Long-Term Care: Indwelling Urinary Catheter Insertion Checklist

Resident Name (print) _____ Med Rec# _____Unit _____Date/Time _____

Inserting Clinician (print) _____ Signature _____

Technique Reviewer[1], if applicable (print) _____ Signature _____

I. BEFORE CATHETER INSERTION	✓	COMMENTS
1. Confirm order, to include catheter and balloon size; use the smallest effective catheter size.		
2. Assemble and verify supplies. Consider bringing a second catheter to use if the first one is accidentally contaminated.		
3. Identify the resident, per facility policy. Explain the procedure, its necessity, and its potential complications to the resident and/or family.		
4. Ensure privacy and good lighting.		
5. Position the resident correctly for the procedure; consider using an assistant to help resident stay in position and decrease potential contamination of sterile catheter.		
6. Perform hand hygiene, don clean gloves, and cleanse the perineal area with a washcloth, skin cleanser, and warm water, moving from front to back.		
7. Remove gloves and perform hand hygiene.		

II. DURING INSERTION	✓	**COMMENTS**
1. Open the sterile catheterization kit on a clean bedside table, using sterile technique. Ensure all supplies are conveniently positioned.		
2. Put on sterile gloves and drape the resident.		
3. Prepare the antiseptic solution; ensure the resident is not allergic to iodine. Apply sterile lubricant to the catheter tip. Consider attaching catheter to drainage system now, if not already attached, and ensure the drainage bag emptying port is clamped.		
4. With nondominant hand, identify meatus, and be prepared to keep this hand in this position until after the urine is flowing.		
5. With dominant (sterile) hand, clean the meatus opening with the antiseptic solution, moving from top to bottom. Use a new wipe/swab each time. Allow the antiseptic to dry.		
6. With the dominant (sterile) hand, insert the catheter slowly into the urethra until there is a return of urine. Then advance the catheter 2-3 inches more. (Do not force the catheter through the urethra). Leave the catheter in the vagina, if accidentally inserted, until after the new sterile urinary catheter is inserted into the bladder.		
7. Hold the catheter with the nondominant hand; use the dominant hand to fully inflate the catheter balloon with the entire volume of supplied sterile water in the prefilled syringe.		
8. Gently pull on catheter after balloon inflation to feel resistance.		

III. AFTER INSERTION	✓	**COMMENTS**
1. Remove used equipment and dispose of used supplies in trash per facility policy. Place syringe in sharps container. If a bladder scanner was used, wipe it with appropriate disinfectant cleaner before storing for use with the next resident.		
2. Secure catheter to the resident's leg with securement device. Remove gloves and perform hand hygiene		
3. Cover the resident with linens and assist to a comfortable position.		
4. Ensure the tubing in not kinked and the drainage bag is below the level of the bladder. Place a cover over the drainage bag to maintain resident dignity.		
5. Perform hand hygiene.		
6. Document— Type and size of catheter and balloon Amount of fluid inserted in the balloon How the resident tolerated the procedure Amount of urine obtained and its characteristics Name of person performing the insertion and the date it was completed.		
7. Label a urine collection container with a resident identifier and date.		

[1]Licensed nursing staff member present during insertion to ensure that correct procedural steps/aseptic technique are performed.