

# SESLHD GUIDELINE COVER SHEET

<b>NAME OF DOCUMENT</b>	Urinary Catheter Management in the Community Setting
<b>TYPE OF DOCUMENT</b>	GUIDELINE
<b>DOCUMENT NUMBER</b>	SESLHDGL/065
<b>DATE OF PUBLICATION</b>	February 2018
<b>RISK RATING</b>	Medium
<b>LEVEL OF EVIDENCE</b>	<p><b>Standard 1:</b> Governance for Safety and Quality in Health Service Organisations</p> <p><b>Standard 3:</b> Preventing and Controlling Healthcare Associated Infections</p> <p><b>Standard 9:</b> Recognising and Responding to Clinical Deterioration in Acute Health Care</p>
<b>REVIEW DATE</b>	February 2021
<b>FORMER REFERENCE(S)</b>	SGSHHS CBR. 2016. Urinary Catheter Management in the Community Setting
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<b>KEY TERMS</b>	Catheterisation, Urethral, Community Setting, Suprapubic
<b>SUMMARY</b>	Provide community nurses with guidance for the assessment, insertion, removal and management of indwelling catheters in the community setting.

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## Section 1 - Background

The change of an IUC in the community setting is a routine procedure that facilitates direct drainage of urine from the bladder, by urethral or supra pubic methods. As in acute care settings, it is essential that aseptic technique and the use of sterile equipment and supplies are observed to ensure patient safety and infection prevention.

The community setting presents clinicians with unique work health and safety challenges, so it is important to ensure a safe, clean environment for both the patients and clinicians. Additionally, it is important to ensure that spare equipment is on hand in case of an accidental breach in asepsis or an emergency situation.

Any need for change of type or gauge of catheter size will be determined in consultation with the Community Continence/Urology CNC as per the client's re-assessment.

Ensure the client has a set up area in their home which is an appropriate size, location and height (if possible) and position rubbish bag for quick and easy disposal of rubbish and previous catheter and empty drainage equipment.

If client is at high risk of AD at time of community catheter change and/or has experienced AD at time of catheter change, consider that the client's IUC may need to be changed in a hospital setting (outpatient clinic or inpatient) where medical intervention is available.

## Section 2 - Definitions

IUC	Indwelling urinary catheter
SPC	Suprapubic catheter: A catheter positioned in the bladder through the abdominal wall via a surgically made fistula
CNC	Clinical nurse consultant
AD	Autonomic dysreflexia: A medical emergency which can occur in spinal cord injured clients (SCI) at or above the thoracic vertebra 6 level. It is characterised by sudden acute uncontrolled hypertension, it results from widespread reflex activity of the sympathetic nervous system below the level of injury, triggered by an ascending sensory stimulus. Autonomic Dysreflexia requires immediate attention and can be life threatening. Client at risk of Autonomic Dysreflexia should not have their catheter clamped prior to catheter change as clamping the catheter may cause AD (ACI 2014).
UTI	Urinary tract infection
Urethral catheterisation	Insertion of a catheter through the urethra into the bladder.
Residual volume	The urine obtained following the insertion of the catheter until the initial flow of urine ceases, usually after 15- 20 minutes
Bifurcation	The junction where the urethral catheter divides into two
Paraphimosis	A urological emergency that can occur in uncircumcised men only, whereby the penile foreskin once retracted and left in that position may be difficult to return to its original position. Paraphimosis can occur after male urethral catheter insertion in the uncircumcised male. The retracted foreskin may become a tight band of preputial skin (foreskin) causing vascular occlusion, resulting in oedema leading to ischaemia of the glans penis.
SCI	Spinal Cord Injury
Constipation	The normal bowel opens easily without straining varying between three times a day or three times a week with type 3 to 4 stool (Bristol Stool Chart). Constipation can present as straining when toileting, hard stool, bowels opening less than three times a week, abdominal discomfort and/or distension, feeling of incomplete evacuation, or overflow faecal incontinence related to a loaded bowel / constipation. REMEMBER: the most common cause of faecal incontinence is constipation.
ANTT	Aseptic Non Touch Technique
PPE	Personal Protective Equipment
CAUTI	Catheter Associated Urinary Tract Infection
CNA	Continence Nurse Advisor
GCN	Generalist Community Nurse
Coude Tip/ Tieman Tip Catheter	Curved tip IUC used to enable insertion off a male urethral catheter for some men with an enlarged prostate or urethral stricture. Registered Nurses must be assessed as competent to insert this type of IUC.

