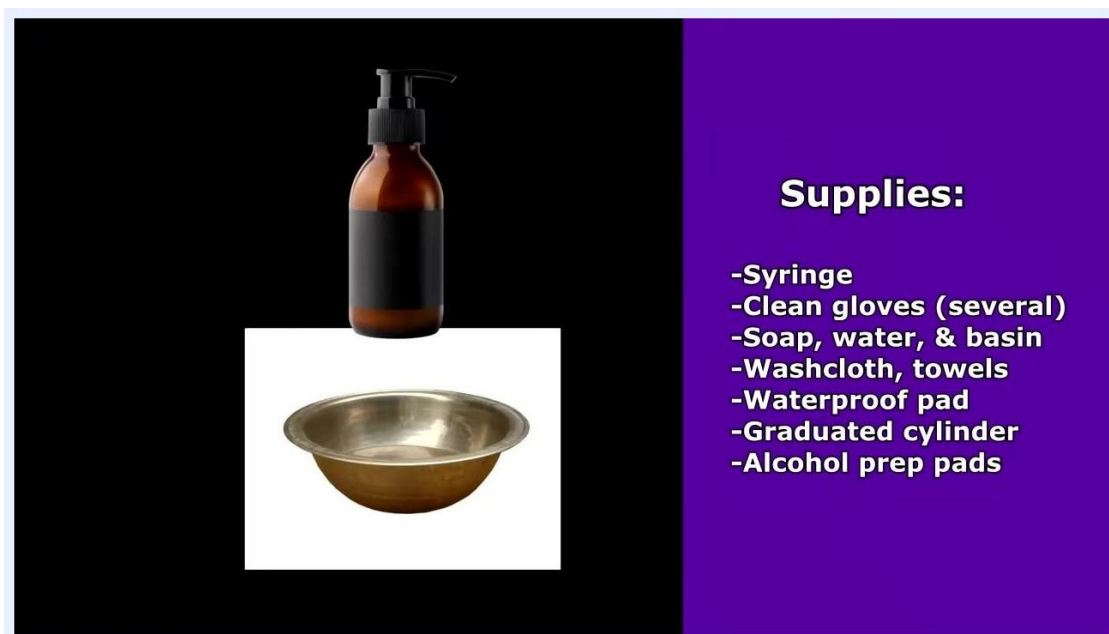
Gather all supplies within reach before you begin:

Supply	Purpose
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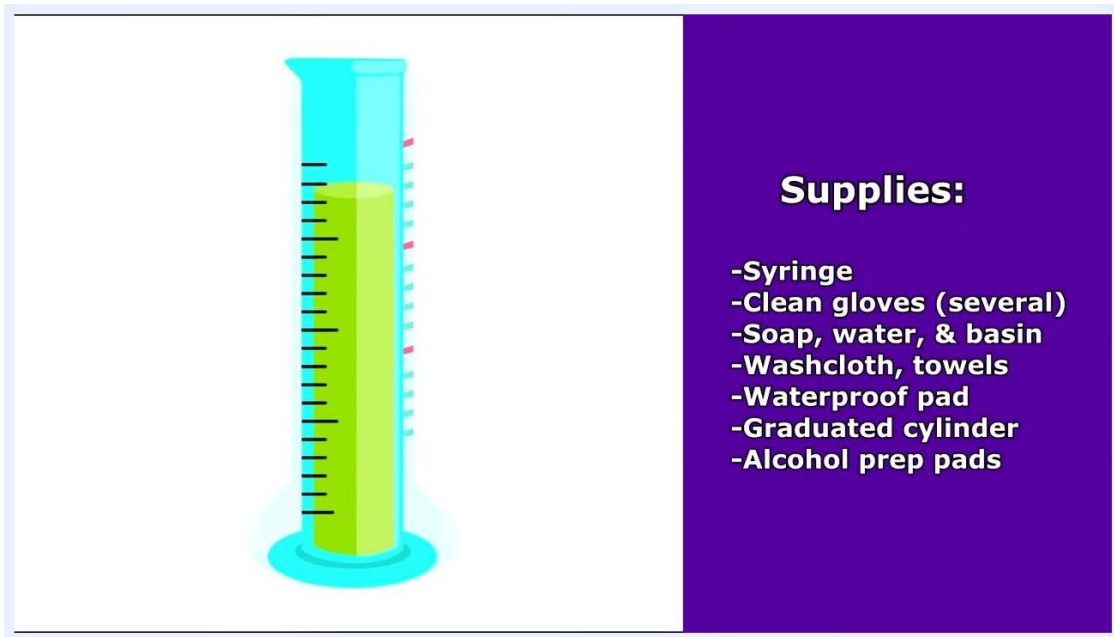
Syringe	Removes water from the retention balloon
Clean gloves (several pairs)	Hand protection at each stage of the procedure
Soap, water, and basin	Hand hygiene and perineal care
Washcloth and towels	Perineal care and drying
Waterproof pad	Protects bedding during peri-care and removal
Graduated cylinder	Measures urine output
Alcohol prep pads	Dissolves the adhesive of the securement device



Nurse standing next to a mannequin beside an on-screen checklist reading: Obtain doctor's order, Verify everything, Explain procedure and get consent

