



ACI NSW Agency
for Clinical
Innovation

ACI Urology Network – Nursing

Supra Pubic Catheter (SPC) - Adult

Clinical Guideline, Competencies & Patient Information Leaflet

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Acknowledgements

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The following pages provide a clinical guideline template to enable clinicians to develop their own resource material relevant to their hospital and Area Health Service. They have been compiled by clinicians for clinicians. If you wish to use this material please acknowledge those that have kindly provided their work to enable use by others. Revise all material with colleagues before using to ensure it is current and reflects best practice.

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Published Oct 2014. Next review 2024. ACI/D23/3334 (ACI) © State of NSW (Agency for Clinical Innovation) CC-ND-BY

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Assessing Competencies

What is a competency?

Although the words sound alike, competence and competency are not synonymous. Competence refers to a potential ability, a capability to function in a given situation. Competency is defined as a combination of attributes enabling performance of a range of professional tasks to the appropriate standards. Competency focuses on your actual performance in a situation. This means you need competence before you can expect to achieve competency. Competence enables you to be capable of fulfilling your job responsibilities. Competency however, means that you fulfil your job as expected.

Competency is determined by comparing where you are now with established performance standards developed in the work environment according to your role and setting¹ Competency standards specify the level of achievement expected and the tasks and contexts of professional practice in which we may see the competency demonstrated.

Competence does not mean expert. Various levels of competence exist and each of these has a minimum acceptable level or standard. Beginners are rarely expert however they can be competent. They perform a wide range of nursing activities methodically and well. The time to complete tasks may take longer however as skill level develops so too will proficiency. They have to ask many questions however are aware of which questions to ask.

Competency:

Supra Public Catheter (SPC) change - Adult

The aim of the competency is to ensure the Nurse/Midwife/Medical Officer/Student is able to demonstrate prior knowledge and can perform suprapubic catheter change to the standard set by the Local Health District or Health Care Provider.

It is necessary that the Nurse/Midwife/Medical Officer/Student have theoretical knowledge and technical skill. This knowledge may be gained by attending a study day or undertaking a learning package (discretion of each Local Health District).

The Nurse/Midwife/Medical Officer/Student is required to undertake practical sessions with a supervisor in SPC change (competency). The supervisor is responsible for identifying the number of supervised sessions for each student in order to be deemed competent. A supervisor must be a clinician deemed capable of supervising SPC change.

The Nurse/Midwife/Medical Officer/Student is responsible for maintaining their skill level. In the event where a clinician has been unable to undertake a catheterisation procedure for a significant period and feels they require supervision, it is their responsibility to contact the supervisor for additional supervision. Electronic records will be kept of each clinician that undertakes competency assessment, at the discretion of the Local Health District.

Rationale

Indications for suprapubic catheterisation

- No urethral access.
- Failed urethral catheterisation.
- Long term catheter management and quality of life.
- Urethral trauma.

Contraindication:

- History of urothelial bladder cancer.

N.B: Please refer to Local Health District Policy.

Competency assessment is required because:

- The ability to change a suprapubic catheter safely and effectively is an advantageous clinical skill for Nurse/Midwife/Medical Officer/Student.
- Competent assessment and education of the patient/client requiring suprapubic change is necessary to minimise and prevent complications.

Skill assessment in suprapubic catheter change procedure should be measured against the standard established in the relevant facility policy and protocol. Prerequisites prior to undertaking the skill assessment should include the following:

- Attend an in-service or Introduction to Continence Program or a Urinary Catheterisation Workshop or education package.
- Completed online Invasive Device Module (HETI Online).
- Completed online Aseptic Technique Module (HETI Online).
- Completed online Hand Hygiene Module (HETI Online).
- Completed online Waste Management Module (HETI Online).
- Has read the facility specific policy and procedure guidelines on suprapubic catheter change.
- Has knowledge of the clinical indications for suprapubic catheter changes.
- Observe a Nurse/Midwife/Medical Officer/Student who has achieved competency in this procedure.
- Identify the WH&S principles that apply to the safe insertion of urinary catheters.

Preparation for assessment

- Schedule a time to attend a catheter clinic or liaise with an accredited assessor in your facility.
- Discuss the assessment process with the patient in order to gain verbal consent.
- Community nurses may be able to have their assessments completed in the patient's home, subject to the patient's consent and following negotiation with the appropriate staff member.

Essential components to be assessed

- Patient gives consent where appropriate.
- Professional attitude and rapport with the patient.
- Comprehensive patient specific assessment and planning.
- Performance of the suprapubic catheter change.
- Problem-solving skills and application of theoretical aspect.
- Infection control and aseptic technique.
- Relevant occupational health and safety principles applied to the procedure.
- Patient/carer/family information, education and follow up.

Methods of assessment

- Direct observation of the catheter change technique.
- Questioning techniques.
- Demonstrated problem-solving skills in relation to catheter management.

