



ACI NSW Agency
for Clinical
Innovation

ACI Urology Network – Nursing

Female Indwelling Urinary Catheterisation (IUC) - Adult

Clinical Guideline, Competencies & Patient Information Leaflet

Street address:
Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

Postal address:
Agency for Clinical
Innovation
PO Box 699
Chatswood NSW 2057

T +61 2 9464 4666
F +61 2 9464 4728
info@aci.health.nsw.gov.au
www.aci.health.nsw.gov.au

Acknowledgements

Colleen McDonald (CNC Urology: Westmead Hospital), Karina So (CNC Urology: Concord Repatriation General Hospital), Virginia Ip (CNC Urology: Royal Prince Alfred Hospital), Michelle Paul (Nurse Practitioner: Community Health, Greater Newcastle Cluster), Wendy Watts (CNC Urology: John Hunter Hospital) and Suzanne Cruickshanks (CNC Continence: The Continence Service of the University Medical Clinics of Camden & Campbelltown Hospitals). Originally compiled by Urology Nursing Education Working Party Members (September 2008).

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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AGENCY FOR CLINICAL INNOVATION
Level 4, Sage Building
67 Albert Avenue
Chatswood NSW 2067

Agency for Clinical Innovation
PO Box 699 Chatswood NSW 2057
T +61 2 9464 4666 | F +61 2 9464 4728
E info@aci.nsw.gov.au | www.aci.health.nsw.gov.au

Produced by: ACI Urology Network Nurses Working Group

Ph. +61 2 9464 4666
Email. infor@aci.health.nsw.gov.au

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TABLE OF CONTENTS

ASSESSING COMPETENCIES	4
What is a competency?	4
COMPETENCY:	4
RATIONALE	5
Indications for catheterisation	5
FEMALE INDWELLING URINARY CATHETERISATION AND CARE - ADULT	7
Definition	7
Expected Outcomes	7
Considerations	7
Equipment	9
Procedure	9
REFERENCES	11
APPENDIX 1.	12
Competency Assessment Forms	12
1. Theory	12
2. Practical	13
APPENDIX 2.	17
Discharge Planning Checklist for Indwelling Catheter	17
Urethral catheter	17
Problem solving with catheters	18
Criteria for use of intermittent urinary drainage device – Catheter Valve:	20
APPENDIX 3.	21
Questionnaire	21
Answers	22
APPENDIX 4.	24
Patient Education Leaflet	24
Troubleshooting: Problems You May Encounter	25
APPENDIX 5.	26
Supply of Equipment and Funding Bodies	26

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 setting. 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:

Female Indwelling Urinary Catheterisation (IUC) - Adult

The aim of the competency is to ensure the Nurse/Midwife/Medical Officer/Student is able to demonstrate prior knowledge and can perform female urethral catheterisation 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 are required to undertake practical sessions with a supervisor in female catheterisation (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 nurse deemed capable of supervising female catheterisations.

The Nurse/Midwife/Medical Officer/ Student are responsible for maintaining their skill level. In the event where a nurse 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 nurse that undertakes competency assessment, at the discretion of the Local Health District.

Rationale

Indications for catheterisation

- To relieve urinary retention
- To monitor accurate urinary output
- To instil medications
- To manage and maintain urinary system during surgical procedure
- Establish bladder irrigation for management of haematuria
- To manage fistula and promote healing
- To conduct investigative procedures
- To preserve skin integrity
- To provide end-of-life care

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

Competency assessment is required because:

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

Skill assessment in female catheterisation 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 in-service or Introduction to Continence Program or a Urinary Catheterisation Workshop.
- 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 female catheterisation.
- Has knowledge of the clinical indications for insertion of indwelling urinary catheters.
- Observe a Nurse/Midwife/Medical Officer/Student who has achieved competency in this procedure.
- Identify the OH&S principles that apply to the safe insertion of urinary catheter in a female patient.

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

- Confirm that patient meets Indications for catheterisation.
- Patient gives consent where appropriate.
- Professional attitude and rapport with the patient.
- Comprehensive patient specific assessment and planning.
- Performance of the female patient catheterisation.
- 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 female catheterisation technique.
- Questioning techniques.
- Demonstrated problem-solving skills in relation to female 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 female catheter technique may be required on request.

Nurse/Midwife/Medical Officer/Student is required to maintain continuous professional development in female catheterisation.

Female Indwelling Urinary Catheterisation and Care - Adult

Definition

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

Expected Outcomes

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 indwelling catheter 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 urethral catheter 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 2- way 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.
- Another alternative for long term catheters, may need to consider supra pubic catheterisation.

