Self-Directed Learning Package

For Registered and Enrolled Nurses

Insertion and Management of Indwelling Male Urethral Catheters

Name: _________________________________
**Authors**
Initiated by: Marree Porch, Nurse Educator, Surgical Services, Cairns Hospital  
Reviewed by: Erin Bell, Urology Clinical Nurse  
Nurse Educators, CHHHS.

**Version Control**
This is version 15 of the Insertion and Management of Indwelling Male Urethral Catheters and will remain current until 11/2017 – or until modifications are required.

**Statement of Indemnity**
This learning package is designed for utilization through the CHHHS and Queensland Health does not accept any responsibility for the use of this material outside of the scope for which it has been intended.

**Documentation**
This package has been developed in conjunction with the CHHHS Catheterisation Procedure  
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**Introduction**

This learning package has been formulated to provide the requisite theoretical knowledge to attain competency in the insertion of indwelling catheters in males and the appropriate care of a patient with an indwelling catheter.

To enable the nurse to become competent in the skill of male catheterisation the following process must be followed:
1. Identify that male catheterisation is a skill required in their clinical area
2. Completion of this self-directed learning package and an achievement of 80% on the written test.
3. Attendance of a simulated training session and successful completion of the Clinical Skills Assessment Tool (CSAT)
4. Gain clinical experience in the clinical environment under the supervision of a competent senior member of staff

It is the responsibility of the nurse to maintain their competence and identify the need for additional learning or reassessment of their competence (i.e. extended period of leave).

**Recognition of Prior Learning**

In accordance with the Queensland Health Recognition of Prior Learning (RPL) guidelines nursing officers are able to be recognised for already possessing a current male catheterisation competency obtained at another health service. To apply for RPL the nursing officer is required to produce evidence such as a completion of attainment document or certificate of achievement. The nursing officer is then to undertake a practical assessment and complete the male catheterisation CSAT.

**Objectives**

On completion of this learning package and training session the learner will able to:
- Describe the anatomy of the lower urinary tract of a male
- Identify appropriate indications for catheterisation
- Identify current infection control principles of insertion and maintenance of a catheter.
- Demonstrate competence in male catheterisation in a simulated environment.
- Describe the nursing care of a patient with an indwelling catheter.
Review of Anatomy and Physiology

The urinary system consists of the kidneys, ureters, urinary bladder and urethra.

**Kidneys:** The kidneys are the principle organ of the urinary system. Every day the kidneys filter nearly 200 litres of fluid from the bloodstream, allowing toxins and metabolic wastes to be excreted by the body in urine.

**Ureters:** Are slender tubes that convey urine from the kidneys to the bladder. The tubes are approximately 26-30cm long and only 3-4mm wide.

**Urinary bladder:** The urinary bladder is a hollow organ which holds urine. The bladder wall is lined with mucous membrane and is surrounded by three layers of smooth muscle, collectively known as the detrusor muscle. The smooth muscle fibres are capable of considerable distension during bladder filling and contraction during emptying.

These layers of smooth muscle come together at the base to form the internal sphincter, which is under reflex control from the spinal cord. An empty bladder lies entirely in the pelvis and looks like a deflated balloon when empty. As it fills, the bladder assumes a more spherical shape as its dome and upper aspect enter the abdomen, approaching the level of the umbilicus.

The size of the bladder varies with the amount of urine it contains. In healthy adults the bladder holds about 300-500 ml of urine before internal pressure rises and signals the need to empty the bladder through micturition, however the bladder can hold 600-800mls if necessary. If the bladder becomes distended with more than 1000mls, there is danger of resultant loss of bladder tone.

The trigone is the triangular area formed by the two urethral openings and the bladder neck at the base of the bladder. The trigone does not change its shape during bladder filling or emptying. The bladder is attached to the abdominal wall by an umbilical ligament. As a result of this attachment, as the bladder fills, it rises towards the umbilicus.