Unsatisfactory Assessment

In the event of an unsatisfactory assessment the assessor may use the following guide to manage and support staff training:

- The assessor gives feedback on the observed deficits in the performance of the Nurse/Midwife/Medical Officer/Student.
- The assessor determines with the Nurse/Midwife/Medical Officer/Student how the skill or knowledge deficit could be best improved.
- Further educational support might be required to prepare the Nurse/Midwife/Medical Officer/Student for the repeat assessment. This will need to be negotiated between both parties and documented.
- A repeat assessment is to be scheduled.
- If three consecutive attempts are unsuccessful, a further educational, development plan is to be implemented following discussion with the relevant parties. Relevant parties may include the assessor, with the nurse unit manager, nurse educator or clinical nurse consultant.
- Additional education and support are given until competency is achieved.

Reassessment/Professional Development

Reassessment of change of suprapubic catheter technique may be required on request.

Nurse/Midwife/Medical Officer/Student is required to maintain continuous professional development in suprapubic catheter change.

Changing of a SPC and Care - Adult

Definition

A urinary catheter is passed through the abdomen into the bladder to drain urine. This procedure is performed using sterile equipment under aseptic technique by qualified clinicians.

Expected Outcome

1. Urinary catheter inserted only when clinically indicated.
2. The urinary catheter is inserted into the bladder without adverse clinical outcomes.
3. Patient and clinicians safety is maintained.

Considerations

- Clinical indications for insertion, maintenance and removal of an SPC must be documented in patient health care records.
- Community nurse may require a Letter of Authority for catheter replacement and removal from the Health Care Team. Please refer to Local Health District Policy.
- Nursing staff should notify Medical Officer of abnormal urine output, less than 30mls in two consecutive hours or urine volume is greater than 1000mls on catheter insertion.
- Long term SPC is usually changed every 4 - 6 weeks or as specified by the medical team or certified nurse practitioner / senior urology nurse clinician in some LHDs.
- Catheter urine specimen can be collected from the sampling port within the first 48 hours following catheter insertion. After this period, catheters will be colonized by bacteria. If a urine specimen is required after the first 48 hours, a new catheter should be inserted before the collection is made.
- Patient who is on regular anticholinergic drug for bladder spasms should have the procedure performed one hour after taking the medication.
- If a urinary catheter is blocked, remove catheter and insert a new catheter and assess possible causes.
- In an acute setting, if patient requires opioid medication before catheter change, the patient has to be monitored for a period of time following the medication guidelines before discharge.

High Risk for Adverse Outcomes

- **Artificial Heart Valve**
 - Discussion with infection control team
- **Specific Spinal Cord Considerations**
 - If client is a spinal cord injured client above T6 understand autonomic dysreflexia and ensure treatment algorithm for autonomic dysreflexia in spinal cord injury is present
 - If spinal client ascertain if client has used Viagra or Levitra in the last 24hrs or Cialis in the last 4 days as GTN spray, tablet or patches cannot be used

Alerts

- Do not clamp the catheter in SCI above T6
- Ascertain if client is on anticoagulants prior to procedure
- If the client has an artificial heart valve, discuss antibiotic cover with medical officer prior to change.
- Potential risk of creating a false passage associated with forced instrumentation
- Balloon inflated in urethra/tract resulting in trauma, haemorrhage, rupture or necrosis
- **Autonomic dysreflexia handout to be given to all patients/ clients with a spinal cord injury at or above the 6th thoracic level and who have a catheter in situ**

Autonomic Dysreflexia (AD) is a potentially life-threatening condition, which affects people with a spinal cord injury (SCI) at or above the thoracic level 6 (T6). This condition results from widespread reflex activity of the sympathetic nervous system below the level of injury, triggered by an ascending sensory (usually noxious) stimulus. AD can cause a sudden rise in blood pressure that can lead to stroke or even death. One of the common causes is a distended or severely spastic bladder, urinary tract infection, bladder or kidney stones, urological procedure or even inserting a catheter. Episodes of AD could occur during a catheter change. Be alert for sudden hypotension due to rapid draining of bladder or sudden resolution of AD. Initially drain 500mls and then 250mls every 15minutes until bladder is empty. (http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0019/155143/algorithm.pdf)

Remember: this is a medical emergency and the patient is not to be left alone. Blood pressure should be monitored throughout treatment.