## Section 3 - Responsibilities

### All nursing staff are required to:

- Complete mandatory training as outlined in [Section 9](#)
- Adhering to work health and safety policy directives as outlined in [NSW Ministry of Health Policy - PD2013\\_050 Work Health and Safety: Better Practice Procedures](#).

### Enrolled Nurses (EN) are responsible for:

- Providing educational instruction and material to clients with IUCs
- Attending physical assessment of clients with IUCs
- Ensure arrangements for follow up for initial home visit are attended within period of time specified by hospital guidelines
- Escalating concerns, or abnormal findings to case manager (RN) in a timely manner.

### Registered Nurses (RN) are responsible for:

- Providing educational instruction and material to clients with IUCs
- Ensure arrangements for follow up for initial home visit are attended within period of time specified by hospital guidelines
- Attending physical assessment of clients with IUCs
- Establishing and maintaining aseptic technique/sterile equipment throughout the procedure
- Escalating concerns, or abnormal findings to CNC/CNS in a timely manner.

### Clinical Nurse Specialists are responsible for:

- Providing education and competency assessments of ENs/RNs
- Supporting community nursing staff and advanced skills/trouble shooting of difficult or advanced catheter placements
- Escalating concerns, or abnormal findings to Urology doctor in a timely manner.

### Clinical Nurse Consultants are responsible for:

- Providing education and competency assessments of ENs/RNs
- Supporting community nursing staff and advanced skills/trouble shooting of difficult or advanced catheter placements
- Escalating concerns, or abnormal findings to Urology doctor in a timely manner.

### Medical officers are responsible for:

- Completing the medical authority for catheter insertion/change (according to hospital guidelines)
- Reviewing and assessing patients referred by the CNC/CNS.

## Section 4 - Equipment

### 4.1 IUC Equipment:

- Clean trolley or work surface.
- Catheter pack containing:
  - sterile gauze swabs
  - 1 x pair of sterile gloves
  - dressing towel
  - fenestrated drape
  - 2 x forceps
  - 2 x trays
- 2 way catheter strap or disposal catheter fixation device
- Rubbish bag
- Specimen jar (if required)
- Blue disposable sheet
- 1-2 x 30mL Sodium Chloride Ampule
- 10mL Sterile Water
- Water soluble lubricant (sterile sachet)
- 2 x 10mL syringes
- Lignocaine 2% gel
- Catheter leg bag clamp
- PPE:
  - Protective eye wear
  - Disposable protective apron or gown
  - Disposable gloves

### 4.2 Drainage Equipment:

- 1 x sterile catheter appropriately sized
- Sterile drainage bag and/or catheter valve

### 4.3 Emergency Catheter Equipment:

- 14fg sterile Nelaton catheters (SPC changes)
- Spare 14fg, 16fg, 18fg sterile Balloon Foley catheter (as individually required)
- Spare complete catheter change pack (see above 4.1)
- Spare sterile drainage equipment
- Coudé Tip/Tiemann 16fg (as per scope/competency)
- 1 x spare pair sterile gloves

## Section 5 - Urethral Urinary Catheterisation in the Community

### 5.1 Indications for Indwelling Urinary Catheter (IUC)

- To relieve urinary retention
- To manage fistula and promote healing
- To preserve skin integrity
- To provide end-of-life care

### 5.2 Recommendations for Urethral Urinary Catheter (IUC) Changes in the Community

- Community clients should be contacted the day prior to the visit to confirm appointment and encourage oral fluids (be mindful of those clients who are on oral fluid restriction).
- The client should be encouraged to wash their genitals with soap and water or take a shower before procedure.
- Read the client's notes and be aware of any clinical risks at catheter change for the individual client living in the community setting including: enlarged prostate gland, anticoagulants, SCI, history of AD, male catheter change, past difficulties with SPC, fluid restriction, history of constipation.
- The client's urethral catheter should be clamped or removed at least 20 minutes prior to each change.
  - **ALERT:** Do not clamp or remove the urethral catheter in clients with a history of Spinal Cord Injury (SCI) above T6.
  - However, these clients should be told to drink well two (2) hours prior to catheter change (risk of AD)
- Clamping or the removal of the previous urinary urethral catheter for a short duration prior to insertion of the new catheter, allows the nurse clinician to:
  - Confirm catheter is placed into the urinary bladder
  - Observe the type of urine draining from the bladder
  - Observe urine flowing through the catheter from the urinary bladder prior to inflation of the catheter balloon
- If the client is incapable of clamping the catheter or non-compliant the RN should remove the urethral catheter and discard the catheter and drainage equipment when first arriving at the client's home, then wait for at least 20 minutes before inserting the new urethral catheter to ensure urine drainage from the bladder at catheter insertion occurs.
- The nurse must never leave the client after insertion of the new urethral catheter until urine is seen to be draining from the newly inserted catheter.
- Male IUC: Insert Foley up to the bifurcation or hub of the male length catheter and wait for urine to drain prior to inflation of balloon.

