Bladder Management – Catheter Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care and management of urinary catheters and bladder washouts throughout the WA Country Health Service (WACHS).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

Further information relating to specialty areas can be found via HealthPoint if not covered in this policy.

- For intrapartum or postnatal women, midwives are to follow the relevant Women and Newborn Health Service (WHNS) clinical guidelines via HealthPoint Policies
- For paediatric bladder management refer to Perth Children's Hospital Guidelines via HealthPoint Policies

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency.

- Refer to Bladder Management Continence Clinical Practice Standard for
  - Bladder assessment and Scanning
  - Bladder training techniques
  - Urinary retention
- Refer to Stoma Management Clinical Practice Standards for urostomy management and care.
- Refer to Clinical Observations and Assessments Clinical Practice Standard (physiological, neurovascular, neurological and fluid balance) for fluid balance management guidance

3. Procedural Information

Where care requires specific procedures that may vary in practice, staff are to seek senior clinician advice.

- Appendix 1 Urethral Catheter Insertion
- Appendix 2 Suprapubic Catheterisation
- Appendix 3 Self Intermittent catheterisation
- Appendix 4 Indwelling Catheter Management
- Appendix 5 Removing an Indwelling Catheter
- Appendix 6 Bladder Washout

4. Considerations

- Assess the clinical need for an indwelling catheter (IDC) daily, removing the IDC as soon as possible, when no longer required.
- Replace dislodged suprapubic catheters immediately to avoid cystostomy closure.

5. General Information

A urinary catheter is a thin flexible tube inserted into the bladder to monitor urine output or provide bladder drainage, and can be either[1-3]:

- Urethral: direct insertion through the urethral meatus into the bladder
  - Urethral catheterisation may be by an indwelling or intermittent catheter.
  - Intermittent catheterisation may be by either a clinician or by the patient (self-intermittent catheterisation [SIMC]).
- Suprapubic cystostomy: from an incision made through the abdominal wall, above the symphysis pubis into the bladder

6. Indications for Procedure

Indications and rationale for of bladder drainage will vary according to the patient's clinical requirements.

Urethral catheter[1,2]:

- Acute urine retention management
- Bladder washout or irrigation
- Monitoring urine output or renal function
- Intravesical medication administration
- During or post-surgical procedure
- Urinary system investigations
- Quality of life issues: e.g. end of life
- Short term bladder management: e.g. post-urethral surgery, pelvic trauma
- Long term bladder management of the neurogenic bladder e.g. spinal cord injury

Contraindications for urethral catheterisation may include:

- Traumatic injury to the lower urinary tract
- Urethral stricture, recent urethral/bladder surgery
- Bladder or urethral tumours
- Prostatic tumours
- Prostatic/Prosthetic devices in/surrounding the urethra

Suprapubic catheter[1,7]:

- Situations requiring long term bladder drainage or where the urethra cannot be catheterised.
- Short term use:
  - Complex urethral or abdominal surgery
  - Urethral or pelvic trauma
  - Inability to catheterise via the urethra.
- Long term use:
  - Management of atonic or neurogenic bladder
  - To enhance quality of life for people with incontinence e.g. sexual functioning
  - Management of intractable incontinence when continence assessment has determined that there are no suitable alternatives for maintaining social continence.

Contraindications for suprapubic catheter may inlcude[7]:

- unexplained haematuria
- known bladder tumours
- prosthetic devices or materials in lower abdomen
- previous pelvic or abdominal surgery
- small fibrotic bladder.

Intermittent catheterisation[7]:

- Post-surgery: commonly related to bowel or urinary tract surgery.
- Management of urinary retention.
- Neurogenic bladder dysfunction.
- Dilation of urethral stricture
- Management of neobladder with continent diversion.

7. Patient Monitoring

Catheterising patients place them at significant risk of acquiring a urinary tract infection. The risk of infection is associated with the method and duration of catheterisation, the quality of catheter care and host susceptibility. The longer a urinary catheter is in place, the greater the risk of infection[2].

Potential signs and symptoms of urinary tract infection include:

- urethral pain or burning sensation
- sensation of urgency to void
- offensive smelling urine
- discoloured, cloudy or macroscopic haematuria
- self-reported feeling generally unwell
- discomfort in the lower back or loin area
- increased incontinence in the intermittent catheter patient.
- elevated body temperature
- confusion.

To minimise risk of catheter-associated urinary tract infections (CAUTI), refer to relevant procedure appendices for strategies specific to insertion, indwelling catheter management, the removal of urinary catheters, and bladder washout.

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

8. Staffing Requirements

Medical Officer

- Decides the insertion and removal of a urethral catheter.
- Undertakes the insertion of urethral catheter following urological procedures (radical prostatectomy, urethroplasty, neobladder), due to risk of disrupting anastomoses.
- Orders manual or continuous bladder washout.
- Undertakes the initial insertion of a suprapubic catheter.

Nursing Staff

Where patient presents with the following, refer urethral catheter insertion to Medical Officer, Nurse Practitioner or Senior Clinician as appropriate:

- Blood at urethral meatus
- Actual or suspected pelvic and/or urethral trauma
- the first suprapubic catheter replacement after initial insertion should be undertaken by a Continence Advisor or a suitably experienced Registered Nurse or Senior Clinician.
- Subsequent suprapubic catheter replacement requires a minimum of one staff member skilled to undertake the procedure.

For further patient management and escalation of care processes in sites with limited resources for accessing Medical Officer, Nurse Practitioner or Senior Clinician advice.

- Contact local Continence Advisor within 24 hours for patient follow-up, if available
- Refer to patient's General Practitioner for follow-up, if available

Continence Advisor (where available)

- Practice and give recommendation as per scope of practice.
- Liaise with Urologist and Medical Officers when applicable.

9. Clinical Communication

Clinical Handover

Information exchange is to adhere to the Department of Health Clinical Handover Policy using the iSoBAR framework.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Documentation

An individualised management plan is to be documented in the patient's health records as soon as practicable, in regard to this CPS.

Refer to WACHS Documentation CPS.