High Risk for Adverse Outcomes

- **Artificial Heart Valve**
 - Discussion with urology and/or 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 urethral 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 lubricant
 - sterile water 10ml ampoule
 - 0.9% Sodium Chloride ampoule 10mls
 - 1pair of sterile gloves
 - dressing towel
 - fenestrated drape
- 1 sterile catheter appropriately sized
- 2 way 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)
- Sterile kidney dish (if catheter pack has only one tray)
- 30mls of normal saline for irrigation

Procedure

1. Check correct patient and obtain consent.
2. Perform hand hygiene.
3. If possible, patient should wash their genitals with soap and water or take a shower before procedure
4. Explain procedure to patient, obtain consent and identify allergies.
5. Ensure patient privacy.
6. Remove underpants and position patient in semi recumbent position with legs apart.
7. Place blue disposable sheet under patient's buttock. Fold blanket exposing the genitals.
8. Perform hand hygiene.
9. Open catheter pack and separate trays, by holding non-sterile side of plastic sheeting. Using non touch technique, add equipment to the sterile field.
10. Open sterile gloves.
11. Open sterile drainage bag (if required) and place near patient.
12. Put on apron, goggles and non-sterile gloves.
13. Deflate balloon with 10 ml syringe. Observe amount of water obtained; expect loss of

approximately 1ml per week in balloon size.

14. With non-dominant hand separate labia and with dominant hand gentle rotate and remove catheter
15. Discard old catheter, remove gloves and perform hand hygiene
16. Put on sterile gloves
17. Organize equipment. Remove covering from catheter and place in sterile tray. Draw up 10 ml sterile water with 10 ml syringe and place in sterile tray.
18. Add lubricant on catheter.
19. Dip gauze squares in saline and place in cleaning tray **OR** Irrigate with 30mls of normal saline
20. Using dominant hand, pick up forceps and clean left and right labia majora with saline swabs. One stroke per swab and one swab for each side.
21. With non-dominant hand, pick up gauze squares to separate labia minora exposing the urethral meatus. Using dominant hand pick up forceps with saline swab to clean labia minora and urethral orifice. One stroke per swab in a downward direction, discard. Discard cleaning tray. Alternatively irrigate area.
22. Open fenestrated drape and place it over patient's genitals.
23. Place catheter tray on fenestrated sheet.
24. Pick up catheter with dominant hand, ensuring drainage end of catheter is in tray, gently insert catheter into urethral meatus for approximately 5 - 7 cm while watching for urine flow. When urine returns, continue to advance catheter another 5cm or more, then inflate balloon with sterile water (observe patient for any signs of discomfort). Gently withdraw catheter till resistance is felt. Connect catheter to drainage device.
25. If there is no urine flow following insertion, do not inflate balloon and examine patient to ensure catheter is in the urethra.
26. Secure catheter, valve or leg bag appropriately.
27. Assist patient to get dressed and make patient comfortable.
28. Reinforce patient/carer/family education on catheter management.
29. Dispose waste according to local policy.
30. Remove gloves and perform hand hygiene
31. Document on patient integrated notes catheter type, size, balloon size and amount of water in balloon, any abnormalities during the procedure, residual urine colour and volume. Urinary Catheter Record sticker is used in NSW Health public hospitals for easy identification on the Clinical Progress Notes
32. Establish and maintain fluid intake/output chart
33. Also, document plan for a catheter review or catheter removal

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Appendix 1.

Competency Assessment Forms

1. Theory

Competency: Female Indwelling Urinary Catheterisation (IUC) - Adult

The student is required to show theoretical knowledge of female urethral catheterisation either verbally or in writing prior to undertaking the practical component.

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

2. Practical

Clinical Skill Assessment Form: Female Indwelling Urinary Catheterisation (IUC) – 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 urinary catheterisation 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 regarding 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 planned for potential difficulties.		
Considered the need for pre-procedure medication.		
Performance Criteria on Procedure		
Urethral Catheterisation on a female patient.	Yes	No
Assembled and prepared equipment.		

Performed hand hygiene.		
Positioned patient correctly and continually reassured the patient during the procedure.		
If IUC insitu, put on non-sterile gloves, deflated balloon and removed catheter.		
Put on goggles. Performed hand hygiene and put on sterile gloves. Maintained sterile field and used aseptic technique.		
Cleaned the labia using the appropriate solution (as per local policy).		
Placed fenestrated drape on patient.		
For difficult catheterisation, instilled xylocaine gel. Waited at least three minutes before inserting the catheter.		
Inserted catheter into the urethra and bladder, watched for urine flow.		
Further advance catheter 5 cm or more before inflating the balloon with sterile water.		
Collected sterile urine specimen if required.		
Connected catheter to the appropriate drainage device.		
Secured catheter and make patient comfortable.		
Provided appropriate patient education.		
Discarded all equipment appropriately.		
Performed hand hygiene.		
Documented the procedure and any abnormalities.		
Performance Criteria		
Problem Solving Skills. Assessee nurse outlines the reasons for and the management of.	Yes	No
Peri-catheter leakage (bypassing).		
Unable to locate urethral orifice.		
No urine drained on catheter insertion.		
Residual urine is over one litre.		

