SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Urinary Catheter Management in the Community Setting
TYPE OF DOCUMENT	GUIDELINE
DOCUMENT NUMBER	SESLHDGL/065
DATE OF PUBLICATION	February 2025
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1: Clinical Governance Standard 3: Preventing and Controlling Healthcare Associated Infection Standard 8: Recognising and Responding to Acute Deterioration
REVIEW DATE	February 2028
FORMER REFERENCE(S)	SGSHHS CBR. 2016. Urinary Catheter Management in the Community Setting
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Aged Care and Rehabilitation
AUTHOR	Jinwa Li (CNC) Lisa Sothern (CNC) Madhuri Manandhar (CNC) Lisa Malcolmson (CNS)
POSITION RESPONSIBLE FOR DOCUMENT	SESLHD Clinical Stream Manager, Aged Care & Rehabilitation Jane.Treloggen@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Nursing and Midwifery
KEY TERMS	Catheterisation, Urethral, Community Setting, Suprapubic
SUMMARY	Provide community nurses with guidance for the assessment, insertion, removal and management of indwelling catheters in the community setting.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Table of Contents

Section 1 - Background

The change of an Indwelling Urinary Catheter (IUC) in the community setting is a routine procedure that facilitates direct drainage of urine from the bladder, by urethral or supra pubic methods. As in acute care settings, it is essential that aseptic technique and the use of sterile equipment and supplies are observed to ensure patient safety and infection prevention.

The community setting presents clinicians with unique work health and safety challenges, so it is important to ensure a safe, clean environment for both the patients and clinicians. Additionally, it is important to ensure that spare equipment is on hand in case of an accidental breach in asepsis or an emergency situation.

Any need for change of type or gauge of catheter size will be determined in consultation with the Community Continence/Urology CNC as per the client's re-assessment.

Ensure the client has a set up area in their home which is an appropriate size, location and height (if possible) and position a rubbish bag for quick and easy disposal of rubbish and previous catheter and empty drainage equipment.

If client is at high risk of Autonomic Dysreflexia (AD) at time of community catheter change and/or has experienced AD at time of catheter change, consider that the client's IUC may need to be changed in a hospital setting (outpatient clinic or inpatient) where medical intervention is available.

Section 2 - Definitions

AD	Autonomic dysreflexia: A medical emergency which can occur in spinal cord injured clients (SCI) at or above the thoracic vertebra 6 level. It is characterised by sudden acute uncontrolled hypertension, it results from widespread reflex activity of the sympathetic nervous system below the level of injury, triggered by an ascending sensory stimulus. Autonomic Dysreflexia requires immediate attention and can be life threatening. Client at risk of Autonomic Dysreflexia should not have their catheter clamped prior to catheter change as clamping the catheter may cause AD (ACI, 2024).
ANTT	Aseptic Non Touch Technique
Bifurcation	The junction where the urethral catheter divides into two
Catheter maintenance Solutions (CMS)	Catheter maintenance solutions are pre-packaged sterile solutions ready for administration and come in 50mL or 100mL flasks (and twin flasks). These solutions act to reduce debris within the catheter. Catheter maintenance solutions are defined for the purpose of this document as most commonly: • Normal Saline (0.9%) • Citric acid 3.23% • Citric acid 6% PHMB 0.2% Polihexidine
CAUTI	Catheter Associated Urinary Tract Infection
Closed Drainage System	The drainage system consists of indwelling urinary catheter and a sterile urine drainage bag attached to the catheter. This forms a pathway that goes from the tip of the catheter inside the bladder to the urine bag. It is a closed drainage system when there are no leaks or disconnections. The urinary system normally is sterile and a closed drainage system prevents microorganisms from entering.
CNC	Clinical nurse consultant
CNA	Continence Nurse Advisor
Constipation	The normal bowel opens easily without straining varying between three times per day to three times per week with type 3 or 4 stool (Bristol Stool Chart). Constipation can present as straining when toileting, hard stool, bowels opening less than three times a week, abdominal discomfort and/or distension, feeling of incomplete evacuation, or overflow faecal incontinence related to a loaded bowel / constipation. REMEMBER: the most common cause of faecal incontinence is constipation.
Coude Tip/ Tieman Tip Catheter	Curved tip IUC used to enable insertion of a male urethral catheter for some men with an enlarged prostate or urethral stricture. Registered Nurses must be assessed as competent to insert this type of IUC.
GCN	Generalist Community Nurse
IUC	Indwelling urinary catheter
Paraphimosis	A urological emergency that can occur in uncircumcised men only, whereby the penile foreskin once retracted and left in that position may be difficult to return to its original position. Paraphimosis can occur after male urethral catheter insertion in the uncircumcised male. The retracted foreskin may become a tight band of preputial skin (foreskin) causing vascular occlusion, resulting in oedema leading to ischaemia of the glans penis.
PPE	Personal Protective Equipment
Residual volume	The urine obtained following the insertion of the catheter until the initial flow of urine ceases, usually after 15- 20 minutes

SCI	Spinal Cord Injury
SPC	Suprapubic catheter: A catheter positioned in the bladder through the abdominal wall via a surgically made fistula
Urethral catheterisation	Insertion of a catheter through the urethra into the bladder.
UTI	Urinary tract infection

Section 3 - Responsibilities

All nursing staff are required to:

- Complete mandatory training as outlined in Section 13
- Adhere to work health and safety policy directives as outlined in NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Practice Procedures.

Enrolled Nurses (EN) are responsible for:

- Providing educational instruction and material to clients with IUCs
- Attending physical assessment of clients with IUCs
- Ensure arrangements for follow up for initial home visit are attended within a period of time as specified by hospital guidelines
- Escalating concerns, or abnormal findings to case manager (RN) in a timely manner.

Registered Nurses (RN) are responsible for:

- Providing educational instruction and material to clients with IUCs
- Ensure arrangements for follow up for initial home visit are attended within a period of time as specified by hospital guidelines
- Attending physical assessment of clients with IUCs
- Establishing and maintaining aseptic technique/sterile equipment throughout the procedure
- Escalating concerns, or abnormal findings to NUM/CNC/CNS in a timely manner.

Clinical Nurse Specialists are responsible for:

- Providing education and competency assessments of ENs/RNs
- Supporting community nursing staff and advanced skills/trouble shooting of difficult or advanced catheter placements
- Escalating concerns, or abnormal findings to Continence CNC, Urology doctor in a timely manner.

Clinical Nurse Consultants are responsible for:

- Providing education and competency assessments of ENs/RNs
- Supporting community nursing staff and advanced skills/trouble shooting of difficult or advanced catheter placements
- Escalating concerns, or abnormal findings to Urology doctor in a timely manner.