Related Documents / Forms

- MR144 WACHS Fluid Balance Work Sheet
- MR144P WACHS Neonatal / Paediatric Fluid Balance Work Sheet
- RC17 WACHS Continence Assessment form and Care Plan

Patient/Carer information (including Discharge)

Ensure patients with ongoing urinary catheter management requirements are provided with education prior to discharge. Provide the opportunity for the presence of a family member, carer or significant other during education, particularly if they will be providing patient care following discharge. Deliver education that addresses the patients:

- Cultural and ethnic needs
- Cognitive and functional ability
- Language and communication requirements
- Adaptive response to illness or disability
- Level of self-care or available carer support
- Opportunity to ask questions

At time of discharge provide patient with:

- ongoing and patent urinary drainage system if appropriate
- details of ongoing management plan, e.g. trial of void, catheter and bag change
- arrangements for any future urinary catheter management interventions, e.g. domiciliary nursing services, hospital outpatient continence services, follow up appointments
- spare sterile urinary catheters or drainage products
- details of urinary catheter or drainage product suppliers for ongoing equipment requirements
- contact details for patient in event of complications or emergencies.

Relevant documents can be located via:

- Healthy WA – Your Lifestyle with a catheter
- Healthy WA – Your indwelling urinary catheter
- Healthy WA – Your self-intermittent catheter
- Healthy WA – Your suprapubic catheter
- Healthy WA – General Hygiene Tips for your catheter
- Healthy WA – Caring for your catheter

10. Education and Training

- The skill of urinary catheter insertion does not require a formal WACHS practical assessment.
- Staff are to work within their professional and individual scope of practice.
- Staff are able to have their clinical practice audited using the ANTT Urinary Catheter Guideline audit tool.
- Optional learning resources are available from 'ClinicalKey' (accessed via our WACHS Library using a health device/login). Resources include procedural videos and written information: Urethral Catheterisation: Female and Urethral Catheterisation: Male.

11. Compliance Monitoring

Evaluation, audit and feedback processes are to be in place to monitor compliance.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

12. Relevant Legislation

(Accessible via: Government of Western Australia (State Law Publisher or ComLaw))

- *Carers Recognition Act 2004*
- *Civil Liability Act 2002*
- *Disability Services Act 1993*
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Privacy Act 1988*
- *Public Sector Management Act 1994*
- *State Records Act 2000*

13. Relevant Standards

National Safety and Quality Health Service Standards

- Standard 3 Preventing and Controlling Healthcare Associated Infections Criteria 3.1, 3.2, 3.9. 3.10 and Standard 5 Comprehensive Care Standard Criteria 5.11, 5.13, 5.14

Australian Commission on Safety and Quality in Health Care (ACSQHC) National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines

14. Related WA Health Policies

MP0095 Clinical Handover Policy
MP0122/19 Clinical Incident Management Policy
OD0651/16 Clinical and Related Waste Management Policy
MP0086/18 Recognising and Responding to Acute Deterioration Policy
OD0657/16 WA Health Consent to Treatment Policy
MP0053/17 WA Clinical Alert (Med Alert) Policy
MP0051/17 WA Health System Language Services Policy

15. Relevant WACHS documents

Bladder Management Continence - WACHS Clinical Practice Standard
Clinical Observations and Assessments Clinical Practice Standard (physiological, neurovascular, neurological and fluid balance)
Chemotherapy Administration Clinical Practice Standard
Documentation Clinical Practice Standard
Infection Prevention and Control Policy
MR144 WACHS Fluid Balance Work Sheet
MR144P WACHS Neonatal / Paediatric Fluid Balance Work Sheet
Patient Identification Policy
Pre and Post Procedural Management Clinical Practice Standard

RC17 WACHS Continence Assessment form and Care Plan
Specimen Collection (including Phlebotomy) and Pathology Results Clinical Practice Standard

16. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

17. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Bladder Management - Catheters Clinical Practice Standard.

18. References

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19. Definitions

Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged.
Patient	A person who is receiving care in a health service organisation

20. Appendices

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1 Urethral Catheter Insertion

Pre-Procedure

- The patient has received information relating to the intended procedure, and has given appropriate consent.
- Patient identification and procedure matching processes are undertaken.
- Maintain patient privacy and dignity.
- Offer the presence of a chaperone where appropriate to patient and clinician requirements.
- Provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements. (See WA Health System Language Services Policy.)
- Determine the specific type of catheter required and balloon size. There are 2 commonly used balloon sizes:
  - 10mL for routine drainage in adults
  - 30mL usually post-urological surgery
- Determine the ongoing management plan, e.g. estimated length of catheterisation

Infection Control Considerations

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

Equipment Required

- Catheter selected must be appropriate for the: gender, and patient's clinical requirements. For routine urethral drainage catheter size is usually: female 10/12/14fg and male 14/16/18fg. Use smallest size appropriate to clinical indication
- Refer to Appendix 4: Indwelling Catheter Management for information relating to urinary drainage system equipment.
- Contents may vary where sites have pre prepared urinary catheter insertion packs. The following items may also be required:
  - Urinary catheter insertion pack
  - Sterile cotton swabs
  - Sterile gloves
  - Sanitised measuring jug
  - Appropriate urinary catheter
  - Cleansing solution
  - Waterproof sheet e.g. bluey
  - Sterile lignocaine gel 2% syringe with introducer
- Indwelling Catheter Equipment
  - Sterile water for injection: sufficient to inflate IDC balloon
  - Sterile drainage bag as clinically indicated
  - Syringe for balloon inflation
  - Catheter securement device

- Additional Equipment
  - Angled examination light
  - Dressing trolley (decontaminated)
  - Disposal bag
  - Specimen jar

Procedure

1. Adjust bed height suitable to those undertaking procedure. Perform hand hygiene.
2. Prepare equipment. Ensure to use an aseptic non-touch technique. Pour solutions into the appropriate gallipot at this stage
3. Ensuring privacy and chaperone considerations, position patient comfortably:

Male Patient Positioning		Female Patient Positioning
• Supine position with legs extended.		• Supine with knees bent, hips flexed (and supported or not) heels together or feet apart. Or: • Supine with one knee bent and supported, and one knee straight. Or: • Left lateral side lying position with the right knee bent upwards - to enable posterior view. • Ensure to be able to visualise the urethral meatus.

4. Perform hand hygiene and don sterile gloves.
5. Complete equipment preparation.
6. Drape patient using fenestrated sheet.
7. Place sterile galipot with cleansing solution and swabs on the sterile field between patient's thighs.