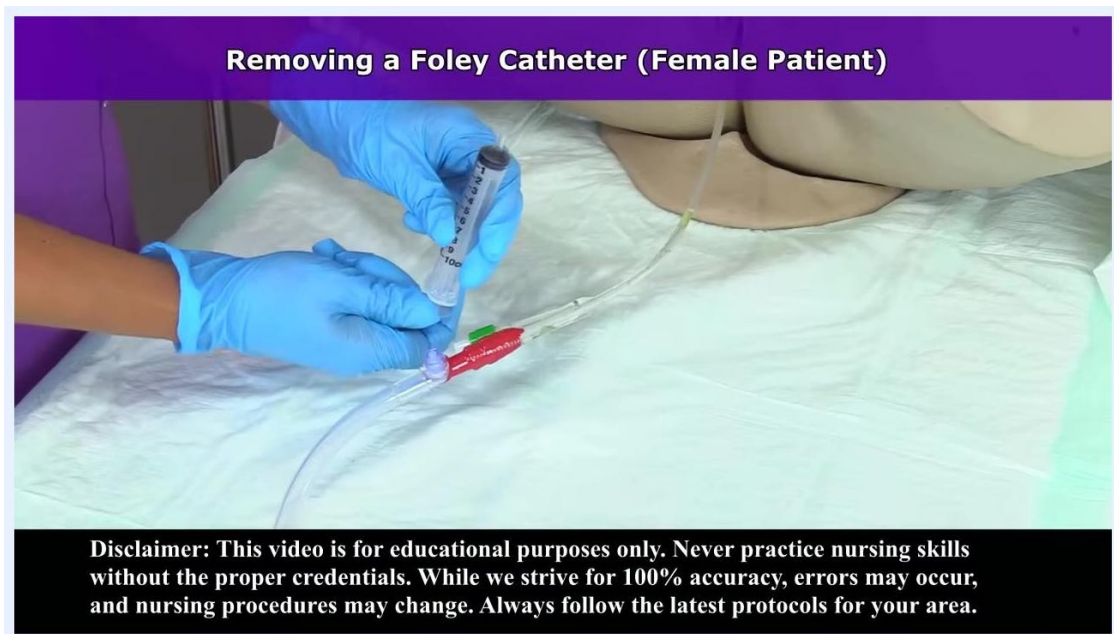


Soap dispenser and basin beside a supply checklist listing syringe, clean gloves, soap and basin, washcloth, towels, waterproof pad, graduated cylinder, and alcohol prep pads



Graduated cylinder beside the same supply checklist

As part of your initial assessment, check the balloon port for the catheter's balloon-volume information (for example, "14 French, inflated with 10 ml of water") and prepare a syringe matching that volume for deflation.



Gloved hands holding a syringe attached to the balloon port of a Foley catheter, with a mannequin and a waterproof pad in the background

Care protocol

Phase 1: Hand hygiene and gloving

Wash your hands thoroughly with soap and water, or use hand sanitizer, and don a pair of clean gloves before handling any equipment or the patient.



Hands being washed under running water with soap, labeled: Perform hand hygiene

Phase 2: Empty and measure the Foley bag

If urine remains in the tubing, unclamp or unclip it as needed and gently lift the tubing so gravity drains the urine into the collection bag.



Gloved hands pointing to urine remaining in the Foley catheter tubing, with a waterproof pad underneath

Unhook the drainage port on the collection bag, drain the urine into a graduated cylinder, and record the measured volume in the patient's chart.



Urine collection bag beside the same supply checklist

Tip the bag if necessary so all urine reaches the main compartment, then empty and measure the full output again before recording the final total.

Remove your gloves and wash your hands again, or use hand sanitizer, before donning a new pair of clean gloves.

Phase 3: Position the patient and remove the securement device

Slide a waterproof pad under the patient's hips to catch fluids during peri-care and catheter removal.

Instruct the patient to lie on her back with knees bent and legs apart (dorsal recumbent position) to expose the genital area, keeping her covered as much as possible for privacy.



Dorsal Recumbent Position

Nurse in purple scrubs placing a waterproof pad under a mannequin's hips, with the mannequin covered by a sheet



Dorsal Recumbent Position

Patient lying on her back with knees bent and legs apart, hands resting on her abdomen, labeled: Dorsal recumbent position

Locate the securement device (such as a StatLock) on the patient's thigh and read its instructions, which typically state "REMOVE with ALCOHOL." Gather several alcohol prep pads, since it may take 3–6 pads to dissolve the adhesive.



Gloved hands near a Foley catheter securement device on a mannequin's thigh, labeled: Remove with alcohol

Push the sides of the clip on the securement device to release the catheter, then gently lift it out and lay it securely to the side.

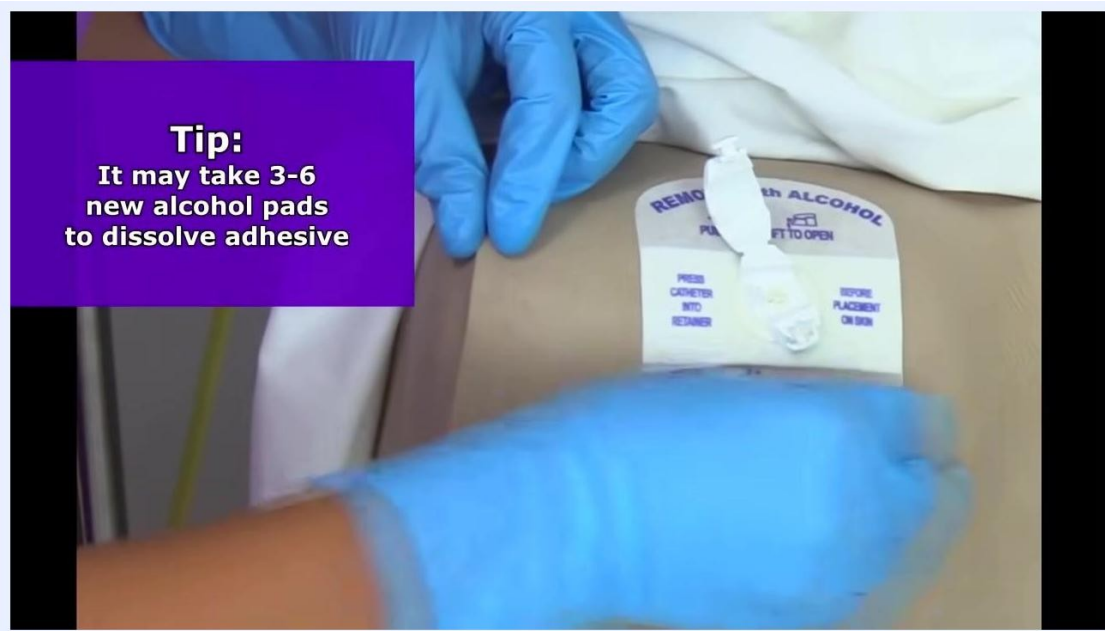
Saturate the adhesive with an alcohol prep pad, start at one edge, and gently work the alcohol under the adhesive as you lift. Apply new pads as needed until the device is fully removed.