#### 5.2.1 Female Urethral Catheter (IUC) Competency

- It is important to observe the site of the female urethral catheter prior to the removal of catheter and again clearly observe the location of the female urethral meatus when the catheter has been removed.
- In the home/community/clinic setting good lighting or a bright well positioned head torch are required to clearly observe the female urethral meatus.
- If experiencing difficulty visualising the female urethral meatus with the client lying on her back please consider the option of rolling the client on her side with her knees bent to better visualise the female urethral meatus.

Community Guidelines for Female Urethral Catheter Change incorporating the Five Moments of Hand Hygiene	
1	Perform hand hygiene and don non-sterile gloves
2	Confirms this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent
3	Position client on a disposable blue sheet and ensure privacy
4	Don personal protection equipment PPE (apron and eye protection)
5	Deflate balloon – allow to self-deflate (start by drawing back .5 ml) and confirm balloon is completely deflated by slowly drawing back syringe
6	Position client correctly for procedure and using good lighting observe location of female urethral meatus and gently remove catheter
7	Observe old catheter for encrustation and blockage and discard, remove gloves and perform hand hygiene
8	Open sterile catheter pack, empty top tray by tipping tray from under pack and add all sterile equipment using ANNT, adjust lighting to enable vision of female urethral meatus
9	Perform procedural hand hygiene and don sterile gloves
10	Arrange equipment on the opened sterile pack and don second pair sterile gloves (found in pack) if using double glove technique
11	Enclose new catheter in single empty tray and connect full 10mls syringe (containing sterile water) firmly to balloon port
12	Ensure tip of catheter is lubricated
13	Fold fenestrated drape horizontally and place below genital area on client's thighs, white absorbent side up and blue waterproof side down(to reduce the risk of wetting client or bedding)
14	Place cleaning tray just below patient's genital area on blue area of folded fenestrated drape
15	Using dominant hand, pick up moistened cleaning swabs with forceps and clean left and right labia majora. One stroke per swab and one swab for each side, in a downward direction.
16	Part labia with non-dominant hand, using dominant hand pick moistened swabs with forceps, and clean labia minora and urethral orifice as above. Assess the need for further attention to hygiene.
17	Use all swabs and all cleaning solution (30 to 60mls), discard tray and if using double glove technique remove outer gloves
18	Open fenestrated sheet to expose all of white absorbent sheet if good vision can still be maintained of the female urethral meatus
19	Move the tray containing the catheter onto the fenestrated sheet, part labia and insert the catheter into the female urethral meatus
20	Wait for urine to drain before inflating balloon with 10mls sterile water
21	No resistance to be felt and client should have no discomfort / pain
22	Obtain CSU only if clinically indicated
23	Attach suitable sterile drainage equipment firmly to reduce risk of catheter/drainage disconnection, remove gloves and perform hand hygiene
24	Don non-sterile gloves and anchors catheter to reduce the risk of traction, and client discomfort and pain/urethral injury
25	Measure the residual urine volume if clinically indicated
26	Disposes of all urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and perform hand hygiene
27	Maintains ANTT throughout procedure
28	Document in "urinary catheter change care plan" in eMR / CHOC

### 5.2.2 Male Urethral Catheter (IUC) Competency

- **NOTE:** If there is a failed first attempt by the RN, the RN is to contact the CNC/CNS who are proficient in using a Size 16 FG Coude/Tiemann's tip catheter. The RN should have one attempt only.
- If attempt with a Coude/Tiemann's tip catheter is again unsuccessful the client should be admitted to the emergency department for review.