Medical officers are responsible for:

- Completing the medical authority for catheter insertion/change (according to hospital guidelines)
- Reviewing and assessing patients referred by the CNC/CNS.

Section 4 - Procedure

4.1 General Precaution:
A urinary catheter is inserted using a safe and aseptic technique[3] to facilitate drainage of urine from the bladder.

Insertion of an indwelling urinary catheter must only occur after completion of SESLHD Authority for Catheterisation by the relevant medical officer and patient consent.

Caution should be taken when:

- There is concern or possibility of having to use force to insert the catheter
- The previous / last change of catheter by SESLHD required hospitalisation
- The client is currently receiving chemotherapy/radiotherapy
- The client has an artificial urinary sphincter implant
- The client has advanced bladder, urethral or prostate cancer
- The client has recently experienced paraphimosis.

Please Note:
First SPC change after insertion **must** be done by the Urology CNC, Continence CNC or CNS2 as a **joint visit** with the primary nurse. If the first SPC change has been performed by the attending Urologist or at the hospital urology clinic, and there are no identified clinical issues with the catheter change, then the primary nurse can perform the "first" community SPC change.
Prior to urethral catheterisation if the reason for the catheter is listed above, the Continence CNC and Continence CNS must be consulted and there must be a clear directive from the Urologist or Specialist Medical Officer.

Maintain Standard Precautions as per SESLHDPD/271 - Aseptic Technique and SESLHDPR/343 - Bare Below the Elbows.

Observe Work Health and Safety principles and adhere to manual handling guidelines as per NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Practice Procedures.

Please Note:
Check if the patient is taking any cytotoxic medication (topical, oral, intramuscular or intravenous). Refer to SGH-TSH CLIN083 *Cytotoxic Waste - Management of* within SESLHD policy and procedure Cytotoxic Drug Administration and Management of Body Waste.

Refer to SGH-TSH CLIN201 *Cytotoxic medication – including staff training, administration, extravasation management, patient identification, and documentation requirements* for Drug Administration and Management of Body Waste to determine what Personal Protective Equipment (PPE) is required. If possible, postpone catheter change until after period of risk.

The catheter balloon should be 5–10mL capacity (consult with Continence CNC or Urologist if required <10 mL) and only sterile water is to be used for inflation. Use of normal saline may cause blockage of the inflation channel. Silicone catheters can allow diffusion of water from the balloon into the bladder. Large catheters and balloons have been associated with pressure necrosis and increased bladder irritation resulting in bladder spasm and urine bypassing the catheter (Pomfret, 2006).
Nurses must complete the Catheter Management Care Plan in the Patient Clinical Record.
Clients /carers must be educated regarding the general care of the catheter by the nurse. SESLHD Client information booklets 'How to care for your urinary Catheter - Information for Patients' are available to client.

The RN must be familiar with the Catheter Troubleshooting Guide (Appendix A).

Catheter Materials

- 100% Silicone is the preferred material.
- Latex catheters with hydrophilic/hydrogel coating (eg: Bard Biocath) are sometimes used by clients with no known latex allergy.
- Silastic Catheters contain both latex and silicone and cannot be used by clients with latex allergies.
- 100% latex catheters have been linked to urethral strictures, encrustation and urethritis due to toxicity and as such, are not recommended (Jane Hall et al., 2020).
- 100% silicone and hydrogel-coated catheters are less irritative compared with silicone-coated latex catheters. NSW Health aims to eliminate the use of latex as far as possible from NSW public health facilities.
- Less commonly used catheter materials include silver alloy hydrogel-coated silicone and antibiotic-coated catheters. These catheters are designed to reduce the incidence of urinary tract infection but should not be initiated without review by the Continence CNC and authorisation by a medical officer (Jane Hall et al., 2020).
- Specially designed suprapubic Foley catheters are available (e.g. “Supracath”) to reduce the incidence of catheter blockage.

Latex Allergies

- Any client with a coated latex catheter should be checked for latex allergy – as noted in the Client’s Medical Surgical History.
- The RN should not initiate the use of a catheter containing latex without consulting with the Client, Continence CNC or Medical team

Section 5 - Equipment

5.1 IUC Equipment:

- Clean trolley or work surface.
- Catheter pack containing:
  - 1x White plastic field 70x70cm
  - 2x OPS long tray
  - 1x urinary catheter securement device
  - 5x gauze swabs
  - 1x lubricating jelly sachet
  - 1x sodium chloride ampoule
  - 3x forceps green
  - 1x prefilled 10mls syringe
  - 1x fenestrated drape
  - 1x medical towel 30x50cm
- 2 way catheter strap
- Waste bag
- Specimen jar (if required)
- Blue disposable sheet
- 1x 10mL syringe
- Lidocaine (lignocaine) Hydrochloride 2% gel
- Catheter leg bag clamp
- Sterile gloves (1-2 pairs)
- PPE:
  - Protective eye wear
  - Disposable protective apron or gown
  - Disposable gloves

5.2 Drainage Equipment:

- 1 x sterile catheter appropriately sized
- Sterile drainage bag and/or catheter valve

5.3 Emergency Catheter Equipment:

- 14fg,16fg,18fg sterile Nelaton catheters (SPC changes)
- Spare 14fg, 16fg, 18fg sterile Balloon Foley catheter (as individually required)
- Spare complete catheter change pack (see above 5.1)
- Spare sterile drainage equipment
- Coudé Tip/Tiemann 16fg (as per scope/competency)
- 1 x spare pair sterile gloves

Section 6 - Urethral Urinary Catheterisation in the Community

6.1 Indications for Indwelling Urinary Catheter (IUC)

- To relieve urinary retention
- To manage fistula and promote healing
- To preserve skin integrity
- To provide end-of-life care

6.2 Recommendations for Urethral Urinary Catheter (IUC) Changes in the Community

- Community clients should be contacted the day prior to the visit to confirm appointment and encourage oral fluids (be mindful of those clients who are on oral fluid restriction).
- The client should be encouraged to wash their genitals with soap and water or take a shower before procedure.
- Read the client's notes and be aware of any clinical risks at catheter change for the individual client living in the community setting including enlarged prostate gland, anticoagulants, SCI, history of AD, male catheter change, past difficulties with catheter, fluid restriction, history of constipation.
- The client's **urethral** catheter should be clamped or removed at least 20 minutes prior to each change.

