

## Foley Catheter Audit

Review Date: \_\_\_\_\_

Unit: \_\_\_\_\_

Foley POA:      Yes      No

MRN: \_\_\_\_\_

Admit Date: \_\_\_\_\_

Room #: \_\_\_\_\_

Name: \_\_\_\_\_

Age: \_\_\_\_\_      Gender: \_\_\_\_\_

Foley insert date: \_\_\_\_\_

Perfect Compliance:      Yes      No

Unit Foley inserted in: \_\_\_\_\_

\* Anchor Clip Present:      Yes      No

\* Disinfectant Cap:      Yes      No

\* Anchor Clip Used:      Yes      No

\* Is Bag Touching Floor:      Yes      No

➤ Reason: \_\_\_\_\_

\* Sitting in Chair:      Yes      No

\* Securement Device in Place:      Yes      No

\* Mattress Low/On Floor:      Yes      No

➤ Reason: \_\_\_\_\_

Chart Documented:      Yes      No

\* Is Bag Overfilled (>2000mls):      Yes      No

### BUNDLE COMPONENTS

### NOTES

\* Seal Intact:      Yes      No

\_\_\_\_\_

Chart Documented:      Yes      No

\_\_\_\_\_

Need Assessed Daily:      Yes      No

\_\_\_\_\_

Daily Catheter/Pericare Doc:      Yes      No

\_\_\_\_\_

\* Dependent Loop Present:      Yes      No

\_\_\_\_\_

\* Is Patient Immobile:      Yes      No

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**Target Zero**<sup>®</sup>  
Every Person. **Every Time.**

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