Community Guidelines for Male Urethral Catheter Change incorporating the Five Moments of Hand Hygiene		
1	Perform hand hygiene and don non-sterile gloves	
2	Confirm this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Position client on a disposable blue sheet and ensure privacy	
4	Don personal protection equipment PPE (apron and eye protection)	
5	Deflate balloon – allow to self-deflate (start by drawing back .5 ml) and confirm balloon is completely deflated by slowly drawing back syringe	
6	Hold penis, retract foreskin if necessary and gently remove catheter	
7	Observe old catheter for encrustation and blockage and discard, remove gloves and perform hand hygiene	
8	Open sterile catheter pack, empty top tray by tipping tray from under pack and add all sterile equipment using ANNT	
9	Perform procedural hand hygiene and don sterile gloves	
10	Arrange equipment on the opened sterile pack and don second pair sterile gloves (found in pack) if using double glove technique	
11	Enclose new male length catheter in empty tray and connect full 10mls syringe (containing sterile water) firmly to balloon port	
12	Adjust nozzle of Lignocaine 2% gel and expel air	
13	Fold fenestrated drape horizontally and place below genital area on client's thighs, white absorbent side up and blue waterproof side down (to reduce the risk of wetting client or bedding)	
14	Place cleaning tray just below patient's genital area on blue area of folded fenestrated drape, place Lignocaine 2% gel below tray on drape	
15	Retract foreskin if client is uncircumcised and clean entire penis (lastly glans penis) using all swabs and all cleaning solution (30 to 60mls)	
16	Holding penis at right angle to the body (with non-dominant hand), lubricate male urethral meatus with 1ml of lignocaine gel prior to gently inserting the Lignocaine Gel nozzle into urethral meatus, inject slowly into the urethra and wait 4 minutes (ensuring firm seal around meatus)	
17	After 4 minutes, carefully place penis on folded dressing towel to keep clean and remove outside gloves (if using double glove technique)	
18	Open fenestrated sheet to expose all of white absorbent sheet	
19	Hold penis at right angle to the body (with non-dominant hand) and insert the male length catheter. When resistance is felt at the bladder neck point the penis towards the client's feet. Insert all the way to the point of catheter bifurcation.	
20	Hold catheter in place and wait for urine to drain before inflating balloon with 10mls sterile water. During balloon inflation there should be no resistance, client discomfort or pain	
21	Obtain CSU only if clinically indicated	
22	Attach suitable sterile drainage equipment	
23	If the man is uncircumcised, it is very important to reposition his foreskin over the glans penis to prevent paraphimosis, remove gloves and perform hand hygiene	
24	Don non-sterile gloves and anchor catheter to reduce the risk of traction, and client discomfort and pain	
25	Measure the residual urine volume if clinically indicated	
26	Dispose of all urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and perform hand hygiene	
27	Maintains ANTT throughout procedure	
28	Document in "urinary catheter change care plan" in eMR / CHOC	

## Section 6 – Change of a Supra Pubic (SPC) Catheter

### 6.1 Indications for SPC Insertion

- Long term catheterisation and quality of life
- No urethral access or urethral trauma
- Failed urethral catheterisation

### 6.2 Considerations/Precautions for SPC Insertion

- History of bladder cancer
- Obesity
- Thin or underweight
- Anticoagulants
- Constipation
- If the client has a history of AD, check if the client has used sildenafil or vardenafil in the last 24hrs or Tadalafil in the last four (4) days as GTN spray, tablet or patches cannot be used in the treatment of AD.

### 6.3 Recommendations for SPC Changes

- Community clients should be contacted the day prior to the visit to confirm appointment and encourage oral fluids (be mindful of those clients who are on oral fluid restriction)
- Confirm client has suitable catheter and drainage equipment at home
- Preferable to use clear silicone catheter for SPC insertion where possible to enable the nurse to see urine drainage when it first occurs in the catheter
- Ensure 14fg Nelaton catheters are kept in the home and always have spare Nelaton catheters and a 14fg Foley Balloon catheter with you for emergencies
- The client should be encouraged to take a shower before procedure
- Read the client's notes and be aware of any clinical risks at catheter change for the individual client living in the community setting, for example history of problems with past SPC changes, painful or difficult catheter removal or insertion, haematuria, anti-coagulant therapy, constipation, ED visit or recent UTI
- Observe the SPC stoma site for inflammation, discharge or over-granulation
- The old catheter may be marked at point of entry to the SPC stoma with tape if this is helpful to the clinician
  - **ALERT:** Do not clamp the catheter for clients with a history of spinal cord injury above T6 and / or a history of AD.
  - However, these clients should be reminded to drink well for two (2) hours prior to catheter change
- Clamp / spigot all other client's catheters at least 20 minutes prior to change.
- Clamping of the previous SPC catheter allows the nurse clinician to:
  - Ensure there is urine in the bladder at time of removal of old SPC catheter
  - Observe the type of urine draining from the bladder when the new SPC catheter is inserted
  - Confirm SPC catheter has been placed into the urinary bladder and remains sitting within the urinary bladder
  - To enable the clinician to observe urine flowing via the SPC catheter prior to inflation of the catheter balloon
- If the client is incapable of clamping the catheter or is non-compliant the RN should clamp the leg bag with a catheter clamp device or spigot the SPC catheter when they first arrive at the

