

ALL PROCEDURES MUST HAVE A CORRESPONDING ORDER DOCUMENTED IN THE INMATES EHR. IF THERE IS NO DOCUMENTED ORDER, WRITE A VERBAL ORDER AND ASSIGN TO THE HEALTH CARE PROVIDER FOR SIGNATURE.

Subjective Data: _____ **Allergies:** _____

Chief complaint: _____

Foley Catheter Materials:

1. Indwelling or straight catheter kit with drainage system
2. Syringe
3. Protective pad
4. Wash cloth
5. Clean and Sterile gloves

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ O₂ sats. _____ FSBS: _____

Urine:	<input type="checkbox"/> Clear	<input type="checkbox"/> Dark	<input type="checkbox"/> Cloudy	<input type="checkbox"/> Bloody	<input type="checkbox"/> Foul oder
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REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

<input type="checkbox"/> Urine is cloudy or has a foul odor.	<input type="checkbox"/> Feeling of bladder fullness.
<input type="checkbox"/> Temperature of 100.4 degrees F.	<input type="checkbox"/> Urine leaking around the tube.
<input type="checkbox"/> Unusual itching, rash, burning or pus.	<input type="checkbox"/> Blood in your urine.

Health Care Provider: _____ **Time Notified:** _____ **Orders Received for Treatment:** Yes No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Intervention: (check all that apply)

<input type="checkbox"/> Routine Foley Catheter Care	<input type="checkbox"/> Removal of Foley Catheter	<input type="checkbox"/> Foley Catheter Insertion
<input type="checkbox"/> Provided privacy and procedure explained to inmate. <input type="checkbox"/> Hands washed with soap and water and gloves applied. <input type="checkbox"/> Protective pad placed under inmate. <input type="checkbox"/> Using clean technique, area cleansed with soap and water. <input type="checkbox"/> Foley catheter tube cleansed. <input type="checkbox"/> No signs/symptoms of infection noted. <input type="checkbox"/> Protective pad removed and disposed. <input type="checkbox"/> Gloves removed, disposed, and hands rewashed. <input type="checkbox"/> Inmate tolerated procedure well.	<input type="checkbox"/> Provided privacy and procedure explained to inmate. <input type="checkbox"/> Hands washed with soap and water and gloves applied. <input type="checkbox"/> Protective pad placed under inmate. <input type="checkbox"/> Using clean technique, sterile water removed from retention bulb, Foley catheter removed without difficulty and discarded. <input type="checkbox"/> Area cleansed with soap and water. <input type="checkbox"/> No signs/symptoms of infection noted. <input type="checkbox"/> Protective pad removed and disposed. <input type="checkbox"/> Gloves removed, disposed, and hands rewashed. <input type="checkbox"/> Inmate tolerated procedure well.	<input type="checkbox"/> Provided privacy and procedure explained to inmate. <input type="checkbox"/> Hands washed with soap and water and gloves applied. <input type="checkbox"/> Protective pad placed under inmate. <input type="checkbox"/> Using clean technique, area cleansed with soap and water. <input type="checkbox"/> Gloves removed, disposed, and hands rewashed. <input type="checkbox"/> Using sterile technique, Foley catheter established on sterile field. <input type="checkbox"/> Foley catheter prepared, Inmate draped, area cleansed with povidone-iodine solution. <input type="checkbox"/> Foley catheter inserted, retention bulb filled with sterile water, and catheter secured without difficulty. <input type="checkbox"/> Protective pad removed and disposed. <input type="checkbox"/> Gloves removed, disposed, and hands rewashed. <input type="checkbox"/> Inmate tolerated procedure well.
<input type="checkbox"/> Education/Intervention: Instructed inmate to follow-up sick call if experiencing any signs and symptoms that warrant treatment. Inmate verbalizes understanding of instructions.		

Progress Note: _____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/Credentials: _____ **Date:** _____ **Time:** _____

Inmate Name
 (Last, First)

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