

WEST LIMERICK INDEPENDENT LIVING CLG

Catheter and Stoma Care Policy

Policy Reference	WLILP15/16 — recommend the Board formally retire one number and keep the other, rather than running a combined document under two numbers
Category	Clinical & Care Practice — Specialist Physical Care
Version	1.0 (new combined policy, legislatively and clinically strengthened)
Status	APPROVED — by the Board of Directors on 9 October 2026
Supersedes	WLILP15 - Stoma Care Policy (2025); WLILP16 - Catheter Care Policy (reviewed Apr 2025)
Policy Owner	Board of Directors, West Limerick Independent Living CLG
Applies To	All Personal Assistants and Home Care Assistants who provide catheter or stoma care to a person supported by WLIL
Related Policies	WLILP20 - Personal and Intimate Care Policy; WLILP38 - Infection Prevention and Control Policy; WLILP48 - Medication Policy for Personal Assistants; Incident Reporting Policy
Review Cycle	Annually, or sooner if clinical guidance or national standards change

1. Purpose and Scope

This policy sets out WLIL's approach to catheter care and stoma care, brought together in one document because they share the same governance requirements: both are specialist physical care tasks that a PA or HCA may only carry out once shown how to do so correctly and signed off as competent, both require particular attention to dignity and consent, and both carry specific emergency signs that must never be ignored.

This policy applies to all WLIL staff who may be asked to provide catheter or stoma care to a person they support.

2. Legislative and Regulatory Framework

- Health Act 2007 — establishes HIQA and its role in regulating health and social care services
- Health (Amendment) (Home Support Providers) Act 2026 — enacted 1 July 2026 but not yet commenced; once in force, home support providers such as WLIL will come under HIQA's Chief Inspector of Social Services
- HIQA Draft National Standards for Home Support Services (2024) — the applicable standard for home-based specialist care tasks such as these
- Assisted Decision-Making (Capacity) Act 2015, as amended by the 2022 Act (both fully commenced 26 April 2023) — governs consent where a person's capacity to direct this care is in question

This policy should be read together with WLILP20 - Personal and Intimate Care Policy, which sets out WLIL's general principles on dignity, consent, and staff gender preference for intimate care — all of which apply equally to catheter and stoma care.

3. Responsibility

- It is the responsibility of every staff member who manages catheter or stoma care to follow this policy
- It is the responsibility of Service Coordinators to ensure staff are familiar with this policy, to arrange training, and to monitor compliance
- It is the responsibility of the General Manager to ensure appropriate training is available and that no PA or HCA is asked to carry out a task they have not been signed off as competent to perform

4. Definitions

4.1 Stoma Types

"Stoma" comes from the Greek word for "mouth" or "opening." A bowel or urinary stoma is created by bringing a section of the bowel or urinary tract out to the abdominal wall, usually because the tract beyond that point is no longer viable.

Colostomy: formed from a section of the large bowel, opening from the large intestine to the abdominal wall, so faeces bypass the anal canal

Ileostomy: formed from a section of the small bowel, opening from the small intestine to the abdominal wall, so faeces bypass the large intestine and anal canal

Urostomy: a connection between the urinary tract and the abdominal wall forming a "urinary conduit," so urine passes directly into a stoma bag, bypassing the urethra

4.2 Catheter Types

Urethral catheter: a catheter inserted through the urethra into the bladder

Suprapubic catheter: a catheter inserted directly into the bladder through a small opening in the abdomen

5. Training and Competency

No PA or HCA should carry out any catheter or stoma task beyond basic bag emptying without first being shown how to do it correctly and signed off as competent.

This applies in particular to changing a leg bag, changing a night bag, changing a stoma pouching system, and assisting with peristomal or catheter-site hygiene. Training must be arranged by the Service Coordinator before any such task is included in a person's support plan, and where possible the first time a task is carried out, it should be done under the supervision of a Public Health Nurse (PHN), stoma care nurse, or clinical advisor.

6. Consent, Dignity and Privacy

- Explain the procedure to the service user before starting, and throughout, in a way they understand
- Ensure privacy and the service user's comfort at all times
- Where a staff gender preference has been recorded for this task, it should be respected wherever practicable, in line with WLILP20

- Where a service user can manage part or all of the task themselves, support should be limited to what they ask for or what their care plan specifies

7. Infection Prevention and Control

- Wash and dry hands thoroughly before and after every task, and immediately after removing gloves
- Wear disposable gloves and an apron for all catheter and stoma tasks; never reuse gloves between tasks or between visits
- Avoid any contact between drainage ports, connection points or the stoma itself and any container or surface
- Dispose of soiled materials, used bags and pouches in clinical waste (yellow bag), not general household waste

Refer to WLILP38 - Infection Prevention and Control Policy for full PPE and hygiene requirements.

Section A — Catheter Care

A1. Equipment

- Gloves and apron
- Alcohol wipes / paper towel
- A jug, preferably with a cover (use paper towel if not)

A2. Procedure — Emptying the Catheter Bag

- Wash and dry hands thoroughly, then apply gloves
- Use a separate, clean container each time; avoid any contact between the drainage tap and the container
- Explain the procedure to the service user and ensure their privacy and comfort
- Bring equipment to the service user, or bring the service user to an appropriate area (e.g. the bathroom), according to their preference
- Protect clothing and the surrounding area from spillage
- Position the jug under the drainage port (the bag does not need to be removed from its stand)

Do not allow the port to touch the jug.