## Section 6 Change of a Supra Pubic (SPC) Catheter

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client's home, then wait for at least 20 minutes prior to removal and insertion of the new SPC catheter to ensure urine drainage from the bladder

- After inserting the new SPC catheter into the SPC stoma wait for urine to drain before inflating balloon with 10mls sterile water
  - Ask the client to cough, or gently apply pressure above the stoma site, if urine slow to drain
- There should be no resistance felt at time of balloon inflation and the client should not feel any pain or discomfort during balloon inflation if the SPC urinary catheter is positioned correctly within the urinary bladder
- The community nurse must never leave the client after insertion of the new catheter until urine is seen to be flowing from the newly inserted SPC catheter.

#### 6.4 SPC Competency

Community Guidelines for Supra Pubic Catheter Change incorporating the <b>Five Moments of Hand Hygiene</b>		
1	<b>Perform hand hygiene</b> and don non-sterile gloves	
2	Confirm this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Position client on a disposable blue sheet and ensure privacy	
4	Don personal protection equipment PPE (apron and eye protection)	
5	Observe SPC stoma for any inflammation, discharge or over-granulation, ensure urine in the bladder when catheter removed by clamping drainage bag or spigot the catheter	
6	If client is cognitively intact and the clinical risk of SPC catheter falling out is low, balloon may be "self-deflated" <b>but not removed</b> at this time to reduce risk of cuffing of SPC catheter. Remove non-sterile gloves and <b>perform hand hygiene</b>	
7	Open sterile catheter pack, empty top tray by tipping tray from under pack and add all sterile equipment using ANNT. Ensure unopened Nelaton 14fg /16fg available if required.	
8	<b>Perform procedural hand hygiene</b> and don sterile gloves	
9	Arrange equipment on the opened sterile pack and don second pair sterile gloves (found in pack) if using double glove technique.	
10	Enclose new catheter fully in single empty tray and connect full 10mls syringe (containing sterile water) firmly to balloon port	
11	Ensure tip of catheter is lubricated	
12	Fold fenestrated drape horizontally and place below SPC stoma white absorbent side up and blue waterproof side down	
13	Place cleaning tray just below patient's SPC stoma on blue area of folded fenestrated drape	
14	Using dominant hand pick up forceps with swabs and clean SPC stoma	
15	Deflate balloon or finish deflating balloon (using non-dominant hand with two hand technique) – allow to self-deflate (start by drawing back .5 ml) and then confirm balloon is completely deflated by slowly drawing back syringe to 2mls	
16	Gently remove SPC, (with non-dominant hand using two hand technique), put some support just above stoma, observe distance of SPC tract and discard old SPC catheter	
17	Remove outer gloves promptly (if using double glove technique)	
18	Turn out fenestrated sheet to expose all of white absorbent sheet	
19	Insert the SPC catheter into the SPC stoma using dominant hand, when urine starts to drain insert catheter 2 to 3 cm further	
20	Wait for urine to drain into clear catheter or tray before inflating balloon with 10mls water, (ask client to cough if urine slow to drain)	
21	Hold SPC catheter at SPC stoma to keep catheter in correct position during balloon inflation, no resistance to be felt and client must have no discomfort / pain at inflation	
22	Obtain CSU only if clinically indicated	
23	Attach suitable sterile drainage equipment firmly and correctly, remove gloves and <b>perform hand hygiene</b>	
24	Don non-sterile gloves and anchor catheter to reduce the risk of traction, and client discomfort and pain	
25	Observe the old catheter for encrustation and blockage and measure the residual urine volume if clinically indicated	
26	Disposes of urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and <b>perform hand hygiene</b>	
27	Maintain ANTT throughout procedure	
28	Document in "urinary catheter change care plan" in eMR / CHOC	

## Section 7 - Possible Complications of Catheterisation

### 7.1 Possible complications of catheterisation

- Balloon inflation in somewhere other than the bladder may result in discomfort, pain, trauma, and haematuria
- False passage, associated with forced procedure
- Haemorrhage from traumatic catheterisation
- Symptomatic Catheter Associated Urinary Tract Infection (CAUTI)
- Urinary Sepsis

### 7.2 Signs of asymptomatic CAUTI

If clinical signs of a symptomatic CAUTI are present at change of a new catheter, a specimen is required for urinalysis from the newly inserted catheter.

