



ACI Urology Network - Nursing

Female Urethral Catheterisation

Clinical Guideline, Competencies & Patient Information Leaflet

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TABLE OF CONTENTS

ASSESSING NURSING COMPETENCIES	2
What is a competency?	2
NURSING COMPETENCY:	2
Female Urethral Catheterisation	2
RATIONALE	3
FEMALE URETHRAL CATHETERISATION AND CARE	5
COMPETENCY ASSESSMENT FORMS	9
DISCHARGE PLANNING CHECKLIST FOR INDWELLING CATHETER	14
TEST HOW MUCH YOU KNOW	18
Questionnaire	18
Answers	19
REFERENCES	21
PATIENT EDUCATION LEAFLET	22
Urinary Catheter Care Guide	22
How to Care for Your Catheter	22
Please Ensure That You:	22
Urinary Drainage Bags	22
Catheter Valve	22
Catheter Change	23
Troubleshooting: Problems You May Encounter	23
SUPPLY OF EQUIPMENT AND FUNDING BODIES	24
Program of Appliances for disabled people (PADP)	24
Continence Aids Payment Scheme (CAPS)	24
BrightSky Australia offers	25
Independence Australia	25
Intouch Direct	25
Chemist	25
Supermarkets	26
Department of Veterans' Affairs (DVA)	26

Assessing Nursing 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 demonstrated².

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.

Nursing Competency:

Female Urethral Catheterisation

The aim of the competency is to ensure the student or nurse is able to demonstrate prior knowledge and can perform female urethral catheterisation to the standard set by the Area Health Service or Health Care Provider.

It is necessary that the student is competent in theoretical knowledge. This knowledge may be gained by attending a study day or undertaking a learning package (discretion of each Health Care Service).

The student is 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 student is 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. Written records will be kept of each nurse that undertakes competency assessment, at the discretion of the Area Health Service.

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

Competency assessment is required because:

- The ability to change a catheter safely and effectively on a female patient is an essential and basic skill for Registered Nurses.
- Competent assessment and education of the patient/client requiring catheterisation is necessary to minimise and prevent complications.

Nursing 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 nursing skill assessment: may include the following:

- Attend an Introduction to Continence Program or a Urinary Catheterisation Workshop.
- Study the facility specific policy and procedure guidelines on female catheterisation
- Observe a Registered Nurse who has achieved competency in this procedure.
- Identify the OH&S principles that apply to the safe change of urinary catheter in a female patient.
- Complete a worksheet prior to undertaking the assessment.

Underpinning knowledge is required of the following:

- Facility policy
- Standard precautions
- Principles of manual handling

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

- Professional attitude and rapport with the patient
- Patient assessment and planning
- Performance of the female patient catheterisation
- Problem-solving skills and application of theoretical aspect
- Relevant occupational health and safety principles applied to the procedure

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.
- The assessor determines with the nurse how the skill or knowledge deficit could be best improved.
- Further educational support might be required to prepare the nurse 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.

Registered Nurses are required to maintain continuous professional development in female catheterisation.

Female Urethral Catheterisation and Care

Definition

A urinary catheter is passed through the urethra into the bladder to drain urine. This procedure is performed under aseptic technique by qualified nursing staff.

Expected Outcome

The urinary catheter is inserted into the bladder without problem.

Patient and staff safety are maintained.

Considerations

- Medical Officer must document the reason and order for catheter insertion and removal of an indwelling catheter in patient health care records.
- Community nurse needs a Letter of Authority for catheter replacement from the Medical Team.
- 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.
- 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.
- 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.

Equipment

- Catheter pack (check contents of pack; add following items if not included in pack)
- Water soluble lubricant
- Sterile water (10ml ampoule)
- Normal saline (30 ml)
- 2x 10 ml syringes
- 1 pair sterile gloves (size appropriate to user)
- 1 pair non sterile gloves
- One 2 way Foley's catheter appropriate size, type

- Fenestrated drape
- Catheter fixation device e.g. Catheter strap
- Appropriate drainage device (e.g. sterile leg bag, 2 litre bag or catheter valve)
- Blue under sheet (bluey)
- Rubbish bag
- Specimen jar (if required)
- Protective Personal Equipment (PPE): Disposable gloves, goggles, apron
- Sterile kidney dish (if catheter pack has only one tray)

Procedure

1. If possible, patient should wash their genitals with soap and water or take a shower before procedure
2. Explain procedure to patient
3. Ensure patient privacy
4. Remove underpants and position patient in semi recumbent position with legs apart.
5. Place 'bluey' under patient's buttock. Fold blanket exposing the genitals.
6. Wash hands
7. Open catheter pack and separate trays, by holding non sterile side of plastic sheeting. Using non touch technique, add equipment to the sterile field.
8. Open sterile gloves
9. Open sterile drainage bag (if required) and place near patient.
10. Don PPE – put on apron goggles and non-sterile gloves.
11. Deflate balloon with 10 ml syringe. Observe amount of water obtained; expect 1-2mls less than what was put in. With non dominant hand separate labia and with dominant hand gentle rotate and remove catheter.
12. Discard old catheter, remove gloves and wash hands according to infection control policy.
13. Don sterile gloves
14. 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.
15. Add lubricant on catheter.
16. Dip gauze squares in saline and place in cleaning tray.
17. Open fenestrated drape and place it over patient's genitals.
18. Place cleaning tray just below patient's genitals on fenestrated drape.
19. 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.
20. With non dominant hand, pick up gauze squares to separate labia 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.