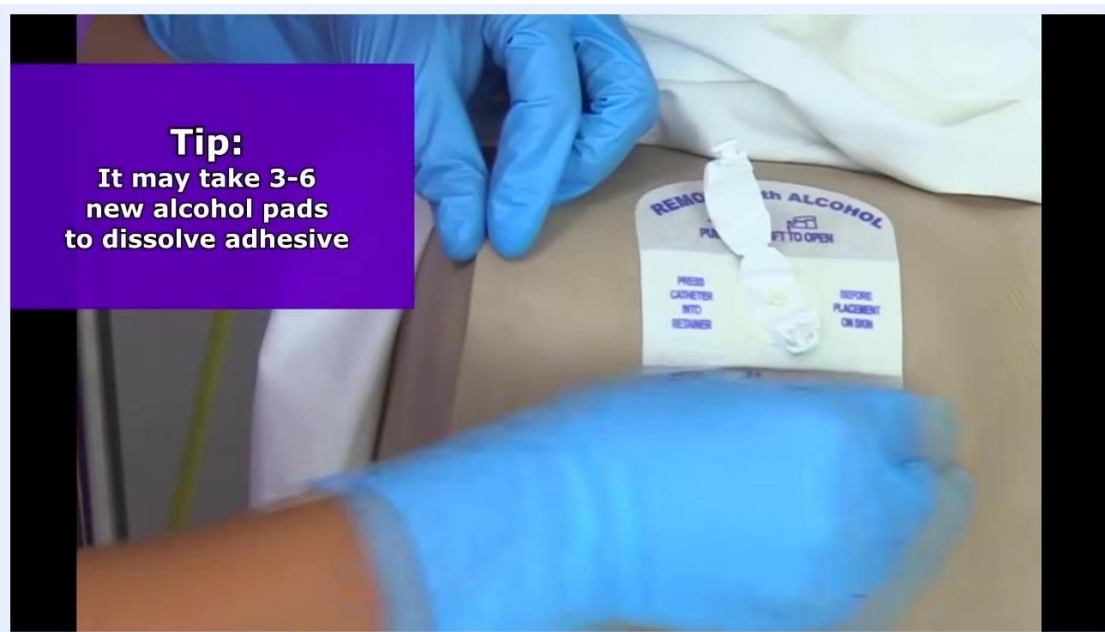
Gloved hands unclipping the Foley catheter from the securement device

Continue peeling the device up gently while cleaning the patch and skin with alcohol pads. If the adhesive stops lifting easily, switch to a new pad rather than pulling the device off, which can injure the skin.

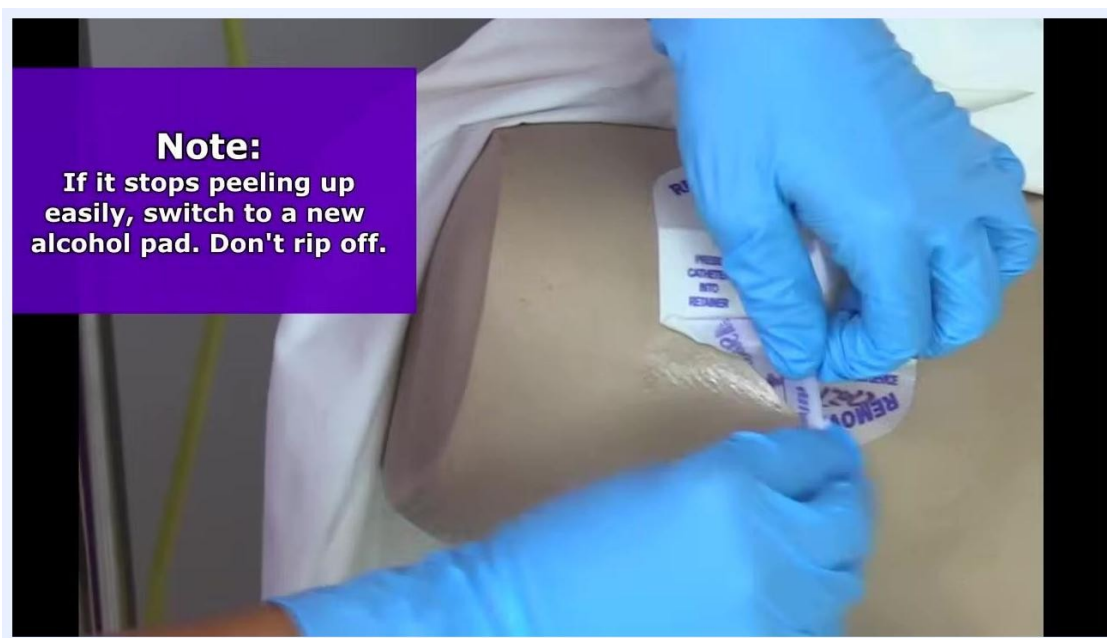
Keep cleaning the skin and patch until the last of the adhesive comes away smoothly.