Patients with a spinal cord injury at T6 and their carers should have a copy of the NSW Health 'Autonomic Dysreflexia Medical Emergency Card' which is available using the following link:

http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0020/163442/Medical-Emergency-Card.pdf

Equipment

- Clean trolley or work surface
- Adhere to current Hand Hygiene NSW Health Policy and Infection Control NSW Health Policy.
- Catheter pack. This includes
 - Sterile gauze squares
 - sterile water-soluble lubricant
 - sterile water 10ml ampoule
 - 0.9% Sodium Chloride ampoule 10mls
 - 1 pair of sterile gloves
 - 2 pairs of forceps
 - 2x 10ml syringes
 - dressing towel
 - fenestrated drape
- 1 sterile urinary catheter appropriately sized and recommended for supra pubic use (a female or male length catheter can be used)
- Additional sterile gloves will be required if using procedure B
- Catheter strap or disposal catheter fixation device
- Sterile drainage bag and or catheter valve
- Protective eye wear
- Disposable protective apron or gown
- Disposable gloves
- Blue disposable sheet
- Rubbish bag
- Specimen jar (if required)
- Split drainage sponge (if required)
- Local anaesthetic (if required)
- Sterile suture cutter if required (initial SPC may be sutured in)

Procedures

Single glove procedure and double glove procedure can be used to change a SPC. Once the catheter has been removed a new catheter must be inserted immediately. This is particularly relevant for those that experience bladder or abdominal spasm.

Single Glove Procedure (A)

The removal of the catheter occurs with the non-dominant hand (non sterile hand) the new catheter is immediately inserted with the dominant hand (sterile hand). The dominant hand and non-dominant hand should not be interchanged.

1. Perform hand hygiene.
2. Explain procedure to patient, obtain consent, identify allergies and ascertain the appliances you are using are correct e.g. catheter size and type, drainage system.
3. Clamp catheter for ½ - 1 hour prior procedure (unless contraindicated).
4. Ensure privacy.
5. Ensure patient is lying down for procedure.
6. Perform hand hygiene.
7. Apply protective eye wear and protective apron or gown.
8. Perform hand hygiene and put on disposable gloves.
9. Open catheter pack without contaminating sterile items. Protect all items from contamination.
10. Open catheter onto sterile field.
11. If required open sterile catheter valve onto sterile field.
12. Open sterile disposable drainage bag leaving drainage bag cap in place.
13. Expose supra pubic site, remove dressing if necessary.
14. Empty urine drainage bag.
15. Remove or undo catheter strapping.
16. Using 1 x 10mL syringe deflate the catheter balloon.
17. Remove disposable gloves.
18. Perform procedural hand hygiene.
19. Put on sterile gloves.
20. Arrange equipment on sterile field, remove covering from catheter, open sterile water and normal saline into separate compartments of the catheter pack tray, apply lubricant to tip of sterile catheter and draw up recommended instillation volume as per catheter package. (Child SPC catheters generally have 3cc balloon)(Individual clinician choice if balloon of catheter is to be tested prior to inserting, if testing balloon use passive deflation).
21. Soak sufficient gauze with normal saline to clean SPC site.

22. Place drape onto client immediately beneath the SPC site, leave sufficient room to clean the around the SPC site.
23. Clean around the SPC site with pre-soaked gauze in a clockwise direction using new gauze for each wipe with non-dominant hand.
24. Look at the catheter insitu and assess how much of the catheter is inserted through the SPC site.
25. Place the catheter tray or kidney dish onto the drape.
26. With non-dominant hand rotate the catheter insitu, then remove and discard the catheter.
27. Immediately with dominant hand insert new catheter to the depth and angle of previous catheter, generally about 10cm although this can vary dependant on the abdominal girth of the client, ensuring the outflow end of the catheter is in the catheter tray or kidney dish (**Do not insert the catheter so far that it is in the urethra**).
28. If urine drains, continue to insert the catheter another 2-3cms to ensure the balloon is inflated within the bladder. Inflate the balloon in accordance with product recommendations. Gently pull back on the catheter until resistance is felt throughout this procedure observe the client for signs of discomfort.
29. If urine is not draining wait for this to occur.
30. Flick the protective cap off the drainage bag and connect sterile drainage bag (apply leg drainage bag straps as per manufactures instructions) or connect catheter valve ensuring valve is in the off position.
31. Apply catheter strap or disposable catheter fixation device.
32. Apply leg drainage bag straps as per manufacturer's instructions.
33. Apply split drainage sponge to SPC site if required. If gauze is used do not cut it but rather wrap around the catheter (to protect possible migration of fibres).
34. Remove PPE and perform hand hygiene.
35. Dispose of waste in accordance with infection control policy.
36. Perform hand hygiene.
37. Assist client to dress and mobilize.
38. Perform hand hygiene.
39. Document catheter type, amount of water used in balloon and any incidences e.g. autonomic dysreflexia, difficulty removing catheter, bleeding site.
40. Also, document order for a catheter review or catheter removal.

Double Glove Procedure (B)

This procedure maybe used for people who experience bladder spasm throughout the procedure. Double gloved procedure that uses the dominant hand to both remove and replace SPC maintaining asepsis.