**Urethra:** is a thin-walled muscular tube that channels urine to the outside of the body. In males the urethra is 20-25 cm long and is ‘S’ shaped. The prostate gland encircles the urethra at the base of the bladder.
Male Urinary Bladder Anatomy

**Urethovesical Unit**
Together the bladder, urethra, and pelvic floor muscles form what is called the urethovesical unit. Together these organs form a functional system that allows the bladder to fill with and store urine until the individual empties the system through voluntary expulsion, called micturition. Voluntary control of this unit is defined as continence.

Micturition
http://www.shutterstock.com
Urinary continence relies on three mechanisms: an anatomically intact urinary system; integration of neural modulatory structures in the brain, spinal cord, and peripheral nervous system and a competent urethral sphincter mechanism.

Stimulating and inhibiting impulses are sent from the brain through the thoracolumbar (T11 to L2) and sacral (S2 to S4) areas of the spinal cord to control voiding. Distension of the bladder stimulates stretch receptors within the bladder wall. Impulses are transmitted to the brain, causing a desire to urinate. If the time to void is not appropriate, inhibitor impulses in the brain are stimulated and transmitted back through the thoracolumbar and sacral nerves innervating the bladder.

In a coordinated fashion, the detrusor muscle accommodates to the pressure (does not contract) while the sphincter and pelvic floor tighten (contract) to resist bladder pressure. If voiding is appropriate, cerebral inhibition is voluntarily suppressed and impulses are transmitted via the spinal cord for the bladder neck, sphincter, and pelvic floor muscles to relax and for the bladder to contract. The sphincter closes and the detrusor muscle relaxes when the bladder is empty.

Any disease or trauma that affects the function of the brain, spinal cord, or nerves that directly innervate the bladder, bladder neck, external sphincter, or pelvic floor can affect bladder function. These conditions include diabetes mellitus, multiple sclerosis, paraplegia and tetraplegia. Drugs affecting nerve transmission also can affect bladder function.

Physiological changes that occur with aging such as loss of elasticity and muscle support can affect urinary continence. An enlarged prostate may affect urinary patterns causing hesitation, retention, slow stream and incomplete bladder emptying which can cause bladder infections.

Neurological Control of the Bladder Function
**Urine Characteristics**

Normal adult urine output is approximately 1500ml/day, which varies with food and fluid intake. The volume of urine produced at night is less than half of that formed during the day because of hormonal influences. This diurnal pattern of urination is normal. Typically an individual will urinate five or six times a day and occasionally at night.

Freshly voided urine is clear and pale to deep yellow. Its yellow colour is due to urochrome, a pigment that results for the body’s destruction of haemoglobin (bilirubin). The more concentrated the urine the deeper the colour. An abnormal colour such as pink, red or brown may result from eating certain foods, taking certain vitamins or medications or the presence of blood. Haematuria can be either microscopic or macroscopic and is associated with either trauma or an underlying disease process. Anticoagulant therapy will increase the risk of catheter associated haematuria especially following insertion. Cloudy urine may indicate a urinary tract infection.

Water accounts for about 95% or urine volume, the remaining 5% consists of solutes, urea being the most common. Urea is derived by the normal breakdown of amino acids. Fresh urine is slightly aromatic, but if allowed to stand, it develops an ammonia odour as bacteria metabolize its urea solutes.

Urine output is directly affected by renal perfusion and the Glomerular Filtration Rate (GFR). In an adult the minimum urine output is 0.5ml – 1 ml per kg per hour. Low urine output is a sign of deterioration and may identify patients who have poorly perfused kidneys and may require treatment for low blood pressure, dehydration or electrolyte imbalance.

**Disorders of the lower urinary tract**

Urinary retention is the inability to empty the bladder to completion. It may be acute, chronic or acute on chronic.

**Acute Urinary Retention (AUR)**

Is the inability to voluntarily pass urine and is the most common urologic emergency. Acute urinary retention is common in men and the incidence increases with age, occurring most frequently in men over the age 60. The male to female incidence ratio is 13:1.

Pathophysiological mechanisms of AUR are outflow obstruction, neurological impairment and inefficient detrusor muscle. There are a number of causes of AUR which include but are not limited to the following:
**Benign Prostatic Hyperplasia (BPH):** The most common cause of AUR in men is obstruction secondary to BPH. The prostate gland tissue grows causing the urethra to narrow making it difficult to void. Prostate cancer can also cause AUR.