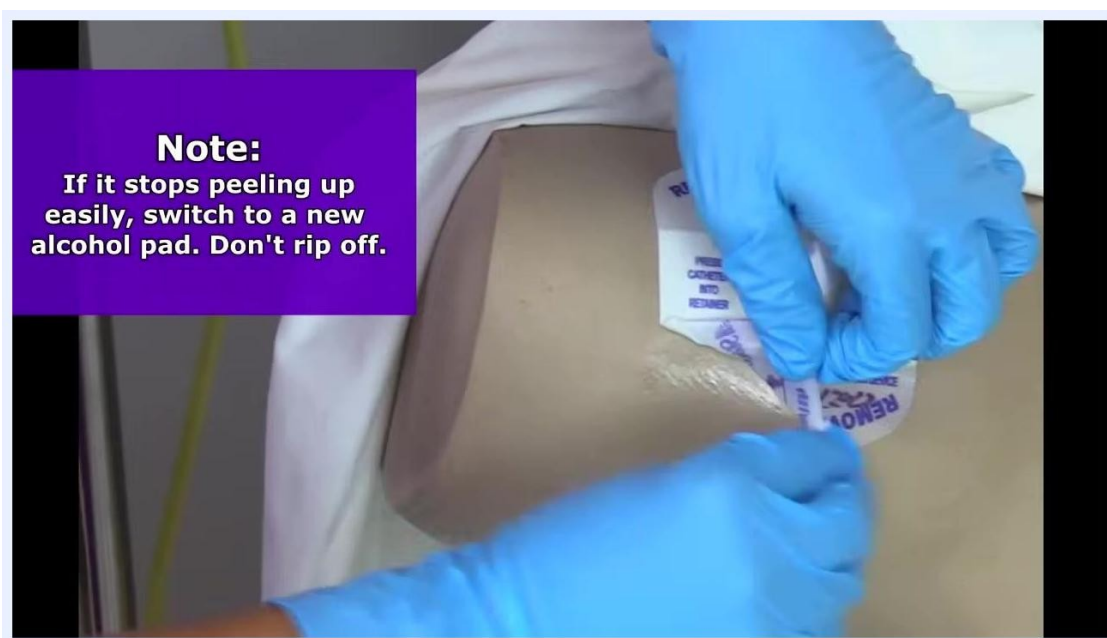
Gloved hands using an alcohol pad to dissolve the adhesive of the securement device, labeled: Remove with alcohol



On-screen tip reading: It may take 3-6 new alcohol pads to dissolve adhesive, with gloved hands working to remove the securement device



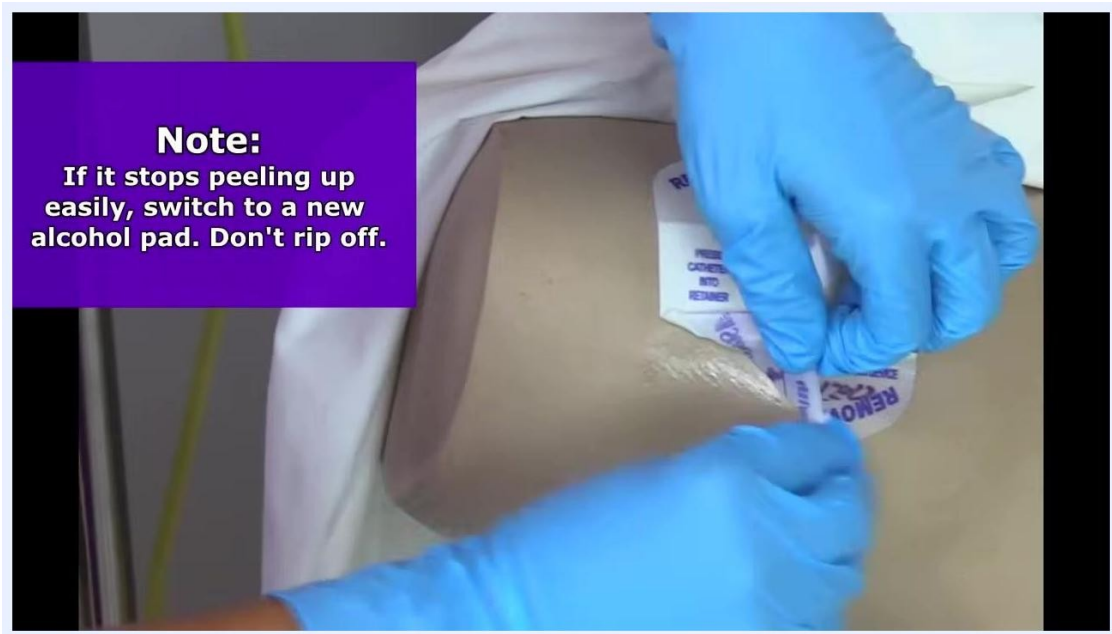
Gloved hands gently peeling up the securement device with an alcohol pad, next to the note: If it stops peeling up easily, switch to a new alcohol pad. Don't rip off



