Shropshire Community Health NHS Trust

Standard Operating Procedure (SOP) for suprapubic recatheterisation using a warm bladder infill, for patients with a spinal cord injury (adult patients)

Document Details		
Title		Standard Operating Procedure (SOP) for suprapubic recatheterisation using a warm bladder infill, for patients with a spinal cord injury (adult patients)
Trust Ref No		2291-86031
Author		Nicola Head Continence Nurse Specialist
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Who has been consulted in the development of this SOP?		Midland Centre for Spinal Injuries Continence Advisory Service
Approved by (Committee/Director)		Clinical Policies Group
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Amendments History		
No	Date	Amendment
1	Oct 2023	New Standard Operating Procedure

Standard Operating Procedure for suprapubic recatheterisation using a warm bladder infill, for patients with a spinal cord injury (adult patients)

- **Catheterisation must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**
- **The Midlands Centre for Spinal Injury (MCSI), change suprapubic catheters using a warm saline infill for some patients, to reduce bladder spasm and help maintain the cystostomy stoma tract**
- **Patients requiring catheter change in the community using bladder infill, will be identified by MCSI, who will liaise directly with the community nursing team involved in the patient's care**
- **The nurses from MCSI will teach the community nurses how to undertake bladder infill, on a named patient basis**
- **This procedure requires two people to perform it. The second person may be a health care assistant, assistant practitioner, another nurse, or the patient**
- **The saline used for the bladder infill must be warmed in tap water to body temperature. Infilling with cold saline increases the risk of autonomic dysreflexia and bladder spasm which may cause the tract to close**
- **This SOP has been written in collaboration with MSCI**

Equipment:
Sterile catheterisation pack
Catheter (licensed for supra pubic use, and the same charriere size as the existing catheter)
6ml sterile lubricating gel containing Lidocaine (licensed for suprapubic use)
Disposable procedure sheet
Non-sterile nitrile gloves
Sterile nitrile gloves
Sterile water in 10ml syringe to inflate new catheter balloon **(the nurses from MCSI will identify how much water to inflate the balloon with)**
x2 100ml B/braun Uro Tainer Saline catheter maintenance solutions **(the nurses from MCSI will identify the volume of saline to be administered for each individual patient. The volume is approximately 200ml, hence x2 bags of saline catheter maintenance solutions, may be required)**
Sterile 10ml syringe to deflate existing catheter balloon
Single use apron
0.9% sodium chloride (saline) for meatal cleansing
Urine drainage bag, with adjustable straps or a leg bag sleeve
Fixation device (eg G-strap)
Alcohol hand gel
Protective eye wear
Check that all items are within their expiry date and that packaging is undamaged

Explain the procedure to the patient including the consideration of a chaperone, and gain consent
Check the patient has no known allergies to any of the equipment to be used

Decontaminate hands and put apron on

Leave the x2 saline catheter maintenance solutions in the outer packaging, and bring the solution up to body temperature by immersing them in warm tap water

Open catheterisation pack, and open the equipment onto the sterile field, including the warmed saline

Prepare the patient, maintaining their dignity (procedure sheet underneath their bottom, underwear removed, drainage bag emptied, patient lying down with legs straight)

Nurse and assistant to decontaminate hands and apply protective eye wear
Nurse to apply sterile gloves. Assistant to apply non sterile gloves

Nurse to remove packaging from the end of the new catheter and attach the sterile drainage bag. Catheter must remain on 'free drainage' for 24 hours post catheter change (DO NOT use catheter valves for 24 hours, post catheter change) Nurse to remove packaging from tip of new catheter, and apply lubrication gel to first 5cm of catheter
Nurse to clean the cystostomy stoma site with gauze soaked in sterile saline, and apply lubricating gel to the cystostomy stoma site
Nurse to place sterile towel immediately below the cystostomy stoma, ensuring that the genital area is covered. Place the receiver between the patient's legs
Nurse to administer the warmed saline into the bladder, via the existing catheter (do not drain the saline back) **If autonomic dysreflexia occurs during bladder infill, STOP instilling the saline immediately, and continue the catheter change, to empty the bladder**
Nurse to tie a piece of gauze around the existing catheter, close to the abdominal wall
Nurse to remove gloves, decontaminate hands and apply second set of sterile gloves
Assistant to deflate the catheter balloon with syringe, and place their index and middle finger on either side of the catheter, applying gentle pressure to the abdomen
Assistant to slowly remove existing catheter, maintaining the position of the gauze on the catheter, with the nurse noting the lie of the existing catheter and the angle of insertion. Assistant to lay removed catheter on edge of sterile field (there may be a gush of urine from the cystostomy stoma, as the catheter is removed)
Nurse to measure the new catheter against the old catheter, to assess the insertion length. Immediately, insert the new catheter, at the same angle as the old catheter. Do not allow the new and old catheters to touch each other
Nurse to advance the catheter into the tract, 3cm deeper than the removed catheter
Once urine starts to drain, and while the nurse holds the catheter insitu, the assistant to slowly inflate the balloon with the required volume of water. Balloon inflation should be pain free. If discomfort is displayed during balloon inflation stop and nurse to recheck the position of the catheter. Nurse to withdraw the catheter slightly until it is felt to be firm against the bladder wall
If unable to insert suprapubic catheter, insert a urethral catheter and transfer patient to urology at Royal Shrewsbury Hospital for reinsertion. If unable to insert a urethral catheter, arrange urgent transfer to Royal ShrewsburyHospital, as a medical emergency
Ensure that the patient's abdomen is clean and that the patient is comfortable and dry Observe the colour and measure the amount of urine drained
Secure the drainage system to the patient, with adjustable straps or a leg bag holder, and a fixation device (eg G-strap) Ensure that the catheter tubing does not become taut when the patient is mobilising and that the patient's clothing has been repositioned and is comfortable
Retain the sticky labels from the catheter packaging. Dispose of waste, remove gloves and apron. Decontaminate hands
Seek advice from other health care professionals about any clinical concerns, queries or outcomes
Record consent, procedure and outcomes in the patient's catheter care pathway documentation Complete / update the patient's Catheter Card