![NORMAL PROSTATE](http://www.shutterstock.com) ![ENLARGED PROSTATE](http://www.shutterstock.com)

**Constipation:** The rectum is located near the bladder and there is a close relationship between the muscles and nerves that control bladder functions and those that control bowel movements. Large amounts of stool in the colon can put pressure on the bladder which can cause the bladder not to fill adequately; to contract when it is not supposed to or not to empty adequately.

![Stool in rectum](http://www.mountnittany.org/ARTICLES/HEALTHSHEETS/11940)

Benign Prostatic Hyperplasia

http://www.shutterstock.com

Constipation

http://www.mountnittany.org/ARTICLES/HEALTHSHEETS/11940
**Urethral Stricture:** Some conditions can cause a portion of the ureter to become narrowed known as a urethral stricture. This can be congenital, or as the result of scarring from previous surgery, urinary stones, or bacterial or viral infections. Strictures can cause bladder outflow obstruction and symptoms of reduced urine flow. When inserting a urethral catheter resistance may be felt at the point of the stricture. If resistance is felt a smaller catheter may be helpful. If the catheter does not advance consult the urology team.

![Possible complications - from strictures to spastic bladders explained?](http://www.manfred-sauer.co.uk/IQCATH.ASP)

**Paraphamosis:** Occurs when the foreskin has been retracted and not replaced resulting in swelling of the glans and the inability to urinate.

**Medications:** Patients taking opioids and anticholinergic medications are at high risk for AUR due to decreased bladder sensation. Anticholinergic medications also reduce detrusor contractility (e.g. atropine, glycopyrrolate, oxybutynin). Some antidepressants, antiparkinsonian, antipsycotics, antihistamines and muscle relaxants can also cause urinary retention.

**Infections:** Infections may cause inflammation that result in urinary obstruction, for example prostatitis and urethritis.

**Trauma:** Mechanical disruption may occur due to trauma to the pelvis, urethra or penis.
**Postoperative Urinary Retention (POUR)**

Postoperative urinary retention is described as the inability to void after a surgical procedure despite a full bladder. Risk factors include:

- Age, over 50 years doubles your risk
- Administration of >750ml of fluid
- Duration of surgery >2hours
- Intraoperative anticholinergic medication use e.g. atropine, glycopyrrolate
- Use of regional anaesthetic
- Opioid use
- Pelvic surgery

Acute urinary retention needs to be treated promptly to prevent bladder overdistension injury. Acute prolonged bladder overdistension is a primary, temporary neurogenic detrusor dysfunction causing retention. It is associated with decreased or absent bladder sensation therefore patients do not complain and management is delayed. Complications can include nerve damage and damage to the detrusor muscle.

The insertion of an indwelling catheter to keep the acutely overdistended bladder empty for days to weeks with the aim of improving bladder tone and enabling resumption of spontaneous voiding is current practice under the guidance of the urology team.

**Incontinence of Urine**

Incontinence is the involuntary or uncontrolled loss of urine from the bladder and includes the following subtypes:

- **Stress** – associated with increased intra-abdominal pressure through coughing, sneezing or lifting.
- **Urge** – associated with urgency; the patient is aware of the need to urinate but is unable to reach the toilet in time.
- **Reflex** – associated with involuntary urethral relaxation due to loss of sensation, as in paraplegia.
- **Overflow** – associated with over distension of the bladder and frequent small loss of urine; the bladder does not fully empty; maybe caused by medications, strictures or prostatic enlargement.
- **Mixed** – combination of stress and urge incontinence.

**Chronic Urinary Retention (CUR)**

Is defined as the persistent inability to completely empty the bladder despite maintaining an ability to urinate, which results in elevated Post Void Residual (PVR) urine volumes of >300mls. CUR affects elderly men more than any other population. CUR may be asymptomatic or associated with urinary frequency, urgency or incontinence.
Practice Alert: Some patients may experience a vasovagal response, becoming pale, sweaty and hypotensive, if the bladder is rapidly drained. Haematuria may also occur with rapid decompression. If you are aware prior to insertion of an indwelling catheter that the patient has in excess of 500mls in their bladder consider resting the drainage bag on the bed, rather than hanging the bag on the side of the bed, to allow for slower drainage of the bladder. Once the bladder has drained, for approximately 30 minutes hang, the drainage bag on the side of the bed below the level of the patient’s bladder.