Gloved hands finishing removal of the securement device, cleaning the area with an alcohol pad

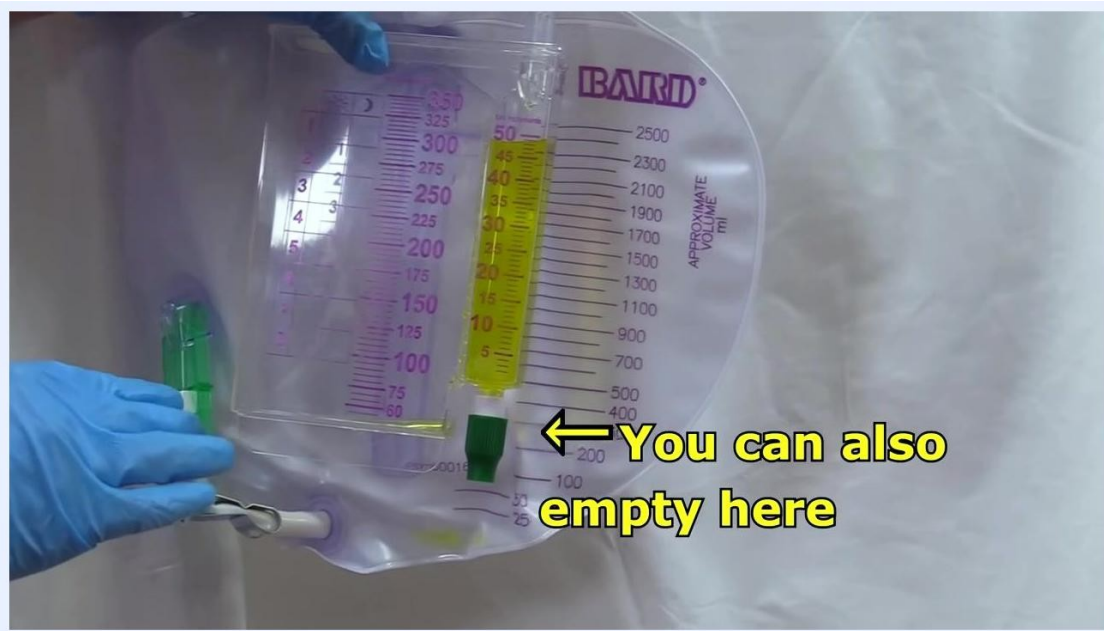
Phase 4: Provide perineal and catheter care

Clean the perineal area and catheter insertion site thoroughly using your facility's peri-care technique.



Gloved hand cleaning the perineal area of a mannequin, labeled: Next, provide peri-care and catheter care

Remove your gloves, perform hand hygiene again, and don a fresh pair of clean gloves before proceeding to remove the catheter.



Close-up of the urine collection bag with measurement markings and the drainage port, repeated to confirm the full volume has been measured

Phase 5: Deflate the balloon

Gather a 10 mL syringe. If it is new, pop the seal by pulling back on the plunger and pushing it back in. Locate the color-coded balloon inflation port (often green) and attach the syringe to it.



Gloved hands holding a 10 mL syringe, preparing to attach it to the green balloon inflation port, with the mannequin and catheter tubing on a waterproof pad

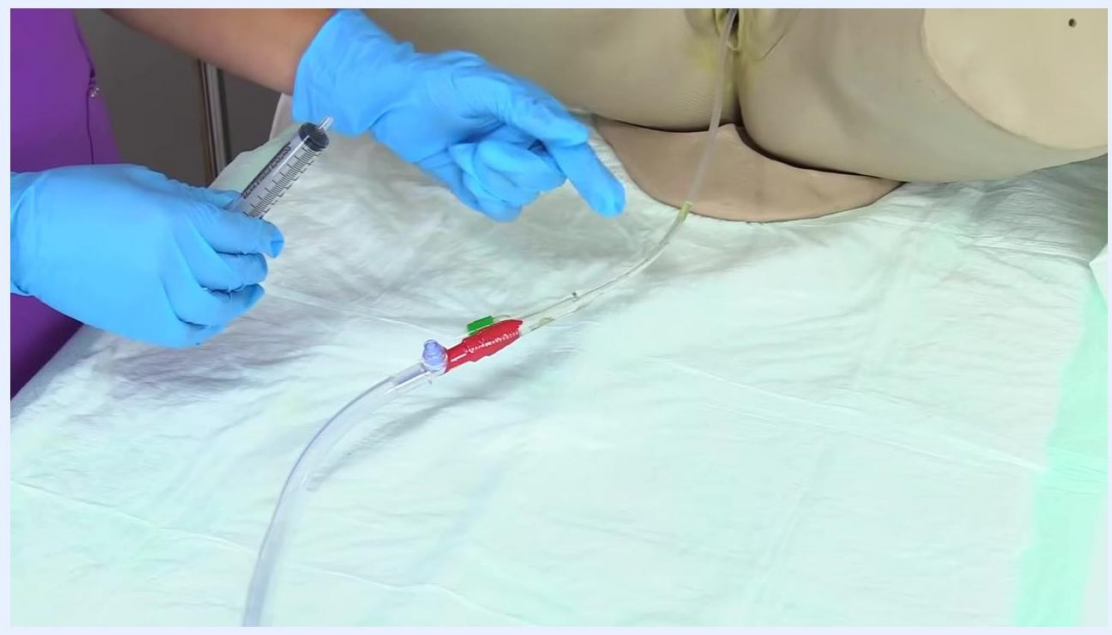
Do not pull back on the plunger. Let the water drain out of the balloon into the syringe on its own; pulling back can distort the balloon and risk urethral injury.



