Prior to performing the procedure refer to Urethral Catheterisation Policy, CP/Pol/B1, and determine if the patient has a latex allergy.

1.0 PRINCIPLES

1.1 Urethral catheterisation will be performed according to the following practice principles:

Aseptic technique
Patient consent
Standard Precautions
2.0 APPLICATION OF PRINCIPLES

2.1 Equipment Required

2.1.1 Sterile gloves

2.1.2 Catheter pack from Sterile Processing Centre (SPC)

2.1.3 1 x 30ml sachet sterile Normal Saline

2.1.4 Lubricant/anaesthetic gel. For female patient: sterile lubricating jelly or xylocaine jelly. For male patient: xylocaine jelly sterile syringe pack

2.1.5 Protective faceshield

2.1.6 2 x pack gauze squares

2.1.7 Sterile Foley hydrogel-coated (hydrophilic bonded) urethral catheter. Size 16 Charriere (Ch) catheter or as otherwise indicated, refer CP/Pol/B1, point 7.0, for size information. N.B. In particular circumstances a silicone catheter may be required, e.g. if the patient has a latex allergy.

2.1.8 1 x 10ml ampoule of sterile water

2.1.9 10ml syringe

2.1.10 Disposable plastic bag

2.1.11 Closed drainage system (sterile catheter bag and tubing with needleless port) and stand/other appropriate suspension apparatus

2.1.12 Plastic disposable apron

2.1.13 Incontinent sheet

2.1.14 Optional: sterile yellow specimen container if specimen is to be collected.

: portable light

2.2 Preparation

2.2.1 Verify the Medical Officer's (MO's) request for the procedure.

2.2.2 Wash the pubic area with soap and water.

2.2.3 Position the patient in a supine position.
   - Female patient: the knees are to be bent, the hips flexed and the feet resting on the bed approximately 60cms apart.
   - Male patient: the legs are to be extended.

2.2.4 Place an incontinent sheet under the patient's buttocks.
2.2.5 Ensure direct light for visualisation of genital area.

2.2.6 Wash hands and prepare equipment. Set up sterile catheterisation field.

2.2.7 Check catheter balloon for patency.

2.2.8 Fill the syringe with 10ml of sterile water without contaminating the syringe.

2.3 Procedure

2.3.1 Don faceshield. Wash hands and don sterile gloves.

2.3.2 Remove the perforated end of the plastic cover containing the catheter. Place lubricant/anaesthetic gel on the catheter tip and place the catheter tip in a sterile kidney dish leaving the rest of the catheter in the plastic cover until use.

2.3.3 For Female Catheterisation:

2.3.3.1 Using a succession of gauze squares moistened in Normal Saline and held with forceps, cleanse the external labia, right side, left side and centre. Swab in a downward motion from anterior to posterior and use each swab only once. Keep one gauze square in a sterile dish for swabbing the urethral meatus prior to insertion of the catheter.

2.3.3.2 Discard the forceps and the kidney dish.

2.3.3.3 Drape fenestrated drape over perineum and drop sterile towel onto bed below the patient's vulva. Place a sterile container between the patient’s legs for urine collection.

2.3.3.4 Using gauze swabs, separate the labia and expose the urethral meatus. The gloved hand used to hold the external genitalia is to be considered contaminated.

2.3.3.5 Take the second pair of forceps (the pair that has not previously been used to swab the patient) and swab the urethral meatus with the remaining gauze square.

2.3.3.6 Holding the sterile plastic cover, insert the catheter into the urethral orifice and advance the catheter until urine drains into the sterile container between the patient’s legs. Once urine drains, advance the catheter a further 5cm. Do NOT touch the catheter with your hands. Remove the plastic cover when urine flows.
2.3.3.7 Inflate the balloon via the retaining cuff of the catheter with the sterile water previously drawn up into the syringe. Inflate the balloon to the volume recommended by the manufacturer.

2.3.3.8 Check catheter position by gently withdrawing the catheter until resistance is felt.

2.3.3.9 Connect the sterile drainage bag and tubing to the catheter using aseptic technique.

2.3.3.10 If a sterile specimen of urine is required for pathology, prepare the specimen.

2.3.3.11 Dry the patient.

2.3.3.12 Strap the catheter to the patient's thigh.

2.3.4 **For Male Catheterisation:**

2.3.4.1 Using a succession of gauze squares moistened in Normal Saline and held with forceps, cleanse the penis and surrounding skin area. Use each gauze square only once. Retract the foreskin of the penis, if applicable, and swab again. Discard the forceps and kidney dish.