1. Perform hand hygiene.
2. Explain procedure to patient, obtain consent, identify allergies and ascertain the appliances you are using are correct e.g. catheter size and type, drainage system.
3. Clamp catheter for ½ - 1 hour prior procedure.
4. Ensure privacy.
5. Ensure patient is lying down for procedure.
6. Perform hand hygiene and put on disposable gloves.
7. Expose supra pubic site, remove dressing if necessary.
8. Empty urinary drainage bag.
9. Remove or undo catheter strapping.
10. Using 1 x 10mL syringe deflate the catheter balloon.
11. Remove disposable gloves and perform hand hygiene.
12. Open catheter pack without contaminating sterile items. Protect Key Parts from contamination.
13. Open catheter onto sterile field.
14. If required open sterile catheter valve onto sterile field.
15. Open sterile disposable drainage bag leaving drainage bag cap in place.
16. Perform procedural hand hygiene.
17. Put on two pairs of sterile gloves.
18. Arrange equipment on sterile field, remove covering from catheter, open sterile water and normal saline into separate compartments of the catheter pack tray, apply lubricant to tip of sterile catheter and draw up recommended instillation volume as per catheter package. (Child SPC catheters generally have 3cc balloon)(Individual clinician choice if balloon of catheter is to be tested prior to inserting, if testing balloon use passive deflation).
19. Soak sufficient gauze with normal saline to clean SPC site.
20. Place drape onto patient immediately beneath the SPC site, leave sufficient room to clean the around the SPC site.

21. Clean around the SPC site with pre-soaked gauze in a clockwise direction using new gauze for each wipe with non-dominant hand.
22. Look at the catheter insitu and visualize how much of the catheter is inserted through the SPC site.
23. Place the catheter tray or kidney dish onto the drape.
24. Place the non-dominant hand around the SPC site ensuring that the catheter insitu is exposed between the thumb and index finger.
25. Apply gentle pressure to supra pubic area with the non-dominate hand, at the same time place the dominant hand around the catheter close to where the catheter exits the body, rotate, remove and discard the catheter.
26. Remove the first pair of sterile gloves leaving on the second pair of sterile gloves.
27. Immediately with your dominate hand pick up the new catheter and insert new catheter to the depth and angle of previous catheter, generally about 10cm although this can vary dependant on the abdominal girth of the client, ensuring the outflow end of the catheter is in the catheter tray or kidney dish (**Do not insert the catheter so far that it is in the urethra**).
28. If urine drains, continue to insert the catheter another 2-3cms to ensure the balloon is inflated within the bladder. Inflate the balloon in accordance with product recommendations. Gently pull back on the catheter until resistance is felt throughout this procedure observe the client for signs of discomfort.
29. If urine is not draining wait until urine drains and then inflate the balloon in accordance with product recommendations. Gently pull back on the catheter until resistance is felt. Throughout this procedure observe the client for signs of discomfort.
30. Remove the protective cap from the drainage bag and connect sterile drainage bag to catheter (apply leg drainage bags straps as per manufacturers' instructions) or connect catheter valve ensuring valve is in the off position.
31. Apply split drainage sponge to SPC site if required. If gauze is used do not cut it but rather wrap around the catheter.
32. Apply catheter strap or disposable catheter fixation tape.
33. Dispose of waste in accordance with infection control policy.
34. Assist client to dress and mobilize.
35. Document catheter type, amount of water used in balloon and any incidences e.g. autonomic dysreflexia, difficulty removing catheter, bleeding site etc.
36. Also, document order for a catheter review or catheter removal.

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Appendix 1.

Competency Assessment Forms

1. Theory

Competency: Changing a Suprapubic Catheter (SPC) - Adult

The employee/student is required to show theoretical knowledge of suprapubic catheter change either verbally or in writing prior to undertaking the practical component.

COMPONENTS OF SPC CATHETER CHANGE TO BE DISCUSSED	YES	NO	COMMENTS
Described the anatomy and physiology of the urethra, the bladder and abdominal cavity			
Understood the indications for indwelling suprapubic catheterisation			
Discussed the procedure including the equipment required and maintaining aseptic technique to minimise CAUTI.			
Discussed types of catheters available, duration of catheterisation, balloon size, closed drainage systems and can provide rationale for choice			
Identified complications that can occur during catheterisation and discuss preventative measures and solutions			
Identified problems that can occur during the removal of the catheter and discuss preventative measures and solutions			
Identified care of the indwelling urinary catheter and the drainage system			
Discussed special implications related to patients/clients with eg Multiple Sclerosis (MS) and Spinal Cord Injuries at risk of autonomic dysreflexia sexuality and quality of life issues			
Discussed WH & S considerations			
Discussed legal issues (verbal consent, education, documentation of procedure)			

2. Practical

Clinical Skill Assessment Form: Suprapubic catheter change – Adult

Name of Assessee

Signature of Assessee

Ward/Location

Date of Assessment

Name of Assessor

Signature of Assessor

Performance Criteria		
Professional Attitude and Patient Communication.	Yes	No
Introduced self to patient.		
Explained that the procedure for SPC catheter change is being observed and assessed.		
Gained verbal or inferred consent from the patient.		
Directed visitor / spouse to the waiting area if applicable.		
Addressed any patient concerns that may arise re the procedure.		
Performance Criteria		
Patient Assessment and Planning.	Yes	No
Explained the procedure to the patient.		
Stated indication(s) for change of catheter.		
Followed the requirements for patient preparation – as per local policy.		
Provided rationale for catheter selection.		
Identified and plan for potential difficulties.		
Considered the need for pre-procedure medication.		
Performance Criteria on Procedure		
Change of SPC Procedure.	Yes	No
Performed hand hygiene.		