Performance Criteria		
WH&S Issues Identified and Applied.	Yes	No
Identified the following aspects of WH&S and performs a risk assessment prior to performing female urinary catheterisation.		
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 Female Urethral Catheterisation:

Knowledge on female urethral catheterisation procedure

- Satisfactory _____
- Unsatisfactory _____

Female Catheterisation 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 Indwelling Catheter

Urethral catheter

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

Problem solving with catheters

Problem	Potential Solution
Removal of the indwelling 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 urinary catheter	Ensure client is not constipated. Gently rotate the catheter while inserting. 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 12 - 14 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 catheter is in the bladder by inspection of the urethral orifice or obtain permission to perform gentle digital assessment. 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	Correct constipation. Treat bladder spasms. Secure catheter with appropriate device to avoid movement reducing irritation to the bladder. Check catheter patency and drainage bag should be below the level of the bladder. Ensure drainage tubing is not kinked, blocked or looped. 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:

- Urine retention.
- 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 fill used in a standard Foley Catheter?
2. How often should a leg bag be changed?
3. How often should the all silicone and hydrogel coated catheters be changed?
4. What are possible causes for difficult insertion of a female IDC?
5. What are the four most likely causes of difficulty in removing an IDC in a female patient?
6. After insertion of a new catheter what could be the cause(s) of no urine return?
7. What are the signs and symptoms of autonomic dysreflexia?
8. What action would you take if your patient develops autonomic dysreflexia?
9. What should be included in educating patient on catheter care?
10. What are the principles of a closed drainage system?
11. Give 5 reasons when use of catheter valve is inappropriate.
12. How much oral fluid is recommended for patients with catheter insitu?
13. When would anticholinergics medication be recommended in patient with a catheter?
14. How long does it take for Xylocaine gel to work?
15. What would you document in the notes following a catheter change?
16. What could be the possible reasons for difficult inflation of a balloon?
17. What are the current continence assistance schemes?
18. What are the common adverse effects of anticholinergic medications?

Answers

1. Preferred balloon fill used in a standard Foley catheter is 10 mls
 2. A leg bag should not be removed on a daily basis. It is changed every seven days.
 3. It is recommended that all silicone and hydrogel coated catheters be left insitu for 4-6 weeks or depending on patient's individual condition.
 4. Difficult insertion on a female patient may be due to
 - Difficult to visualize the urethral orifice
 - Urethral or bladder neck stricture
 - Patient anxiety and inability to maintain her body position.
 5. Four possible reasons for difficult removal of catheter are;
 - Hysteresis (failure of tissue to follow the same course during relaxation as during distension)
 - Muscular spasm
 - Stenosis of the bladder neck
 - Debris attached to catheter balloon or eyelets.
 6. Possible causes of no return of urine post catheterisation are:
 - Catheter not in the bladder
 - Catheter lumen is blocked with lubricant
 7. Signs and symptoms of Autonomic Dysreflexia:
 - Rising, high blood pressure
 - Sweating, flushing above level of lesion
 - Pins and needles
 - Pounding headache
 8. What to do if your patient develops Autonomic Dysreflexia:
 - 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
 9. Patient education on catheter care should include:
 - Hygiene
 - Fluids
 - Care of catheter and drainage device including frequency of catheter change
 - Signs and symptoms of symptomatic UTI
 - Equipment information, including supply of catheters
 - Prevention of constipation
 - Problem solving strategies
- Possible causes of leaking, these include:
- Constipation
 - Kinked tubing
 - Urinary tract infection
 - Inappropriate type of catheter
 - Catheter or balloon too large or too small
 - Catheter movement due to un- anchored drainage
 - Medications which decrease urethral resistance
 - Blocked catheter with sediment/debris
 - Inappropriate use of valve

10. Principles of closed drainage are:
 - Maintain a sterile system
 - Avoid disruptions to the drainage system
 - Change bags weekly.
11. Patients who can use a catheter valve must
 - Be cognitively intact
 - Have normal dexterity or have a carer
 - Be motivated
 - Have a stable storing bladder (no urge incontinence)
 - No recent bladder surgery
12. Fluid intake is recommended to be 2 litres unless otherwise indicated by doctor
13. 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 contraction.
14. Xylocaine works within 2-3 minutes
15. Documentation should include catheter/balloon size, type and material, use of xylocaine gel, urine colour and volume, any problem in catheter removal or on insertion, any bleeding or pain experienced during or after procedure.
16. Difficulty inflating balloon could be due to:
 - Faulty catheter
 - Catheter is not in the bladder.
17. Current funding schemes are:
 - Enable Health
 - CAPS
 - DVA
18. Dry mouth and dry eyes, blurred vision, hallucinations, constipation.

Appendix 4.

Patient Education Leaflet

Urinary Catheter Care Guide

You have had a urinary catheter inserted through your urethra (water pipe) 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, and after defaecation.
- 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.
- Avoid constipation as this can prevent the catheter from draining properly.

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 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