Signs and symptoms of CAUTI may include:

- Foul smelling urine
- Urine that is cloudy, blood or dark
- Sediment in the urine
- Pain or discomfort around the catheter
- Fever or chills
- Stomach, flank pain or lower back pain
- Confusion
- Catheter blockage
- Bladder spasms

Please refer to local clinical business rules for dipstick and urinalysis procedures. Please notify clients GP and/or Urologist to review the client regarding the need for a CSU from the newly inserted catheter, order a CSU, review need for further treatment and follow up the pathology results.

### 7.3 Autonomic Dysreflexia Recommendations

- Refer to the [ACI Guidelines for the management of AD](#):
  - [Autonomic Dysreflexia Medical Emergency Card](#)
  - [Autonomic Dysreflexia Algorithm](#)
  - [Treatment of Autonomic Dysreflexia in Adults and Adolescents with Spinal Cord Injuries](#)

## Section 8 - Documentation

### 8.1 Clinical Documentation

Documentation (including rationale for catheterisation) must be noted in:

- EMR- Catheter Change Care Plan
- Community Health Notes on EMR

## Section 9 - Mandatory Training

Registered and enrolled nurses must complete the following prior to undertaking catheterisation on patients:

- My Health Learning: Aseptic Technique
- My Health Learning: Catheterisation (Male and SPC)
- My Health Learning: Hand Hygiene
- My Health Learning: Invasive Device Module
- My Health Learning: Waste Management

Additionally, nurses must complete competency assessments for both SPC and male IUC insertions prior to undertaking the task without supervision.

## Section 10 - Related Policies

[NSW Ministry of Health Policy - PD2013\\_050 Work Health and Safety: Better Practice Procedures](#)  
[NSW Ministry of Health Policy PD2017\\_013 Infection Prevention and Control Policy](#)  
[NSW Ministry of Health Guideline - GL2015\\_016 Adult Urethral Catheterisation for Acute Care Setting](#)

## Section 11 - Resources

Joanna Briggs Institute (2016). Indwelling Urinary Catheter Management Community Setting. *JBI Recommended Best Practice*

NSW Agency for Clinical Innovation (ACI) Urology Network (2014). Female Indwelling Urinary Catheterisation (IUC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) Urology Network (2017). Male Indwelling Urinary Catheterisation (IUC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) Urology Network (2014). Supra Pubic Catheter (SPC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) (2014). Treatment of Autonomic Dysreflexia for Adults and Adolescents with Spinal Cord Injuries.

## Revision and Approval History

Date	Revision no:	Author and approval
October 2017	DRAFT	Draft for Comment
January 2018	DRAFT	Processed by Executive Services prior to progression to SESLHD Clinical and Quality Council

