Sullivan County Department of Public Health

Title: Suprapubic Urinary Catheter Insertion and Management **Number**: CP-18 **Page Number:** 1 of 2	Original Approval: 12/17 Reviewed/ revised: 5/24

Statement/ Purpose:
To provide guidance on suprapubic catheter insertion, irrigation and care

Authority:

Application:
CHHA RNs

Terminology:

Responsible Party:
Training and Quality Improvement Coordinator

Cross-Reference:
Hand Hygiene

Procedure:
Suprapubic Catheter Insertion

1. Confirm provider's orders.
2. Explain the procedure to the patient/ caregiver.
3. Gather supplies
4. Perform hand hygiene, don non-sterile gloves
5. Position the patient supine with legs extended, knees slightly flexed. Make patient as comfortable as possible.
6. Place moisture-resistant pad under patient's buttocks.
7. Remove saline from balloon of indwelling catheter and gently remove old catheter.
8. Remove gloves and perform hand hygiene.
9. Prepare a sterile field. Maintain sterility while opening all packaging.
10. Don sterile gloves.
11. Apply water-soluble lubricating jelly on approximately three inches of the catheter tip and place in the sterile field.
12. Insert syringe into balloon-channel, inflate balloon, assess for defects and deflate the balloon.
13. Cleanse the skin using the 2 alcohol-soaked swabs, followed by 3 betadine-soaked swabs. (Use one swab at a time then discard). Begin cleaning the skin with a circular motion moving outward from the catheter insertion site to surrounding skin. An are 4-6" around the catheter insertion site is to be cleaned. Do not touch the cleans skin area.
14. Introduce the well-lubricated catheter firmly into suprapubic opening. The length of catheter insertion depends on the position of the bladder and the thickness of the abdominal wall.

15. Instill sterile saline through the appropriate port in accordance with manufacturer's instructions. If the catheter is not draining properly, gently withdraw in 1" increments until urine flow begins or pressure of the balloon is felt. Bladder spasms may last 5-10 minutes and can hinder the flow of urine. Allow time for cessation of bladder spasm.
16. Disposed of used materials in proper garbage receptacle.
17. Apply appropriate dressing or securement device as indicated. Remove and dispose of gloves.
18. Perform Hand hygiene.
19. Document procedure, including the following in the patient's clinical record:
    a. Date of procedure
    b. Size of catheter
    c. Amount of saline used to inflate the balloon.
    d. How the patient tolerated the procedure.
    e. Any difficulties encountered
    f. Teaching, including patient's and/or caregiver's response to teaching.

Suprapubic Catheter Irrigation

1. Confirm provider's order.
2. Explain the purpose and procedure to the patient. The purpose is to eliminate harmful bacteria from around the insertion site, thus avoiding urinary tract infections.
3. Gather supplies.
4. Perform hand hygiene, don non-sterile gloves.
5. Position the patient supine with legs extended and knees slightly flexed.
6. Place moisture-resistant pad under patient's lower torso.
7. Drape patient to expose abdomen
8. Open irrigation set
9. Don nonsterile gloves
10. Clean lip of irrigating solution bottle by pouring a small amount of the irrigant into the tray.
11. Clean the connection site between the catheter and tubing with alcohol.
12. Disconnect catheter from drainage tube by twisting in the opposite direction and carefully pulling them apart.
13. Clamp the suprapubic catheter.
14. Insert the tip of the syringe into the catheter and fill with the irrigant to the prescribed volume.
15. Unclamp the catheter and allow it to drain by gravity.
16. If the catheter is clogged, gently insert the plunger and attempt to irrigate with slightly applied pressure.
17. Remove the syringe and allow the irrigant to return into the tray, taking caution to maintain sterility.
18. Clean the insertion sites of the tubing and catheter with alcohol.
19. Reattach the catheter tubing and secure it to the abdomen.
20. Discard waste material in the patient's household trash and dispose of the used irrigant into the toilet.
21. Remove gloves and perform hand hygiene.
22. Document procedure, including the following in the patient's clinical record:
    a. Condition of the surrounding skin
    b. Characteristics of the urine
    c. Patient's reaction to the procedure

Suprapubic Catheter Care

1. Confirm provider's order.
2. Explain the purpose and procedure to the patient. The purpose is to drain urine from the bladder.

3. Gather supplies.
4. Perform hand hygiene, don non-sterile gloves.
5. Position patient supine with knees slightly flexed.
6. Place moisture-resistant pad under patient's torso.
7. Drape patient to expose abdomen.
8. Remove old dressing and place in plastic bag.
9. Clean insertion site and approximately four inches around insertion site with sterile saline solution or other provider-prescribed solution, in a circular motion.
    a. Use each saturated 4x4 for only one swipe and discard.
    b. Begin in center circle with the first swipe and proceed outward.
    c. Place solution-soaked 4x4 over encrusted area to permit easy removal of crusted areas.
10. Clean one inch of distal catheter with sterile saline solution or other prescribed solution.
11. Gently pat dry the area and provide time for air drying.
12. Apply antibiotic ointment if prescribed by the provider.
13. Place pre-cut gauze around catheter and dry dressing on top
14. Secure with tape.
15. Discard all waste materials in the patient's household trash.
16. Remove gloves and perform hand hygiene
17. Patient and caregivers are provided with demonstration and instruction of the procedure.
18. Document procedure, including the flowing in the patient's clinical record:
    a. Condition of surrounding skin
    b. Procedure
    c. Characteristics of the urine
    d. Instructions provided to the patient/ caregiver
    e. Reactions of the patient/ caregiver.