21.11: Checklist for Foley Catheter Insertion (Female)

Use the checklist below to review the steps for completion of "Foley Catheter Insertion (Female)."

**Steps**

**Disclaimer: Always review and follow agency policy regarding this specific skill.**

1. Gather supplies: peri-care supplies, clean gloves, Foley catheter kit, extra pair of sterile gloves, Velcro™ catheter securement device to secure Foley catheter to leg, linen bag, wastebasket, and light source (i.e., goose neck lamp or flashlight).

2. Perform safety steps:
   - Perform hand hygiene.
   - Check the room for transmission-based precautions.
   - Introduce yourself, your role, the purpose of your visit, and an estimate of the time it will take.
   - Confirm patient ID using two patient identifiers (e.g., name and date of birth).
   - Explain the process to the patient.
   - Be organized and systematic.
   - Use appropriate listening and questioning skills.
   - Listen and attend to patient cues.
   - Ensure the patient’s privacy and dignity.
   - Assess ABCs.

3. Assess for latex/iodine allergies, GYN surgeries, joint limitations for positioning, and any history of previous difficulties with catheterization.
4. Prepare the area for the procedure:
   ◦ Place hand sanitizer for use during/after procedure on the table near the bed.
   ◦ Place the catheter kit and peri-care supplies on the over-the-bed table.
   ◦ Secure the wastebasket and linen cart/bag near the bed for disposal.
   ◦ Ensure adequate lighting. Enlist assistance for positioning if needed.
   ◦ Raise the opposite side rail. Set the bed to a comfortable height.

5. Position the patient supine and drape the patient with a bath blanket, exposing only the necessary area for patient privacy.

6. Apply nonsterile gloves and perform peri-care.

7. Remove gloves and perform hand hygiene.

8. Create a sterile field on the over-the-bed table.

9. Open the outer package wrapping. Remove the sterile wrapped box with the paper label facing upward to avoid spilling contents and place it on the bedside table or, if possible, between the patient’s legs. Place the plastic package wrapping at the end of the bed or on the side of the bed near you, with the opening facing you or facing upwards for waste.

10. Open the kit to create and position a sterile field:
   ◦ Open the first flap away from you.
   ◦ Open the second flap toward you.
   ◦ Open side flaps.
   ◦ Only touch within the outer 1” edge to position the sterile field on the table.

11. Carefully remove the sterile drape from the kit. Touching only the outermost edges of the drape, unfold and place the touched side of drape closest to linen, under the patient. Vertically position the drape between the patient’s legs to allow space for the sterile box and sterile tray.

12. Wash your hands and apply sterile gloves.

13. OPTIONAL: Place the fenestrated drape over the patient’s perineal area with gloves on inside of the drape, away from the patient’s gown, with peri-area visible through the opening. Maintain sterility.

14. Empty the lubricant syringe or package into the plastic tray. Place the empty syringe/package on the sterile outer package.

15. Simulate application of iodine/antimicrobial cleanser to cotton balls.

16. Remove the sterile urine specimen container and cap and set them aside.

17. Remove the tray from the top of the box and place it on the sterile drape.

18. Carefully remove the plastic catheter covering, while keeping the catheter in the sterile box. Attach the syringe filled with sterile water to the balloon port of the catheter; keep the catheter sterile.

19. Lubricate the tip of the catheter by dipping it in lubricant and place it in the box while maintaining sterility.

20. If preparing the kit on the bedside table, prepare to move the items to the patient. Place the plastic tray on top of the sterile box and carry as one unit to the sterile drape between the patient’s legs, taking care not to touch your gloves to the patient’s legs or bed linens.

21. Place the plastic top tray on the sterile drape nearest to the patient. An alternate option is to leave the plastic tray on top of the box until after cleaning is complete.

22. Tell the patient that you are going to clean the catheterization area and they will feel a cold sensation.

23. With your nondominant hand, gently spread the labia minora and visualize the urinary meatus. Your nondominant hand will now be nonsterile. This hand must remain in place throughout the procedure.
24. With your sterile dominant hand, use the forceps to pick up a cotton ball. Cleanse the periurethral mucosa with the saturated cotton ball. Discard the cotton ball after use into the plastic bag, not crossing the sterile field. Repeat for a total of three times using a new cotton ball each time. Discard the forceps in the plastic bag without touching the sterile gloved hand to the bag.

25. Pick up the catheter with your sterile dominant hand. Instruct the patient to take a deep breath and exhale or "bear down" as if to void, as you steadily insert the catheter maintaining sterility of the catheter until urine is noted.

26. Once urine is noted, continue inserting the catheter 1"-2". Do not force the catheter.

27. With your dominant hand, inflate the retention balloon with the water-filled syringe to the level indicated on the balloon port of the catheter. With the plunger still pressed, remove the syringe and set it aside. Pull back on the catheter until resistance is met, confirming the balloon is in place.

If the patient experiences pain during balloon inflation, deflate the balloon and insert the catheter farther into the bladder. If pain continues with the balloon inflation, remove the catheter and notify the patient’s provider.

28. Remove the sterile draping and supplies from the bed area and place them on the bedside table. Remove the bath blanket and reposition the patient.

29. Remove your gloves and perform hand hygiene.

30. Apply new gloves. Secure the catheter with securement device, allowing room as to not pull on the catheter.

31. Place the drainage bag below the level of the bladder, attaching it to the bed frame.

32. Perform peri-care as needed; assist the patient to a comfortable position.

33. Dispose of waste and used supplies.

34. Remove gloves and perform hand hygiene.

35. Assist the patient to a comfortable position, ask if they have any questions, and thank them for their time.

36. Ensure safety measures when leaving the room:
   - CALL LIGHT: Within reach
   - BED: Low and locked (in lowest position and brakes on)
   - SIDE RAILS: Secured
   - TABLE: Within reach
   - ROOM: Risk-free for falls (scan room and clear any obstacles)

37. Perform hand hygiene.

38. Document the procedure and related assessment findings. Report any concerns according to agency policy.