  ALERT:
  - Do not clamp or remove the **urethral** catheter in client with history of Spinal Cord Injury (SCI) above T6.
  - However, these clients should be told to drink well two (2) hours prior to catheter change (risk of AD)
- Clamping or the removal of the previous urinary **urethral** catheter for a short duration prior to insertion of the new catheter, allows the nurse clinician to:
  - Confirm catheter is placed into the urinary bladder
  - Observe the type of urine draining from the bladder
  - Observe urine flowing through the catheter from the urinary bladder prior to inflation of the catheter balloon
- If the client is incapable of clamping the catheter or non-compliant the RN should remove the **urethral** catheter and discard the catheter and drainage equipment when first arriving at the client's home, then wait for at least 20 minutes before inserting the new **urethral** catheter to ensure urine drainage from the bladder at catheter insertion occurs.
- The nurse must never leave the client after insertion of the new **urethral** catheter until urine is seen to be draining from the newly inserted catheter.

  ALERT:
  - Male IUC: Insert Foley up to the bifurcation or hub of the male length catheter and wait for urine to drain prior to inflation of balloon.

6.3 Female Urethral Catheter (IUC) Performance

- It is important to observe the site of the female urethral catheter prior to the removal of catheter and again clearly observe the location of the female urethral meatus when the catheter has been removed.
- In the home/community/clinic setting good lighting or a bright well positioned head torch are required to clearly observe the female urethral meatus.
- If experiencing difficulty visualising the female urethral meatus with the client lying on her back, please consider the option of rolling the client on her side with her knees bent to better visualise the female urethral meatus.

- For procedure refer to Table 1. Note, this table can also be used as a tool for observational competency assessment by using the tick column.

Table 1. Female Urethral Catheter Change Procedure

	Community Guidelines for Female Urethral Catheter Change incorporating the Five Moments of Hand Hygiene	**Step performed √**
1	**Perform hand hygiene**	
2	Confirms this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Don personal protective equipment PPE (gloves, apron and eye protection)	
4	Position client on a disposable blue sheet and ensure privacy	
5	Deflate balloon – allow to self-deflate (start by drawing back 0.5 mL) and confirm balloon is completely deflated by slowly drawing back syringe	
6	Position client correctly for procedure and using good lighting observe location of female urethral meatus and gently remove catheter	
7	Observe old catheter for encrustation and blockage and discard, remove gloves and **perform hand hygiene**	
8	Clean the work surface using a neutral detergent wipe and perform hand hygiene Open sterile catheter pack using ANTT, adjust lighting to enable vision of female urethral meatus	
9	**Perform procedural hand hygiene** and don sterile gloves	
10	Arrange equipment on the opened sterile pack and don second pair sterile gloves if using double glove technique	
11	Enclose new catheter in single empty tray and connect full 10mL syringe (containing sterile water) firmly to balloon port, attach suitable sterile drainage equipment (vale or leg bag) firmly and correctly	
12	Ensure tip of catheter is lubricated	
13	Fold fenestrated drape horizontally and place below genital area on client's thighs (to reduce the risk of wetting client or bedding)	
14	Place cleaning tray just below patient's genital area on blue area of folded fenestrated drape	
15	Using dominant hand, pick up moistened cleaning swabs with forceps and clean left and right labia majora. One stroke per swab and one swab for each side, in a downward direction.	
16	Part labia with non-dominant hand, using dominant hand pick moistened swabs with forceps, and clean labia minora and urethral orifice as above. Assess the need for further attention to hygiene.	
17	Use all swabs and all cleaning solution (30 to 60mL), discard tray and if using double glove technique remove outer gloves	
18	Open fenestrated sheet. Ensure good vision can still be maintained of the female urethral meatus	
19	Move the tray containing the catheter onto the fenestrated sheet ensuring drainage end of catheter is in tray, part labia and insert the catheter into the female urethral meatus for approximately 5-7 cm while watching for urine flow. When urine returns, continue to advance catheter another 5 cm or more.	
20	Wait for urine to drain before inflating balloon with 10mL sterile water. If there is no urine flow following insertion, do not inflate balloon and examine patient to ensure catheter is in the urethra.	
21	No resistance to be felt and client should have no discomfort / pain. Gently withdraw catheter till resistance is felt. Attach suitable sterile drainage equipment firmly (valve or leg bag) if not attended in step 11 to reduce risk of catheter/drainage disconnection appropriately and secure catheter with anchoring device (catheter securing device).	
22	Obtain CSU only if clinically indicated	
23	Remove gloves and **perform hand hygiene**	
24	Don non-sterile gloves and anchors catheter to reduce the risk of traction, and client discomfort and pain/urethral injury	

25	Measure the residual urine volume if clinically indicated	
26	Disposes of all urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and **perform hand hygiene**	
27	Maintains ANTT throughout procedure, reinforce patient/carer/family education on catheter management.	
28	Document in "urinary catheter change care plan" in eMR / CHOC	

6.4 Male Urethral Catheter (IUC) Performance

- **NOTE:** If there is a failed first attempt by the RN, the RN is to contact the CNC/CNS who are proficient in using a Size 16 FG Coude/Tiemann's tip catheter. The RN should have one attempt only.
- If attempt with a Coude/Tiemann's tip catheter is again unsuccessful the client should be admitted to the emergency department for review.
- For procedure refer to Table 2. Note, this table can also be used as a tool for observational competency assessment by using the tick column.

Table 2. Male Urethral Catheter Change Procedure

	Community Guidelines for Male Urethral Catheter Change incorporating the Five Moments of Hand Hygiene	**Step performed √**
1	**Perform hand hygiene**	
2	Confirm this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Don personal protective equipment PPE (gloves, apron and eye protection)	
4	Position client on a disposable blue sheet and ensure privacy	
5	Deflate balloon – allow to self-deflate (start by drawing back 0.5 mL) and confirm balloon is completely deflated by slowly drawing back syringe	
6	With non-dominant hand hold penis, retract foreskin if necessary and with dominant hand gently remove catheter	
7	Observe old catheter for encrustation and blockage and discard, remove gloves and **perform hand hygiene**	
8	Clean the work surface using a neutral detergent wipe and perform hand hygiene Open sterile catheter pack, empty top tray by tipping tray from under pack and add all sterile equipment using ANNT	
9	**Perform procedural hand hygiene** and don sterile gloves	
10	Arrange equipment on the opened sterile pack and don second pair sterile gloves (found in pack) if using double glove technique	
11	Enclose new male length catheter in empty tray and connect full 10mL syringe (containing sterile water) firmly to balloon port. Attach suitable sterile drainage equipment (valve or leg bag) firmly and correctly	
12	Adjust nozzle of Lidocaine (lignocaine) 2% gel and expel air	
13	Fold fenestrated drape horizontally and place below genital area on client's thighs (to reduce the risk of wetting client or bedding)	
14	Place cleaning tray just below patient's genital area on blue area of folded fenestrated drape, place Lidocaine (lignocaine) 2% gel below tray on drape	
15	With non-dominant hand, using folded gauze strip hold patient's penis. Retract foreskin if client is uncircumcised. Using dominant hand, pick up forceps and clean entire penis (lastly glans penis) tip to downwards, one stroke per swab using all swabs and all cleaning solution (30 to 60mL). Discard cleaning tray.	
16	Holding penis at right angle to the body (with non-dominant hand), lubricate male urethral meatus with 1mL of lidocaine (lignocaine) gel prior to gently inserting the Lidocaine (lignocaine) Gel nozzle into urethral meatus, inject slowly into the urethra and wait 4 minutes (ensuring firm seal around meatus).	

