MANAGEMENT OF THE BLADDER AND URINARY DRAINAGE APPARATUS

SELF CATHETERISATION (INTERMITTENT)

Key words: Intermittent, self-catheterisation, bladder, assessment

AIM

- To enable the woman to have the confidence and competence to self-catheterise.

BACKGROUND

Intermittent self-catheterisation (ISC) is the passing of a catheter into the bladder to remove urine, with the catheter then being immediately removed. Patients who need to undertake intermittent self-catheterisation have voiding or storage problems, resulting in retention of urine. For bladder emptying dysfunction, ISC is considered gold standard. It is important that catheterisation is carried out regularly to prevent bladder distension and the frequency will depend on the individual woman's bladder assessment.

KEY POINTS

1. It is vital that the woman is able to store urine in her bladder.
2. The woman must be able to understand the technique, have reasonable dexterity and mobility and be motivated to commit to the procedure.
3. In the hospital setting, an aseptic technique shall be used.
4. Assess the patient and ensure she understands why she has to undertake the procedure and what is involved.
5. Encourage the woman to identify a position that is comfortable to them to perform the procedure e.g. standing with one leg resting on the toilet, sitting on the toilet or a chair, or lying down.
6. Instruct the woman on hand hygiene and the importance of not touching anything other than the items needed until the procedure is complete.
7. Instruct the woman to prepare the catheter according to the manufacturer’s instructions.
8. The woman should try to pass urine prior to catheterisation.

EQUIPMENT

- Soap & water or disposable cleansing wipe
- Nelaton catheter 10-12FG
- Lubricating jelly
- Sterile gloves (to assist)
- Collection receptacle
PROCEDURE

1. Explain the procedure to the woman, and supervise her ability for the following
2. Attend hand hygiene\(^2\), then wash the genital area- from the urethra towards the anus.\(^1\) Repeat hand hygiene and place catheter / lubricant within reach.\(^1\)
3. Part the labia with the index and middle finger of the non-dominant hand and identify the urethra. A mirror may be useful when initially teaching the woman.\(^1\)
4. The staff member can attend hand hygiene and put on sterile gloves to assist if required.\(^1\)
5. Instruct the woman how to remove the catheter from the packaging, and lubricate, without touching/contaminating the tip.\(^1\) Gently insert the lubricated catheter into the bladder, pointing the funnel end into the toilet or collection receptacle.\(^1\)
6. If the woman has difficulty inserting the catheter, advise her to relax\(^1\), cough or to try and pass urine. Continue to insert the catheter until urine starts to flow.
7. When the urine flow stops, slowly remove the catheter. If the urine starts to flow again, wait and then gently begin to withdraw the catheter.\(^1\)
8. To avoid spillage, place a finger over the funnel before finally removing from the urethra.
9. Dispose of waste, and the catheter\(^1\) according to the manufacturer’s instructions. Single use catheters should be placed back in their sleeve and discarded in the general waste. Attend hand hygiene\(^1\).
10. Provide the woman with information on signs of infection\(^2\), hygiene & fluid advice.
11. Document the procedure and urine amount.

REFERENCES / STANDARDS


Acknowledgement