

# CATHETERS (URINARY) MANAGEMENT PROCEDURE<sup>®</sup>

## DOCUMENT SUMMARY/KEY POINTS

- Relevant to all nursing staff and medical staff inserting urinary catheters.
- This document contains information on:
  - the insertion and removal procedures and management of:
    - indwelling catheters
    - supra pubic catheters and
    - intermittent catheters
- The collection of urine specimens/samples from urinary catheters.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

<b>Approved by:</b>	SCHN Policy, Procedure and Guideline Committee	
<b>Date Effective:</b>	1 August 2016	<b>Review Period:</b> 3 years
<b>Team Leader:</b>	Clinical Nurse Consultant	<b>Area/Dept:</b> Kids Rehabilitation

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This Policy/Procedure may be varied, withdrawn or replaced at any time. Compliance with this Policy/Procedure is mandatory.

## CHANGE SUMMARY

- Due for mandatory review – no changes made other than update links.
- *Note:* Clean Intermittent Catheterisation Homecare Guideline has been split into a guideline for 'boys' and a guideline for 'girls'.

## READ ACKNOWLEDGEMENT

- All nursing staff and medical staff inserting urinary catheters should read and acknowledge this document.
- Training required for clinical staff who insert urinary catheters.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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## Introduction – Catheterisation

- Catheters provide drainage of urine from the bladder.
- Intermittent and indwelling catheters may be inserted into male and female patients by registered nurses experienced in the procedure. Staff who require a review of their skills or those performing the procedure for the first time should seek a teaching session and supervision of the procedure.
- Intermittent catheters may be inserted by enrolled nurses deemed competent in the procedure.
- Nurses experienced in the procedure may irrigate the bladder of a child with a urinary catheter.
- An **indwelling catheter** provides continuous drainage for the purpose of ongoing monitoring of urine output; to prevent or relieve urinary retention; to keep urine away from a surgical wound; intra-operatively, and following major surgery to enhance patient comfort. It may also be used short term for management of a neurogenic bladder.
- A **suprapubic catheter** is surgically placed through the abdomen into the bladder to divert urine from the urethra.
- An **intermittent catheter** involves inserting a catheter through the urethra at regular times. It is performed to prevent bladder distension and reduce urinary incontinence for the long term management of a neurogenic bladder, usually due to spinal injury or damage. It may also be done to collect a sterile specimen, and to measure residual urine output.
- An **appendico-vesicostomy** is a channel using the appendix to gain access to the bladder from outside the body. A stoma is formed and used for catheterisation.

**Note:** The Aboriginal Health Education Officer (p6030) should be contacted if a male Aboriginal child needs catheterisation.

## 1 Indwelling Catheter

### **Equipment**

- Dressing pack
- Indwelling silastic catheter of appropriate size. \* (or as directed by urologist)

### **Size selection guideline (approximate)**

- Babies/small children: FG6-8
- 5-10 years: FG8
- 10-12 years FG10
- >12 years: FG12

- Sterile gloves (1 pair).
- Single packaged water based lubricant
- Aqueous chlorhexidine 0.1% disposable ampoule
- Urinary drainage bag (with measurement attachment if required)
- Ampoule of sterile water
- 5mL syringe
- tapes
- protective eyewear
- (Male) sterile lignocaine 2% gel with chlorhexidine 0.5% pre-loaded syringe or 5mL syringe and 2% lignocaine gel.
- (Female) extra cotton balls and lignocaine gel 2%.