## Appendix A - Trouble Shooting Guide

CATHETER PROBLEMS		READ CLIENT'S NOTES PRIOR TO HOME OR CLINIC VISIT
<b>DIFFICULT REMOVAL</b>		<b>REVIEW CATHETER PROBLEMS WITH THE CONTINENCE ADVISOR</b>
<b>Balloon not fully deflated</b>	<ul style="list-style-type: none"> <li>*Check balloon volume (3-way catheter may have a 30ml balloon).</li> <li>*Do not discard syringe so you can double check balloon.</li> </ul>	
<b>Balloon cuffing</b>	<ul style="list-style-type: none"> <li>*100% Silicone catheters (all clear and blue catheter) are prone to cuffing (ridging).</li> <li>*Allow balloon to passively-deflate (may need to gently start deflation) and remove remaining water.</li> <li>*Wait 5 to 10 minutes post deflation to allow cuffing to improve prior to catheter removal.</li> <li>*Try reinflation of balloon and passive-deflation again.</li> <li>*If cuffing continues to be an issue, consider trialling an alternative catheter.</li> <li>*Insert 0.5ml into the balloon to help smooth out the ridging, prior to attempting to remove catheter.</li> </ul>	
<b>Bladder spasms and pain</b>	<ul style="list-style-type: none"> <li>*Remove catheter slowly.</li> <li>*Consider requirement for anticholinergic medication (i.e. Oxybutynin).</li> <li>*Consider need for urology review.</li> </ul>	
<b>Possible bladder debris or stones in bladder</b>	<ul style="list-style-type: none"> <li>*Educate client to rotate SPC catheter daily.</li> <li>*Drink well.</li> <li>*Client may require urology review and/or cystoscopy.</li> <li>*Client may require thick walled catheter (i.e. Bard Biocath).</li> <li>*Catheter may be at risk of falling out if the balloon is damaged by a sharp stone.</li> </ul>	
<b>Anxiety and pain</b>	<ul style="list-style-type: none"> <li>*Provide reassurance.</li> <li>*Provide client with pain relief prior to catheter change.</li> <li>*Assess for signs of constipation and CAUTI.</li> <li>*Client may require referral to Urologist.</li> </ul>	
DIFFICULT INSERTION		REVIEW CATHETER PROBLEMS WITH THE CONTINENCE ADVISOR
<b>Urethral obstruction</b>	<ul style="list-style-type: none"> <li>*Assess for constipation.</li> <li>*Consider possibility of urethral stricture.</li> <li>*Single attempt at catheter insertion.</li> <li>*Contact Continence Advisor.</li> <li>*Consider need for Coudé Tip catheter.</li> <li>*Two attempts at catheter insertion in the community setting and then transfer to ED.</li> </ul>	
<b>Avoidance of false passage (male IUC)</b>	<ul style="list-style-type: none"> <li>*Do not force insertion of the catheter.</li> <li>*With client lying flat, grasp penis firmly at 90° to the body (point towards the ceiling) and insert.</li> <li>*When resistance is felt point the penis towards the client's feet.</li> <li>*Ask client to cough or bear down.</li> </ul>	
<b>Pain on insertion of male urethral catheter</b>	<ul style="list-style-type: none"> <li>*Insert Lignocaine jelly.</li> <li>*Ensure jelly remains in the male urethral for four (4) minutes prior to catheter insertion to allow for effect.</li> <li>*Ensure catheter is inserted all the way to the bifurcation and urine is sighted prior to balloon inflation (reduce risk of balloon inflation in the prostatic bladder neck).</li> </ul>	
<b>Avoid SPC stoma becoming unaligned with the bladder</b>	<ul style="list-style-type: none"> <li>*Lie patient flat when possible.</li> <li>*Ask client to remain still following SPC removal (empty stoma).</li> <li>*Insert new SPC promptly.</li> <li>*Avoid distractions at time of SPC removal and insertion.</li> <li>*Always use sterile lubricant on catheter tip.</li> </ul>	

<b>Unable to reinsert SPC</b>	<ul style="list-style-type: none"> <li>*Always have 14fg Nelaton and spare 14fg balloon catheter and catheter with you at time of SPC change.</li> <li>*Gently insert Nelaton to maintain stomal patency.</li> <li>*Attempt a 14fg catheter insertion.</li> <li>*Call for assistance (GCN or CAN).</li> <li>*Resize up to usual SPC size at next change (with CNA).</li> <li>*Consider urethral catheterisation if SPC access difficult.</li> <li>*<b>ALERT</b> for client at risk of AD.</li> </ul>
<b>No urine output upon IUC/SPC insertion</b>	<ul style="list-style-type: none"> <li>*Ensure adequate urine volumes prior to catheter insertion.</li> <li>*If client is <b>not</b> at risk of AD, clamp catheter for at least 20 minutes.</li> <li>*If client is at risk of AD instruct them to have two large drinks prior to catheter change.</li> <li>*Gently press on lower abdomen (above pubic bone) to increase bladder pressure and assist urine drainage.</li> </ul>
<b>Balloon will not inflate</b>	<ul style="list-style-type: none"> <li>*Ensure the catheter is in the bladder, there will be no resistance to balloon inflation if the catheter is in the hollow bladder.</li> <li>*Ensure the male urethral catheter is inserted to catheter bifurcation and urine is sighted prior to balloon inflation.</li> <li>*<b>Under no circumstances</b> force the balloon to inflate.</li> </ul>
<b>POST URETHRAL AND SPC CATHETER INSERTION REVIEW CATHETER PROBLEMS WITH THE CONTINENCE ADVISOR</b>	
<b>Little/No urine output</b>	<ul style="list-style-type: none"> <li>*<b>Assess:</b> <ul style="list-style-type: none"> <li>* Catheter placement/location</li> <li>*Adjust position of the catheter very slightly</li> <li>*Hydration</li> <li>*Pain.</li> </ul> </li> <li>*Do not leave the client.</li> <li>*Caution with balloon inflation.</li> <li>*Ask the client to cough while holding the catheter in place.</li> <li>*Gently press on lower abdomen (above pubic bone) to increase bladder pressure and assist urine drainage.</li> </ul>
<b>Reported catheter pain or discomfort</b>	<ul style="list-style-type: none"> <li>*<b>Assess:</b> <ul style="list-style-type: none"> <li>*Catheter placement/location.</li> <li>*Did the pain occur with balloon inflation?</li> <li>*Has the client had pain after past catheter changes?</li> <li>*Is urine draining?</li> <li>*Is the pain / discomfort settling quickly?</li> <li>*Is the catheter supported?</li> <li>*Symptoms of UTI?</li> </ul> </li> </ul>
<b>Client reports bowel problems (constipation or faecal incontinence)</b>	<ul style="list-style-type: none"> <li>*<b>Review and Assess:</b> <ul style="list-style-type: none"> <li>* Review client's bowels and asses for constipation at catheter change.</li> </ul> </li> </ul>
<b>Haematuria</b>	<ul style="list-style-type: none"> <li>*Assess haematuria: Light, moderate, heavy, bright, dark.</li> <li>*Was urine clear prior to catheter change.</li> <li>*Client may be required to attend ED for Urology review +/- bladder irrigation.</li> <li>*Symptomatic CAUTI?</li> </ul>
<b>Symptomatic catheter related UTI</b>	<ul style="list-style-type: none"> <li>*Consider need to collect a CSU from newly inserted catheter at time of change.</li> </ul>
<b>Uncircumcised male with a urethral catheter</b>	<ul style="list-style-type: none"> <li>*Attend face to face (home or clinic) catheter assessment within 24 to 48 hours of referral.</li> <li>*Examine urethral meatus for any oedema / swelling.</li> <li>*Try to replace foreskin using traction and lubricant / Lignocaine jelly.</li> <li>*Paraphimosis is a urological emergency, client must attend ED.</li> </ul>
<b>Client has valve and not</b>	<ul style="list-style-type: none"> <li>*Client leaking urethrally with a flip flow valve.</li> <li>*Educate client to empty valve more than eight (8) times per day.</li> </ul>