Catheter-Associated Urinary Tract Infections (CAUTIs)

CAUTIs are a commonly reported healthcare-associated infection. Approximately 80% of hospital acquired urinary tract infections are associated with a urinary catheter. The longer the catheter remains insitu, the greater risk of infection. Most microorganisms causing CAUTI derive from the patient’s own colonic and perineal flora or from the hands of healthcare workers. Bacteria can enter the urinary tract at the time of catheter insertion via the catheter tip or subsequently once the patient is catheterised by either migrating through the column of urine within the catheter or by moving up the mucous sheath of the urethra outside the catheter. Biofilm, a living layer of pathogens, forms on the catheter itself. These biofilms are relative resistant to antibiotics making it necessary to remove the source of infection.

To reduce the risk of CAUTI it is vital to implement prevention measures. Practices to minimize the risk of CAUTIs can be summarized into three distinct areas: insertion, maintenance and quality improvement.

Insertion

- Only insert a catheter if the indication is appropriate. Consider other possible alternatives e.g. uridine.
- Only trained, competent staff insert urinary catheters.
- Insert catheter using an aseptic technique using sterile equipment.
- Ensure insertion site is thoroughly cleaned.
- Healthcare worker performs hand hygiene prior to insertion.
- Use the smallest catheter as possible to minimize urethral trauma.
- Document clearly in the patient record post insertion.
- Educate the patient and significant others on the care and maintenance of the urinary catheter to prevent infection.

Maintenance

- Secure the catheter to the patient’s leg to prevent movement and urethral trauma.
- Perform the 5 moments of hand hygiene before and after any contact with the catheter or catheter bag.
- Use standard precautions and don appropriate PPE during any contact with the catheter or catheter bag.
The catheter bag must be maintained as a sterile, continuously closed drainage system, with unobstructed urine flow.

Keep the bag below the level of the bladder at all times, do not rest the bag on the floor.

Do not allow the drainage bag or collection chamber to over fill.

For examination of fresh urine, aspirate from the sample port – do not take samples from the drainage bag.

If breaks in aseptic non-touch technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic non-touch technique and sterile equipment.

Maximum dwell time for silicone catheters is 12 weeks unless otherwise indicated.

Date the drainage bag and replace weekly.

Minimise the duration of catheterisation, remove as soon as the indication for insertion no longer exists.

Catheters should not be inserted for the management of incontinence.

Clean the tip of the penis and catheter daily during routine bathing.

**Quality improvement**

- Patients should be reviewed daily to assess the need for the catheter.
- Inpatient audits to monitor appropriate management of indwelling urinary catheters.
- Infection Control Department review and monitor bloodstream infections secondary to healthcare acquired CAUTI’s.

**Urinary Catheters**

The most commonly used indwelling urinary catheter is a Foley catheter. Foley catheters have a balloon which is inflated to keep the catheter in place and have 2 or 3 lumens, one to drain urine, a second to inflate the balloon and if present a third to irrigate or instil fluid into the bladder.

The French (Fr) gauge system is widely used to specify the size of a catheter. The larger the gauge number, the larger the catheter. The catheter size used should be fit for purpose, ensuring that the internal lumen is large enough to drain the type of urine expected, for example urine with clots and debris will need a larger size catheter. If too large a catheter is used, it may cause urethral irritation, discomfort and mucosal damage. Catheter size for males is generally 14-16 Fg unless otherwise ordered.

The balloon retains the catheter in the bladder and the recommended volume for inflation is printed on the balloon port. The usual volume for 2 way catheters is 5-10mls; larger volumes are required for larger gauged 3 way catheters. Under inflation of the balloon should be avoided, as this may cause distortion and the catheter may not be properly retained in the bladder. Over inflation should also be avoided as this may result in occlusion of the drainage eyes or balloon failure.