## Procedure

### *Initial Procedure for Male and Female indwelling catheterisation*

1. Explain procedure to child and carer.
2. Standard precautions and principles of asepsis apply.
3. Clean trolley with a neutral detergent (eg: lemex).
4. Wash hands for one minute.
5. Open catheter tray onto trolley ensuring plastic drape provides a sterile field.
6. Open catheter onto sterile field. Place lubricant into the sterile tray. DO NOT inflate balloon prior to insertion as it may distort the balloon and cause pain and/or tissue damage during catheter removal.
7. Pour aqueous chlorhexidine 0.1% over cotton balls in tray.
8. (For female) soak extra cotton balls in lignocaine gel.
9. (For male) open lignocaine pre-loaded syringe or prepare 5mL syringe with 4mL lignocaine gel.
10. Place blue waterproof towel under buttocks.
11. Put on goggles.
12. Wash hands for three minutes.
13. Don gloves.
14. With assistant:
  - Draw up appropriate water volume into syringe for balloon inflation.
  - Lubricate catheter tip.
  - Assistant places child in supine position with legs in appropriate position.
  - Assistant arranges examination light if necessary.

- Place tray with cotton balls and solution into 2<sup>nd</sup> kidney dish and position between legs. Position drape appropriately around genitalia.

### **a) Then for Males**

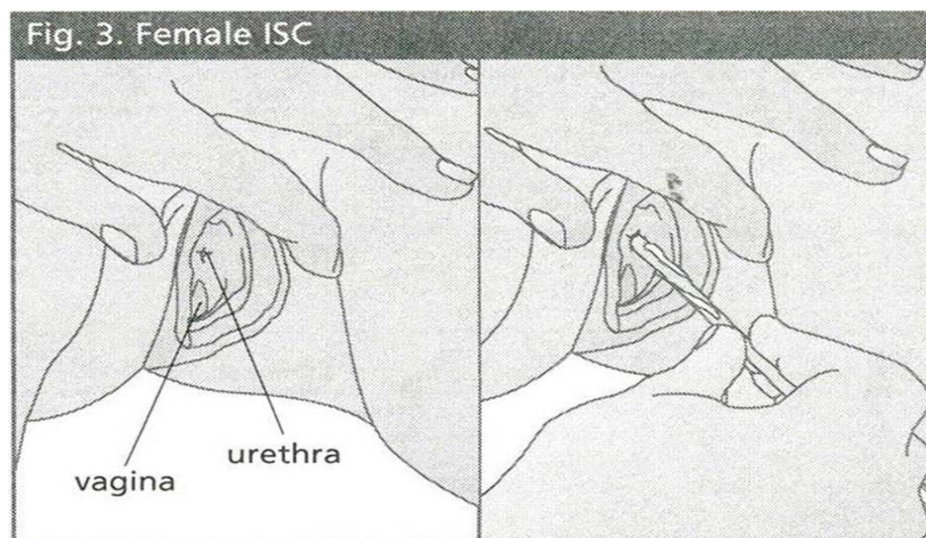
1. Using gauze square, take hold of penis with non-dominant hand. Gently retract foreskin to reveal urethral opening. **DO NOT** force back the foreskin. In 60% of males the foreskin is able to be retracted by the age of 6 years. **CONTACT RMO** if the foreskin cannot be retracted.
2. Swab urethral opening with a circular motion from the tip of the penis radiating outwards.
3. For children over 1 year of age, hold penis at 90 degree right angle to abdomen and insert 2-4mL lignocaine gel into urethra and leave for 3 minutes.
4. Lubricate catheter prior to catheter insertion.
5. Insert catheter through urethral orifice all the way to the inflation port. **DO NOT** continue if resistance occurs. Wait for muscle (urethral sphincter) to relax (this may take a few seconds) then retry. If the problem persists seek assistance\*. In some instances urine may not flow, due to hypovolaemia, or catheter tip not being in bladder. In this situation it is best to tape the catheter in place with steri strips placed along the length of the penis (not circumferential) and do not inflate the balloon.
6. If the catheter goes into the bladder easily and urine is seen to flow, inflate balloon with water (not saline) according to the manufacturer's instructions. **NOTE:** Balloon volume varies with catheter size. **Do not** over inflate balloon as it may distort and cause pain or tissue damage on removal. **Do not** use normal saline to inflate balloon as it may crystallise and prevent balloon deflation.
7. Gently withdraw the catheter until resistance is met. This places the balloon just inside the bladder at the bladder/urethral junction.
8. Connect a urinary drainage bag. If a urine sample/specimen is required collect at this stage before connecting bag.
9. Tape catheter securely to the groin or abdomen with hypafix or white elastoplast, or other suitable tape to allow the penis to point upwards in the natural resting position. Taping the catheter downwards may risk urethral trauma or iatrogenic hypospadias, especially in neurologically impaired children. This position also involves less movement of the catheter when the thigh moves. Ensure there is no tension on the catheter and is free from twists and kinks. Make sure the connection of the catheter to the drainage bag is secured to the thigh to prevent catheter torsion and obstruction.
10. Measure urine, document and enter on fluid balance record.
11. Leave the child clean and comfortable.
12. Dispose of equipment appropriately.