2.3.4.2 Place fenestrated drape over penis.

2.3.4.3 Place sterile towel and a sterile container on bed between the patient's legs.

2.3.4.4 Hold the penis at a 90° angle to the body and insert the xylocaine jelly into the urethra. Continue to hold the penis upright for 1-2 minutes and close the urethral meatus by placing thumb over urethral opening so that the anaesthetic gel will not run out.

2.3.4.5 Lower the penis to a horizontal position. Holding the sterile plastic cover, insert the catheter and advance it approximately two-thirds of its length, while simultaneously withdrawing the plastic cover.

2.3.4.6 Hold the penis at a 90° angle to the body and continue inserting the catheter up to the 'Y' junction. When inserting the catheter do NOT touch the catheter with your hands. Remove the plastic cover when urine flows into the sterile container between the patient’s legs.

If difficulty is experienced during the procedure, e.g. obstruction, abort the procedure. A maximum of three (3) attempts is permitted for the female patient. If the procedure is aborted notify a more senior nurse or MO. A new sterile catheter is to be used following an aborted catheterisation attempt.
2.3.4.7 Inflate the balloon via the retaining cuff of the catheter with the sterile water previously drawn up into the syringe. Inflate the balloon to the volume recommended by the manufacturer.

2.3.4.8 Check catheter position by gently withdrawing the catheter until resistance is felt.

2.3.4.9 Connect the sterile drainage bag and tubing to the catheter using aseptic technique.

2.3.4.10 If a sterile specimen of urine is required for pathology, prepare the specimen.

2.3.4.11 **Reduce or reposition the foreskin if it has been retracted.**

2.3.4.12 Dry the patient.

2.3.4.13 Strap the catheter to the patient's thigh.

2.3.5 **For both Female and Male Catheterisation:**

- Insert the catheter slowly and carefully to minimise trauma. A traumatic catheterisation increases the risk of infection.
- Discard the catheter if it becomes contaminated at any time.
- If resistance is felt at the urethral sphincter:
  - use anaesthetic gel (xylocaine jelly) and wait for the anaesthetic effect to reduce sphincter spasm.
  - ask the patient to do relaxation breathing and then try to advance the catheter again.
  - ask the patient to try to void before advancing the catheter.

2.4 **Post Procedure**

2.4.1 Inform the patient that bladder spasms and cramps are common in the initial period following catheterisation.
2.4.2 Ensure the drainage bag is kept in a dependent position below the level of the bladder and placed in either a stand or other appropriate suspension apparatus attached to the bed to facilitate drainage and reduce infection risks.

2.4.3 Monitor urinary output to ensure adequate urinary flow to prevent stasis and infection.

2.4.4 Record urine drainage within ten (10) minutes to ensure accurate residual urine measurement. (More than 10 minutes may be required if urine is still draining after this time, particularly if the patient is known to be in chronic retention).

2.4.5 If no urine drains for several hours, check:
   - is the tubing bent or kinked?
   - is the bag below the bladder level?
   - the patient's hydration status
   - is the patient constipated?
   - that the patient is mobilising, if appropriate to the patient's condition. Mobilisation may dislodge a blockage.

2.4.6 If no urine drains following urethral catheterisation notify the MO. (The MO may consider removal of the catheter if no drainage and the patient is in pain).

2.4.7 Notify the MO if any of the following symptoms occur:
   - Blood in urine
   - Strong urinary odour
   - Cloudy urine
   - Leakage of urine around catheter
   - Rigors, chills or fever
   - Pain or tenderness across the lower back.

2.5 Disposal of Equipment

2.5.1 Dispose of all equipment appropriately.

2.5.2 Remove gloves and wash hands.

3.0 DOCUMENTATION

3.1 Document volume of residual urine on 24 Hour Fluid Record Chart, P460/B140

3.2 Refer to CP/Pol/B1 for additional documentation requirements.
4.0 CROSS-REFERENCES


5.0 REFERENCES


NSW Health Department. (1999), Standard Precautions Infection Control Policy 99/87


6.0 ENDORSED BY

Visiting Medical Officer, Urology, St. Vincent's Hospital Sydney.