21. Place catheter tray on fenestrated sheet.
22. 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.
24. If there is no urine flow following insertion, do not inflate balloon and examine patient to ensure catheter is in the urethra.
25. Strap catheter, valve or leg bag appropriately.
27. Assist patient to get dressed and make patient comfortable.
28. Reinforce patient education on catheter management.
29. Dispose waste according to infection control policy.
30. 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.

Specific Spinal Cord Considerations

- If client is spinal cord injured (SCI), above thoracic vertebrae level 6 (T6), the nurse must understand autonomic dysreflexia and ensure treatment algorithm for autonomic dysreflexia in spinal cord injury is present.

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 inserting catheter into the vagina
- 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 at or above the thoracic level 6. 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

Competency Assessment Forms

Theory

Competency: Female Urethral Catheterisation

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 URETHRAL CATHETERISATION TO BE DISCUSSED	YES	NO	COMMENTS
Describes the anatomy and physiology of the urethra, the bladder and abdominal cavity			
Understands the indications for indwelling catheterisation			
Discuss the procedure including the equipment required and the technique			
Discuss types of catheter available, duration of catheter, balloon size, closed drainage systems and can provide rationale for choice			
Identify complications that can occur during catheterisation and discuss preventative measures and solutions			
Identify complications that can occur during the removal of the catheter and discuss preventative measures and solutions			
Identify care of and complications of the indwelling catheter			
Discuss special implications of catheterisation eg MS client, autonomic dysreflexia in the spinal injured client, sexuality, quality of life			
Discuss OH & S considerations			
Discuss legal issues (verbal consent, education, documentation of procedure)			

Practical

Nursing Skill Assessment Form: Female Urethral Catheterisation Part 1 & 2

Name of Individual

Date of Assessment

Name of Assessor

Signature of Assessor

Ward/Location

Signature of Nurse

Performance Criteria	Yes	No
Professional Attitude and Patient Communication.		
Introduce self to patient.		
Explain that the procedure for urinary catheterisation is being observed and assessed.		
Gain verbal or inferred consent from the patient.		
Direct visitor / spouse to the waiting area if applicable.		
Address any patient concerns that may arise re the procedure.		
Performance Criteria: Patient Assessment and Planning		
Explain the procedure to the patient.		
State indication(s) for change of catheter.		
Follow the requirements for patient preparation – as per local policy.		
Provide rationale for catheter selection.		
Identify and plan for potential difficulties.		
Consider the need for pre-procedure medication.		
Performance Criteria on Procedure Urethral Catheterisation on a female patient	Yes	No
Assemble and prepare equipment.		
Position patient correctly and continually reassure the patient during the procedure.		
If IDC insitu, don non-sterile gloves, deflate balloon and remove catheter		

Nursing Skill Assessment Continue:

Performance Criteria on Procedure Female Urethral Catheterisation continue:	Yes	No
Don goggles. Perform handwash and don sterile gloves.		
Clean the labia using the appropriate solution (as per local policy).		
Place fenestrated drape on patient.		
For difficult catheterisation, instill xylocaine gel. Await at least three minutes before inserting the catheter.		
Insert catheter into the urethra and bladder, watch for urine flow.		
Further advance catheter 5 cm or more before inflating the balloon with sterile water		
Collects sterile urine specimen if required.		
Connect catheter to the appropriate drainage device.		
Secure catheter and make patient comfort.		
Provide appropriate patient education.		
Discard all equipment appropriately.		
Document the procedure and any abnormalities.		

Nursing Skill Assessment: Female Urethral Catheterisation Part 2

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 OH&S Issues Identified and Applied. RN identifies the following aspects of OH&S whilst performing female urinary catheterisation:		
Procedure requires aseptic technique.		
Use of personal protective equipment (PPE)		
Back care and positioning of the patient, self and equipment trolley.		
Correct disposal of contaminated waste.		
Prevention of cross infection.		