**Note:** Record catheter size, volume of water in balloon, insertion date and time in the clinical record.

\* Seek assistance from the team or on-call Resident, Registrar and Consultant in that order until a satisfactory solution is reached.

**b) Then for Females**

1. Using non dominant gloved hand open labia to expose urethral orifice. Maintain hand in this position until the catheter has been inserted.
1. Swab vulva with cotton balls from inner labia to outer using a downward motion, using a clean swab each time.
2. Place lignocaine gel soaked cotton balls onto urethral meatus and leave for three minutes.
3. Lubricate catheter.
4. With dominant hand insert catheter 5-10cm until there is flow of urine



*Nursing Standard Volume 16 Number 29*

5. If resistance occurs, **DO NOT** continue. Wait for muscle to relax (few seconds) then retry. **Contact RMO** if problems persist.
6. If urine is absent, may be hypovolaemic or the bladder tip may not have passed into the bladder. If the catheter has been inserted into the vagina, leave this catheter insitu until a new catheter is successfully inserted into the urethra.
7. Insert the catheter a further 5cm to ensure the balloon is clear of the urethra.
8. Inflate balloon with water according to the manufacturer's instructions. **NOTE:** Balloon volume varies with catheter size. **Do not** over inflate balloon as it may distort and cause pain or tissue damage on removal. **Do not** use normal saline to inflate balloon as it may crystallise and erode balloon.
9. Connect urinary drainage bag. If a urine sample is required collect at this stage before connecting bag.

10. Tape catheter securely to inner thigh with hypafix or white elastoplast or other suitable tape. Ensure there is no tension on the catheter and is free from twists and kinks.



11. Measure urine, document and enter on fluid balance record.
12. Leave child clean and comfortable.
13. Dispose of equipment appropriately.

**Note:** Record catheter size, volume of water in balloon, insertion date and time in the clinical record.

## Length of time indwelling catheter may be left insitu

After 2 weeks of a catheter being insitu consideration should be given to placing a suprapubic catheter (SPC). Long term urethral catheters can lead to strictures in males and incontinence in females. If a SPC is decided against, then after 4 weeks indwelling catheters should be changed for a new catheter.

## 2 Intermittent catheterisation

### Equipment

- Appropriate male or female catheter
- Approximate sizes only:
  - FG6-8 for 0-5years
  - FG8 for 5-10years
  - FG10 for 10-12 years
  - FG12 for > 12 years
- Sterile gloves (1 pair)
- Dressing pack



- Aqueous chlorhexidine 0.1%
- Single packaged water based lubricant
- Kidney dish (clean)
- Protective eyewear

## Procedure

**NOTE:** If a child is routinely having intermittent catheters at home please attempt to keep to the same times. The parental Homecare Guidelines differ to what is expected in the hospital setting. (see [Clean Intermittent Catheterisation – Boys/Girls \[link provided below\]](#))