Sterile water is used to inflate the balloon. Normal saline can cause balloon failure through deflation or blockage due to crystallization.
**Insertion of Indwelling Urethral Catheter**

Prior to insertion of the catheter there needs to be clear documentation indicating the reason for insertion.

**Insertion Indications**

a) Patient has acute urinary retention or obstruction  
b) Urinary output monitoring in critically ill patients  
c) Peri-operative use for selective surgical procedures, such as:  
   - Urological surgery or surgery involving other contiguous structures of genitourinary tract  
   - Prolonged duration of surgery (removed in recovery)  
   - Large volumes of infusions or diuretics administered intra-operatively  
   - Operative patients with urinary incontinence  
   - Need for intraoperative monitoring of output  
   - Spinal anaesthetic and epidural analgesia  

N.B In these settings the catheter should be removed within 24 hours post-operatively where possible.  
d) Healing of wounds (sacral/perianal) in incontinent patients (as part of a holistic plan).  
e) Instillation of medically ordered intravesical medications e.g. BCG.  
f) Patient requiring prolonged immobilisation e.g. potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures.  
g) Neurogenic bladder e.g. spinal cord lesions, cerebrovascular accident, brain tumour.  
h) Exceptional circumstances e.g. comfort at end of life.  
i) Epidural analgesia.

➤ Avoid using indwelling urinary catheters for the management of incontinence. This includes residential aged care residents.

**Contraindications for insertion.**

Caution must be taken in the presence of;  
> Blood at the urethral meatus/gross haematuria secondary to trauma,  
> Pelvic fractures or trauma,  
> Acute prostatitis,  
> Known urethral strictures,  
> Recent urinary tract surgery, or  
> Patients with an artificial sphincter;  

Consult with an urologist prior to insertion for correct management.
Procedure for Insertion

It is strongly advised to have an assistant to assist with the insertion of a catheter. The role of the assistant is to assist with the set-up of the equipment to maintain aseptic technique and to assist in the positioning of the patient to maintain privacy.

Equipment and Supplies

- Dressing trolley
- Disposable Foley Catheter of the appropriate size
- Sterile catheter pack.
- Chlorhexidine irrigation solution 0.1% 30ml 1-2 ampoule (or 0.9% saline if not available)
- 2% lignocaine gel syringe
- Sterile water for balloon inflation
- Appropriate sterile catheter drainage bag
- Catheter securing tape
- Plastic apron and protective eye wear
- Sterile gloves x2 (and non-sterile gloves if removing old catheter)
- Sterile specimen container (if collecting specimen)
- Bluey/plastic backed sheet or towel
- General waste bag
Procedure