Agreement: Clinical Nursing Skill Assessment

Competency Performance on Female Urethral Catheterisation:

Knowledge on female urethral catheterisation procedure

- Satisfactory _____
- Unsatisfactory _____

Female Catheterisation Skill

- Satisfactory _____
- Unsatisfactory _____

Comments by supervisor:

Comments by student (reflection of learning):

Clinical supervisor (print name): _____

Signature _____

Date: _____

Students (print name): _____

Signature: _____

Date: _____

Discharge Planning Checklist for Indwelling Catheter

Urethral catheter

Item	Yes	No	N/A
Educate Patient or Carer on care of indwelling catheter and drainage system (including problem solving strategies)			
Provide "Catheter care at home" fact sheet			
Provide minimum one week supply of drainage bags.			
Arrange medical follow up appointment or Trial of void clinic			
Provide information on supplier for patient to purchase catheter and drainage equipment.			
Provide contact details for community nursing support and advice.			
Inform patient with permanent catheter on government continence aids assistance schemes (PADP/ CAPS)			
Inform patient who is DVA client with gold card of supply arrangement.			
Referral to Primary Health Nursing team (PHN)			
Authorisation letter from Medical Officer for change of catheter by community nurse.			
Name and Signature of Registered Nurse or Enrolled Nurse _____			
Date _____			

Problem solving with catheters

Problem	Potential Solution
Removal of the indwelling catheter	
Balloon not fully deflated	Refill balloon and allow fluid or air to enter syringe by gravity (this is called passive balloon deflation)
Cuffing of balloon	Use different type of catheter . Ensure catheter is in the bladder, reinflate balloon with 3 ml of water and allow balloon to deflate passively.
Bladder spasms	Consider use of anti-cholinergic medication one hour before catheter replacement Remove catheter slowly
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.
Cannot remove catheter	Apply lubricating gel, rotate catheter gently, maintain traction, and ask the patient to bear down. Seek help from advanced practice nurse or medical officer when the above options have been tried and problem persists.
Patient anxiety	Reassure client and identify anxiety reasons.
Insertion of catheter	
Obstruction of urethra or bladder neck	Ensure client is not constipated. Use Xylocaine gel to lubricate the whole urethra.
False passage	Uncommon in female. Use plenty of lubricant and do not force the insertion of catheter. Consider the use of a Coude tip catheter.
Patient anxiety	Reassure client and identify anxiety reasons.
Incorrect catheter size	Check catheter size when preparing equipment. Use the correct catheter size and type. Smaller size 14 is usually adequate.

Bladder spasm	<p>Take anti-cholinergic medication one hour before the procedure.</p> <p>Maintain steady pressure on insertion. Hold catheter firmly during balloon inflation to avoid catheter expulsion by bladder contraction.</p> <p>Correct symptomatic Urinary Tract Infection</p>
Pain	<p>Identify cause of pain. Ensure adequate lubricant is used.</p> <p>Consider use of analsthetic gel, wait 3-5 minutes prior to insertion of catheter.</p>
Balloon will not inflate	Remove catheter and insert a new catheter.
Post insertion of catheter	
No urine return	<p>Check catheter is in the bladder by inspection of the urethral orifice or obtain permission to perform gentle digital assessment.</p> <p>Bladder could be emptied just after catheter removal.</p> <p>Instruct patient to drink a couple of glasses of water before the procedure whenever possible.</p> <p>Patient may have low urine output. Report to Medical Officer.</p>
Catheter bypassing	<p>Correct constipation.</p> <p>Treat bladder spasms</p> <p>Secure catheter with appropriate device to avoid movement reducing irritation to the bladder</p> <p>Check catheter patency and drainage bag should be carried below the level of the bladder. Ensure drainage tubing is not kinked.</p> <p>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).</p> <p>Ensure catheter size and balloon size is appropriate to patient's condition. e.g. patient has diuresis requires catheter with a bigger lumen.</p> <p>Correct symptomatic UTI.</p>

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

- Stable detrusor (bladder) function
- Normal upper urinary tract function
- No active UTI
- No active haematuria
- No vesico-rectal, vesico-vaginal or vesico-colonic tear or fistula
- No cognitive impairment
- Mental status is stable
- Hand dexterity is adequate

Test How Much You Know

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:

- PADP Enable Health
- CAPS
- DVA

18. Dry mouth and dry eyes, blurred vision, hallucinations, constipation.

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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. Discuss re-usable recommendations with your continence or community nurse.
- The leg bag is changed once a week

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 will 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 4 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

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.

Program of Appliances for disabled people (PADP)

Program of Appliances for Disabled People (PADP) provides a wide range of equipment (including continence aids) to people with permanent disabilities living in the community who:

- Have a permanent or indefinite disability
- Have a Health Care Card, Health Interim Voucher or Pension Concession Card
- Have not received compensation for their injuries or disability, including not being on a Commonwealth rehabilitation Program or being supplied with aids and appliances under the Motor Accident Act
- Are State wards or children in foster care who have a disability.

Continence aids are available to people 3 years and older living in the community or who have recently been discharged from hospital or acute care. The person must be discharged for at least one month and not be under outpatient treatment.

Subsidy is decided by product quota rather than by financial amount. Clients are required to make a \$100 co-payment each year in which an item is received. In the case of continence products, where the supply is generally ongoing, the client would contribute \$100 each year. PADP is meant as an assistance program not to cover all costs incurred by a person.

Assessment is required by an authorised health professional (assessment by medical practitioners is not accepted) to obtain a prescription for appropriate aids and apply to EnableNSW, the PADP manager. Information on PADP is available on the NSW Health 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.

Address: 47B Princes Road West, Auburn NSW 2144

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