1. Explain procedure to child and carer.
2. Clean trolley with a neutral detergent (e.g. lemex).
3. Wash hands for one minute.
4. Open dressing tray onto trolley ensuring plastic drape provides a sterile field.
5. Open catheter onto sterile field. Place lubricant onto sterile tray.
6. Pour aqueous chlorhexidine 0.1% over cotton balls in tray.
7. Place blue waterproof towel under buttocks.
8. Put on goggles.
9. Wash hands for three minutes.
10. Don gloves.
11. Lubricate catheter tip.
12. Assistant places child in supine position with legs in appropriate position.
13. Assistant arranges examination light if necessary.
14. Place tray with cotton balls and solution into 2nd kidney dish and position between legs.
15. Position drape appropriately over genitalia.
16. Insert catheter.
17. Reposition the child by assisting into a sitting position to aid the urine flow.
18. When urine flow ceases, slowly withdraw catheter. If further drainage occurs, pause until complete.
19. Leave child clean and comfortable.
20. Measure and record urine output.

## Homecare Guideline

### ***Clean Intermittent Catheterisation - Girls***

- <http://chw.schn.health.nsw.gov.au/o/documents/policies/homecare/2012-8018.pdf>

### ***Clean Intermittent Catheterisation – Boys***

- <http://chw.schn.health.nsw.gov.au/o/documents/policies/homecare/2006-8126.pdf>

### 3 Discharge supplies

Discharge supplies will be provided by the appliance centre using the appropriate form from the internet. A form can be filled out by the RN caring for the child. These supplies need to be paid for by the parents and if there is any financial difficulty, they should be referred to social work. Another resource for the long term provision of intermittent catheters is Paraquad who can be contacted by telephone 87415600.

### 4 Supra Pubic Catheter

Supra-Pubic Fistulas (SPF) are established surgically when long term catheterisation is required. They are commonly used for people with urinary incontinence or spinal cord pathology, due to either disease or injury.

The main advantage of a supra-pubic catheter is that trauma to the urethra is minimised due to the catheter being located on the anterior abdominal wall, rather than via the urethra.

#### Points of emphasis

- The catheter is initially inserted in the operating theatre. The first change of catheter is 4-6 weeks later and the procedure is performed by a medical officer, usually in theatre. Subsequent changes are at 4-6 weekly intervals and can be changed by a Clinical nurse consultant who has been trained in the procedure.
- If the patient has normal sensation they will require adequate pain relief prior to the procedure – analgesia should be given at least half an hour before.
- The catheter should be clamped half an hour before the change of catheter, as a full bladder makes it easier to insert the new catheter.
- The patient should be placed in a comfortable position that allows best access to the supra-pubic catheter.
- The replacement catheter needs to be inserted as quickly as possible once the old catheter has been removed.
- Explain procedure to patient and family as appropriate.

#### Equipment

- 1 Sterile Catheter Pack
- Sterile Kidney Dish
- 1 pair of Sterile Gloves & 2 pairs of unsterile gloves **Note:** ask if the patient is allergic to latex
- Sterile lignocaine gel in a syringe (lignocaine 2% gel with chlorhexidine 0.5%)
- Replacement sterile silicone catheter of appropriate size with 10 ml balloon

- Replacement sterile urine drainage bag
- Aqueous Chlorhexidine for cleaning around fistula
- 2 x 10 mL sterile syringes
- 1 x 10mL ampoule sterile water
- Sterile gauze square for final dressing to fistula site
- Micropore to secure gauze
- Elastoplast or Catheter Strap to secure tubing to thigh