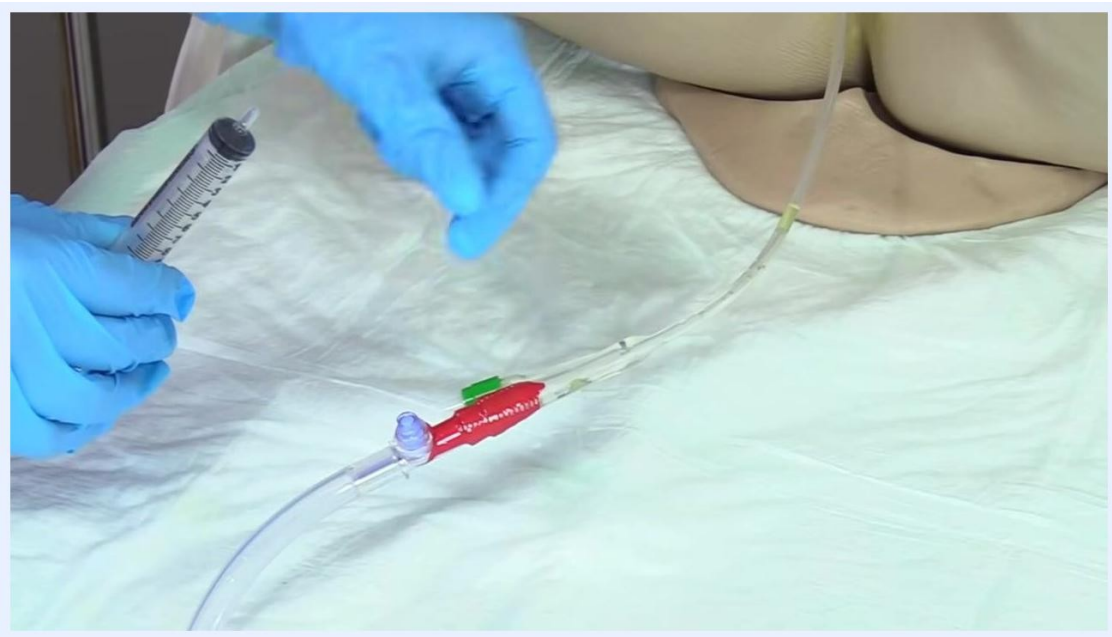
Gloved hands connecting the 10 mL syringe to the green balloon port, preparing for passive deflation

Let the balloon continue deflating until the syringe reads 10 cc, confirming the balloon is fully deflated. This may take a few seconds.

Disconnect the syringe once the balloon is fully deflated.



Gloved hands holding the syringe connected to the balloon port, ready for deflation



Gloved hands holding the syringe with water visible inside as the balloon deflates



Gloved hands holding the syringe as the balloon water is withdrawn passively

Phase 6: Remove the catheter

Position your hands to withdraw the catheter smoothly, and instruct the patient to breathe calmly.

As the patient exhales, gently pull the catheter out in one steady, continuous motion. Stop immediately and reassess if you feel any resistance.



Gloved hands holding the catheter tubing at the port, with the catheter still in place



Gloved hands beginning to withdraw the catheter, with the catheter partially removed

Phase 7: Post-removal care

Inspect the removed catheter for breakage, stretching, or missing pieces, and check for any unusual or abnormal drainage.

Wrap the used catheter in a waterproof pad and dispose of it, along with all related materials, in the appropriate biohazard or medical waste container per facility protocol.



Gloved hand holding a gauze pad while cleaning the perineal area of a mannequin, labeled: Next, provide peri-care and catheter care

If the patient is able, assist her out of bed and provide support for ambulation or further peri-care as needed.

Remove your gloves carefully to avoid contamination, then wash your hands thoroughly with soap and water or use an alcohol-based hand sanitizer.



Next, provide peri-care & catheter care

Hands donning blue gloves, labeled: Don gloves



Gloved hands holding the removed catheter and inspecting it for integrity, with the mannequin visible



Gloved hands wrapping the catheter in a waterproof pad, with the catheter tubing visible



Nurse assisting a patient out of bed, patient holding an IV pole, hospital room with a monitor in the background

Pain management

The procedure identifies expected post-removal sensations rather than a formal medication protocol: mild bladder and urethral irritation or burning, frequent urges to urinate, mild incontinence, or difficulty starting a stream during the first few voids are considered normal and temporary. Advise the patient to notify nursing staff if these symptoms persist. A multimodal medication table with drug, dose, route, and frequency should be added here if the ordering physician prescribes analgesics for this patient.



Patient Education:

- Tell patient bladder & urethra may be irritated & burn for first few voids
- My have urge to urinate often & have trouble starting stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
- Provide fresh water & encourage patient to drink every 2 hours & to avoid caffeine

Person holding their nose in discomfort, with bold text reading Not Normal! next to Patient Education notes on abnormal findings and hydration advice

Mobility milestones

Timeframe after removal	Goal	Nursing action
1–3 hours	Patient begins getting up and attempts to void	Assist the patient to safely ambulate to the bathroom; monitor for dizziness or weakness during initial ambulation
Up to 6 hours	First complete void achieved	Confirm the patient has voided a complete stream; notify the physician if the patient has not voided within this window



Patient Education:

- Instruct patient to notify you before voiding (urinating)
- Patient should typically void within next 6 hours (if not, notify physician)
- Void should be a complete stream
- If patient isn't voiding, Dr may order bladder scan
- Measure & document 1st void (output, color, smell)