Assembled and prepared equipment correctly.		
Positioned the patient correctly and continually reassured the patient during the procedure.		
Performed hand hygiene correctly.		
Deflated the balloon.		
Put on facial protection (PPE). Performed hand hygiene and puts on sterile gloves.		
Draped the client correctly.		
Cleaned the area using the appropriate solution (as per local policy).		
Correctly placed gauze in 'no-touch' technique.		
Removed catheter with non-dominant hand, and then inserted new catheter. If untoward resistance was felt on removal; placed non-dominant hand on abdomen close to the stoma to support the site, as the catheter was withdrawn.		
Inflated the balloon with the correct amount of sterile water.		
Described why the catheter should be gently pulled until resistance is felt.		
Connected the catheter to the appropriate drainage system.		
Ensured urine flow was present prior to leaving the patient/client.		
Collected sterile urine specimen for microanalysis if required.		
Connected the catheter to the appropriate drainage system.		
Secured the catheter appropriately and ensured patient comfort.		
Applied dressing if SPC site was oozing.		
Provided appropriate patient education to the patient/carer..		
Removed PPE (as per the sequence in the current NSW Health Infection Control Policy) and performed hand hygiene.		
Documents the procedural information and outcomes.		
Informed the nurse in-charge of results.		

Performance Criteria		
Problem Solving Skills. Assessee outlines the reasons for and the management of:	Yes	No
No urine flow.		
Bladder spasm or bypassing.		
Reinflates then deflates balloon (ensure balloon in bladder) if difficulty removing catheter.		
Inability to insert the catheter. Possible solutions: <ul style="list-style-type: none"> • Got patient to cough, apply gentle pressure to abdomen and give a glass of water if SPC difficult to insert. • Instilled 2-3ml of lignocaine into SPC site if difficulties persist. • Inserted a smaller intermittent catheter and secure to abdomen if catheter cannot be inserted. • Contacted appropriate personnel as per local policy if SPC could not be inserted. 		
Stoma assessment.		
Correct disposal of waste.		
Performed hand hygiene in accordance with 5 Moments for Hand Hygiene.		
Performance Criteria		
WH & S (Work, Health & Safety) Issues Identified and Applied.	Yes	No
Nurse/Midwife/Medical Officer/Student identified the following aspects of WH&S and performed a risk assessment prior to performing SPC change.		
Positioned patient to minimise need to twist, bend or maintain awkward position. Obtained assistance if required.		
Maintained aseptic technique.		
Used personal protective equipment (facial protection, gown/apron, gloves).		
Correctly disposed of waste.		
Performed hand hygiene in accordance with 5 Moments for Hand Hygiene.		

Agreement: Clinical Skill Assessment

Competency Performance on SPC change:

Knowledge on SPC change procedure

- Satisfactory _____
- Unsatisfactory _____

SPC change Skill

- Satisfactory _____
- Unsatisfactory _____

Comments by Assessor:

Comments by Assessee (reflection of learning):

Clinical Assessor (print name): _____

Signature _____

Date: _____

Assessee (print name): _____

Signature: _____

Date: _____

Appendix 2.

Discharge Planning Checklist for Suprapubic Catheter

Item	Yes	No	N/A
Educate Patient / Carer / Family on care of the indwelling catheter and drainage system (including hygiene and problem solving strategies).			
Provide "Catheter care at home" fact sheet.			
Provide minimum one week supply of drainage bags.			
Arrange medical/ Community follow up appointment or Trial of void clinic.			
Provide information on supplier for patient to purchase catheter and drainage equipment.			
Inform patient with permanent catheter on government continence aids assistance schemes.			
Inform patient who is DVA client with gold card of supply arrangement.			
Authorisation letter from Medical Officer for change of catheter by community nurse, if required.			
<p>Name and Signature of Clinician</p> <p>_____</p> <p>Date _____</p>			