17	Use forefinger and thumb, clamp the urethra, still maintaining penis at right angel to body. After 4 minutes, carefully place penis on folded dressing towel to keep clean and remove outside gloves (if using double glove technique)	
18	Open fenestrated sheet	
19	Pick up catheter with dominant hand, ensuring drainage end of catheter is in tray, hold penis at right angle to the body (with non-dominant hand) and gently insert the male length catheter. When resistance is felt at the bladder neck point the penis towards the client's feet. Insert all the way to the point of catheter bifurcation.	
20	Hold catheter in place and wait for urine to drain before inflating balloon with 10mL sterile water. During balloon inflation there should be no resistance, client discomfort or pain. Gently withdraw catheter till resistance is felt. Attach suitable sterile drainage equipment firmly (valve or leg bag) if not attended in step 11 to reduce risk of catheter/drainage disconnection appropriately and secure catheter with anchoring device (catheter securing device).	
21	Obtain CSU only if clinically indicated	
22	If the man is uncircumcised, it is very important to reposition his foreskin over the glans penis to prevent paraphimosis, remove gloves and **perform hand hygiene**	
23	Measure the residual urine volume if clinically indicated	
24	Dispose of all urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and **perform hand hygiene**	
25	Maintains ANTT throughout procedure, reinforce patient/carer/family education on catheter management.	
26	Document in "urinary catheter change care plan" in eMR / CHOC	

Section 7 - Insertion of a Supra Pubic Catheter (SPC)

7.1 Indications for SPC Insertion

- Long term catheterisation and quality of life
- No urethral access or urethral trauma
- Failed urethral catheterisation

7.2 Considerations/Precautions for SPC Insertion

- History of bladder cancer
- Obesity
- Thin or underweight
- Anticoagulant use, for example apixaban, rivaroxaban, dabigatran, heparin, enoxaparin, warfarin
- Constipation
- If the client has a history of AD, check if the client has used sildenafil or vardenafil in the last 24hrs or tadalafil in the last four (4) days, as glyceryl trinitrate spray, tablet or patches cannot be used in the treatment of AD.

7.3 Recommendations for SPC Changes

- Community clients should be contacted the day prior to the visit to confirm appointment and encourage oral fluids (be mindful of those clients who are on oral fluid restriction)
- Confirm client has suitable catheter and drainage equipment at home
- Preferable to use clear silicone catheter for SPC insertion where possible to enable the nurse to see urine drainage when it first occurs in the catheter
- Ensure 14fg, 16fg Nelaton catheters are kept in the home and always have spare 14fg, 16fg, 18fg Nelaton catheters and a 14fg, 16fg, 18fg Foley Balloon catheter with you for emergencies
- The client should be encouraged to take a shower before procedure

- Read the client's notes and be aware of any clinical risks at catheter change for the individual client living in the community setting, for example history of problems with past SPC changes, painful or difficult catheter removal or insertion, haematuria, anti-coagulant therapy, constipation, ED visit or recent UTI
- Observe the SPC stoma site for inflammation, discharge or over-granulation
- The old catheter may be marked at point of entry to the SPC stoma with tape if this is helpful to the clinician

  ALERT:
  - Do not clamp the catheter for client with a history of spinal cord injury above T6 and / or a history of AD.
  - However, these clients should be reminded to drink well for two (2) hours prior to catheter change
- Clamp / spigot all other client's catheters at least 20 minutes prior to change.
- Clamping of the previous SPC catheter allows the nurse clinician to:
  - Ensure there is urine in the bladder at time of removal of old SPC catheter
  - Observe the type of urine draining from the bladder when the new SPC catheter is inserted
  - Confirm SPC catheter has been placed into the urinary bladder and remains sitting within the urinary bladder
  - To enable the clinician to observe urine flowing via the SPC catheter prior to inflation of the catheter balloon

  If the client is incapable of clamping the catheter or is non-compliant the RN should clamp the leg bag with a catheter clamp device or spigot the SPC catheter when they first arrive at the client's home, then wait for at least 20 minutes prior to removal and insertion of the new SPC catheter to ensure urine drainage from the bladder
- After inserting the new SPC catheter into the SPC stoma wait for urine to drain before inflating balloon with 10mL sterile water
- Ask the client to cough, or gently apply pressure above the stoma site, if urine slow to drain
- There should be no resistance felt at time of balloon inflation and the client should not feel any pain or discomfort during balloon inflation if the SPC urinary catheter is positioned correctly within the urinary bladder
- The community nurse must never leave the client after insertion of the new catheter until urine is seen to be flowing from the newly inserted SPC catheter.

7.4 SPC Performance

- For procedure refer to Table 3. Note, this table can also be used as a tool for observational competency assessment by using the tick column.

Table 3. Supra Pubic Catheter Change Procedure

	Community Guidelines for Supra Pubic Catheter Change incorporating the Five Moments of Hand Hygiene	**Step performed** √
1	**Perform hand hygiene** and don non-sterile gloves	
2	Confirm this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Don personal protective equipment PPE (gloves, apron and eye protection)	
4	Position client on a disposable blue sheet and ensure privacy	
5	Observe SPC stoma for any inflammation, discharge or over-granulation, ensure urine in the bladder when catheter removed by clamping drainage bag or spigot the catheter	
6	Using 1x10mL syringe deflate the catheter balloon (start by drawing back 0.5 mL) let the balloon passively deflate and then confirm balloon is completely deflated by slowly drawing back syringe. If client is cognitively intact and the clinical risk of SPC catheter falling out is low, balloon may be "self-deflated" **but not removed** at this time to reduce risk of cuffing of SPC catheter. Remove non-sterile gloves and **perform hand hygiene**	