Male Patient		Female Patient
• Hold patient's penis (with non-dominant hand) using sterile towel. Gently retract foreskin to expose glans, if required. Maintain holding with towel until procedure is completed • Using forceps, swab the meatus with single downward strokes, with cleansing solution. • Hold penis vertical (to straighten urethra), and extend to full length. Maintain this position throughout the procedure. • Using syringe gently instil entire contents of lignocaine gel into urethra. Place empty syringe at distal edge of the sterile field. • Gently squeeze the meatus closed to prevent seepage of gel for 3-5 minutes. • Place kidney dish containing the catheter onto the sterile field between patient's thighs. • Hold penis vertically and extended. Use clamping forceps, to hold catheter and insert the catheter directly into the urethral meatus. • Gently advance until urine flows. Never force catheter. IDC: insert catheter to bifurcation. IMC: advance a further 3cm after urine flow commences		• Separate patient's labia (with non-dominant hand), and expose urethral meatus. - Maintain this position until catheterisation complete. • Using forceps, swab the meatus, with single downward strokes, with cleansing solution. • Lubricate the external meatus with lignocaine gel. • If appropriate and without discomfort to the patient, gently instil the remaining gel into the urethral meatus. • Place kidney dish containing the catheter onto the sterile field between patient's thighs. • Using clamp forceps insert the catheter into urethral meatus using an upward and backward direction until urine flows. • Never force catheter. • IDC: with female length catheter, insert to bifurcation • With male length catheter, advance a further 6-8cm after urine commences flow. • IMC: advance a further 3cm after urine commences flow

If resistance is encountered with insertion - refer to Table 1: Potential Problems on Insertion of Urinary Catheter

8. Once catheter is inserted allow urine to drain into sterile kidney dish.
   - If kidney dish becomes full, clamp the catheter without clamping the balloon inflation channel. Ensure to hold catheter in place.
   - Aseptically empty the urine into the measuring jug.

Correctly clamped catheter (Continence Service RPH)

For Urine Specimen: First allow a small amount of urine to drain into sterile kidney dish.

- Collect a small amount into a sterile specimen container.
- Ensure to label and package specimen appropriately. Refer to WACHS Specimen Collection (including Phlebotomy) and Pathology Results Clinical Practice Standard

9. Proceed as per catheter type: Indwelling (IDC) or Intermittent (IMC) If no urine flow refer to: Table 1: Potential Problems on Insertion of Urinary Catheter

Indwelling Catheter (IDC)		Intermittent Catheter (IMC)
If the catheter is inserted to the bifurcation, and there is urine drainage: • With the syringe firmly attached, slowly inflate the balloon with the exact amount of **sterile water**. • **Stop:** if any pain or discomfort is felt. Deflate balloon and check position of catheter. Contact Continence Advisor, Nurse Practitioner, Medical Officer or Senior Clinician if indicated. • Gently withdraw the catheter until resistance is felt. **(Male:** Return foreskin to normal position as indicated) • Attach the drainage bag to the catheter lumen. • Ensure the drainage bag firmly remains in continuous connection until catheter is removed or bag replaced. • Allowing a gentle curve from the patient's external meatus, attach the catheter with an catheter securement device to the upper thigh. • Ensure patient's genital area is clean and dry. Assist the patient to redress and reposition, as appropriate. • Position drainage bag below the level of the bladder. • Ensure bag is hung off the floor.		Once catheter is inserted allow urine to drain into kidney dish. - If kidney dish becomes full, clamp the catheter and hold the catheter in place - Aseptically empty the urine into the measuring jug - When the urine flow has ceased, slowly withdraw the catheter by half a centimetre each time to drain urine from the base of the bladder. • When no further urine drains, gently remove catheter and place in kidney dish. • Ensure patient's genital area is clean and dry. Assist the patient to redress and reposition, as appropriate.

10. Dispose of equipment appropriately, remove gloves and perform hand hygiene.
11. Document details of procedure.
12. Notify Medical Officer if any problems were experienced, or there is: blood at meatus, macroscopic haematuria or significant blood clots.

Potential Problems

Table 1: Potential Problems on Insertion of Urinary Catheter

Issue	Possible Cause	Suggested Actions
Female urethral meatus not visible	• Vaginal prolapse • Atrophic vaginitis	• Consider changing patient position • Cease procedure; Liaise with Continence Advisor, Medical Officer or Senior Clinician to assess patient and perform catheter insertion. • Introducing a catheter without first identifying urethral meatus may compromise asepsis and cause patient trauma.
Resistance during insertion	• Urethral stricture • Enlarged prostate • Urethral false passage	• **Do not force** the catheter. May cause urethral trauma. • Maintaining gentle but firm pressure against the resistance, assist sphincter relaxation by asking the patient to: - cough - strain/ bear down as if trying to pass urine - take slow, deep breaths. • If unsuccessful, cease procedure, remove catheter; Document and liaise with Medical Officer.
Pain during insertion	• Insufficient lubricant • Catheter size • Insertion technique • Patient anxiety	• Cease procedure and seek assistance. • Liaise with Continence Advisor, Medical Officer or Senior Clinician.
Paraphimosis	• Failure to return foreskin to normal position following procedure	• Always return foreskin to normal position immediately following procedure. • Liaise with Medical Officer immediately if not achievable, as this is a urological emergency.

Continued…

Issue	Possible Cause	Suggested Actions
No urine drainage on insertion	• Incorrect placement	• Check catheter is correctly sited
	• Incorrect identification of female urethral meatus	• If the catheter has been inserted into the vagina, leave the catheter in situ to act as guide • Re-identify urethra, catheterise with new sterile catheter. • Remove incorrectly sited catheter post procedure.
	• Catheter blockage	1. If No urine flow: • ensure catheter remains insitu. • wait a minute to enable lubricant gel to dissolve. 2. If still No urine flow: • place the palm of the “clean” hand (protecting fingers from contamination) onto the sterile field over the lower abdomen and apply gentle pressure. • ask the patient to cough several times. 3. If still No urine flow: • without contaminating the sterile open catheter port, hold the catheter with finger and thumb of your “contaminated” hand. • place the empty gel syringe firmly into the drainage lumen of the catheter and aspirate gently. • if a 3-way catheter is being used, clamp the irrigation channel prior to attempting drainage channel aspiration. 4. If No urine is obtained after these steps: - remove the catheter - liaise with Medical Officer without delay. Delay in the drainage of a distended bladder may result in distention injury and potential loss of bladder function. Urine flow must occur prior to balloon inflation occurs.