## Procedure

1. Prepare equipment on clean dressing trolley.
2. Wash hands.
3. Open catheter pack, expose sterile field and add lignocaine gel syringe; aqueous chlorhexidine; sterile catheter and syringes.
4. Put on **unsterile** gloves
5. Expose SPF and remove dressing.
6. Deflate balloon of existing catheter using a 10 mL syringe.
7. Wash and put on sterile gloves.
8. **ASSISTANT** to wash and put on unsterile gloves ready to remove existing catheter.
9. Fill sterile 10 mL syringe with sterile water.
10. Lubricate tip of replacement catheter with lignocaine gel.
11. Place fenestrated drape over SPF site.
12. Clean around fistula site with cleaning solution.
13. Place a small amount of lignocaine gel around fistula site.
14. **ASSISTANT** to remove existing catheter gently and firmly (there may be some resistance due to ridge around tip of catheter, but catheter should come out easily as balloon is deflated).
15. As soon as catheter is removed, insert 2 – 3mL of lignocaine gel into fistula and then **immediately insert the replacement catheter** into the fistula. Place sterile kidney dish to receive urine draining from catheter.
16. Fill catheter balloon with 10mls sterile water, gently draw the catheter back until resistance is felt to ensure balloon is inflated and catheter is secure.
17. Connect catheter to sterile urine drainage bag.
18. Apply sterile gauze square around fistula site and secure with micropore. Tape tubing to inner thigh with elastoplast or use commercial catheter strap if available. **Note:** If child is paraplegic or has limited sensation, please use caution with tapes to maintain skin integrity.

19. Discard equipment as appropriate.
20. Remove gloves and wash hands.
21. Leave patient comfortable.

**Note:** If there is any doubt about the correct placement of the catheter, then contact the Medical Officer to review the patient and organise a cystogram. A small amount of haemorrhagic ooze from around the stoma or into the catheter itself may occur following this procedure. If bleeding continues, the patient should be reviewed by a medical officer.

## 5 Clean Intermittent catheterisation via appendico-vesicostomy or the Mitrofanoff catheterisable urinary channel

This is a procedure that has been developed to enhance the quality of life for people who for a variety of reasons are unable to perform self-clean intermittent catheterisation through the natural urethra. In 1980, Mitrofanoff, a French physician, described his technique for creating a continent urinary channel that could be catheterised. The technique consisted of creating a channel, using the appendix, to gain access to the bladder from outside the body. This is done by isolating the appendix with its blood supply intact and creating an entire fluxing tunnel submucosally into the bladder wall. The colonic end is then brought to the skin and used as a stoma for catheterisation. The stoma is quite often located in the umbilicus.

The recommended method for catheterising the Mitrofanoff channel or appendico-vesicostomy is the clean technique used for urethral intermittent catheterisation. This procedure is usually performed independently by the person with the stoma (usually every 3-4 hours or as required), but some assistance may be required to lubricate the catheter or hold the urine collecting bottle or container.

### Equipment

- Nelaton PVC male length catheter of appropriate size
- Water based gel to lubricate catheter
- Dressing pack
- Kidney dish to collect urine
- Aqueous chlorhexidine
- Sterile gloves

