TRANSCERVICAL FOLEY CATHETER

**TRANSCERVICAL FOLEY CATHETER QRG**

**PRIOR**
1. Explain the procedure to the woman, gain verbal consent, prepare equipment & maintain privacy.
2. Encourage bladder emptying prior & perform abdominal palpation.
3. Apply Cardiotocograph (CTG) for 20 minutes. Proceed if normal fetal heart rate (FHR) trace.
   - If abnormal trace discuss with obstetric team and midwifery co-ordinator.
4. Position the woman in lithotomy.
5. Wash hands, put on sterile gloves & assess the Bishop’s score on vaginal examination if not assessed prior.

**INSERTION**
6. Cleanse the vulvo-vaginal area and insert a bi-value speculum until the cervix visualised.
7. Insert the 16g (30mL size balloon) Foley catheter through the internal os of the cervix using sponge forceps to assist.
8. Inflate the balloon with 50mL sterile water and spigot the catheter.
9. Gently withdraw the catheter until it rests at the level of the internal os. Placement should be confirmed with a vaginal examination. Remove the speculum. Apply traction to the catheter & tape the catheter to the inside of the woman’s thigh.
10. Assess the FHR. Discard equipment and wash hands.

**AFTER CARE**
12. Women with an uncomplicated pregnancy and normal maternal & fetal observations 1 hr post insertion may be considered for transfer to an obstetric ward. Return to Labour and Birth Suite if: spontaneous rupture of membranes, contracting or requiring prostaglandins.
13. Observations: High risk pregnancies where there is potential for a change in the maternal or fetal condition should have observations performed overnight observations include 4 hourly FHR, fetal movements, uterine activity, per vaginal loss, temperature, pulse, blood pressure and oxygen saturations.
   For low risk women undertake 4 hourly observations as above unless the woman is sleeping in which case undertake observations at the earliest opportunity upon waking but within 8 hours of the previous observations.
14. Vaginal examination (VE): At 12 & 18 hours after insertion to confirm balloon placement.
15. If Foley catheter falls out in <12hours perform a VE. If favourable transfer to labour suite at 12 hours; if unfavourable discuss with medical team.

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Note: This flowchart represents minimum care & should be read in conjunction with the following full guideline, the Induction of labour guideline & disclaimer. Additional care should be individualised as needed.
AIM

- To provide a non-pharmacological method of induction of labour (IOL) in situations where birth is indicated but not urgent, and the Bishop’s score is less than 7 with an unfavourable cervix.

BACKGROUND INFORMATION

The use of the transcervical Foley’s catheter for cervical ripening has been shown to be an efficient, reversible method to induce labour, and is associated with a low incidence of uterine contractile abnormalities.\(^1\) This method is one recommended by the World Health Organization,\(^2\) and it provides an option for cervical ripening when there are contraindications to pharmacological agents.\(^3\) In nulliparous women where IOL is necessitated before the cervix is favourable, the single Foley catheter may be the safest, least costly and most accepted choice by women when compared to a double balloon catheter or Prostaglandins.\(^4\) Balloon catheter use has been shown to improve Bishop’s scores and decrease the interval until birth.\(^5\)

The lower risk for hypertonus when compared to prostaglandins\(^6\) may result in lower risk for uterine rupture in women who have had a previous caesarean section.\(^7\) Therefore, the use of the Foley catheter may provide a safer option for women requiring cervical ripening for vaginal birth after caesarean birth (VBAC).\(^1,6-10\)

KEY POINTS

- This guideline should be used in conjunction with Restricted Area Clinical Guideline Induction of labour.
- The woman should be informed of the risks, benefits and alternatives associated with IOL,\(^11\) the transcervical Foley catheter and of continued pregnancy, and be involved in the decision making process.\(^12,13\)

POTENTIAL RISKS ASSOCIATED WITH TRANSCERVICAL FOLEY CATHETER\(^14\)

- Infection\(^15\)
- Discomfort\(^15\)
- Antepartum bleeding
- Prelabour rupture of membranes
- See also Restricted Area Clinical Guideline Induction of labour for non-specific induction risks.

CONTRAINDICATIONS\(^15\)

- Placenta Praevia or Vasa praevia
- HIV infection
- Active herpes lesions
- Malpresentation.

