

	Policies & Procedures Title: SUPRAPUBLIC CATHETER <ul style="list-style-type: none"> • Care of • Changing • Removal I.D. Number: 1021
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DEFINITION: A suprapubic catheter is a urinary drainage tube inserted surgically into the bladder through the abdominal wall above the symphysis pubis.

1. PURPOSE

- 1.1 To provide a guide for safe, aseptic care, removal and change of a suprapubic catheter.
- 1.2 To prevent infection.
- 1.3 To maintain catheter patency.

2. POLICY

Staff who will perform these procedures	<u>Changing & emptying urine drainage bags</u> - All Health Care Professionals (HCPs) and Continuing Care Assistants <u>Care of</u> - All Health Care Professionals <u>Removal</u> - Rural, LTC & Home Care – All Health Care Professionals - Urban Acute Care – RN, GN, RPN, GPN <u>Change of suprapubic catheters</u> is a Special Nursing Procedure requiring certification for RNs/GNs/RPNs/GPNs and an Additional Competency requiring certification for LPNs/GLPNs as identified and targeted by unit Managers of Nursing.
Practitioner Order required	- Catheter change stating catheter size, type and frequency of change, if applicable - Irrigation solution, if indicated - Removal of catheter
Care of	- Dressing will be changed daily & prn - Established sites (after 5 – 7 days) without drainage may not require a dressing - All suprapubic catheters must be secured to the abdomen with an appropriate anchoring device (i.e. Statlock Universal securement device)

	<p>or Flexitrack) to prevent accidental dislodgement or removal.</p> <ul style="list-style-type: none"> - If a suprapubic catheter requires irrigation, refer to the Bladder Irrigation policy #1119 in the SHR Nursing Policy & Procedure Manual
Changing	<ul style="list-style-type: none"> - The first catheter change post-insertion will be performed by the most responsible physician (MRP). - Complex changing of suprapubic catheters, involving probing or dilating for example, must be performed by the MRP. In these cases or if there is a history of difficult catheter changes, eligibility for suprapubic catheter changes should be reviewed in consultation with a Urologist. - This is a sterile procedure. - A second catheter will be available one size smaller to use in the event of difficulty inserting the current size - The patient will be assessed for pain medication requirements before catheter change

3. PROCEDURE

3.1 Care of Suprapubic Catheter

Note: For newly inserted suprapubic catheters (up to 5-7 days post insertion) use sterile technique and sterile gloves. For established sites (post 5-7 days) use clean technique.

3.1.1 Supplies

- Gloves – see note above
- Dressing tray, if available.
Note: Home Care doesn't use a dressing tray.
- 0.9% Sterile Sodium Chloride
- Sterile cotton-tipped swabs or sterile 2X2 gauze
- 4x4 drain sponges
- Tape
- Catheter anchoring device (I.e. SKU# 60418 – Flexitrak Tube Anchor; Statlock universal securement device)

3.1.2 Follow procedure in nursing textbook Perry, Potter & Ostendorf, 2014, Clinical Nursing Skills & Techniques, 8th edition pp. 837-839.

Note: When removing the old dressing, **DO NOT use scissors.**

Note: Examine catheter insertion site for:

- Signs of infection including discomfort when light pressure applied to site.
- Catheter slippage – partially or completely out. **DO NOT attempt to reinsert catheter.**

Note: Notify practitioner of any of the above.

Note: When securing catheter to abdomen, do not pull catheter taut – allow enough room to insert 2 fingers under the catheter.

3.2 Removal of Suprapubic Catheter

- 3.2.1 Confirm the type of suprapubic catheter and any special removal procedures with the practitioner prior to removing. Assess how the catheter is secured in place:
- a regular Foley catheter held in place by an inflated balloon.
 - a catheter secured by sutures.
 - a catheter secured with tape.
 - a catheter held in place internally by a small basket-like device.