### Procedure

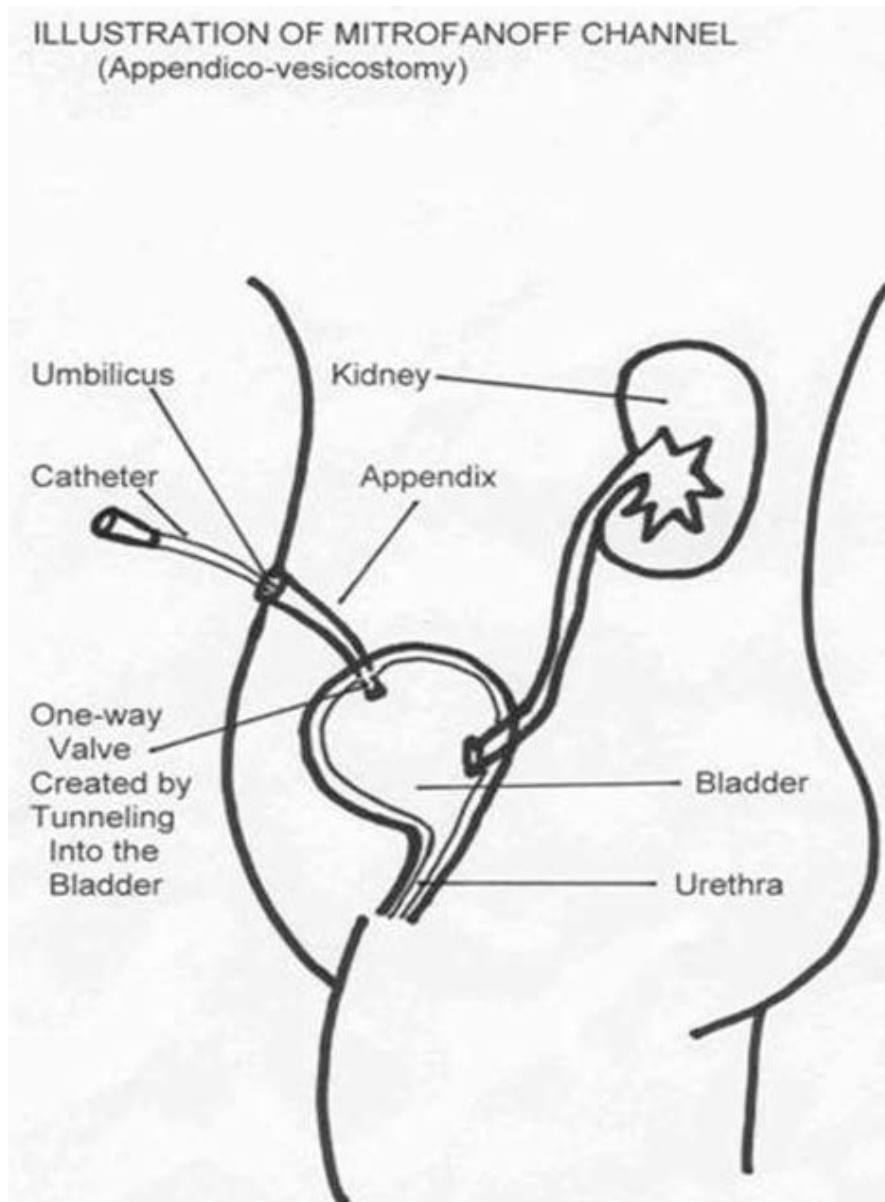
1. Wash hands.
2. Access stoma and clean with chlorhexidine.
3. Lubricate catheter.
4. Insert catheter into stoma channel until urine appears and collect in kidney dish.
5. Change position to ensure bladder drained.

6. Remove catheter.
7. Discard urine.
8. Wash hands.

## CHW Homecare Guideline

### ***Intermittent Catheterisation via an appendico-vesicostomy or Mitrofanoff Catheterisable Urinary Channel***

- <http://chw.schn.health.nsw.gov.au/o/documents/policies/homecare/2006-8113.pdf>

