

Urinary Catheters Procedures

Appendix 1: IDC and SPC Bag Management

Procedure

As per Australian Quality Care's *Infection Control Policy and Procedure*, thorough hand hygiene practices and infection control processes should always be maintained before, during and post supporting participant's with urinary catheter care.

Prior to starting any procedure, appropriately qualified staff will need to review the participants' individual *Urinary Catheter Support Plan* and then, gather all the equipment needed.

Ensure consent has been given by the participant and explain to them the overall procedure.

Once you have obtained the participants' consent, ask the participant about their pain and comfort and assist accordingly before commencing.

Emptying Catheter Bags

The catheter bag should be emptied regularly (when two-thirds full or every eight hours) to maintain urine flow and prevent reflux.

Equipment

- A container
- Disposable glove
- Disposable apron
- Alcohol rub
- Gauze
- Protective glasses.

Procedure

1. Explain to the participant what you intend to do, and the procedure involved and obtain his/her consent. For dementia participants, inform the family member if available and show the catheter to the participant.
2. Ensure privacy.
3. Discuss with the participant, if they have been having any issues with the catheter/fluid intake/ or any concerns.
4. Perform hand hygiene and put on gloves and glasses.
5. Open the tap and let the urine drain into the container. Avoid the tap touching the container.

6. If the catheter bag is emptied in the toilet, ensure the toilet is clean and do not let the bag or tube openings touch the surface of the toilet (toilet bowl, toilet seat, floor, wall etc).
7. Clean the tap with alcohol and gauze.
8. Make note of the content of the urine (normal urine should be straw in colour)
9. Discard gloves into the waste bin. Perform hand hygiene.
10. Report any abnormalities to the Registered Nurse and document in the participant's Progress Notes.

Urinary Catheters Procedures

Appendix 2: When to Seek Medical Attention with the SPC / IDC

Procedure

Report to the Registered Nurse if you have detected or the participant has reported the following:

- Excoriation to the SPC site
- The SPC site smells bad and there is pus or blood in the urine
- Pain or bloating to the abdomen
- Concentrated urine and reduce urinary output
- Fevers or chills
- Pain to the site of the catheter
- Leakage of the catheter
- The participant's cognition has changed
- Catheter is dislodged from the site, **call 000 immediately** and notify the Registered Nurse. Complete an incident report.

The Registered Nurse is responsible for notifying the participant's Health Practitioner.

Urinary Catheters Procedures

Appendix 3: Indwelling Catheter

Procedure

Securing the IDC

The catheter should be secured for stability and prevent excessive traction of the catheter against the neck of the bladder or accidental dislodgement of the catheter.

The inflated balloon may descend in the urethra, causing pain, trauma and adverse events, if not properly secured.

There are different types of catheter securing devices:

- Strap devices
- Adhesive devices
- Other (new developments).

Choice of securing device should be based on the participant's needs and preferences.

Excessive Hair

Ensure hair is trimmed to allow better adhesion.

Allergies

Check that the participant does not have allergies to adhesive tapes and plasters.

Securing Catheter Bag

Catheter leg bags must be secured against the participant's leg using the participant's preferred securing devices.

Urinary Catheters Procedures

Appendix 4: Bathing/Showering

Procedure

The participant can have a bath/shower with the catheter and bag (unless stated otherwise).
Ensure the bag is emptied prior to the bath/shower and remains below the participant's waist.
Ensure the catheter and bag is thoroughly dried after the bath/shower.

Urinary Catheters Procedures

Appendix 5: Suprapubic Catheter

Procedure

Suprapubic Catheters (SPCs) should be FIRST inserted by an appropriately qualified Health Practitioner due to the technical surgical procedure it entails. Once inserted, support workers will do the following to maintain and manage participant's SPC:

Suprapubic Site

The suprapubic site should be clean with no redness, drainage, or excoriation.

The site should be cleaned with warm soapy water when hygiene is attended and thoroughly dried.

Securing the SPC

Always secure the SPC to the participant's abdomen with the participant's preferred securing device.

SPC Dislodgement

If the SPC is dislodged, cover the site with a sterile dressing and call 000 immediately and notify the Registered Nurse. Complete and incident report.