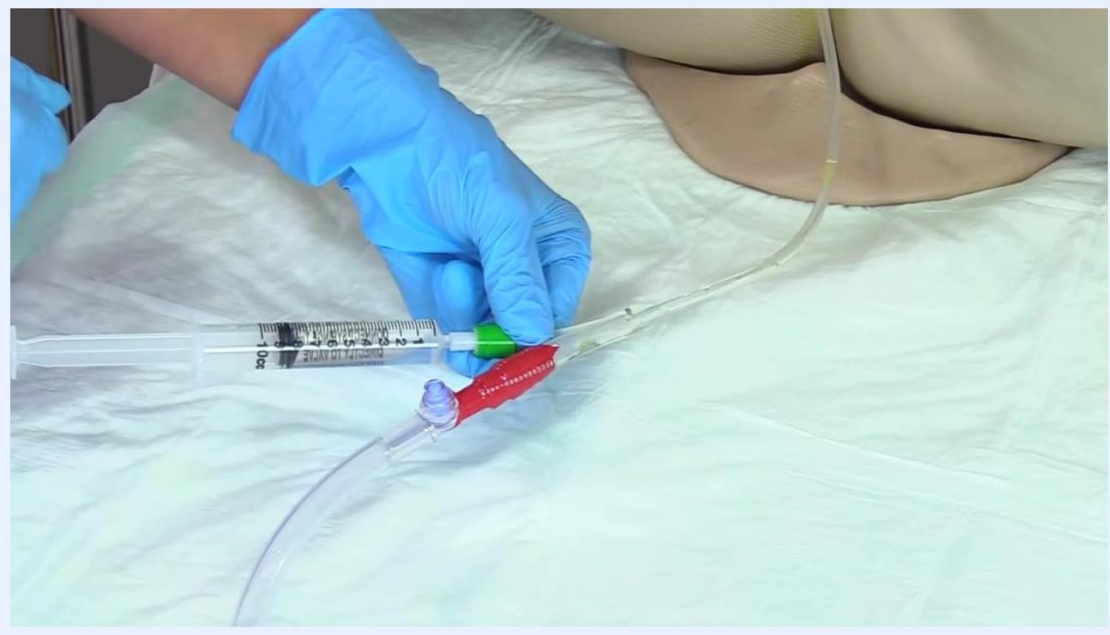
Patient in a hospital bed, smiling, next to Patient Education notes: notify before voiding, void within 6 hours, complete stream, notify physician if not voiding, measure and document first void

Complication monitoring

Monitor for the following during and after the procedure:

- Resistance felt while withdrawing the catheter — stop immediately and reassess the situation.
- Breakage, stretching, or missing pieces on the removed catheter, or unusual drainage on it.
- Fever.
- Inability to void.
- Foul-smelling (odorous) urine.
- Excessive bleeding.

- Abnormal urine color.



Syringe attached to the green port of the catheter tubing, gloved hands holding syringe and port, patient mannequin on a white absorbent pad

Instruct the patient that these findings are not normal and must be reported to nursing staff immediately.



Not Normal!

Patient Education:

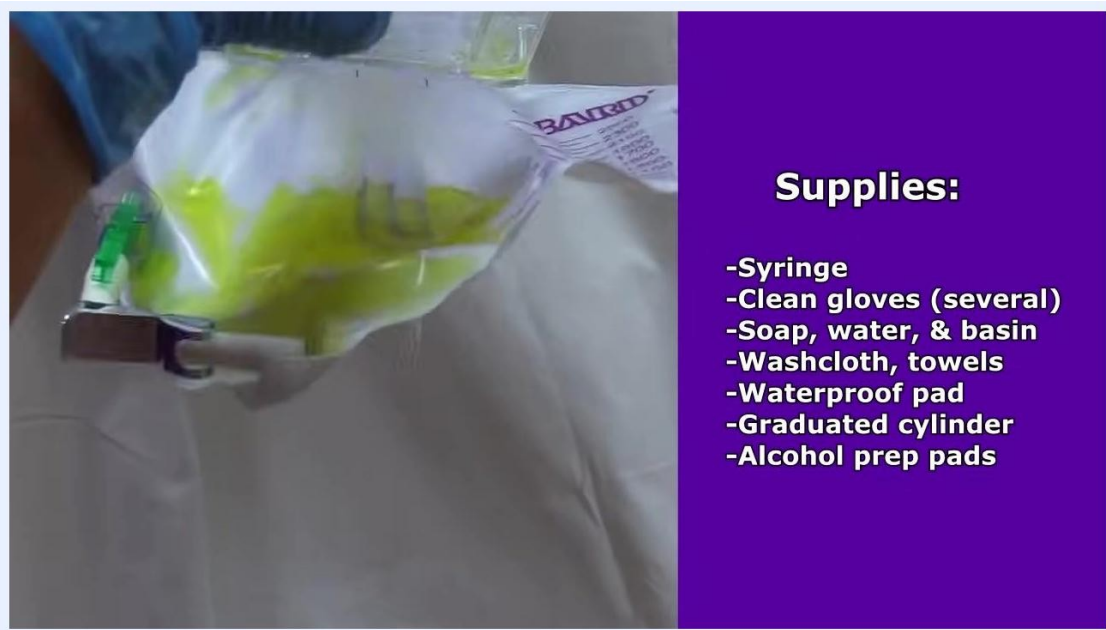
- Tell patient bladder & urethra may be irritated & burn for first few voids
- My have urge to urinate often & have trouble starting stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
- Provide fresh water & encourage patient to drink every 2 hours & to avoid caffeine

Person with curly hair, head in hands, looking uncomfortable, next to Patient Education notes on irritation, urge, trouble starting the stream, abnormal findings, and hydration advice

Discharge criteria

The following measurable criteria should be met and documented before the patient is considered ready to progress:

- The catheter has been removed intact, with no signs of breakage or abnormal drainage.
- The patient has voided a complete stream within 6 hours of removal; if not, the physician has been notified.
- The first void has been measured in a graduated container and its amount, color, and odor documented in the chart.
- No abnormal symptoms (fever, inability to void, foul-smelling urine, excessive bleeding, abnormal urine color) are present.



