Health
Northern Sydney
Local Health District

Facility: COM HKH MQE MVH RNS RYD

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. / /	M.O.
ADDRESS	
	PH
M/C	FIN
LOCATION / WARD	ADM / /

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CPL09929

NSHNS TROUBLESHOOTING FOR CATHETER MANAGEMENT

Problem	Possible Cause	Action — RN - Contact CNC if unsure of action to be taken; EN - Consult RN re. action to take within professional limitations
Unable to remove catheter	Balloon not deflating or faulty balloon port	Detach syringe then reattach and try again allowing spontaneous deflation. Insert 3 mL sterile H_2O and attempt to deflate noting volume withdrawn. If problem persists seek advice.
	SPC - Bladder spasm	Wait until spasm passes. Ensure not constipated. If catheter patent postpone catheter change until following day. If ongoing problem seek advice on anticholinergic medication.
	Cuffing of deflated balloon	After complete deflation, instil 0.5 mL sterile H_2O back into balloon and retry. Examine catheter tip after removal.
	Encrustation	SPC - Rotate catheter 3600,
• **Aim to deflate balloon about 10 mins. prior to removal.** • **A fair degree of pull may be required, holding the catheter close to stoma whilst supporting the abdomen with the non-dominant hand. If ongoing problem see Action for Bladder Spasm.** • **After removal examine catheter tip. If cuffing or encrustation apparent seek CNC advice on catheter type and appropriate preventative action.**		
Pain/Bleeding	Traumatic removal	Monitor severity and frequency, address cause. Reassure client
	SPC - over granulation due to yawing	Prevent catheter traction and alternate catheter lie on weekly basis. Apply dressing as necessary.
Unable to insert catheter **N.B. Keep Nelaton catheter of same size at house to maintain patency of tract if problems arise**	SPC - spasm of tract/bladder	Await release of spasm and reattempt. Insert Nelaton, then remove and quickly reinsert usual catheter, or try smaller size of Foley catheter. Alleviate possible causes e.g constipation. MS and CVA patients may require anticholinergic medication.
	SPC - Not following tract	Re-attempt at correct angle. Always observe the angle of tract during catheter removal. [If above measures fail, consider a temporary IDC after discussion with LMO/CNC]
	Male IDC - sphincter contraction, strictures or prostatic enlargement	Place penis in horizontal plane, apply slight traction and ask patient to cough, bear down or try to pass urine, while advancing catheter. Do not force. Seek advice. Discuss possible SPC.
No drainage - after insertion of new catheter	Catheter not in bladder	Advance catheter further [male IDC -up to Y junction, SPC no further than 10 cm].
	No urine in bladder	Give fluids, wait to see urine before inflating balloon. Advise to increase fluids generally and particularly on day of catheter change [about 100 mL per hour]. Clamp drainage tubing for approx. 15 minutes [after deflating balloon] prior to removal. **N.B Except in spinal cord injured persons.**
	Blockage	Give fluids. Sit patient up to promote urine drainage. If ongoing, seek CNC advice.
Unable to inflate balloon or resistance encountered	Balloon not in bladder	Insert further
	Syringe not firmly connected to balloon port	Detach syringe then reattach and try again.

Holes punched as per AS2828 - 2012
BINDING MARGIN - NO WRITING

CATALOGUE NUMBER NS09929 NOV19/V4

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NSW GOVERNMENT

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Problem	Possible Cause	Action – RN - Contact CNC if unsure of action to be taken; EN - Consult RN re. action to take within professional limitations
No drainage +/- leakage	Low fluid intake	Ensure good fluid intake, at least 2 litres daily, unless contraindicated.
	Kinked tubing	Check lie of tubing.
	Bag higher than bladder	Lower to assist gravity.
	Constipation	Alleviate and prevent.
	Encrustation/stones/debris	Check patency by instilling [by gravity] 20 mL of warmed normal saline into catheter via syringe. Change catheter and record frequency of blockage to plan catheter changes. Encourage good fluid intake, mobility/passive changes in position. Review medications, including non-prescribed. Urological consult every 2 years.
	Catheter not in bladder	Insert new catheter.
	Valve or connection closed	Ensure valve or connection open.
Pain	Infection - symptomatic	Collect CSU from new catheter, increase fluids. Treat with appropriate antibiotic. If valve insitu put on free drainage. Recurrent infections require investigation.
	Catheter not in bladder	Insert new catheter.
	IDC: urethritis [in postmenopausal women]	Discuss possible use of vaginal oestrogen with LMO. Discuss possible urological consult re. SPC.
	Balloon too large Catheter too large	5-10 mL balloon advised. IDC: less than 18FG advised.
	Traction of catheter	Secure with tape/strap.
Bleeding persistent haematuria	Trauma Infection	Ensure catheter not under tension; advise use of leg strap. Contact LMO re CSU Contact LMO/urological consult
Bladder spasm/ cramps +/- leakage	Infection - symptomatic	Collect CSU from new catheter, increase fluids. Treat with appropriate antibiotic. If valve insitu, put on free drainage.
	Balloon too large Catheter too large	5 -10 mL balloon advised IDC: less than 18FG advised
	Traction of catheter	Secure with tape/strap to prevent traction.
	Overactive bladder	Have on free drainage and discuss use of anticholinergic therapy with LMO.
	Constipation	Alleviate and prevent.
	New catheter insitu	Spasms should settle within 24 – 48 hrs.
Skin or Stoma Issues	Allergy to catheter material	Change catheter type.
	Overgranulation of stoma due to yawing	Prevent catheter traction and alternate catheter lie on weekly basis. Apply dry dressing as necessary.
	Infection of stoma	Arrange for wound swab, treat as required.

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