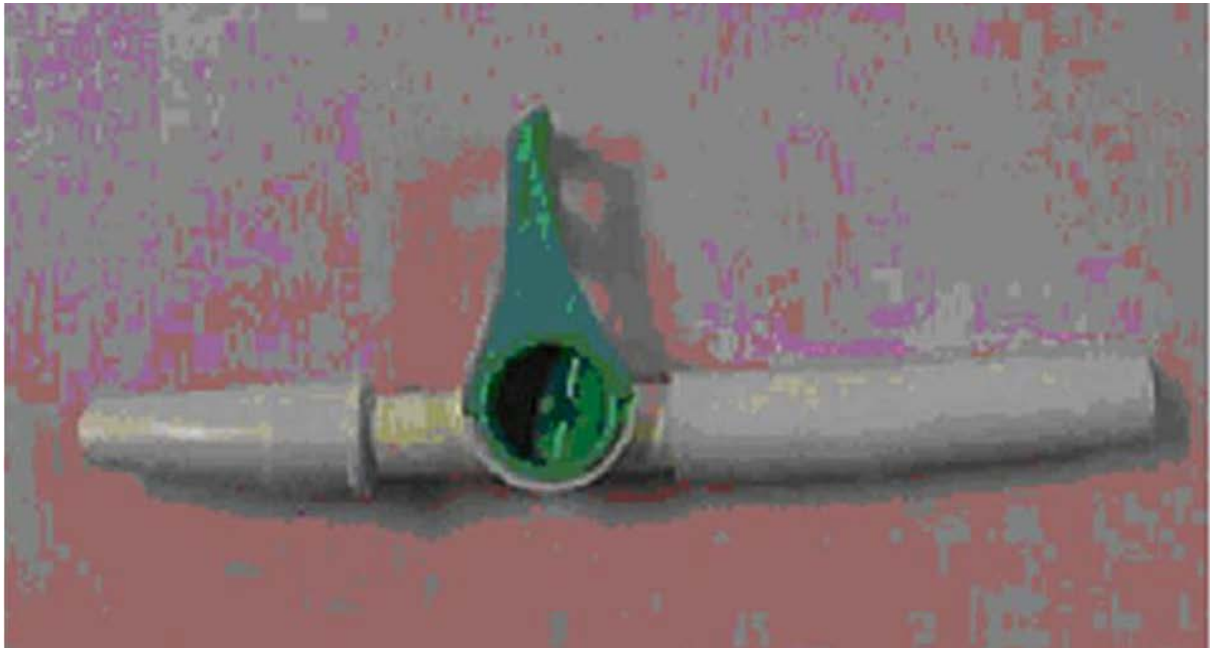


*Adapted by Julie Dicker CNC from illustration by Kurtz, M et al 1996.*

## 6 Open Catheter Drainage

The indwelling catheter is inserted peri-operatively for children undergoing repair of hypospadias and/or chordee or for complication of previous urethral surgery. It is shortened in length post insertion, and left to drain into double nappies.

### Catheter Valve (eg Flip Flo valve™)



*BARD flip-flo catheter valve™ (hospital stock may vary)*

- The catheter valve is used on the catheter when the urologist wants the bladder to fill normally rather than being continuously drained. This may occur in children who have had hypospadias repair when the catheter is protecting the operative site, or bladder augmentation where there is a need to maintain bladder tone or help to slowly increase bladder capacity. This valve also has a silicon extension that allows a night bag to be added if required. The valve needs to be changed weekly and this is accomplished using a non-touch technique after a 3 minute hand wash.
- The valve is connected to the end of the catheter.
- The valve is available from stores for the ward supplies and from the appliance centre for home supplies.

## 7 Bladder Scanner

The BARD bladderscan BVI3000 is used to prevent unnecessary catheterisation, minimise risk of nosocomial urinary tract infection, to reduce unnecessary patient trauma and discomfort, assess for urinary retention, measure pre void bladder volume and post void

bladder volume, measure bladder capacity and to assist in bladder training programs. It is important to select the appropriate male/female icon before commencing bladderscan.

- Instruction steps located on machine.
- Bladderscanner is stored in the surgical ward storeroom and available for all wards to borrow. Spare battery is also located in storeroom.
- Scanning should only be used and results interpreted by nurses experienced in the procedure.

## **Checklist for Bladder Scanner Bard Bladderscan Bvi 3000**

1. Turn on Bladderscan and press SCAN.
2. Select appropriate MALE/FEMALE icon.
3. Place patient in comfortable position.
4. Put gel on scanhead.
5. Make sure scanhead icon marking has head of the icon pointing towards head of patient.
6. Find the symphysis pubis and place the scanhead about 2.5cm superior to the symphysis pubis pointing toward the expected bladder location.
7. Press the scanhead button and hold the scanhead steady until you hear a beep.
8. The aiming icon and screen will display the bladder position and volume. Reposition the probe and scan until the bladder is in the crosshairs of the aiming screen. The largest measurement will be saved.
9. Press DONE when finished.
10. Wipe gel from patient's abdomen and leave patient in a comfortable position.
11. Clean Scanhead and restock gel as required.