3.2.2 Supplies

- PPE: Non-sterile gloves, eye/face protection
- Dressing tray, if available. In Home Care use standard dressing supplies.
- Incontinent pad, if available
- 0.9% Sterile Sodium Chloride
- Sterile cotton-tipped swabs
- Sterile gauze dressing
- Tape
- 10mL luer lock syringe to deflate balloon if Foley (or 30mL syringe if catheter is a 3-way Foley)
- Stitch cutter or sterile scissors – if catheter secured with sutures

3.2.3 Perform hand hygiene.

3.2.4 Glove and don eye/face protection.

3.2.5 Place incontinent pad under patient/client/resident.

3.2.6 Remove dressing and anchoring device

3.2.7 Cleanse site with 0.9% sterile Sodium Chloride.

3.2.8 Remove suture, if present, taking care not to sever the catheter.

3.2.9 Deflate catheter balloon using an appropriate sized syringe if necessary.

3.2.10 Grasp catheter firmly and gently pull straight out in a slow, steady motion.

Note: *As you pull out the basket-style catheter, the basket closes and allows the catheter to be pulled out. It may take firm pressure by the hand pulling the catheter to remove it.*

3.2.11 Inspect the site for redness and drainage.

3.2.12 If changing the catheter, proceed to 3.3.

3.2.13 Apply a sterile gauze dressing. Change prn.

Note: *Leaking of urine from insertion site often occurs for the first 24 hours or longer following removal of a suprapubic catheter.*

3.2.14 Document time of removal on Progress Record or other appropriate record, noting ease of removal, condition of site and patient/client/resident tolerance of procedure.

3.2.15 Monitor urine output, frequency of voids and signs and symptoms of infection.

3.3 Changing a Suprapubic Catheter

Note: *The suprapubic tract even in well-established sites will begin to close within hours. Place the new catheter within minutes of removal of the old catheter.*

3.3.1 Supplies

- PPE: eye/face protection, gown
- Incontinent pad
- Sterile catheterization tray
Note: *Home Care doesn't use a tray. Instead they would add lubricant (muco), 0.9% sterile sodium chloride, 10 mL syringe, & blunt needle (to draw up sterile water).*
- 0.9% sterile sodium chloride to clean site
- Sterile catheters of appropriate type and size as ordered (1 of appropriate size and 1 a size smaller)
- Sterile gloves (2 pairs)
- 10mL Sterile Water
- Prescribed irrigation solution, if ordered
- 60 mL catheter tip syringe for irrigation, if ordered
- Appropriate urine drainage bag
- Sterile gauze dressing
- Tape
- Catheter anchoring device

3.3.2 Perform hand hygiene.

3.3.3 Explain procedure to patient/client/resident

3.3.4 Position patient/client/resident in supine position.

3.3.5 Place incontinent pad under patient/client/resident.

3.3.6 Prepare sterile field close to work area and add catheter to sterile field.

3.3.7 Don PPE and sterile gloves.

3.3.8 Apply sterile drape to patient/client/resident.

3.3.9 Wet cotton balls with 0.9% sterile sodium chloride and clean site.

3.3.10 Inspect the catheter for resiliency and leaks.

3.3.11 Lubricate the tip of the catheter.

3.3.12 Remove the existing catheter if needed as per 3.2.

Note: *Use the length of catheter with visible color change as a guide for required length for insertion.*

3.3.13 Change sterile gloves.

3.3.14 Holding the catheter at a 90 degree angle, gently and slowly insert catheter down the cystostomy tract to the distance judged from the catheter removed.

Note: *Length of insertion varies but is usually 3-4 inches (8- 10 cm). Never force or insert roughly.*

Note: *It is normal to feel minor resistance at the stoma site and the catheter “pop” through the bladder wall.*

- 3.3.15 Inflate balloon with 3 – 5 mLs of sterile water if applicable. If resistance felt, the catheter may need to be inserted further or pulled back slightly. Gently pull on the catheter to seat against the bladder wall and inflate with remainder of water.
- 3.3.16 If ordered, irrigate catheter with prescribed solution to remove any residual debris.
- 3.3.17 Clamp catheter or attach urine drainage bag ensuring ends remain sterile and bag remains below level of the bladder.
- 3.3.18 Apply sterile dressing to cystostomy site if necessary.
- 3.3.19 Apply securement device to abdomen.
- 3.3.20 Dispose of supplies, remove gloves and perform hand hygiene.
- 3.3.21 Measure length of external catheter from stoma to “Y” or end of catheter.
- 3.3.22 Document
 - Size of catheter
 - Type of catheter
 - Color and characteristics of the urine
 - Patient/client/resident tolerance of the procedure
 - Amount of sterile water in the balloon if necessary
 - Measured length of external catheter

4. REFERENCES

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