

SUPRAPUBIC CATHETER REINSERTION

SUMMARY

This skill describes how to register a suprapubic catheter during a scheduled catheter change or following accidental dislodgment

ALERT

Assess the patient for latex allergy to ensure that the correct catheter type is selected.

Assess medications the patient is currently taking and exercise caution if anticoagulation therapy is being used.

Remember to route tubes and catheters having different purposes in different, standardized directions (e.g., IV lines routed toward the head; enteric lines toward the feet)

Trace tubing or catheter from the patient to point of origin (1) before connecting or reconnecting any device or infusion, (2) at any transition (e.g., new setting), and (3) as part of the hand-off process.

OVERVIEW

A suprapubic catheter is surgically inserted into the bladder through an incision that is made above the pubis. It provides a temporary or permanent alternate flow of urine in a patient with urinary retention, prostatic obstruction, neurogenic bladder, pelvic fracture, or urethral injury. Catheter changes are performed according to the practitioner's order. Though practitioners may order routine catheter changes, especially for patients who experience obstruction due to catheter encrustation, there is no evidence that changing catheters at set intervals reduces urinary tract infections (UTIs). Catheter changes should be performed based on clinical signs of infection, obstruction, or compromise of the closed drainage system.

Asymptomatic bacteremia may occur with suprapubic catheter changes, but the use of prophylactic antibiotics is not recommended.

EQUIPMENT

Ensure that all necessary supplies and durable medical equipment are available before the home visit.

- Sterile catheter, size ordered by practitioner
- Sterile catheter tray
- Sterile, water-based lubricant
- Urine collection bag
- Sterile medium syringe
- Sterile syringe filled with proscribed amount of sterile water
- Gloves, sterile gloves
- Gauze dressing or drain sponge
- Hypoallergenic tape

PROCEDURE

1. Perform hand hygiene and don gloves
2. Introduce yourself to the patient
3. Verify the correct patient using two identifiers
4. Explain the procedure to the patient and ensure that he or she agrees to treatment
5. Verify the practitioner's order and assess the patient for pain

6. Prepare an area in a clean, convenient location, and assemble the necessary supplies
7. Position the patient in a supine position
8. Remove the dressing over the present site of the suprapubic catheter and assess the skin and note any drainage or odor
9. Remove gloves, perform hand hygiene, and don clean gloves
10. Cleanse around the stoma using aseptic technique. (Common antiseptic solutions that may be used include betadine or chlorhexidine.)
11. If the patient has an indwelling suprapubic catheter in place, use a syringe to withdraw all the fluid from the balloon and remove the catheter. Remove gloves and perform hand hygiene. If the catheter has been accidentally dislodged and is not present in the cystostomy site, proceed with the next step.
12. Prepare the catheter tray using sterile technique. Don sterile gloves
13. Test the balloon of the new catheter, per manufacturer's instructions for use, by inflating it with sterile water and then deflating it. Maintain sterility.
14. Immediately lubricate the suprapubic tract with 5 to 10 ml of water-soluble lubricant and insert the new catheter into the stoma site using aseptic technique and sterile equipment. Point the tip toward the patient's spine and angle it toward the symphysis pubis.
15. Watch for urine return. Once urine return has occurred, proceed as follows:
 - a) Advance the catheter approximately 5 cm (2 in) farther into the bladder
 - b) If the bladder wall is met, withdraw the catheter slightly
 - c) If urine flow is not noted within a few minutes after insertion, irrigate the catheter with sterile water to ensure that it is not occluded with lubricant
16. Using the prescribed amount of sterile water, inflate the balloon halfway and gently withdraw the catheter until it feels firm against the bladder wall, then completely inflate the balloon.
17. Connect the catheter to a drainage bag or leg bag, keeping the tubing free of kinks and below the level of the bladder to prevent urine return
18. If indicated, apply a skin barrier to the skin around the catheter. Secure catheter to the lateral aspect of the patient's abdomen or to his or her thigh.
19. Apply a dry dressing and secure it with tape
20. Discard supplies, remove gloves, and perform hand hygiene
21. Document the procedure in the patient's record

PATIENT AND FAMILY TEACHING

- Instruct the patient and caregiver on daily stoma site care. Teach them to use soap and water or antiseptic swabs to clean the site, using a circular motion beginning at the insertion site and moving outward.
- Instruct the patient and caregiver to call the authorized practitioner or home health nurse in the event of obstruction or accidental dislodgment.
- Instruct the patient and caregiver on signs and symptoms to report to the authorized practitioner or home health nurse.
 - Skin breakdown at site
 - Redness, edema, or odorous drainage or bleeding from the insertion site
 - Hematuria
 - Cloudy or foul-smelling urine
 - Fever or chills

- Decreased urine output, output more than normal for patient
- Instruct the patient on adequate hydration to maintain urine output
- Instruct the patient and caregiver to keep the drainage bag below the level of the bladder to reduce the incidence of UTI.
- Explain the procedure to the patient and caregiver
- Encourage questions and answer them as they arise

REFERENCES

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Gould, C. V. and others (2017)

Joint Commission, The (2014)

Society of Urologic Nurses and Associates (SUNA) (2016)

Stefanacci, R.G., Haimowitz, D. (2013)

ADDITIONAL READINGS

Yates, A. (2016)