

SUPRAPUBIC CATHETER (SPC) CARE AND CLAMP AND RELEASE REGIME

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To improve and promote bladder control, sensation and tone through void and residual measurements via SPC management. To prevent any unnecessary urinary retention or urinary tract infection development in women and to maintain an infection free SPC insertion site.

2. PATIENT

- Any woman with a Suprapubic Catheter insitu

3. STAFF

- Medical Officers
- Certified Midwives
- Registered Nurses
- Enrolled Nurses

4. EQUIPMENT

For Clamp & Release:

- Non sterile gloves
- Alcohol wipe
- Measuring jug
- Urine collector for toilet
- Flip flow catheter valve
- Sterile gloves
- Alcohol wipe
- New urinary catheter drainage bag
- Dressings pack

For SPC site care

- Normal Saline
- Sterile gloves
- Dressing pack

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Patient Safety Committee
16/10/14

SUPRAPUBIC CATHETER (SPC) CARE AND CLAMP AND RELEASE REGIME cont'd

5. CLINICAL PRACTICE

For Clamp & Release

- Check in patient's integrated notes request for SPC clamp and release regime to be commenced.
- Explain procedure and rationale for SPC clamp and release regime to the patient, obtain verbal consent. SPC patient information leaflet can be given to patient.
- Obtain required equipment
- Perform hand hygiene (moment 2)
- Open sterile dressing pack
- Perform hand hygiene again (Moment 1/Moment 2)
- Don sterile gloves
- Disconnect SPC catheter from urinary drainage bag using dressing pack as sterile field.
- Clean end of SPC catheter with alcohol wipe.
- Insert 'flip flow' catheter valve and close (so that arrow points to bladder)
- Reapply new urinary drainage bag or leg bag.
- Dispose of waste and equipment whilst adhering to Royal Hospital for Women's infection control standards
- Perform Hand Hygiene (Moment 3)
- Don gloves and place urine collector in the patient's toilet.
- Perform hand Hygiene (Moment 5)
- Inform patient to contact nurse when she feels the need to void
- Assist patient to toilet if required and instruct patient to void without straining into urine collector.
- Perform hand hygiene (Moment 1) unclamp the SPC and allow to drain for 5 minutes into the urinary bag when patient has completed voiding
- Reclamp SPC after 5 minutes and perform hand hygiene (moment 4/moment 2)
- Measure and dispose of urine after each void and residual
- Perform hand hygiene (moment 3)
- Document voids and residuals on patient's trial of void chart, integrated notes and as indicated on the patients clinical pathway/nursing care plan

For SPC site care

- Explain procedure and rationale to patient
- Obtain equipment required
- Screen patient for privacy
- Perform hand hygiene (Moment 1)
- Don non-sterile gloves
- Remove old dressing if present
- Inspect SPC site for discharge or signs of infection
- Remove non-sterile gloves, perform hand hygiene (Moment 4/Moment 2) and don sterile gloves

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- Using sterile gauze moistened with normal saline clean around the SPC site in a circular motion inwards to outwards
- Dry the site with gauze using the same circular motion
- Apply keyhole dressing if indicated and secure with tape
- Ensure the SPC is securely anchored to the patient's leg with catheter fixative
- Terminate encounter appropriately
- Dispose of rubbish appropriately
- Remove gloves and perform hand hygiene (Moment 3)
- Document procedure in Clinical Pathway and Integrated Notes

Once the patient is mobile, independent and showering, the SPC site can be cleaned in the shower daily. The area is then towel dried carefully on completion. It is not recommended to redress the SPC site after 7 days due to infection risk and colonisation.

6. DOCUMENTATION

- Integrated clinical notes
- Clinical Pathway
- Fluid Balance chart
- Trial of void chart

7. EDUCATIONAL NOTES

- Patients should be encouraged to maintain an average oral intake of between 1500 to 2000mls per day, unless otherwise indicated by patient's medical history or medical officer.
- Encourage voiding after 4 hours of clamping, and aim to keep total void and residual volume under 600ml.
- Urinary catheter bags only require changing when: the system is broken (bag falls off or is removed) if sediment or discolouration is noted within the bag. Evidence does not support frequent changing of catheter bags as a preventative for urinary tract infection.
- Patients should always have their catheter attached to a urinary drainage bag or leg bag as maintaining a closed system reduces the risk of UTI. Urinary drainage bags should be on a free standing catheter stand so that the patient can mobilize freely.
- If the patient experiences any discomfort and cannot pass urine urethrally or has no sensation to void after 4-6 hours, then unclamp the catheter and drain for 5 minutes, then reclamp. If the discomfort continues, if haematuria is present or if residual is 600ml or more, place the SPC on free drainage and notify the patient's Medical Officer. If pain subsides or was never present, re-clamp the SPC and begin clamp and release regime again. Residual urine should then be documented on fluid balance chart or trial of void chart.

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- If patient is unable to void urethrally after 2 attempts of the SPC being clamped for 4-6 hours, then consult with the surgical team for further advice.
- The patient should be left on clamp and release regime overnight if their residuals are decreasing in volume, unless otherwise instructed by the surgical team (check for instructions).
- If residuals are less than 100mls leave catheter clamped overnight, allow patient to void normally and check residual the next morning.
- The SPC is to be removed only after request by patient's medical officer.
- Prior to removal of SPC the patient should have at least two consecutive voids of more than 150mls with 2 residuals of less than 100mls

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Infection Control Commitment PD010
- RHW Infection Control Policy
- Hand and Wrist Jewellery and fingernail Enhancement PD 182
- Hand Hygiene and hand care PD183
- DOH Hand Hygiene Policy PD2010_058
- DOH Infection Control Policy PD2007_36
- SESLHD Infection Control Manual
- Collection of catheter specimen of urine (CSU)

9. RISK RATING

- Low

10. REFERENCES

- HICPAC 2009 Guidelines for prevention of catheter-associated urinary tract infections Gould et al Department of Health and Human Services, USA
- Royal College of Nursing 2012 Catheter Care RCN guidance for Nurses Royal College of Nursing, London, UK

REVISION & APPROVAL HISTORY

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