1. Obtain medical order.
2. Explain the procedure to the patient and obtain consent.
3. Perform hand hygiene.
4. Clean work surface and collect equipment.
5. Position patient in supine position with legs shoulder width apart.
6. Place a towel or blue liner under the patient’s buttocks.
7. Perform hand hygiene and put on disposable apron and protective eyewear.
8. Open sterile catheter pack and add remaining equipment for the procedure.
   Add water to one gailpot, and chlorhexidine to the other.
10. Don sterile gloves.
11. Check the catheter port for the volume of water required to inflate the catheter balloon.
12. Draw up the required amount of sterile water using the sterile syringe.
13. Soak the sterile gauze in the chlorhexidine solution.
14. Zip open proximal end of catheter bag, leaving the distal end of the catheter closed, and place in sterile kidney dish
15. Place the fenestrated drape around the genitals leaving the penis exposed.
16. Use the non-dominant hand to hold the shaft of the penis and if necessary, retract the foreskin gently with the thumb and forefinger.
17. Using dominant hand and gauze, cleanse the penis from the urethral meatus to the base of the glans.
18. With 2% lignocaine gel, insert slowly into the urethral meatus using the dominant hand. Place thumb over urethral meatus to allow the gel to remain inside urethra and allow 3-4 minutes for it to take effect. Place penis on top of sterile towel.
19. Remove outer pair of sterile gloves and dispose.
20. Place catheter in sterile kidney dish on the sterile drape in between the patient’s legs.
21. Hold the penis upright with the non-dominant hand and introduce the catheter tip gently into the urethral meatus using the sterile, dominant hand and advance slowly until urine flows, approximately 15-25cms (if urine specimen required collect this directly into the sterile container).
22. Prior to inflating the balloon advance the catheter a further 1-2cms to ensure that it is not lodged in the bladder neck, prostate or urethra and inflate the catheter balloon with the sterile water – always ensure urine is flowing before inflating the balloon and stop if pain is felt.
23. Gently withdraw the catheter until resistance is felt.
24. If no urine appears or if resistance is felt on inserting the catheter, stop and wait a few minutes to allow any sphincter spasm to settle, before trying again. Do not use force to insert the catheter especially in an elderly male to minimise trauma to the prostate. Consider asking the patient to take a deep breath; ask the patient to cough or bear down; ask the patient to try and pass urine or gently rotate the catheter.
25. If urine does not drain lower the penis, ask the patient to deep breathe and cough, or reposition the catheter by gently rotating it. Refer to the medical officer for assistance if still unable to advance the catheter or obtain urine.
26. Lower the penis and if necessary, reposition the foreskin.
27. Attach the catheter to the urine drainage bag and secure catheter to the inner aspect of the thigh and attach the urine drainage bag to the bed, a carrier, or the patient’s leg if wearing a leg bag. **Ensure that all urine drainage bags used are sterile and connections secure.**
28. Assist patient to reposition as necessary.
29. Remove gloves and dispose of equipment used as per waste procedure.
30. Perform hand hygiene.
31. Documentation in the patient’s health record as per female insertion
References


Manfred Sauer UK 2015, IQ cath safe and simple male catheterisation, viewed 17 November <http://www.manfred-sauer.co.uk/IQCATH.ASP>.


Metro North Hospital and Health Service 2012, Insertion and management of indwelling urethral catheters.


Written Assessment

Name: ____________________________________

Workplace: __________________________________

Date: _____________________________________

Minimum Requirement: participant must achieve a minimum of 80% in the written assessment prior to proceeding to the clinical competency.

Questions

1. What is the maximum recommended dwell time for a silicone urethral catheter?
   a. 2 weeks
   b. 4 weeks
   c. 8 weeks
   d. 12 weeks

2. How frequently should a urinary drainage bag be changed?
   a. Weekly
   b. Fortnightly
   c. Monthly
   d. Only when the catheter is changed

3. What do you use to inflate the balloon on the catheter?
   a. Normal saline
   b. Sterile water
   c. Air
   d. Chlorhexidine

4. Which of the following is an inappropriate indication for the insertion of a catheter?
   a. Palliative care
   b. Acute urinary retention
   c. Incontinence
   d. Epidural analgesia
5. **How long does the lignocaine gel need to be insitu to take effect?**
   a. 1 minute
   b. 3-4 minutes
   c. 5-6 minutes
   d. 10 minutes

6. **List four possible processes to prevent a CAUTI when inserting a urethral catheter?**
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   /2 marks

7. **What 3 mechanisms does the body rely on for urinary continence?**
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   /2 marks

8. **Why would inserting an IDC cause a vasovagal response? How can this be prevented?**
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   /2 marks

9. **What is the contraindication of inflating the balloon without draining urine?**
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

   /2 marks
10. Whilst inserting the catheter there is some resistance felt, what techniques can you implement to assist the insertion?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

/2 marks

11. Why is it important to have an assistant when catheterising?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

/1 mark

12. If you have a foreskin what must you do on completion of insertion and why?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

/2 marks

13. What are two contraindications for inserting a male catheter?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

/2 marks

Result: ___/20
Nurse Educator: ________________________________
# CSAT: Male Catheterisation

## Performance Criteria

1. **Demonstrate evidence of therapeutic interaction & knowledge of legal requirements.**