Appendix 2 Suprapubic Catheterisation

Pre-Procedure

- The patient has received information relating to the intended procedure, and has given appropriate consent.
- Patient identification and procedure matching processes are undertaken.
- Maintain patient privacy and dignity.
- Offer the presence of a chaperone where appropriate to patient and clinician requirements.
- Provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements. (See WA Health System Language Services Policy.)
- The first suprapubic catheter replacement is to occur a minimum of 4 weeks post initial insertion[10].
- Liaise with Medical Officer responsible should the catheter require changing prior to this.
- Confirm date catheter inserted as documented in patient health record prior to replacement.
- Subsequent catheter replacements are required as clinically indicated[11] e.g. reduced drainage, symptomatic urinary tract infection (UTI).
- Ensure catheter does not remain insitu longer than 12 weeks or as per manufacturer instructions.
- The principles of the procedure are the same for male and female patients.
- Consider potential alteration to skin integrity between skin folds in obese patients

Infection Control Considerations

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

Equipment Required

- Refer to Appendix 4: Indwelling Catheter Management for information relating to urinary drainage system equipment.
- Catheter selection - Catheter selection is limited to those products available on the current procurement tender for urinary drainage products. Liaise with Continence Advisor (where applicable) or Senior Clinician to obtain 100% silicone catheters.
    - Usual choice for suprapubic catheter selection male or female is:
        - Standard length (44cm)
        - 16 or 18 Fg/Ch
    - Inflation and drainage: 2 way indwelling catheter
    - Hydrophilic coating
    - A larger size catheter may be required for haematuria, heavy bladder sediment or frequent blocking.
    - Increase size of catheter following consultation with Urology Medical team

- Contents may vary where sites have pre prepared procedure or urinary catheter insertion packs. The following items may also be required:
- Initial Suprapubic Catheterisation
  - Suprapubic catheter and trocar pack
  - Procedure bundle
  - Lignocaine 1% ampoules
  - 19g and 25g needles
  - Sterile water for balloon inflation
  - 10mL syringe x 2
  - Scalpel blade and handle
  - 2:0 silk on hard needle
  - Skin antiseptic solution
  - 50mL catheter tip syringe
  - 5mL syringe
  - Sterile gloves
- Subsequent Replacement Catheter
  - Urinary catheter insertion pack
  - Sterile lignocaine gel 2% syringe with introducer
  - Appropriate urinary catheter
  - Sterile water for injection: sufficient to inflate balloon
  - 10mL syringe x 2
  - Sterile gloves x 2 pairs
  - Cleansing solution
- Additional equipment
  - Appropriate sterile drainage bag
  - Non-sterile gloves
  - Catheter spigot
  - Decontaminated dressing trolley
  - Disposal bag
  - Specimen jar
  - 70% alcohol swab
  - Waterproof sheet e.g. bluey
  - Stitch cutter: if suture present

Procedure

Assisting with Initial Insertion of Suprapubic Catheter

1. Prepare Equipment and Patient.
2. Ensuring privacy, position patient comfortably in supine position.
3. Once procedure is complete:
   - Attach the catheter securement device.
   - Dispose of equipment appropriately, remove gloves and perform hand hygiene.
   - Document details of procedure.
   - If suture insitu: document date set for removal in patient health record.

Replacement Suprapubic Catheter8

1. Prepare Equipment and Patient.
2. Spigot catheter 30 minutes prior to procedure. If a catheter valve is in situ ensure it is in the 'OFF' position.
    - To spigot catheter:
        - Perform hand hygiene and don non-sterile gloves.
        - Loosen drainage bag straps.
        - Swab the junction of the catheter and drainage system with alcohol swab.
        - Disconnect drainage bag from the catheter and insert the spigot.
        - Measure and document urine output if appropriate. Discard drainage bag.
        - Remove gloves and perform hand hygiene.
3. Adjust bed height suitable to those undertaking procedure.
4. Prepare equipment. Ensure to use an aseptic non-touch technique. Pour solutions into the appropriate gallipot at this stage.
5. Ensuring privacy, position patient comfortably in supine position and expose the catheter site.
6. Perform hand hygiene and don both pairs of sterile gloves.
7. Complete equipment preparation ensuring to lubricate the catheter and attach water filled 10ml syringe to the replacement sterile catheter.
8. Place sterile fenestrated drape with catheter exposed.
9. Place sterile gallipot with cleansing solution and empty 10ml syringe on sterile field below catheter.
10. Using forceps and a single swab, clean cystostomy site in single circular motion.
11. Connect 10mL syringe to balloon port of insitu catheter, and allow balloon to deflate passively.
    - Position insitu catheter on top of the sterile drape at the head end.
12. Remove and discard outer pair of sterile gloves.
13. With new catheter in sterile kidney dish, place on sterile field below the cystostomy site.
14. Using non-dominant hand and a sterile towel grip the insitu catheter at skin level, withdraw the catheter keeping fingertips at the same point on removed catheter.
    - The catheter may require to be gently turned in the stoma on removal.
    - Place withdrawn catheter at the head end of the sterile drape.
15. Pick up new catheter and place fingertips at the estimated length required for insertion.
    - Ensuring that the two catheters do not touch carefully measure against the old catheter.
    - The distance from fingertips to the tip of the catheter plus 1 cm is the distance your fingertips need to be on the new catheter.
16. Insert the new catheter until your fingertips are touching the skin.
    - Continue to hold catheter, and allow urine to flow.

17. Using the non-dominant hand, slowly inflate the balloon with the exact amount of **sterile water**.
    - If resistance is encountered either: gently insert or withdraw catheter a short distance.
    - The patient may experience pain or discomfort if balloon inflation occurs in either the cystostomy tract or urethra.
18. Once balloon is inflated, gently withdraw the catheter to bring the balloon to the bladder wall. Ensure the catheter is moving freely.
19. Aseptically attach the catheter drainage bag to the open lumen.
    - Ensure the drainage bag firmly remains connected at all times, maintaining a closed system until catheter is removed or bag replaced.
20. Dispose of equipment appropriately, remove gloves and perform hand hygiene.
21. Observe urine drainage. Urine may be blood stained.
22. Don non-sterile gloves and dry exposed catheter length.
23. Allowing for patient ease of movement, attach catheter securement device to either the abdomen or upper thigh.
24. Ensure patient's cystostomy area is clean and dry. Assist the patient to redress and reposition.
25. Provide patient education as required.
26. Document details of procedure, including condition of removed catheter.
27. Notify Medical Officer or Senior Clinician if any problems were experienced.