EQUIPMENT

- Bi-valve Cuscoe speculum
- Rampley’s sponge holder
- Sterile water (50mL) into sterile bowl
- 16 gauge Foley catheter (30mL sized balloon) and spigot
- Syringe – 10mL or 20 mL
- Lubricating gel
- Tape
PROCEDURE

PRIOR TO INSERTION OF THE TRANSCERVICAL FOLEY CATHETER
1. See Clinical Guideline Induction of labour prior to commencing all IOL types.
2. Inform the woman of the procedure and provide her with the information sheet. The sticker is signed by the woman and the medical officer and placed in the woman’s medical record (MR 250- if the decision for induction is made in LBS/MFAU and left side of MR 222/223 for Clinics).
3. Encourage the woman to empty her bladder.
4. Perform an abdominal palpation to confirm presentation.
5. Perform a 20 minute cardiocograp (CTG) to assess fetal well-being. Proceed after confirming a normal fetal heart rate (FHR) pattern. If abnormal FHR discuss with the Labour / Birth Suite Midwifery Co-ordinator and Obstetric Team prior to continuing.
6. Place the woman in the lithotomy position for the procedure. Maintain her privacy and comfort.
7. Carry out a vaginal examination and assess the Bishop’s score (dilation, effacement, consistency, position, station), if not attended prior.

INSERTING THE TRANSCERVICAL FOLEY CATHETER
1. Prepare the equipment on a cleaned trolley, attend to hand hygiene and don sterile gloves.
2. Using an aseptic non-touch technique, cleanse the vulvo-vaginal area.
3. Insert the speculum. Visualise the cervix.
4. Pass the Foley catheter through the internal os of the cervix, using the sponge forceps to assist.
5. Inflate the balloon with 50 mL sterile water.
6. Spigot the catheter.
7. Gently withdraw the catheter until it rests at the level of the internal os. Remove the speculum. Placement may be confirmed with a vaginal examination.
8. Remove gloves and perform hand hygiene.
9. Apply traction to the catheter and tape it to the inner aspect of the woman’s thigh.
10. Assess the fetal heart rate after the procedure. Monitor the woman as required. See Clinical Guidelines Section B 5.6 Intrapartum Fetal Heart Rate Monitoring.

INDICATIONS FOR REMOVAL OF THE FOLEY’S CATHETER
- Uterine hyperstimulation or hypertonic uterine contractions
- Fetal distress
- Maternal request

MANAGEMENT AFTER INSERTION
1. Women with an uncomplicated pregnancy will be considered suitable for transfer to an obstetric ward if, after 1 hour post-insertion of the Foley catheter, both the maternal and fetal observations are normal. The midwifery staff can make this decision.
2. Midwifery staff shall perform a vaginal examination 12 hours post insertion, and again at 18 hours, to ensure the catheter balloon is not sitting in the vagina. The catheter may remain in situ for 18-24 hours before medical review for removal, ARM or prostaglandins is required.
3. The woman shall be transferred back to the Labour and Birth Suite in the event that they require prostaglandins.
4. If at any time the woman has spontaneous rupture of membranes or is experiencing contractions, she must be transferred to Labour and Birth Suite.
5. If the catheter falls out prior to 12 hours post insertion, perform a vaginal examination. If the cervix is favourable, the woman will be transferred to the Labour and Birth Suite at 12 hours. If the cervix is still unfavourable, discuss the situation with the medical staff with a view to transferring her to Labour and Birth Suite for prostaglandins.
6. The woman may remain on the obstetric ward until medical review.

**OBSERVATIONS**

**Fetal Observations**
- 4 hourly fetal heart rate (FHR) and movements. If low risk and sleeping, undertake observations at the earliest opportunity upon waking but within 8 hours of the previous observations.
- Notify the Medical Officer of any fetal heart rate abnormalities. A CTG should be commenced if any abnormality is identified on intermittent auscultation.

**Maternal Observations**
- Explain to the woman that she needs to inform the midwife if she feels that the traction is lost or the catheter has fallen out.
- 4 hourly uterine activity, vaginal loss, temperature, pulse, respiration rate, blood pressure and Oxygen Saturation, including overnight (for high risk pregnancies only).
- For low risk women undertake 4 hourly observations as above unless the woman is sleeping in which case undertake observations at the earliest opportunity upon waking but within 8 hours of the previous observations.
- Assess and record any maternal systemic effects e.g. nausea and vomiting.
REFERENCES (STANDARDS)