Problem solving with catheters

Problem	Potential Solution
Removal of the suprapubic catheter	
Balloon not fully deflated	Refill balloon and allow fluid to enter syringe by gravity (this is called passive balloon deflation).
Cuffing of balloon	Use different type/brand of catheter. Ensure catheter is in the bladder, reinflate balloon with 3 ml of water and allow balloon to deflate passively. Rotate gently whilst removing the catheter.
Bladder spasms	Consider use of anti-cholinergic medication one hour before catheter replacement. Remove catheter slowly as the patient breaths out.
Debris or a stone lodged in the catheter	Drink at least 2 litre of fluid a day whenever possible to reduce the accumulation of debris in the bladder. Use lubricant before applying traction to remove catheter. Refer to a more experienced clinician for advice
Cannot remove catheter	Apply lubricating gel, rotate catheter gently, maintain traction, and ask the patient to bear down. Seek advice from a more experienced clinician when the above options have been tried and problem persists.
Patient anxiety	Reassure client and identify anxiety reasons.
Insertion of catheter	
Difficulty with insertion of SPC	Gently rotate the catheter while inserting. Attempt to insert a well lubricated Nelaton catheter one size small so as to maintain the tract. Seek advice from a more experienced clinician if unable to advance catheter into the bladder.
Patient anxiety	Reassure client and identify anxiety reasons.
Incorrect catheter size	Check catheter size when preparing equipment. Use the correct catheter size and type. A size 16-18 gauge is usually adequate.

Bladder spasm	Treat symptomatic Urinary Tract Infection (UTI). Take anti-cholinergic medication one hour before the procedure.
Discomfort	Identify cause of discomfort. Ensure adequate lubricant is used. Consider use of anaesthetic gel, wait 3-5 minutes prior to insertion of catheter.
Balloon will not inflate	Remove catheter and insert a new catheter.
Post insertion of catheter	
No urine return	Check that the catheter is not in the urethra or outside the bladder wall. Bladder could be emptied just after catheter removal. Instruct patient to drink a couple of glasses of water before the procedure whenever possible. Do a bladder scan. Patient may have low urine output. Report to Medical Officer.
Catheter bypassing	Check catheter patency and drainage bag should be below the level of the bladder. Ensure drainage tubing is not kinked, blocked or looped. Correct constipation. Treat bladder spasms. Secure catheter with appropriate device to avoid movement reducing irritation to the bladder. If catheter valve is in use, ensure bladder is emptied regularly (frequency can be adjusted according to patient's bladder function e.g. 2- 4 hourly). Ensure catheter size and balloon size is appropriate to patient's condition. e.g. patient has diuresis requires catheter with a bigger lumen. Treat symptomatic UTI.

Criteria for use of intermittent urinary drainage device – Catheter Valve:

- Stable detrusor (bladder) function and adequate bladder capacity
- No recent bladder surgery
- No suspected bladder perforation
- No active UTI
- No active haematuria
- No vesico-rectal, vesico-vaginal or vesico-colonic tear or fistula

Appendix 3.

Questionnaire

1. What is the preferred balloon size used in a standard Foley Catheter?
2. How often should a leg bag be removed and changed?
3. It is recommended that all silicone and hydrogel coated catheters can be left insitu for how long?
4. Mr Smith has an SPC and its leaking urethrally. List 4 possible causes.
5. What are 4 possible reasons for difficult removal of an SPC?
6. What action do you take if you experience difficult reinsertion/ removing of an SPC?
7. After insertion of a new catheter what could be the cause of nil return of urine from the catheter.
8. What are the signs and symptoms of autonomic dysreflexia?
9. What action would you take if you attend a patient with autonomic dysreflexia?
10. What issues need to be covered for patient education?
11. What are the principles of closed drainage system?
12. Valves are only suitable for certain patients. Why?
13. How much fluid is recommended for patients with catheter insitu?
14. When would anticholinergics be recommended in a patient with a catheter?
15. How long does it take for Xylocaine to work?
16. What would you document in the notes following a catheter change?
17. What could be the possible reason for difficult inflation of a balloon?
18. What is the accepted hand wash procedure for in the home when changing a catheter?
19. What options exist for the arrangement of supplies for this patient?

Answers

1. Preferred balloon size used in a standard Foley is 5-10 mls
2. A leg bag should be removed and changed every seven days
3. It is recommended that all silicone and hydrogel coated catheters be left insitu for 4-6 weeks
4. Possible causes of leaking include:
 - Constipation
 - Kinked tubing
 - UTI
 - Too large a catheter/ Balloon
 - Catheter movement due to un- anchored drainage
 - Medications which decrease urethral resistance
 - Blocked catheter with sediment/debris
 - Inappropriate use of valve
 - Inappropriate type of catheter/size lumen too small for drainage
 - Low fluid intake
 - Drainage uphill
 - Localised infection/ fungal /bacterial genital infection
5. Four possible reasons for difficult removal of catheter are;
 - Hysteresis
 - Muscular spasm
 - Stenosis of site
 - Debris attached to catheter
6. Action to take if difficulty:
Removing SPC
 - Twist catheter 360 degrees clockwise
 - Check balloon
 - Pull as hard as you feel comfortable pulling
 - Check brand of catheter for history of hysteresis
 - Liaise with expert and leave for another day
 - If patient anxiety is instrumental in difficulty consider a relaxant prior to next change**Reinserting SPC**
 - Insert catheter (Nelaton or Foley one size smaller) into stoma and call for assistance
 - Catheterise patient with a smaller Foley and resize up to original size as soon as possible
7. Possible causes of nil return of urine post catheterisation are:
 - Catheter not in bladder
 - Catheter lumen blocked with lubricant
8. Signs and symptoms of Autonomic dysreflexia:
 - Rising, high blood pressure
 - Sweating, flushing above level of lesion
 - Pins and needles
 - Pounding headache