<b>suitable for valve drainage</b>	<ul style="list-style-type: none"> <li>*Client has cognitive impairment and is forgetting to empty their valve.</li> <li>* Consider need for valve removal and apply bag on free drainage.</li> </ul>
<b>Client has leg bag and may be suitable for valve drainage</b>	<ul style="list-style-type: none"> <li>*Better QOL with a valve, consider for clients with a long term catheter.</li> <li>*Client has no recent episodes of urinary retention.</li> <li>*Client is not due to have a TOV.</li> <li>*Client has a bladder that stores urine.</li> <li>*Client is not cognitive impaired.</li> </ul>
<b>Catheter blockage/leaking</b>	<ul style="list-style-type: none"> <li>*Assess: <ul style="list-style-type: none"> <li>*Duration of blockage</li> <li>*Tube patency</li> <li>*Hydration</li> <li>*Colour/character of the urine</li> <li>*Urine leakage</li> <li>*Clots/Debris.</li> </ul> </li> <li>*Consider CAUTI and/or constipation.</li> <li>*Change IUC- DO NOT flush/irrigate.</li> </ul>
<b>Client needs regular reinforcement of catheter management</b>	<ul style="list-style-type: none"> <li>*Upon each visit, reinforce/educate client: <ul style="list-style-type: none"> <li>*Hand washing</li> <li>*Hydration</li> <li>*Bowel management</li> <li>*Catheter and equipment care.</li> </ul> </li> </ul>
<b>Catheter falls out</b>	<ul style="list-style-type: none"> <li>*SPC must be re-inserted ASAP.</li> <li>*Consult CNA for assistance.</li> <li>*Have 14fg Nelaton and 14fg Balloon catheter.</li> <li>*If client is at risk of AD, may need ambulance transfer to ED.</li> <li>*Consider why the catheter has fallen out: <ul style="list-style-type: none"> <li>*Bladder stones</li> <li>*Faulty catheter.</li> </ul> </li> </ul>
<b>Client with spinal cord injury above T6 and clients at risk of Autonomic Dysreflexia</b>	<ul style="list-style-type: none"> <li>*Careful planning for catheter change prior to each visit.</li> <li>*Read clients notes prior to each visit.</li> <li>*Complete appropriate documentation in CHOC. If client is symptomatic of AD and does not have a patent catheter draining urine call ambulance for transfer to ED.</li> <li>*Read and be familiar with ACI AD guidelines and keep a copy in client's home.</li> </ul>