Post Procedure

- Cystostomy site management:
  - Renew cystostomy dressing for first 24 hours only. Leave site open.
  - Wash cystostomy in shower daily or clean with 0.9% sodium chloride.
- Measuring urinary drainage:
  - Ensure to measure post catheter insertion.
  - Exceptions to this may relate to patients undergoing routine catheter changes.
- Discharge planning (refer to Refer Patient / Carer information (including Discharge)
  - Liaise with Continence Advisor (if applicable) to arrange first catheter replacement following initial insertion.
  - Ensure there is a plan for domiciliary nursing services in place for routine catheter changes.
  - Provide patient education such as:
    - Healthy WA – Your suprapubic catheter

Appendix 3 Self Intermittent Catheterisation (also known as Clean Intermittent Self-Catheterisation (CISC)

Pre Procedure

- The patient has received information relating to the intended procedure, and has given appropriate consent.
- Patient identification and procedure matching processes are undertaken.
- Maintain patient privacy and dignity.
- Offer the presence of a chaperone where appropriate to patient and clinician requirements.
- Provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements. (See WA Health System Language Services Policy.)
- A new, sterile catheter must be used for all intermittent catheterisation undertaken in the hospital setting by clinicians or patients.

Patient suitability for intermittent self-catheterisation will be influenced by[1,3]:

- Possessing a suitable level of manual dexterity, cognitive function and positional mobility to independently undertake procedure.
- Having a bladder with the capacity to store urine between procedures.

Considerations for male and female include:

Male Patient Considerations		Female Patient Considerations
To prevent smegma ring forming causing irritation ensure to instruct patient to either: • retract foreskin and clean underneath. • return foreskin after catheter insertion. • If paraphimosis occurs seek immediate medical advice. If foreskin is unable to retract due to phimosis: • do not attempt to retract foreskin. • clean underneath foreskin, using cool tap water and syringe.		Instruct the patient to: • find a comfortable position. • use a mirror to visualise urethra, if required Once proficient, the patient may prefer to self-catheterise in the bathroom. Suitable female positions for self-catheterisations may include: • Lie on bed with knees apart • Sitting on toilet or empty bath • Squat against a wall • Stand with one leg raised on toilet, bath or stool.

Equipment Required

- Catheter selected must be appropriate for the patient's: preference and manual dexterity. Unless specifically requested by Medical Officer:
  - Male size: 14 - 16 Fg/Ch
  - Female size: 12 - 14 Fg/Ch
- Select lubricant gel as appropriate: water based with/without anaesthetic. An anaesthetic gel may be required initially, but encourage patient to use water based gel prior to discharge.
- Consider patient need for assistive splint or prosthetic device to aid self-catheterisation.
- Will need:
  - self-catheterisation patient information e.g. Healthy WA – Your self-intermittent catheter
  - measuring container to collect urine
  - clean flannel, soap and warm water or moist wipes
  - waterproof sheet e.g. bluey
  - appropriate lubricant gel
  - appropriate catheter
  - mirror.

Procedure

If appropriate, encourage patient to void before catheterising. Maintaining patient privacy at all times, instruct the patient to:

1. Wash and dry hands.
2. Place unopened catheter packet, plastic side facing downwards on a clean, dry, flat surface.
3. Peel back from the coloured end of the catheter for 5 cm.
4. Gently grasp hold of the funnel to prevent it from flicking out of packet.
5. Slowly peel back the paper side of the packet and remove completely without touching the catheter. The catheter should remain in the clear packet.
6. Apply lubricant onto the tip, and about 6cm along the length of the catheter.
7. Wash genitalia with soap and water or moist wipes. Male: Retract foreskin as appropriate
8. Adopt comfortable position. Demonstrate use of splint if appropriate. Wash and dry hands.
9. Without touching the catheter (that is, grasp hold of it through the packet) pick it up and hold it like a pen in your dominant hand and peel back the clear packet to reveal the tip of the catheter.

Male Patient Procedure	Female Patient Procedure
Continue to instruct patient to: • Using non-dominant hand hold the penis upwards toward the stomach. • Gently but firmly push the catheter into the penis 5 cm. Hold the shaft of the penis firmly so that the catheter does not fall out and peel back the paper to expose another 5 cm of catheter to be inserted. Continue to insert the catheter in this way. Hold the shaft of the penis firmly so that the catheter does not fall out and continue to insert the catheter until urine flows. Advise the patient that some resistance may be felt at the prostate gland and closed sphincter muscle. If catheter will not advance: **Do not force.** Encourage the patient to: • Cough and/or bear down as if trying to void • Deep breathe whilst keeping gentle pressure against the resistance. If difficulties continue, remove catheter and liaise with Medical Officer/ General Practitioner/Senior Clinician. • Patient should feel a give once past this resistance, and can advance catheter 2cm past the point where urine flows. • Direct the flow of urine into toilet or container. Continue to hold catheter and return penis to natural position while urine draining.	Continue to instruct patient to: • Gently part the labia with the non-dominant hand to expose the urethral meatus. • If urethral meatus difficult to visualise, without moving hand position, gently pull upwards until urethral meatus is seen. Using an upward and backward direction, gently insert the catheter into the urethra and advance until urine flows. If the catheter does not advance: **Do not force.** • Remove catheter and contact Medical Officer/Senior Clinician. If the catheter goes into the vagina. Remove the catheter and try again with another clean catheter. • Direct flow of urine into toilet or container. Continue to hold onto catheter until flow of urine stops.

When the urine flow has stopped, continue to instruct patient to:

- cough or press gently over the suprapubic area to expel any remaining urine
- slowly withdraw catheter. If urine begins to flow again, stop withdrawing catheter until flow stops, then continue to remove
- wash and dry genitalia with soap and water. Male: Return foreskin as appropriate
- dispose of catheter in rubbish bin, or wash, dry and store for reuse.

Post Procedure

- Wash and dry hands.
- Provide opportunity for the patient to discuss information contained within self-catheterisation patient information.
    - Healthy WA – Your self-intermittent catheter
- Discuss the required frequency of self-catheterisation.
- Advise the patient to document both voided (if appropriate) and catheter drained urine volume in catheter diary.

Intermittent Catheter for Use – Community Setting Only

For patients undertaking SIMC in the community setting:

- Reinforce the importance of good hand and personal hygiene without the use of gloves, using a clean technique at each SIMC.
- Provide patient information e.g.
    - Healthy WA – General Hygiene Tips for your catheter
    - Healthy WA – Caring for your catheter

Continence Nurses Society Australia (CoNSA) Recommendations on single versus reuse of urinary catheter drainage bags and catheters for intermittent catheterisation (June 2017).

- Nurses who provide advice to clients about using medical devices that are labelled for single use should be aware of the TGA guidelines.
- Nurses who provide advice to clients about using a medical device should check and adhere to the manufacturer's 'Instructions for Use'.
- Organisational policies and practices should align with the TGA guidelines.