Supplies:

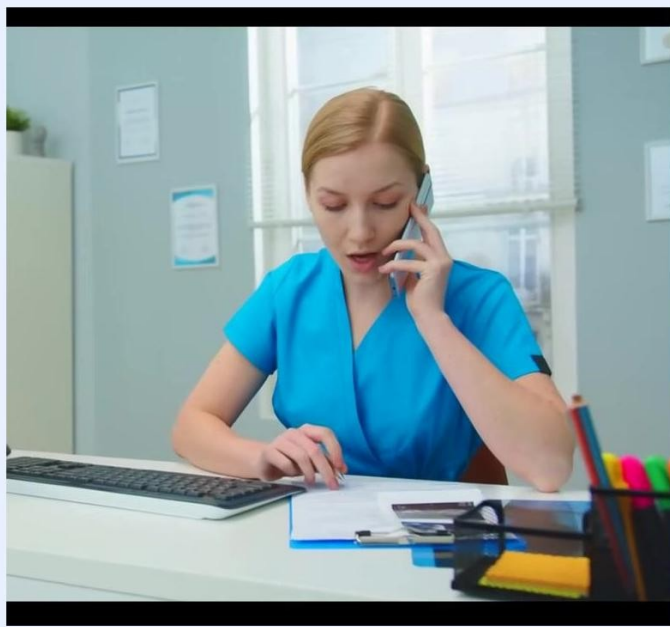
- Syringe
- Clean gloves (several)
- Soap, water, & basin
- Washcloth, towels
- Waterproof pad
- Graduated cylinder
- Alcohol prep pads

Gloved hand lifting the Foley catheter tubing to let urine drain into the collection bag

Patient education

Before discharge or transfer, review the following points with the patient and family.

4. Notify the nurse before the first void after catheter removal so the first void can be observed and documented.



Patient Education:

- Instruct patient to notify you before voiding (urinating)
- Patient should typically void within next 6 hours (if not, notify physician)
- Void should be a complete stream
- If patient isn't voiding, Dr may order bladder scan
- Measure & document 1st void (output, color, smell)

Nurse in blue scrubs on the phone at a desk, writing in a chart, next to Patient Education notes

5. Use the call light or other facility-approved method to alert staff when it is time to void; note that specific protocols may vary by institution.



Patient Education:

- Instruct patient to notify you before voiding (urinating)
- Patient should typically void within next 6 hours (if not, notify physician)
- Void should be a complete stream
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- Measure & document 1st void (output, color, smell)

Patient in a hospital bed, smiling, next to Patient Education notes emphasizing notifying staff and using the call light

6. Begin getting up and attempt to void within 1 to 3 hours after catheter removal, with staff assistance as needed.
7. The first void should be a complete stream; report any difficulty starting the stream or incomplete voiding.

8. Collect the first void in a graduated collection hat or urinal placed in the toilet, rather than voiding directly into the toilet, so the amount can be measured accurately.



Patient Education:

- Tell patient per bladder & urethra may be irritated & burn for first few voids
it should be
- My have urge to urinate often & have dribbling stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
- Provide fresh water & encourage patient to drink every 2 hours & to avoid caffeine

Toilet with a graduated collection hat showing measurement markings in ounces and cc, next to Patient Education notes



Patient Education:

- Tell patient per bladder & urethra may be irritated & burn for first few voids
it should be
- My have urge to urinate often & have dribbling stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
- Provide fresh water & encourage patient to drink every 2 hours & to avoid caffeine

Toilet with a graduated collection hat and a large green check mark, next to Patient Education notes

9. Document the amount, color, and odor of the first void in the patient's chart according to facility protocol.
10. Expect some bladder and urethral irritation or burning, frequent urges, mild incontinence, or difficulty starting the stream during the first few voids; report persistent symptoms to the nurse.
11. Report the following abnormal symptoms immediately: fever, inability to void, foul-smelling urine, excessive bleeding, or abnormal urine color.
12. Drink fresh water every 2 hours and avoid caffeine to support healing and reduce bladder irritation.

Reinforcing these points helps the patient recognize normal recovery sensations, identify warning signs early, and understand the role of hydration and avoiding bladder irritants such as caffeine in a smooth recovery after catheter removal.



Not Normal!

Patient Education:

- Tell patient bladder & urethra may be irritated & burn for first few voids
- My have urge to urinate often & have trouble starting stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
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Person holding their nose in discomfort, with bold text reading Not Normal! next to Patient Education notes on abnormal findings and hydration advice



Patient Education:

- Tell patient bladder & urethra may be irritated & burn for first few voids
- My have urge to urinate often & have trouble starting stream (notify nurse if this persists)
- NOT NORMAL: fever, unable to void, odorous urine, excessive bleeding, abnormal color
- Provide fresh water & encourage patient to drink every 2 hours & to avoid caffeine

Steaming cup of coffee with a large red X over it, surrounded by coffee beans, next to Patient Education notes: avoid caffeine, drink water every 2 hours