7	Clean the work surface using a neutral detergent wipe and perform hand hygiene Open sterile catheter packusing ANTT. Ensure unopened Nelaton 14fg /16fg/18fg must be available in case of emergency	
8	**Perform procedural hand hygiene** and don sterile gloves	
9	Arrange equipment on the opened sterile pack and don second pair sterile gloves (found in pack) if using double glove technique.	
10	Enclose new catheter fully in single empty tray and connect full 10mL syringe (containing sterile water) firmly to balloon port. Attach suitable sterile drainage equipment (valve or leg bag) firmly and correctly	
11	Ensure tip of catheter is lubricated	
12	Fold fenestrated drape horizontally and place below SPC stoma	
13	Place cleaning tray just below patient's SPC stoma on folded fenestrated drape	
14	Using dominant hand pick up forceps with swabs and clean SPC stoma	
15	Deflate balloon or finish deflating balloon (using non-dominant hand with two hand technique) – allow to self-deflate (start by drawing back 0.5 mL) and then confirm balloon is completely deflated by slowly drawing back syringe to 2mL	
16	Gently rotate and remove SPC, (with non-dominant hand using two hand technique), observe length of SPC removed and discard old SPC catheter.	
17	Remove outer gloves promptly (if using double glove technique)	
18	Open fenestrated sheet	
19	Immediately with dominant hand insert new catheter to the depth and angle of previous catheter, generally about 10cm although this can vary dependent on the abdominal girth of the client ensuring the outflow end of the catheter is in the catheter tray or kidney dish **(Do not insert the catheter so far that it is in the urethra)**	
20	When urine starts to drain, insert catheter 2 to 3 cm further to ensure the balloon is inflated within the bladder. Inflate balloon with 10mL water, (ask client to cough if urine slow to drain). Inflate the balloon in accordance with product recommendations.	
21	Hold SPC catheter at SPC stoma to keep catheter in correct position during balloon inflation, no resistance to be felt and client must have no discomfort / pain at inflation. Gently withdraw catheter till resistance is felt. Attach suitable sterile drainage equipment firmly (valve or leg bag) if not attended in step 10 to reduce risk of catheter/drainage disconnection appropriately and secure catheter with anchoring device (catheter securing device).	
22	Obtain CSU only if clinically indicated	
23	Observe the old catheter for encrustation and blockage and measure the residual urine volume if clinically indicated	
24	Disposes of urine in the toilet, dispose of other catheter equipment in accordance with infection control guidelines and ensure client comfort, remove gloves and **perform hand hygiene**	
25	Maintain ANTT throughout procedure, reinforce patient/carer/family education on catheter management.	
26	Document in "urinary catheter change care plan" in eMR / CHOC	

Section 8 - Insertion of Intermittent Catheterisation

8.1: Equipment

- Sterile procedure when attended by credited health care staff
- Catheter pack containing:
    - 1x White plastic field 70x70cm
    - 2x OPS long tray
    - 1x urinary catheter securement device
    - 5x gauze swabs
    - 1x lubricating jelly sachet
    - 1x sodium chloride ampoule
    - 3x forceps green
    - 1x prefilled 10mls syringe

  - 1x fenestrated drape
  - 1x medical towel 30x50cm
- Sterile gloves X 1 pairs
- Sterile nelaton catheter of appropriate size (12fg, 14fg Female / 14fg,16fg, 18g Male)
- Waste bag

8.2 Non Sterile procedure when observing patient attending self-intermittent catheterisation

- Goggles or face mask with visor
- Plastic apron
- Other PPE as required (e.g. long sleeve gown for Contact 2 Precautions)
- Plastic waste bag
- Towel or waterproof sheet
- Extra lighting if required
- Ensure the following documents are in the Patient Clinical Record:
- Medical Authority requesting Intermittent Catheterisation
- Ensure patient has information booklet (Colaplast, GentleCath QR Code, Holister)

or https://www.gentlecath.com/au/

- Autonomic Dysreflexia Care Plan if the patient has a T6 injury or above

8.3: Indications for Intermittent Catheterisation (IC)

- To relieve urinary retention, urinary dilatation
- As per Urologist order

8.4 Actions

This procedure is the same as described in sections 5 Female Catheterisation and Male Catheterisation except that when the bladder has completely drained of urine, the catheter is withdrawn and disposed of appropriately.

Section 9 – Urinary Catheter flushing in Community

Clients with complex Urological history, please consult with Urology team or Continence/Urology CNCs. Evidence based practise for management of blocked catheter in the community is to change the catheter (Sweeney, 2021). This is a guideline to enable community nurses to flush urinary catheter to maintain patency and lengthen the interval between catheter changes if they are obstructed by sediment. Catheter flushing only required for the following indications below.

Indications of catheter flushing in the community

- Clients who are end of life pathway/ palliation: to avoid trauma of unnecessary frequent catheter change.
- Clients with a blocked catheter that would otherwise by referred to ED
- Reduce the risk of infection in client with recurrent UTI secondary to catheter change.

Cautions / Contra-Indications

- Clients with complex Urological history, please consult with Urology team or Continence/Urology CNCs
- Clients who have had a recent radical prostatectomy
    - Catheter MUST NOT be removed
    - On-call urology registrar should be contacted for advice prior to proceeding
    - An attempt should be made to aspirate first, if this is not successful then a gentle flush of 20mL saline should be performed (process detailed below)
- Client with AD (Autonomic Dysreflexia) risk (Spinal cord injuries above T6)

Actions

All requests for catheter flushing regarding blocked catheter must be reviewed by the Continence CNC/CNS. This review likely ensures client safety, prevents complications, and supports best practices for catheter care in the community.

Urinary Catheter flushing for blocked catheter

9.1 Equipment

- Sterile dressing pack
- Catheter tip 50mL syringe (e.g. BARD Toomey Irrigation Syringe with catheter tip and adaptor)
- Normal saline 20mL
- Non sterile gloves or sterile gloves depending on procedure
- Goggles or face mask with visor
- Alcohol swabs x3
- Plastic apron
- PPE as per Infection Control Policy
- Waste bag
- Towel or waterproof sheet
- Extra lighting if required
- Ensure an Autonomic Dysreflexia Care Plan is in the Patient Clinical Record if the patient has a T6 injury or above.

Note: Catheter flushing is only permitted on the direct order from a Urologist, Specialist Medical Officer or Continence CNC/CNS.

9.2 Procedure for catheter flushing

- For procedure refer to Table 4. Note, this table can also be used as a tool for observational competency assessment by using the tick column.