Appendix 4 Indwelling Catheter Management

Key Principles

- Assess patient's clinical requirements daily for ongoing need for indwelling catheter insertion[3].
  - Remove catheter as soon as possible if not required.
- Routine daily personal hygiene is required for ensuring urethral meatus cleanliness[7,8].
  - Use of antiseptic solutions for routine urethral meatus cleansing is unnecessary.
  - Ensure uncircumcised patients clean underneath foreskin.
  - Liaise with a Continence Advisor or Senior Clinician to replace the catheter if gross faecal incontinence or contamination occurs.
- Manage urine drainage system to minimise risk of catheter associated infection[3,8]:
  - Maintain a closed urine drainage system.
  - Position drainage bag below the level of the bladder.
  - Place drainage bag on hook or stand that prevents contact with the floor.
  - Empty urine drainage bag frequently enough to maintain urine flow and avoid reflux.
  - Use only heat sanitised measuring jug to empty catheter drainage bags. Ensure there is no contact between the jug and the urine drainage bag when emptying[8].
  - Position urinary catheter securement device near the catheter-drainage system connection point to avoid kinking and to reduce urethral trauma[1].
  - Replace sterile single use 2L drainage bags daily.
  - Collect a catheter specimen of urine (CSU) for culture only if clinically indicated. Obtain specimen from a sampling port using an aseptic technique[8].

Procedure

For catheter insertion procedures document the following details[1]:

- Date, time and rationale for insertion.
- Type, size and length of catheter.
- Properties of the catheter, balloon volume, 2-way/ 3-way.
- Brand and batch/lot number.
- Any difficulties relating to insertion procedure.
- Problems/abnormalities during procedure such as blood as meatus/cystostomy site
- Discussions or referrals to Continence Advisor, Nurse Practitioner or Medical Officer.
- Whether a specimen collection obtained and sent.
- The frequency of indwelling/suprapubic changes or intermittent regimen.

For urine drainage procedures and observations ensure to document the following details:[1]

- Volume on the appropriate Fluid Balance Work Sheet
- Colour
- Odour
- Sediment
- Macroscopic haematuria
- Significant blood clots
- Frequency of urinary output measures

Undertake daily assessment of:

- Ongoing catheter requirement
- Condition and suitability of drainage system
- Catheter entry site and securement device for the following issues:
  - Skin integrity, pressure injury, or bleeding
  - Inflammation or signs of reaction to product

Catheter Drainage Devices

Indwelling catheters should be connected to a sterile closed drainage system with a:

- drainage outlet
- urine sampling port
- non-return valve.

Selecting the appropriate drainage system requires the following considerations[1]:

- Reason for catheter insertion
- Intended duration of catheterisation
- Infection risk and control issues
- Patient preference and mobility

Types of catheter drainage bags[1]:

- Drainage bag with hourly measurement chamber
- Large capacity bags:
  - Placed on stand or hook for bedside hanging.
  - May be attached to drainage tap of leg bag.
- Leg bags:
  - Useful for ambulant patients.
  - Held in place with two elastic straps or stocking type holder.
  - Worn discretely under clothing, maintains patient dignity and comfort.
  - Leg drainage bags require more frequent opening of closed sterile system, increasing risk for catheter associated urinary tract infection.

Emptying a urinary catheter drainage bag:

Equipment Required

- 70% Isopropyl alcohol swabs
- Sanitised measuring jug
- Non-sterile gloves

Procedure

1. Perform hand hygiene and don gloves.
2. Clean outlet valve with alcohol swab and allow to air dry.
3. Ensuring jug does not touch outlet valve, open tap and allow urine to drain.
4. Once drained close tap and wipe tap with alcohol swab.
5. Dispose of urine. Measure and document amount as appropriate.
6. Decontaminate jug via ward autoclave or utensil decontaminator.

Potential Problems

Table 2: Troubleshooting Catheter Management Issues

Issue	Possible Cause	Suggested Actions
Inability to tolerate indwelling catheter	Urethral mucosa irritation Bladder / pelvic spasm Radiation cystitis Psychological trauma	Liaise with medical staff or senior clinician, and if directed: Remove the catheter and seek alternative means of urine drainage. Consider pharmacological management. Explain the need for and functioning of the catheter.
Reduced urine drainage	Kinked drainage tube	Inspect the drainage system and straighten kinks.
	Blocked catheter e.g. pus, urates, phosphates, blood clots	Liaise with the medical staff or senior clinician, and if directed: Consider bladder washout, if 3-way catheter insitu. Refer to Bladder Washout Flush or replace indwelling catheter.
	Reduced balloon volume	Holding the catheter to prevent movement, deflate the balloon and re-inflate with the exact volume of required sterile water.

Continued…

Issue	Possible Cause	Suggested Actions
Leakage around catheter	Inappropriate catheter size	For IDC only: consider re-catheterising the patient using a smaller sized catheter.
	Balloon size	Select catheter with 10 mL balloon. Only use recommended volume of water for balloon inflation. Under or over inflated balloons can cause bladder irritation
	Bladder hyper-irritability	Bladder hyper-irritability may require pharmacological treatment.
	Urinary tract infection	Assess for signs of UTI. Liaise with medical staff or senior clinician.
	Bladder neck erosion	Ensure catheter is adequately secured to prevent tension. Liaise with medical staff or senior clinician.
Pain post insertion	Urethral mucosal trauma.	Determine aetiology of trauma. May include: Creation of urethral false passage Too rapid insertion of catheter Catheter insertion carried out incorrectly Consider pain relief.
Pain post insertion	Inappropriate catheter size	For IDC only: Consider re-catheterisation using a smaller size.
	Catheter movement in urethra	Consider more appropriate catheter securing device. Some movement of catheter is to be expected
	Reaction to catheter material	Assess for localised signs of redness or swelling. Consider changing catheter type.

Appendix 5 Removing an Indwelling Catheter

Unidentified urinary retention following indwelling catheter (IDC) removal may lead to long-term bladder injury.

Pre-Procedure

- Always undertake bladder monitoring following the removal of an IDC.
- Consider removing IDC at 6am to promote a larger volume first void and commence a normal voiding pattern.
- Ensure any constipation issues, if present, are addressed prior to removal of IDC.

Equipment Required

- Refer to IDC inflation/deflation port and amount recorded in the patient health record to determine syringe size required for deflating balloon volume.
  - Syringe for balloon deflation
  - Non-sterile gloves
  - Waterproof sheet e.g. bluey
  - Clean flannel, soap and warm water or moist wipes
  - Disposal bag.

Procedure

1. Perform hand hygiene and don gloves at appropriate moments throughout procedure.
2. Explain procedure to patient and obtain appropriate consent.
3. Ensuring privacy and chaperone considerations, position the patient comfortably.