9. What to do:
 - Check blood pressure regularly until coming down
 - Remove stimuli: blocked catheter, constipation
 - If still no reduction in symptoms give anti-hypertensive medications
 - If still no reduction in symptoms call ambulance(if in community).

10. Patient education should include:
 - Hygiene
 - Fluids
 - Care of equipment
 - Signs and symptoms of symptomatic UTI
 - Prevention of constipation

11. Principles of closed drainage are:
 - Sterile system
 - Minimal disruptions to system as possible
 - Piggy backed night drainage to eliminate disrupting system
 - Change bags weekly and clean overnight drainage bags on daily basis

12. Patients who can have valves must
 - Be cognitively intact or have a carer
 - Have normal dexterity or have a carer
 - Be motivated
 - Have a storing bladder (no urge incontinence)
 - Have a stable bladder
 - No recent bladder surgery
 - No vesical fistula

13. Fluid intake is recommended to be 2 litres unless otherwise indicated by doctor

14. Anticholinergics are recommended when a patient with a catheter is experiencing bladder spasms that are not related to UTI, blockages, or catheter /balloon size but to bladder irritation.

15. Xylocaine works within 5 -10 minutes

16. Documentation should include catheter/balloon size, type and material made of, if xylocaine was used. If any difficulties were encountered with removal or insertion and what sort of drainage was noted. When the next catheter change is due must also be documented. Also document if patient has been experiencing any complication sand what you have suggested they try to address these problems.

17. Difficulty inflating balloon could be
 - In wrong spot
 - Faulty catheter

18. Hand wash procedure is 2 minute hand wash or use of alcohol rub as per instructions

19. Supply options are:
 - Using CAPS entitlement to buy from BrightSky, Independence Australia, Intouch
 - Enable NSW
 - Private access to individual company

Appendix 4.

Patient Education Leaflet

Urinary Catheter Care Guide

You have had a urinary catheter inserted through your lower abdomen into your bladder as your bladder is unable to empty by itself. The catheter is held inside your bladder by a balloon, which is filled with water to keep it in place. The catheter is connected to either a urinary drainage bag or a catheter valve.

How to Care for Your Catheter

- Wash your hands before you handle your urinary drainage system.
- Empty your urinary drainage bag regularly throughout the day.
- Wash the catheter insertion site everyday with soap and water.
- Wear supportive underpants to prevent irritation by catheter movement. Urinary drainage bags should be secured firmly but not tightly to the leg using leg straps.
- At night attach the overnight urinary drainage bag to the bottom of the leg bag. Ensure the tap between the leg bag and overnight bag is in the open position.
- Hang the overnight night bag on a hanger, below the level of your bladder. Do not place overnight bag on the floor as this increases the risk of contamination.
- In the morning make sure the outlet tap on the leg bag is closed before disconnecting the overnight bag.

Please Ensure That You:

- Drink 2-3 litres of fluid each day unless instructed by your doctor not to. This will promote a steady flow of urine which helps to minimise infection and catheter blockage.

Urinary Drainage Bags

- The overnight bag without a tap is for once only use and should be changed every day.
- The overnight drainage bag with a tap should be cleaned daily and changed weekly.
- The leg bag should be changed weekly.
- The drainage bag should be placed lower than the level of the bladder.

Catheter Valve

- Some patients may have a catheter valve instead of a urinary drainage bag.
- The valve must be released every 3-4 hours to empty the bladder (unless uncomfortable, then release as needed).
- Change the valve according to manufacturer's recommendations or Area Health policy. Common practice is to change the valve at the time of urinary catheter replacement.

Catheter Change

- The catheter is changed every 4 - 6 weeks or depending on individual medical condition.
- Your community nurse may instruct you to clamp off the drainage system prior to the catheter change (approx. ½ - 1 hour before).
- Ensure that you drink two glasses of water before the nurse is due to arrive.

Troubleshooting: Problems You May Encounter

- It is common to experience bladder irritation or cramps when a new catheter has been inserted. This sensation usually passes in a day or two.

If There Has Been No Urine Draining For More Than 2 Hours

- Check the tubing is not kinked.
- Drink some water - this may flush away any blockage.
- Try walking - this may dislodge a blockage.
- Try milking the catheter or tubing by applying direct pressure.
- If the above fails, contact your nurse or doctor.

