

Audit checklist for urinary catheter care compliance (Patient)

Date: _____

Please "✓" where appropriate

Name: _____	HN: _____	
Sex: _____	Age: _____	
Hospital: _____	Ward: _____	Department: _____
Date admitted to hospital: _____		

(ONLY for patients with bed number ending with 1, 4, 7. E.g. 1, 4, 7, 11, 14, 17, 27A, 31B, 44A, etc.)

Type of Urinary Catheterization	Yes	No
1. Long-term (>30 days) urinary catheter		
2. First catheter insertion date: _____		
Standard Criteria (Individual Level)		
3. Documentation		
a. Indication for insertion of urinary catheter documented in patients' record		
b. What are the indications? (can <input checked="" type="checkbox"/> more than one) <ul style="list-style-type: none"> <input type="checkbox"/> to relieve urinary obstruction and/or acute urinary retention <input type="checkbox"/> to monitor urine output in critically ill patients <input type="checkbox"/> to aid in urologic surgery <input type="checkbox"/> in urinary incontinent patients with open wounds or skin graft in the sacral and/or perineal area <input type="checkbox"/> in terminally ill patients, as request for comfort care <input type="checkbox"/> Others (please specify): _____ 		
For short-term catheterization		
c. Daily review indication for urinary catheter		
d. Date of planned removal of the catheter documented		
4. Observation		
a. Secure the urethral catheter properly If yes, which site: <input type="checkbox"/> abdomen <input type="checkbox"/> thigh		
b. Closed drainage system		
c. Unobstructed urine flow and a tube free from kinking		
d. Tubing and bags are kept below level of bladder		
e. Drainage bag and outlet kept above the floor		
f. Prevention of overfilling of the drainage bag (not more than 3/4 full)		