Male Patient	Female Patient
• Supine position. • Patient may experience some mild discomfort as the catheter passes through the prostatic urethra.	• Supine with knees bent, hips flexed (and supported or not) heels together or feet apart. Or: • Supine with one knee bent and supported, and one knee straight.

4. Remove drainage bag from leg or drainage bag holder.
5. Place protective sheet under catheter.
6. If visibly soiled, wash around the urethral meatus using flannels or moist wipes.
7. Attach the syringe to the balloon inflation/deflation port.
8. Allow balloon to passively deflate, and then gently aspirate the syringe to ensure complete balloon deflation. Liaise with Medical Officer, Senior Clinician or Continence Advisor if unable to deflate balloon. Do not cut catheter
9. Ask the patient to breathe in and out slowly. As the patient exhales, gently remove the catheter. Do not use force to remove catheter. Seek assistance from Medical Officer, Senior Clinician or Continence Advisor if IDC cannot be removed.
10. Ensure genital area is clean and dry. Assist patient to reposition and redress.
11. Measure output in drainage bag.

12. Dispose of equipment appropriately, remove gloves and perform hand hygiene.
13. Document date and time of catheter removal and any complications in patient health record.
14. Instruct the patient to inform clinical staff of any pain, discomfort or voiding difficulties experienced post IDC removal, and that clinical staff will monitor the patients voiding pattern post IDC removal to ensure a return to normal bladder function.

Post Procedure

Monitor bladder function by undertaking: Fluid Balance Chart, Bladder Assessment and Trial of Void.

Fluid Balance Chart[13]

- A comprehensive fluid balance work sheet needs to be maintained for a minimum of 24 hours or until discharge (if less than 24 hours).
- Measure and document all voids.
- Unless clinically contraindicated, encourage oral fluid intake: one cup (250mL) of water per hour, plus tea/coffee.
- Refer to WACHS Clinical Observations and Assessments Clinical Practice Standard (physiological, neurovascular, neurological and fluid balance)

Bladder Assessment

- Undertake bladder scan if patient has not voided for 4-6 hours following IDC removal.
- Measure post void residual (PVR) volume for the first 3 voids to ensure adequate bladder emptying.
- Refer to WACHS Bladder Management Continence Clinical Practice Standard for advice regarding urinary retention management.

Trial of Void (TOV)

A TOV following catheter removal is undertaken to determine the patient's ability to successfully urinate. A formal TOV is performed after the removal of an IDC for all patients who have had a catheter insitu, where urinary catheterisation is not their normal bladder management.

Further consideration may be required for those patients with previous:

- High residual urine
- Post-operative urinary retention
- Urology or gynaecology surgery

Plan and undertake TOV as soon as safe and feasible. The most common method for TOV following IDC removal is to:

- Encourage fluid intake
- Allow bladder to fill and void naturally
- Monitor urine output over time.

Appendix 6 Bladder Washout

Refer to the following in conjunction with this appendix:

- Australian Commission on Safety and Quality in Health Care National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines for information relevant to bladder irrigation (intravesicular infusion) labelling.
- WACHS Chemotherapy Administration Clinical Practice Standard for information relevant to Intravesical Chemotherapy and Immunotherapy Administration.
- WACHS Bladder Management Continence Clinical Practice Standard for information relevant to undertaking Bladder Assessment and Scanning.

Continuous Bladder Washout (CBWO) also known as Closed Continuous Bladder Irrigation is the continuous flushing and draining of the bladder to prevent the formation and retention of blood clots. CBWO is indicated after the following procedures:

- Trans Urethral Resection of Prostate (TURP)
- Trans Urethral Resection of Bladder Tumour (TURBT)

CBWO may also be indicated for macroscopic haematuria, and other clinical indications.

Manual Bladder Washout (MBWO), also known as Open Intermittent Bladder Irrigation is the intermittent flushing and draining of the bladder to resolve clot retention and restore urine flow. Manual Bladder Washout is not to be attempted in the following:

- Ureteric re-implantation
- Bladder repair
- Suspected bladder trauma
- Radical prostectomy.

Pre-Procedure

- The patient has received information relating to the intended procedure, and has given appropriate consent.
- Patient identification and procedure matching processes are undertaken.
- Maintain patient privacy and dignity.
- Offer the presence of a chaperone where appropriate to patient and clinician requirements.
- Provide the opportunity for an accredited interpreter and/ or Aboriginal Liaison Officer where appropriate to the patient's language or communication requirements. (See WA Health Language Services Policy.)

Infection Control Considerations

Staff are to comply with the specific requirements for hand hygiene, aseptic non-touch technique and personal protective equipment, in alignment with the WACHS Infection Prevention and Control Policy.

Undertake Continuous and Manual Bladder Washout as an aseptic procedure.

- Maintain a sterile closed irrigation and urinary drainage system.
- If outer cover of irrigation fluid bag is removed and fluid not used, sterility of contents is ensured for 24 hours.
- Ensure to label irrigation fluid bag with date and time of opening.

Staffing Requirements

- Staff undertaking continuous or manual bladder washout, are required to maintain the level of competency and continuing professional education necessary for this role.
- Initiation of continuous and manual bladder washout requires a Medical Officer decision.
- Continuous bladder washout management requires a minimum of one staff member skilled to undertake the procedure.
- Assistance may be required for the procedure dependent upon patient condition.
- Manual bladder washout requires two staff members to maintain strict asepsis during procedure.

Refer to Staffing Requirements section

Continuous Bladder Washout Procedure

Equipment

- Ensure patient has 22 French, 3-way catheter insitu. Refer to Appendix 1 Urinary Catheter Insertion.
- If reservoir system required refer to Senior Clinician.
    - 2 x 2000mL 0.9% sodium chloride for irrigation
    - 4L urinary drainage bag (with pump ball)
    - Catheter strap or securing device
    - Non-sterile gloves
    - Alcohol swabs
    - Large sanitised measuring jug
    - Decontaminated dressing trolley
    - Large disposal bag
    - Intravenous (IV) stand
    - Fluid balance chart
    - Bladder Washout chart
    - Plain stickers and Irrigation line labels
    - Marker pen

Procedure

1. Perform hand hygiene and don/change gloves at all appropriate moments.
2. Remove protective cover from Y-tube irrigation set. Clamp lines closed.
3. Using a non-touch technique, spike both bags of irrigation solution.
4. Open one clamp and prime line, close clamp. Repeat for second line.
5. Place IV stand at end of bed. Hang one bag of irrigation solution to IV stand.
6. Label bag in numerical order with sticker
7. Securing with extension hook or tape, hang the second bag lower.
8. Label bag with: Reservoir indicating date and time.
9. Using a non-touch technique swab catheter irrigation lumen with alcohol swab and connect primed irrigation line.
10. Using a non-touch technique swab catheter drainage lumen with alcohol swab and attach 4L urinary drainage bag.
11. Ensure catheter is secured to the patient's leg using securement device or catheter strap.
12. Open clamps on both irrigation bags.
13. Titrate the flow rate of irrigation fluid sufficient to ensure the urine output is not heavily blood stained.
14. Aim to maintain output colour of: light rose, straw or clear.
15. A start rate of 500mL hour is recommended.
16. If the output becomes darker blood stained increase flow rate.
17. If the number of clots increases, increase flow rate.