Table 4. Catheter flushing procedure

Community Guidelines for Catheter flushing incorporating the Five Moments of Hand Hygiene		Step performed √
1	**Perform Hand Hygiene**	
2	Confirms this is the correct client, check for known clinical risks and allergies, explain procedure and obtain verbal consent	
3	Check client clinical record prior to procedure (authority, date of last change, any special orders and any issues during last catheter change).	
4	**Perform Hand Hygiene**	
5	Apply protective sheet or towel to bed and assist client into supine position. Cover with sheet or towel. Position light if needed	
6	Adjust height of bed if required or plan to kneel or squat to avoid bending during the procedure	
7	Attend Hand Hygiene, wear proper PPE (Apron, goggles and non- sterile gloves). Clean the work surface using a neutral detergent wipe. Attend Hand hygiene	
8	Open dressing pack – pour normal saline into container and open Alco wipes onto dressing pack	
9	Open sterile gloves	
10	Open syringe on to sterile field	
11	Expose catheter	
12	**Perform Hand Hygiene (30 Seconds)**	
13	Don sterile gloves	
14	Drape patient, place dish on drape	
15	Draw up 20mL of normal saline in catheter tip syringe	
16	Gently instil 20mL normal saline into bladder. Monitor for pain and/or discomfort	
17	Gently withdraw back plunger of catheter tip syringe to retrieve the normal saline	
18	Disconnect syringe	
19	Attach catheter drainage bag and Secure catheter	
20	Ensure client is clean and comfortable	
21	Remove gloves and **perform hand hygiene**	
22	Note nature of return fluid and document procedure and results	
23	If catheter does not drain, change catheter as per relevant catheter change procedure	
24	Contact Continence CNC/CNS, if problems are encountered	
25	Document in “urinary catheter change care plan” in eMR / CHOC	

Section 10 - Urinary catheter maintenance irrigation using prepacked CMS Solutions

Actions

Requests for bladder irrigations or installation only permitted with the valid authority form from a Urologist, Specialist Medical Officer or Continence CNC. Continence CNC/CNS then attend the first visit with the primary nurse.

Catheter maintenance solutions must be used with caution in people with spinal cord injury due to the potential for AD, if the bladder becomes distended. When irrigating the catheter of an individual with a spinal injury, continual observation must occur. If there are signs of AD, discontinue the irrigation, release the clamp and allow the bladder to drain. Implement escalation and management for dealing with AD.

Catheter maintenance solutions (CMS) must be allowed to flow in via gravity- a small gentle squeeze may be given to start the flow of irrigation.

CMS should not be used prophylactically to prevent CAUTIs, nor should they be used routinely to attempt to unblock a blocked catheter.

Pre Procedure Requirements
The Continence CNC/CNS must be notified of all requests for catheter irrigations and ensure a written medical authority for the catheter maintenance solution is received. Confirm client identification and gain consent and explain the procedure to client

Review client's history, medications, reason for catheterisation, confirm and identify the indications for use of the solution and any related risk factors

Equipment
- Catheter maintenance solution
- Dressing pack
- Non sterile gloves
- Apron
- Goggles
- Alcohol wipe
- Blue sheet
- Waste bag
- Container with warm water

10.1 Procedure for catheter maintenance irrigation

- For procedure refer to Table 5. Note, this table can also be used as a tool for observational competency assessment by using the tick column.

Table 5 Catheter Maintenance Irrigation procedure.

Community Guidelines for Catheter maintenance irrigation incorporating the Five Moments of Hand Hygiene		**Step performed √**
1	**Perform Hand Hygiene**	
2	Warm outer packaging of solution in container of warm water	
3	Apply protective blue sheet and position catheter in accessible position	
4	Open dressing pack, add alcohol wipe, non sterile gloves	
5	Open catheter solution from packaging and place on clean field	
6	**Perform Hand Hygiene**	
7	Don apron, goggles and non-sterile gloves	
8	Remove protective cap from maintenance solution and prime solution tubing, clamp off	
9	Wipe the connection between catheter and drainage bag with alcohol wipe	
10	Disconnect catheter from drainage bag and connect to maintenance solution and invert to facilitate the flow into catheter. Hold the solution higher than the level of the bladder to encourage flow via gravity.	
11	Gently squeeze the flask to encourage the initial flow of the solution. Allow enough solution to flow and bath the catheter lumen (i.e. 30mL Suby G) Refer to manufacturer's instructions for other solutions	
12	Clamp off solution and allow to sit for 5 minutes	
13	Release the clamp, position the flask below the level of the bladder and allow the solution to flow back into the solution bag.	
14	Repeat if a dual solution pack	
15	Disconnect catheter from maintenance flask and reconnect drainage device.	

16	Discard PPE and waste	
17	Attend hand hygiene	

Post Procedure
Ensure client is clean and comfortable.

Documentation
- Maintenance solution used and any difficulty encountered
- Quality of drainage / sediment type
- Any related catheter/ procedure concerns
- Schedule / frequency for irrigation as required.

Ensure client is aware of action plan / and to contact Community Nursing or present to Emergency Department – should catheter block.

Section 11 - Possible Complications of Catheterisation

11.1 Possible complications of catheterisation

- Balloon inflation in somewhere other than the bladder may result in discomfort, pain, trauma, and haematuria
- False passage, associated with forced procedure
- Haemorrhage from traumatic catheterisation
- Symptomatic Catheter Associated Urinary Tract Infection (CAUTI)
- Urinary Sepsis

11.2 Signs of asymptomatic CAUTI

If clinical signs of a symptomatic CAUTI are present at change of a new catheter, a specimen is required for urinalysis from the newly inserted catheter.

Signs and symptoms of CAUTI may include:
- Foul smelling urine
- Urine that is cloudy, blood or dark
- Sediment in the urine
- Pain or discomfort around the catheter
- Fever or chills
- Stomach, flank pain or lower back pain
- Confusion
- Catheter blockage
- Bladder spasms

Please refer to local clinical business rules for dipstick and urinalysis procedures. Please notify clients GP and/or Urologist to review the client regarding the need for a CSU from the newly inserted catheter, order a CSU, review need for further treatment and follow up the pathology results.

11.3 Autonomic Dysreflexia Recommendations

- Refer to the following resources:
  - Agency for Clinical Innovation; Treatment of Autonomic Dysreflexia in Adults and Adolescents with Spinal Cord Injuries

Section 12 - Documentation

12.1 Clinical Documentation

Documentation (including rational for catheterisation) must be noted in:

- EMR- Catheter Change Care Plan
- Community Health Notes (CHOC) on EMR

Section 13 - Mandatory Training

Registered and enrolled nurses must complete the following prior to undertaking catheterisation on patients:

- My Health Learning: Aseptic Technique
- My Health Learning: Inserting an Indwelling Urinary Catheter (IDC)
- My Health Learning: Hand Hygiene
- My Health Learning: Invasive Device Protocol
- My Health Learning: Waste Management
- My Health Learning: Autonomic Dysreflexia in Adults with Spinal Cord Injuries

Additionally, nurses must complete competency assessments for both SPC and male IUC insertions prior to undertaking the task without supervision.