Contact Your Nurse or Doctor if:

- Urine is cloudy or strong smelling.
- Urine has become blood stained.
- Pain or tenderness over kidney region.
- Chills or fever.
- Urine is leaking from around the catheter.
- Pain or discomfort from your catheter.

**IF YOU ARE UNABLE TO CONTACT YOUR NURSE OR DOCTOR AFTER HOURS
PLEASE CONTACT YOUR LOCAL EMERGENCY DEPARTMENT**

Contact Details

Primary Health Nurse:

Family Doctor:

Hospital

Appendix 5.

Supply of Equipment and Funding Bodies

An assessment by a continence nurse advisor is recommended to ensure the most appropriate continence product, including the correct fit and application of the product.

Enable NSW

Enable NSW provides access to funding for the provision of assistive technology to eligible NSW residents with a permanent or long term disability. Program of Appliances for Disabled People (PADP) is now operated under the umbrella of Enable.

For further information:

Phone: 1800 362 253

Website: www.enable.health.nsw.gov.au

Continence Aids Payment Scheme (CAPS)

This is a federal government scheme available to people aged five years and over who have a permanent and severe incontinence due to:

- Neurological conditions (no Pension Concession Card required) such as intellectual disability (e.g. autism, autism spectrum and Aspergers Syndrome), paraplegia & quadriplegia, acquired neurological conditions (e.g. Alzheimer's Disease, dementia), degenerative neurological diseases (e.g. Parkinson Disease, motor neurone disease), or
- Permanent and severe bladder/bowel innervations (e.g. atonic bladder/hypotonic bladder, prostatectomy with nerve removal) or
- Other causes such as bowel cancer, prostate disease and holds a pension Concession Card

Applicants will need to provide a Health Report from an appropriate health professional such as their medical practitioner or continence nurse about their condition.

Eligible CAPS clients receive an annual indexed payment for continence products

A patient is NOT eligible for CAPS if their incontinence is not permanent or severe or any of the following:

- they are a high care resident in a Australian Government funded aged care home
- they are eligible for assistance with continence aids under the Rehabilitation Appliances Program (RAP) which is available through the Department of Veterans' Affairs
- they receive an Australian government funded Extended Aged Care at Home Package (EACH) or an extended Aged Care at Home Dementia Package (EACH D package)

Further information on eligibility and to obtain an application form:

CAPS Helpline: 1300 366 455

Email: continence@health.gov.au

BrightSky Australia offers

- One-stop-shop that provides retail and a national home delivery service of specialist healthcare products.
- Professional continence and wound care advice by phone or appointment. Please call (02) 8741 5600

Address: 6 Holker Street, Newington NSW 2127 (cnr Avenue of Africa)
Phone no.: 1300 88 66 01
Fax: 1300 88 66 02
Email: orders@brightsky.com.au
Web store: www.brightsky.com.au

Independence Australia

Independence Australia offers online and retail shopping for medical and healthcare products to the general public. It is also one of the national suppliers of continence products to eligible veterans in Australia under the Rehabilitation Appliances Program (RAP). The order form has to be completed by a health professional.

Showroom Address: 6/ 25-27 Redfern Street, Wetherill Park NSW 2164 (Showroom hours- 9.00am to 4.00pm Monday to Friday)
Phone: 1300 78 88 55
Fax: 1300 78 88 11
Email: customerservice@independencesolutions.com.au
Web store: www.Independenceaustralia.com

Intouch Direct

Intouch is one of the national suppliers of continence products to general public, eligible veterans and war widows/widowers.

Phone: 1300 13 42 60
Fax: 1300 76 62 41
Email: healthcare@intouchdirect.com.au
Web store: www.intouchdirect.com.au

Chemist

You may like to discuss with your chemist about getting your supply and negotiate the price.

Supermarkets

Incontinence pads are available from local supermarkets.

Department of Veterans' Affairs (DVA)

The Commonwealth Department of Veterans' Affairs (DVA) provides a range of incontinence products to eligible veterans and ward widow/er's via the Rehabilitation Appliances Program (RAP). Eligible applicants need to:

- hold a Gold Card; (eligible for treatment of all conditions whether or not they are related to war service) ;
- hold a White Card and the incontinence is a result of a specific accepted disability;
- have been assessed by a health professional as requiring products for incontinence;
or
- products are provided as part of the overall health care management

Gold and White Card holders are not eligible if they are residents receiving high level aged care.

A form requesting the incontinence products is filled out by the assessing doctor or health professional. It is then sent to an authorised product supplier on behalf of the client.

For all enquiries in regards to continence products and supply arrangements, please Contact the South Australian State Office:

National Continence Contract Team
Department of Veterans' Affairs
GPO Box 1652
(199 Grenfell St)
Adelaide SA 5001
Phone: 1300 131 945

Or NSW Ministry of Health – Primary Health & Community Partnerships: (02) 9391 9515
Continence Promotion Centre: (02) 8741 5699