## **Supervision and Assessment of Nurse Performing Procedure:**

1. Familiar with Bladderscanner basic operation and use as above.
2. Observed as competent in performing procedure.
3. Able to interpret and document results.

## **8 Obtaining a Urine Sample/Specimen from a Catheter**

Specimens of urine must be fresh and need to be collected aseptically to prevent contamination. Specimens must never be collected by disconnecting the catheter from the bag. They must also not be collected from the bag.

## 8.1 During catheterisation:

Following insertion of the catheter, and urine is flowing, place yellow top container under draining catheter using aseptic technique. Label and send specimen immediately.

## 8.2 As an indwelling catheter specimen:

Equipment: gloves, 10mL syringe , yellow top jar, chlorhexidine or alcohol swabs.

- Wash hands.
- Clamp catheter below sample port.
- Wash hands.
- Don gloves.
- Swab with alcohol or chlorhexidine swab.
- Attach syringe to leur lock port and aspirate urine into syringe.
- Transfer urine to yellow top container.
- Remove clamp.
- **Label and send specimen immediately.**



## 9 Bladder/catheter Irrigation

Following urological procedures such as 2nd stage hypospadias repair, it may be necessary to irrigate the indwelling catheter to maintain patency. The most common solution used is Normal Saline. Sometimes, obvious encrustation or catheter blockage with blood clots may require Suby's G solution for irrigation. The procedure is to be ordered by the specific surgeon who did the surgery and must be signed for by the staff doing the procedure.



Suby's G is a compound of Sodium Citrate solution containing citric acid and is used:

1. as an irrigating solution to dissolve a blood clot
2. to dissolve urinary calculi

## Equipment

- Dressing pack
- Catheter tip syringe
- Alco - wipes
- Irrigation solution ordered
- Clamp
- New catheter bag
- Sterile gloves
- Spare sterile gloves

## Procedure

1. Clean trolley and assemble equipment. The procedure can be performed at the bedside or in the treatment room.
2. Explain procedure to child and parent. The procedure may cause slight discomfort.
3. Wash hands for one minute.
4. Open dressing pack including the catheter tip syringe. The end of the syringe can be connected to the end of the catheter easily.
5. Clamp catheter. This prevents urine leaking out when the catheter is disconnected.
6. Wash hands and don gloves.
7. Ask assistant to open and hold prepared solution.
8. Draw up required amount. The usual amount ordered is 30mL and will need to be prescribed by medical officer.
9. Place sterile handtowel under catheter at connection site.
10. Swab around catheter connection using Alco – wipes (twice).
11. Hold connection site with sterile gauze and disconnect catheter.
12. Ask assistant to hold catheter using a separate sterile gauze.
13. Attach syringe and ask assistant to release the clamp.
14. Instil solution gently. Some resistance may be felt if catheter is blocked - **Do Not Use excessive force.**
15. Ask assistant to re-clamp catheter.
16. Withdraw syringe.

17. Reconnect new bag.
18. Unclamp catheter.
19. Check that catheter is draining.
20. Remove handtowel and dispose of equipment
21. Sign for medication.
22. **Record relevant observations in patient's notes and on fluid balance chart noting difficulty in irrigation, large amount of blood clots, catheter not draining well after irrigation.**

## 10 Management of an Indwelling Catheter (IDC)

### At least daily:

- Regular routine perineal/vulval hygiene is required. This includes cleaning catheter regularly to avoid encrustation. Neutral soap and water is sufficient.
- Frequent observation of the catheter for kinks, twists and obstruction or disconnection.
- Catheter bag to remain below the level of the bladder and free of the floor at all times.
- Drainage bag to be emptied regularly and to be checked each shift
- Documentation of urinary output and intake.
- Observe for leakage.

## CHW Homecare Guideline

### *Indwelling Urinary Catheter Care at home*

- <http://chw.schn.health.nsw.gov.au/o/documents/policies/homecare/2006-8115.pdf>

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