Section 14 - Related Policies

- NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Practice Procedures
- Infection Prevention and Control in Healthcare
- NSW Health Policy Directive PD2020_049 – Clinical and Related Waste Management for Health Services
- NSW Health Policy Directive GL2021_015 - Insertion and Management of Urethral Catheters for Adult Patients
- SGH-TSH CLIN201 - Cytotoxic medication – including staff training, administration, extravasation management, patient identification
- SGH-TSH CLIN083 - Cytotoxic Waste- Management of

Section 15 - Resources

NSW Agency for Clinical Innovation (ACI) Urology Network (2019). Female Indwelling Urinary Catheterisation (IUC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) Urology Network (2019). Male Indwelling Urinary Catheterisation (IUC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) Urology Network (2019). Supra Pubic Catheter (SPC) – Adult. *Clinical guideline, competencies & patient information leaflet.*

NSW Agency for Clinical Innovation (ACI) (2024). Treatment of Autonomic Dysreflexia for Adults and Adolescents with Spinal Cord Injuries. https://aci.health.nsw.gov.au/networks/spinal-cord-injury/resources/autonomic-dysreflexia

Tremayne, Penny, (2020) Managing complications associated with the use of indwelling urinary catheters. Nursing Standard Volume 35 number 11 (accessed 30/1/2025)

Reid, S., Brocksom, J., Hamid, R., Ali, A., Thiruchelvam, N., Sahai, A., Harding, C., Biers, S., Belal, M., Barrett, R., Taylor, J. and Parkinson, R. (2021), British Association of Urological Surgeons (BAUS) and Nurses (BAUN) consensus document: management of the complications of long-term indwelling catheters. BJU Int, 128: 667-677. https://doi.org/10.1111/bju.15406 (accessed 30/01/2025)

Doherty L and Lister S (eds) (2015) The Royal Marsden Manual of Clinical Nursing Procedures 9th ed. Wiley-Blackwell Publishers, UK (accessed 30/1/2025)

Nazarko L (2024) Managing urinary catheter blockage and leakage. JCN. 38(3):53-58 https://www.jcn.co.uk/reader/jcn/06-2024/53/index.html (accessed 30/1/2025)

Sweeney, A. (2021) Best practice guideline: Long-term suprapubic catheter related care at home. Best_practice_guideline_-_Long-term_suprapubic_catheter_realted_care_at_home.pdf (accessed 30/1/2025)

Sweeney, A. (2021), Long-term suprapubic catheter-related care requirements when living at home: The development of a best practice guide [Doctoral thesis]. University of Tasmania. (accessed 30/1/2025)

Schaeffer, A., Richie J.P. & Chen W. (2024) Placement and management of urinary catheters in adults (Accessed 30/1/2025) https://www.uptodate.com.acs.hcn.com.au/contents/placement-and-management-of-urinary-catheters-in-adults?search=Placement%20and%20management%20of%20urinary%20catheters%20in%20adults&source=search_result&selectedTitle=1%7E150&usage_type=default&display_rank=1 (accessed 30/1/2025

Jane Hall S, Harrison S, Harding C, Reid S, Parkinson R. British Association of Urological Surgeons suprapubic catheter practice guidelines - revised. BJU Int. 2020 Oct;126(4):416-422. doi: 10.1111/bju.15123. Epub 2020 Jul 28. PMID: 32463982.(accessed 30/1/2025)

B.Braun (2025) Catheter maintenance: The risk of catheter encrustation or CAUTI and Uro-Tainer https://www.bbraun.com/en/products-and-solutions/therapies/continence-care-and-urology/uro-tainer-catheter-maintenance.html (accessed on 24/02/2025)

SESLHD Caring for your indwelling catheter at home brochure, http://seslhdweb.seslhd.health.nsw.gov.au/SGSHHS/Business_Rules/documents/U/Caring_for_your_indwelling_catheter_at_home.pdf

SESLHD, Caring for your suprapubic catheter at home brochure, http://seslhdweb.seslhd.health.nsw.gov.au/SGSHHS/Business_Rules/documents/U/Caring_for_your_suprapubic_catheter_at_home.pdf

Version and Approval History

Date	Version no:	Author and approval notes
October 2017	DRAFT	Draft for Comment
January 2018	DRAFT	Processed by Executive Services prior to progression to SESLHD Clinical and Quality Council
June 2021	1	Major review commenced. Draft for Comment period.
November 2021	1	Approved by Executive Sponsor.
December 2021	1	Approved by SESLHD Quality Use of Medicine Committee. For tabling at SESLHD Clinical and Quality Council.
March 2022	1	Approved by SESLHD Clinical and Quality Council.
26 February 2025	1.1	Minor review to update information and references.

Appendix A - Trouble Shooting Guide

REVIEW CATHETER PROBLEMS WITH THE CONTINENCE ADVISOR

Balloon not fully deflated	*Check balloon volume (3-way catheter may have a 30mL balloon). *Do not discard syringe so you can double check balloon.
Balloon cuffing	*100% Silicone catheters (all clear and blue catheter) are prone to cuffing (ridging). *Allow balloon to passively-deflate (may need to gently start deflation) and remove remaining water. *Wait 5 to 10 minutes post deflation to allow cuffing to improve prior to catheter removal. *Try reinflation of balloon and passive-deflation again. *If cuffing continues to be an issue, consider trialling a different type/brand of catheter eg. Latex catheter if no allergy *Insert 0.2mL into the balloon to help smooth out the ridging, prior to attempting to remove catheter.
Bladder spasms and pain	*Infection – Symptomatic: Collect CSU from new catheter, Increase Fluid, Advise client to visit GP *for antibiotics, If valve insitu put on free drainage, Recurrent infection require investigation *Balloon too large: 5-10 mL balloon advised *Catheter too large: IDC , less than 18 FG advised *Remove catheter slowly. *Consider requirement for anticholinergic medication (i.e. Oxybutynin) one hour before catheter placement *Consider need for urology review.
Possible bladder debris or stones in bladder	*Educate client to rotate SPC catheter daily. *Drink well at least 2Litre (or up to fluid restriction) of fluid a day whenever possible to reduce the accumulation of debris in bladder *Use lubrication to SPC site before applying traction to remove catheter *Client may require urology review and/or cystoscopy. *Client may require different catheter (i.e. Uromed Double Balloon Catheter or Supacath Open tip Catheter) *Catheter may be at risk of falling out if the balloon is damaged by a sharp stone. Latex catheters have a stronger balloon consider changing if no allergy
Anxiety and pain	*Provide reassurance. *Provide client with pain relief prior to catheter change. *Assess for signs of constipation and CAUTI. *Client may require referral to Urologist.