Urinary Catheters Procedures

Appendix 6: Male / Female Catheterisation

Equipment

Personal Protective Equipment

Inserting a urethral catheter requires a standard aseptic technique. Wear gloves, eye protection and apron / gowns, commensurate with the level of protection required to maintain asepsis and to protect self from blood and body fluid exposure during catheter insertion.

Equipment for Catheter Insertion

Prepare the following equipment when inserting a urethral catheter:

- 1 aseptic field
- 1 syringe, 10mL Luer Slip concentric
- 1 sterile paper towel
- 1 large (fenestrated) drape
- 1 sachet water soluble lubricant
- 2 sterile trays
- 1 x 10mL sterile water for injection
- 1 x 30mL sterile 0.9% sodium chloride
- Squeeze pack
- 1 batch tracking label
- 1 catheter securement device
- 3 plastic disposable forceps.

Procedure

1. Perform hand hygiene.
2. Explain the procedure to the participant and gain verbal consent from participant or person responsible. Consider using interpreter service and communication aids if necessary. If participant or environment was touched, perform hand hygiene.

Male Catheterisation

Some Health Practitioners may prefer to insert lignocaine. Before inserting lignocaine, clean the urethral meatus and ensure that hand hygiene is performed before and after this step.

3. Gather equipment and PPE required for the procedure. Ensure that a suitable receptacle for rubbish is available nearby. Perform hand hygiene.
4. Apply manual handling principles and set the bed at a suitable height for the procedure. Position participant in supine position. Ensure adequate privacy is maintained (e.g., draw screens, cover participant if required). Place protective sheet under the participant. Perform hand hygiene.

Female Catheterisation

3. Gather equipment and PPE required for the procedure. Ensure that a suitable receptacle for rubbish is available nearby. Perform hand hygiene.
4. Ensure supine position with the knees flexed and separated, and feet flat on the bed, about 60 cm apart. If uncomfortable, instruct the participant either to flex only one knee and keep the other leg flat on the bed, or to spread legs as far apart as possible.

The left lateral position may need to be considered. Ensure adequate privacy is maintained (e.g., draw screens, cover participant if required) and, if available, adequate light is focussed on the perineal area. Place protective sheet under the participant. Perform hand hygiene.

If an Existing Catheter is Being Replaced

- i. Deflate balloon passively with a 10mL syringe.
 - ii. With the dominant hand remove catheter.
 - iii. Discard used catheter.
 - iv. Remove non-sterile gloves and perform hand hygiene.
 - v. Remove PPE and perform hand hygiene.
5. Assemble the aseptic field (see list of equipment above). Add any additional sterile equipment required to the aseptic field (e.g., catheter, drainage device, sterile water and syringe if not included in catheter pack).
 6. Open sterile gloves onto the sterile surface, maintaining the sterility of the gloves.
 7. Don eye protection and apron / gown.
 8. Perform hand hygiene for aseptic procedures (30-60 seconds) and don sterile gloves.
 9. Fill syringe with 5-10mL of sterile water.
 10. Remove catheter from plastic sleeve, ensuring to always maintain sterility of the catheter.
 - **Male:** If lignocaine was not inserted at step 2 - Attach nozzle to lignocaine syringe.
 11. Lubricate catheter tip and place into an empty tray. This is the drainage tray.

Cleaning Method 1

12. Using non touch technique, pour 0.9% sodium chloride into an empty tray. This is the cleaning tray. Add gauze squares to 0.9% sodium chloride and discard forceps if used. Place the cleaning tray between participant's legs.
- **Male:** With non-dominant hand and using a gauze square, hold the participant's penis. Retract foreskin if uncircumcised. Using the dominant hand, clean urethral meatus and glans penis with gauze soaked with 0.9% sodium chloride, using one downward stroke (e.g., towards tip of the penis) per gauze square.
 - **Female:** With non-dominant hand, use the gauze squares to separate the labia minora exposing the urethral meatus. Using dominant hand, clean the labia minora and urethral orifice with gauze soaked with 0.9% sodium chloride, performing one downward stroke per gauze square.
13. Discard gauze squares after each stroke - do not re-use. When cleaning is completed, discard cleaning tray.