Continued…

18. Bright red urine output: may indicate an arterial bleed. If this occurs:
    - increase flow rate and undertake patient observations
    - immediately contact Medical Officer or Senior Clinician
    - at the completion of each irrigation bag close the flow clamp of the nearly empty bag.
19. Using a non-touch technique, disconnect nearly empty irrigation bag and connect new bag.
20. Ensure new bag is consecutively labelled.
21. Empty the 4L urinary drainage bag and measure contents.
22. Document on appropriate charts:
    - Date, time and bag number.
    - All irrigation input.
    - All urine output and colour, where:
        - Urine Output = Balance of total irrigated fluid (volume in) – volume drained out. **NB:** Hourly urine measurements are not accurate with bladder washout in progress

Catheter Obstruction Management Procedure

Clamp irrigation bags, and close roller clamps. Provide support to patient throughout procedure.

1. Assess urine output volume, urinary drainage and bladder irrigation system.
    - Review the patient's fluid balance and bladder irrigation chart for evidence of urine/ irrigation fluid retention.
    - Assess urinary catheter and drainage tubing for:
        - patency
        - leakage
        - kinking – resolve if found
        - traction – resolve if found
        - securement of device – ensure catheter is adequately secured to patient's thigh
    - Assess bladder irrigation system for:
        - remaining volume
        - height of stand – reposition to above the height of bed head if required
        - level of fluid in drip chamber
    - Assess urinary drainage bag for:
        - amount
        - colour / Consistency
        - position – reposition to below the level of patient's bladder if required
2. Attempt to clear obstruction
    - Attempt to milk catheter tubing.
    - If catheter remains obstructed, and pump ball attached to urinary drainage bag proceed to clear obstruction.
    - Advise patient of intended procedure and potential discomfort. Offer analgesia as required.
    - Close distal clamp.

- Ensuring the proximal clamp remains open, squeeze the pump ball twice. This action will attempt to expel any clots on the end of the catheter.
- Release the distal clamp and assess if any urine drains.
- If urine drainage recommences:
  - Assess urine colour and volume. Continue to monitor colour.
  - Recommence continuous bladder washout.
  - Inform Medical Officer or Senior Clinician and Shift Coordinator of procedure.
  - Document details of procedure in patient health record.
- If nil urine drainage:
  - Inform Medical Officer or Senior Clinician
  - Proceed to Manual Bladder Washout.

Manual Bladder Washout Procedure

Considerations

- Prior to commencing a Manual Bladder Washout, ensure:
  - catheter or drainage tubing is not kinked.
  - urinary drainage bag is below the level of patient's bladder.
- Consider patient clinical and procedural requirements:
  - Where a two or three lumen catheter is insitu or required.
  - With or without Continuous Bladder Washout in progress.
  - Appropriate patient clinical and procedure requirements for undertaking bladder scan. Refer to
  - WACHS Bladder Management Continence Clinical Practice Standard
- Nominate proceduralist and assistant.
- Undertake actions as appropriate to maintaining strict aseptic non-touch technique.

Equipment

- Only use syringes intended for urinary catheter use.
- Contents may vary where specific sites have pre prepared urinary catheter insertion packs.
  - 1 x 1L sterile 0.9% sodium chloride for irrigation
  - 4L urinary drainage bag (with pump ball)
  - Urinary catheter insertion pack
  - 50mL catheter tip syringe
  - Sterile and non-sterile gloves
  - Sterile artery forceps
  - Catheter drainage lumen cleansing solution
  - Decontaminated dressing trolley
  - Sterile jug/cup/bowl
  - Container for waste fluid
  - Bladder Washout chart
  - Fluid balance chart
  - PPE for splash risk protection
  - Waterproof sheet e.g. bluey
  - Large disposal bag

Procedure

1. Perform hand hygiene and don/change gloves at all appropriate moments.
2. If continuous bladder washout in progress:
   a. close roller clamp to cease irrigation. Leave system intact.
3. Using a non-touch aseptic technique, assemble required equipment.
4. Advise patient of potential discomfort and offer analgesia as required.

5. Ensuring privacy, position patient in supine position, with waterproof sheet under buttocks.
6. Place sterile fenestrated drape on patient. Ensure to expose catheter and drainage tubing through fenestration.
7. Using a non-touch technique swab catheter and drainage bag tubing with cleansing solution.
8. Disconnect urinary drainage bag with sterile towel. Dispose.
9. Place catheter drainage lumen into sterile kidney dish placed between patient's thighs.
10. Fill sterile jug with 0.9% sodium chloride for irrigation. Draw up 50mL into catheter syringe.
11. Using non-touch technique connect syringe to catheter drainage lumen.
12. Instil and aspirate 50mL sterile 0.9% sodium chloride via catheter drainage lumen.
13. Clamp catheter drainage lumen.

Do not use excessive force during manual bladder washout.

For the following procedures:

- TURP: use moderate instillation and aspiration force only.
- TURBT: avoid using any instillation and aspiration force.

Stop procedure and liaise with Medical Officer or Senior Clinician.

- If excessive resistance is encountered or,
- **no** fluid is able to be aspirated.

14. Disconnect syringe and expel fluid into waste container.
15. If large amounts of clots are observed: repeat flushing procedure until contents are clear. Measure and document fluid amounts instilled and aspirated.
16. Using a non-touch technique connect new urinary drainage bag.
17. Recommence continuous bladder washout if currently in progress.
18. Dispose of all waste appropriately. Perform hand hygiene.
19. Continue to monitor urine drainage: Assess urine colour and volume.
20. Inform Urology Medical Officer or Senior Clinician and Shift Coordinator of procedure.
21. Document details of procedure in patient health record.