Encrustation	*SPC- Rotate catheter 360 degree
Pain/Bleeding on removal	*Traumatic removal: Monitor severity and frequency. Address cause, reassure client *SPC- Over granulation due to yawing: Prevent catheter traction and alternate catheter lie on a daily basis. *Consider silver nitrate if impeding removal or insertion.
Urethral obstruction	*Assess for constipation. *Consider possibility of urethral stricture. *Single attempt at catheter insertion. *Contact Continence Advisor. *Consider need for Coudé Tip catheter. *Two attempts at catheter insertion in the community setting and then transfer to ED.
SPC –Spasm of tract/Bladder	*Await release of spasm and reattempt *Insert Nelaton, then remove and quickly reinsert usual catheter, or try smaller size of Foley *catheter *MS and CVA clients may require anticholinergic medication
Difficult Insertion of female IUC, difficult access to meatus	*People with high BMI will be difficult to position to visualise the meatus. May need assistance of family to properly position patient. *Patient with dementia of recent hip surgery may not be able to flex their leg to ensure access to the urethral meatus *Plan and organise for 1-2 people assist as required and roll patient on side to gain urethral access If patient has had recent hip surgery roll on affected hip (splinting)
Avoidance of false passage (male IUC)	*Do not force insertion of the catheter. *With client lying flat, grasp penis firmly at 90^{o} to the body (point towards the ceiling) and insert. *When resistance is felt point the penis towards the client's feet. *Ask client to cough or bear down.
Pain on insertion of male urethral catheter	*Insert Lidocaine (lignocaine) jelly. *Ensure jelly remains in the male urethral for four (4) minutes prior to catheter insertion to allow for effect. *Ensure catheter is inserted all the way to the bifurcation and urine is sighted prior to balloon inflation (reduce risk of balloon inflation in the prostatic bladder neck).
Avoid SPC stoma becoming unaligned with the bladder	*Lie patient flat when possible. * Insure urine is in the bladder *Ask client to remain still following SPC removal (empty stoma).

	*Insert new SPC promptly. *Avoid distractions at time of SPC removal and insertion. *Always use sterile lubricant on catheter tip.
Unable to reinsert SPC	*Always have 14fg Nelaton and spare 14fg, 16fg, 18fg balloon catheter and catheter with you at time of SPC change. *Gently insert same size Nelaton to maintain stomal patency. If unable to insert same size Nelaton try one size down *If unable to insert the same size catheter, down size the catheter on insertion. *Call for assistance (GCN or CNA). *Resize up to usual SPC size at next change (with CNA). *Consider urethral catheterisation if SPC access difficult. ***ALERT** for client at risk of AD.
No urine output upon IUC/SPC insertion	*Ensure adequate urine volumes prior to catheter insertion. *If client is **not** at risk of AD, clamp catheter for at least 20 minutes. *If client is at risk of AD instruct them to have two large drinks prior to catheter change. *Gently press on lower abdomen (above pubic bone) to increase bladder pressure and assist urine drainage. *Catheter not in bladder – Advance catheter Further (Male IDC- up to Y junction, SPC no further than 10 cm)
Balloon will not inflate	*Ensure the catheter is in the bladder, there will be no resistance to balloon inflation if the catheter is in the hollow bladder. *Ensure the male urethral catheter is inserted to catheter bifurcation and urine is sighted prior to balloon inflation. ***Under no circumstances** force the balloon to inflate.
Little/No urine output	***Assess**: * Catheter placement/location *Adjust position of the catheter very slightly *Hydration *Pain. *Do not leave the client. *Caution with balloon inflation. * Ensure catheter valve or connection open *Ask the client to cough while holding the catheter in place. *Gently press on lower abdomen (above pubic bone) to increase bladder pressure and assist urine drainage.
Reported catheter pain or	***Assess**:

discomfort	*Catheter placement/location. *Did the pain occur with balloon inflation? *Has the client had pain after past catheter changes? *Is urine draining? *Is the pain / discomfort settling quickly? *Is the catheter supported? *Symptoms of UTI?
Client reports bowel problems (constipation or faecal incontinence)	***Review and Assess**: * Review client's bowels and asses for constipation at catheter change. *consider use of laxatives
Haematuria	*Assess haematuria: Light, moderate, heavy, bright, and dark. *Was urine clear prior to catheter change? *Client may be required to attend ED for Urology review +\- bladder irrigation. *Symptomatic CAUTI?
Symptomatic catheter related UTI	*Consider need to collect a CSU from newly inserted catheter at time of change.
Uncircumcised male with a urethral catheter	*Attend face to face (home or clinic) catheter assessment within 24 to 48 hours of referral. *Examine urethral meatus for any oedema / swelling. *Try to replace foreskin using traction and lubricant / Lidocaine (lignocaine) jelly. *Paraphimosis is a urological emergency, client must attend ED.
Client has valve and not suitable for valve drainage	*Client leaking urethrally with a flip flow valve. *Educate client to empty valve more than eight (8) times per day. *Client has cognitive impairment and is forgetting to empty their valve. * Consider need for valve removal and apply bag on free drainage.
Client has leg bag and may be suitable for valve drainage	*Better QOL with a valve, consider for clients with a long term catheter. *Client has no recent episodes of urinary retention. *Client is not due to have a TOV. *Client has a bladder that stores urine. *Client is not cognitive impaired.
Catheter blockage/leaking	*Assess: *Duration of blockage *Tube patency *Hydration *Colour/character of the urine *Urine leakage *Clots/Debris. *Consider CAUTI and/or constipation.

ALERT for client at risk of AD.	*Change IUC- DO NOT flush/irrigate. *Assess: *see section 9 and 10 of policy
Catheter blockage with sediment/blood clot	*Change IUC- DO NOT flush/irrigate *If bleeding and blockage continue with clot, patient to send to Hospital for medical review and management.
Client needs regular reinforcement of catheter management	*Upon each visit, reinforce/educate client: *Hand washing *Hydration *Bowel management *Catheter and equipment care.
Catheter falls out	*SPC must be re-inserted ASAP. *Consult CNA for assistance. *Have 14fg Nelaton and 14fg Balloon catheter. *If client is at risk of AD, may need ambulance transfer to ED. *Consider insertion of urethral catheter for short term management *Consider why the catheter has fallen out: *Bladder stones *Faulty catheter.
Client with spinal cord injury above T6 and clients at risk of Autonomic Dysreflexia	*Careful planning for catheter change prior to each visit. *Read clients notes prior to each visit. *Complete appropriate documentation in CHOC. If client is symptomatic of AD and does not have a patent catheter draining urine call ambulance for transfer to ED. *Read and be familiar with ACI AD guidelines and keep a copy in client's home.
Skin or Stoma issue	*Allergy to material- Change catheter type *Over granulation of stoma due to yawing: prevent catheter traction *Alternative catheter lie on a daily basis. Consider silver nitrate if impeding removal or insertion *Infection of Stoma: Arrange for wound swap, treat as required