OR Cleaning Method 2

12. Irrigate the insertion site with 30 mL of 0.9% sodium chloride.
Note: If gloves are contaminated during cleaning, remove sterile gloves and discard. Perform hand hygiene for aseptic procedures (30-60 seconds) and don new sterile gloves.
13. Open fenestrated drape and place it over participant's genitals.
- **Male:** If lignocaine was not inserted at step 2 - Hold the penis at right angle to the body and gently insert the lignocaine nozzle into urethral meatus. Inject the lignocaine gel into the urethra ensuring firm seal around the meatus. Compress the penis and hold for 3-5 minutes.
14. Pick up catheter with the dominant hand and ensure that the drainage end of the catheter is in the tray. Place drainage tray on the fenestrated drape between participant's legs.
- **Male:** Hold penis at a 90° angle then gently insert catheter into urethral meatus. When resistance is felt, lower penis and continue inserting until the start of the Y junction of catheter. When urine flows, inflate balloon with sterile water in accordance with manufacturer's recommendations and with clinical discretion (e.g., consider spinal cord injury).
 - **Female:** Use non-dominant hand and gauze square to separate the labia minor and expose urethral meatus. Use the dominant hand to gently insert 5-7 cm of the catheter into the urethral meatus. When urine flows into the tray, advance the catheter 2-3cm then inflate balloon with sterile water in accordance with manufacturer's recommendations and with clinical discretion (e.g., consider spinal cord injury).

If catheter has been incorrectly inserted into the vagina, keep initial catheter in situ until the second catheter is correctly in place in the urethra.

Observe participant for any signs of discomfort. Gently withdraw catheter until resistance is felt.

Note: If there is no urine flow following insertion, **do not inflate balloon**. Examine participant to ensure catheter is in the urethra. If unable to advance the catheter with firm pressure, abort the procedure and notify the Registered Nurse.

Always use a new catheter and reset the aseptic field if a subsequent insertion attempt is required.

15. Securely connect catheter to drainage device (e.g., catheter bag or drainage valve) on the aseptic field. participant should relax their legs. Remove drainage tray, drape and protective sheet and discard.

- **Male:** Reposition foreskin, if required.

16. Secure catheter and drainage device appropriately (e.g., H strap, adhesive tape). Position drainage bags securely, ensuring that it is below the level of the bladder and is not touching the floor.

Ensure that the participant is dry, covered and in a comfortable position.

17. Dispose of waste in accordance with Australian Quality Care's *Management of Waste Policy and Procedure*.

18. Remove gloves and perform hand hygiene.

19. Remove eye protection and then apron/gown. Perform hand hygiene.

20. Document catheter insertion in the participant's healthcare record. The following information should be included:

- How consent was obtained and whom it was obtained from
- Indication for catheterisation
- Catheter option used (in/out, IDC, SPC)
- Size and type of catheter
- Time and date of insertion
- Balloon volume in
- Total urine volume drained on insertion
- Any abnormalities observed during or after catheter insertion (e.g., pain, bleeding)
- Any clinical misadventures during insertion (e.g., false passage, haematuria, blockage)
- Presence of UTI signs and symptoms
- Colour of urine, sediment, or abnormality
- Whether a urine specimen for culture was collected
- Post procedure tests that are clinically relevant
- Follow up actions (e.g., review of catheter, catheter removal).

Care for the Catheter

1. Check if the drainage device requires emptying.
2. Check there are no loops or kinks in the drainage bag tubing and that urine is draining

continuously.

3. Check that the catheter and drainage device are securely connected.
4. Check that the urine drainage bag is supported on a stand or hook that avoids loops in the tubing and keeps the outlet and tubing off the floor.
5. Check the drainage bag is always below the level of the bladder, including when the participant is being transported or ambulating
6. Check the catheter remains secured to the participant with a securing device
7. Check the drainage device is kept closed unless it is being emptied
8. If the participant has a drainage bag, the bag should be emptied when $\frac{3}{4}$ full and prior to any participant transport.
9. If the participant has a catheter valve, clinically assess whether drainage is required prior to opening the valve.
10. A clean receptacle to drain urine should be used for each participant. A used receptacle must not be shared between consecutive participants. When draining into the receptacle, avoid contact between the device's outlet and the receptacle. Clean the device outlet with an alcohol wipe after closing.

