

## D-120 Care of Suprapubic Catheter

A suprapubic catheter is inserted into the bladder surgically through the abdominal wall. The catheter is connected to a straight drainage system. Once the stoma site has healed, changing of the catheter may be done by nursing depending on agency policy and state nurse practice acts.

### Purpose

Maintain catheter patency and adequate urine output.

Promote self care in the home.

### Applies To

Registered Nurses

Licensed Practical/Vocational Nurses

Other (*Identify*): \_\_\_\_\_

### Equipment/Supplies

#### For catheter changing:

- Catheter insertion kit.
- Sterile indwelling catheter (verify size and type of catheter required for procedure).
- One pair of sterile gloves.
- Two sterile drapes, one of which is fenestrated.
- Sterile water soluble lubricant.
- Antiseptic cleansing solution.
- Sterile cotton balls.
- Sterile forceps.
- 10 ml syringe, pre-filled with normal saline.
- 10 ml syringe.
- Sterile drainage bag and tubing.
- Leg strap or tape.
- Sterile specimen container (if specimen is to be collected).
- Sterile receptacle or basin

#### For catheter care:

- Sterile irrigation kit with sterile bulb syringe and container for irrigation.
- Sterile normal saline solution.
- Waterproof pad, gloves, gauze, antiseptic solution.

**Procedure**

**Catheter Care:**

1. Verify physician orders.
2. Wash hands. Refer to the Hand Washing procedure.
3. Position the client for easy access to the catheter site.
4. Remove old dressing and discard.
5. Put on gloves.
6. Assess the stoma site, condition of skin, and patency of the catheter.
7. Cleanse the stoma site using circular motion.
8. Use saline or antiseptic solution as ordered.
9. Cleanse the catheter from distal to proximal end.
10. Apply dry dressing to the site as needed.

**Catheter change: (Follow steps above to prepare site.)**

1. Place waterproof pad under the client.
2. Open catheter kit or individual sterile supplies.
3. Don sterile gloves and organize supplies on sterile field.
  - a. Check patency of indwelling catheter balloon by attaching pre-filled syringe and injecting normal saline. Withdraw solution and set syringe aside on sterile field. *Verifies integrity of balloon.*
  - b. Lubricate catheter tip. *Facilitates catheterization and reduces trauma.*
  - c. If a specimen is to be collected, open specimen container and place lid loosely on top.
4. Drape the client. Expose suprapubic catheter site.
5. Using dominant hand and forceps, pick up cotton ball. Cleanse around catheter site using a circular motion and moving from center to outside.
6. Using non-dominant hand, attach empty 10 ml syringe to the existing catheter injection port to deflate the balloon. Hold catheter in place. The non-dominant hand is no longer sterile.
7. Pick up sterile catheter with dominant hand.
8. Using the non-dominant hand, withdraw existing catheter. Insert sterile catheter with dominant hand. *Insertion must be done quickly, as the site will not remain open long.*
9. Insert catheter at least four inches from the tip. Avoid inserting any farther than when resistance is met. *Resistance during insertion means the catheter is inside the bladder.*

10. Inflate balloon:
  - a. Inject prescribed amount of solution to inflate the balloon.
  - b. After balloon is filled, remove syringe and gently pull on catheter until resistance is met to anchor catheter tip in place.
11. Closed Drainage System:
  - a. *Drainage Bag*: Connect catheter to tubing end of drainage bag. Place the bag below the bladder level and check to be sure there are no kinks or obstructions in the tubing.
  - b. *Leg Bag*: Connect catheter to tubing end of leg bag. A leg bag is usually worn during the day and allows for increased mobility.
12. If urine specimen collected, secure lid on container. Place labeled container in biohazard bag and attach requisition. Deliver to lab within 15 minutes or refrigerate.
13. Remove gloves and dispose of waste according to the Agency Waste Disposal Policy.
14. Wash hands. Refer to the Hand Washing procedure.

**Documentation Guidelines**

Document in the clinical record:

1. Condition of the stoma site.
2. Characteristics of the urinary drainage.
3. Type and size of catheter inserted.
4. Date and time of catheter insertion.
5. Any urine specimens collected and delivery to lab.
6. Teaching done and client/caregiver response.
7. The client’s tolerance of the procedure.

**Related Procedures**

Application of a Leg Bag, Urine Collection from an Indwelling Catheter

**Policy History**

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