<table>
<thead>
<tr>
<th>Critical indicators</th>
<th>Indicators</th>
<th>Observed</th>
<th>Not Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>***</td>
<td>Clarifies the indication for catheterisation</td>
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<tr>
<td></td>
<td>Introduces self to patient/ family/ carer.</td>
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<tr>
<td>***</td>
<td>Displays correct patient identification process</td>
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<td></td>
<td>Obtains patient consent for procedure</td>
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<td></td>
<td>Provides explanations of current condition and subsequent care</td>
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<td>***</td>
<td>Demonstrates concern and respect in all interactions</td>
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<tr>
<td></td>
<td>Identifies any contraindications to catheterisation</td>
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2. **Demonstrate correct collection of equipment**

<table>
<thead>
<tr>
<th>Critical indicators</th>
<th>Indicators</th>
<th>Observed</th>
<th>Not Observed</th>
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<tbody>
<tr>
<td></td>
<td>Perform hand hygiene and clean work surface</td>
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<tr>
<td></td>
<td>Collect equipment for procedure</td>
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<tr>
<td>***</td>
<td>Identify correct size of catheter for insertion</td>
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<td></td>
<td>Don appropriate PPE</td>
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3. **Demonstrate insertion maintain aseptic technique**

<table>
<thead>
<tr>
<th>Critical indicators</th>
<th>Indicators</th>
<th>Observed</th>
<th>Not observed</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Position patient appropriately with towel or blue liner under buttocks, maintaining the patient's dignity at all times.</td>
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<td></td>
<td>2. Perform hand hygiene and open catheter pack and equipment required for procedure.</td>
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<td></td>
<td>3. Perform hand hygiene and don 2 pairs of sterile gloves.</td>
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<td>***</td>
<td>4. Ensure water is ready and appropriate amount for inflation of balloon.</td>
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<td></td>
<td>5. Place fenestrated drape around the genitals leaving the penis exposed.</td>
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<td>6. Cleanse the urethral meatus to the base of the glans with Chlorhexidine soaked gauze retracting the foreskin if present.</td>
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<td>7. Insert 2% lignocaine gel slowly into the urethral meatus. Place thumb over urethral meatus for 3-4 minutes. Place penis on sterile towel.</td>
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<td>8. Remove outer pair of sterile gloves and dispose.</td>
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<td>***</td>
<td>9. Hold the penis upright and introduce the catheter tip into the urethral meatus and advance slowly until urine flows. Continue to insert the catheter a further few centimetres. *If no urine appears or resistance is felt demonstrate techniques to assist insertion.</td>
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<td>10. Inflate the balloon only if urine is flowing and stop inflating if the patient experiences any pain.</td>
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<td>11. Gently withdraw the catheter until resistance is felt.</td>
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<td>12. Lower the penis and reposition the foreskin.</td>
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<td>13. Attach catheter to the inner thigh and position urine drainage bag appropriately. Document the date on the drainage bag.</td>
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<td>15. Educate patient on care and maintenance of catheter.</td>
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<td>16. Documentation in patient record</td>
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</tbody>
</table>

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**Insertion and Management of Indwelling Male Urethral Catheters**
4. Identifies management strategies to reduce the risk of infection

<table>
<thead>
<tr>
<th>Critical Indicators</th>
<th>Indicators</th>
<th>Observed</th>
<th>Not Observed</th>
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</thead>
<tbody>
<tr>
<td>***</td>
<td>Dwell time for catheter</td>
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<tr>
<td></td>
<td>Change of drainage bag every 7 days</td>
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<tr>
<td></td>
<td>Maintaining closed system</td>
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<td></td>
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<tr>
<td></td>
<td>Appropriate position for drainage bag</td>
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</tbody>
</table>

Range of Variables:

- Assessment: in a clinical setting
- Assessment: in an emergency or elective situation
- Assessment required to be demonstrated under supervision twice
- Procedural attempts x 1 only: then referral to a more experienced practitioner

**Date:** ......................  **Procedure setting (please circle):** Clinical/ Simulated

Scenario outline:

___________________________________________________________________________________

**Please circle one:** Competent / Reassessment Required

Assessor’s comments:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Assessor’s name (printed): ________________________
Signature: ________________________

Candidate's comments:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Candidate's name (printed): ________________________
Signature: ________________________