Changing Drainage Devices

The drainage device should only be changed in accordance with manufacturer's recommendations, if the device becomes disconnected from the catheter, or if the device fails.

1. Always use aseptic technique when changing the drainage device.
2. Explain the procedure to the participant and gain consent.
3. Ensure participant privacy.
4. Perform hand hygiene.
5. Select and assemble the appropriate drainage device and alcohol wipes.
6. Put on apron / gown and eye protection. Perform hand hygiene.
7. Don non-sterile gloves
8. Place a protective sheet under the connecting point of the catheter and device.
9. Compress the opening of the catheter to avoid urine leakage.

10. Remove catheter from the securing device.
11. Disconnect the used device and place into a clean receptacle e.g. bedpan for drainage bags.
12. Clean the catheter lumen thoroughly with an alcohol wipe and allow to dry.
13. Attach the replacement device using non-touch technique to avoid contamination of the catheter lumen and drainage device
14. Secure the catheter with the securing device.
15. Attach the urine drainage bag to urine bag stand or hook.
16. Dispose of waste in accordance with Australian Quality Care's *Management of Waste Policy and Procedure*.
17. Remove non-sterile gloves and perform hand hygiene.
18. Remove other PPE and perform hand hygiene.
19. Document device change and volume in drainage bag in the participant's healthcare record.

Removal of Catheter

Criteria-led Catheter Removal

Follow any standing medical order for catheter removal. If no such medical order exists, the Registered Nurse should consider the following criteria to determine whether it is suitable to remove the catheter:

- Is there is a documented reason for the catheter to remain in situ?
- Is there is any clinical indication for catheterisation still present?

Key Principles for Trial of Void

Before Catheter Removal

1. Assess participant's clinical history for:
 - Constipation in past 24 hours. Severe constipation should be corrected before catheter removal.
 - Medications that affect the ability to void (e.g. anticholinergics, Beta3-adrenergic agonist, alpha-blocker, opioid agent)
 - Any clinical conditions that may affect catheter removal (e.g., immunological disease with low white cell count, bleeding tendency, UTI, congestive cardiac failure, sacral or perineal wound, falls risk etc).
2. Explain the trial of void support plan to participant.
3. Ensure adequate privacy for the participant.
4. Provide participant with pain relief if required.

During Catheter Removal

5. Establish the amount of fluid in the balloon.
6. Perform hand hygiene before the procedure.
7. Don apron / gown and protective eyewear. Perform hand hygiene then don non-sterile gloves.
8. Attach syringe onto catheter balloon valve and observe drainage of water by passive deflation. When water stops draining, withdraw plunger to ensure balloon is completely deflated.
9. Remove the catheter slowly and steadily.
10. Discard waste according to Australian Quality Care's *Management of Waste Policy and Procedure*.
11. Remove gloves and perform hand hygiene.
12. Remove other PPE and perform hand hygiene.
13. Document the procedure in the participant's healthcare record.

After Catheter Removal

1. Clean and dry the genital area and ensure participant is comfortable.
2. Provide participant with urine receptacle.
3. If appropriate, educate participant on:
 - How to collect urine
 - Fluid intake requirements
 - Use of continence pads if urinary incontinence is anticipated
 - Need for mobilisation, if appropriate
 - What to do if any abnormal or suprapubic pain arises
4. Information about the catheter removal must be documented in the participant's healthcare record. At a minimum, the following information should be included:
 - Date and time of removal
 - Amount voided after removal
 - Presence of pain during voiding
 - Any bladder scan results from the trial of void
 - Clinical misadventures during removal (e.g., incomplete balloon deflation, catheter broken)
 - Abnormalities observed during removal (e.g., participant bleeding or in pain)
 - Trial of void outcome and clinical care plan

Document Control

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