- Open the port to empty the bag, then close it once empty
- Wipe the port with an alcohol swab or paper towel to prevent dripping or a build-up of contamination
- Reposition the bag so the drainage port is not touching the floor and the tubing is not bent or kinked
- Cover the jug and take it to the bathroom; observe the amount, colour and odour of the urine, and note any blood clots or white, thread-like particles
- Discard the urine and wash the jug thoroughly; remove and discard gloves; wash and dry hands thoroughly
- Record the amount of urine and any observations in the service user's notes, and report any concerns to the PHN or Service Coordinator

A3. Changing the Leg Bag or Night Bag (Trained Staff Only)

This task must only be carried out by a PA or HCA who has been shown how to do it correctly and signed off as competent, in line with Section 5.

- Follow the infection prevention steps in Section 7, including gloves and apron
- Wipe the connection point with an alcohol swab before and after connecting the new bag
- Do not touch the tip of the new bag or the catheter outlet
- Maintain a closed drainage system as far as possible — this reduces the risk of catheter-related infection
- Dispose of the old bag in clinical waste
- Record the change and report any concerns to the PHN or Service Coordinator

A4. Troubleshooting and Signs to Report

This applies to suprapubic and indwelling urinary catheters. If no urine is draining into the bag:

- Check for and remove any kinks in the catheter or drainage bag tubing (firm-fitting underwear can sometimes cause kinks)

- Check the drainage bag is positioned below the bladder whether lying, sitting or standing
- Check the leg bag straps are fitted correctly and are not causing an obstruction

Catheter blockage is an emergency and needs to be resolved as soon as possible by a medical professional. Do not attempt to free the blockage yourself.

Contact the emergency department immediately if, having checked the above, the service user has abdominal discomfort, feels the need to pass urine, or is unable to feel bladder fullness. If none of these apply, encourage two glasses of water immediately; if there is still no drainage after 30 minutes, contact the GP or attend an emergency department.

Daily bathing or showering is encouraged. Report any of the following to the PHN, GP, or Community Intervention Team (CIT): cloudy, dark or bloodstained urine; a strong or unusual odour; pain, burning or pressure; fever or the person seeming generally unwell; redness, swelling or discharge at the catheter site; or the catheter appearing to have moved.

Section B — Stoma Care

B1. Equipment

- Gloves and apron
- Paper towel
- New appliance / pouching system and relevant accessories
- Disposable bag for waste
- Bowl of warm water and a disposable cloth
- Soap (only if advised by the stoma care nurse — warm water alone is often sufficient)
- A jug for the contents of a drainable appliance
- An incontinence sheet

B2. Procedure — Changing the Pouching System

- Ensure privacy for the procedure and explain it to the service user
- Ensure the service user is in a comfortable position
- Place the incontinence sheet to protect clothing and bedding
- If the pouch is drainable, empty the contents into a jug before changing it
- Gently remove the pouch from the flange with one hand while securing the flange with the other (or remove both together if changing the full system), applying gentle pressure on the surrounding skin to prevent skin breakdown
- Gently remove any excess output or adhesive from the skin and stoma with a damp tissue
- Examine the skin for soreness, redness or ulceration
- Wash and dry the stoma and surrounding skin
- Apply the new appliance
- Dispose of soiled materials in clinical waste
- Wash and dry hands thoroughly
- Record the change in the service user's notes, including any adverse changes noted

B3. Emptying a Drainable Pouch

Where the pouch is drainable rather than closed, it should typically be emptied when around one-third to half full, following the same infection prevention steps as Section 7. Record the output (volume, colour, consistency) if required.

B4. Signs to Report — Do Not Ignore These

Treat as a medical emergency and seek urgent medical attention if the stoma looks dark, dusky, purple or black — this can indicate the blood supply to the stoma is compromised.

Contact the coordinator or stoma care nurse immediately for any of the following:

- No output for several hours combined with cramping, nausea, vomiting or abdominal swelling — possible blockage
- Very watery, high-volume output continuing for an extended period — risk of dehydration

- Persistent or heavy bleeding from the stoma itself (a small amount of spotting when cleaning is usually normal)
- Redness, soreness, broken or weeping skin around the stoma (peristomal skin breakdown)
- Swelling, or the stoma pulling in or protruding further than usual
- The pouch repeatedly will not seal or stay attached despite correct technique
- Loose, watery stool, a change in consistency, lumps, itchiness, infection or sensitivity

Do not insert anything into the stoma, and do not attempt to resize, reshape, or resolve a suspected blockage yourself.

Contact the stoma care nurse, PHN, GP, or Community Intervention Team (CIT) as appropriate. If in doubt, stop and contact the coordinator — it is always better to report early than to wait.

8. Documentation and Reporting

All catheter and stoma care provided should be recorded in the service user's notes or the relevant record (e.g. a Stoma Record or catheter care log). Any adverse changes, concerns, or incidents must be reported to the PHN or Service Coordinator promptly, and recorded in line with WLIL's Incident Reporting Policy where appropriate.

9. Review

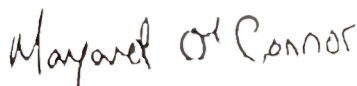
This policy will be reviewed annually, or sooner if clinical guidance, HIQA standards, or relevant legislation change.

This policy reflects established clinical guidance and is checked as accurate as of drafting, but it is not a substitute for individual clinical advice. It should be reviewed and signed off by a Public Health Nurse, stoma care nurse, or other appropriate clinical advisor before Board approval.

Approval

Approved by the Board of West Limerick Independent Living CLG on 9 October 2026.

Signed on behalf of the Board, on its instruction, by the General Manager:



Margaret O'Brien O'Connor, General Manager

Date signed:



References

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- Stoma Care Guidelines for Nurses Caring for Patients with a Stoma (2010), Royal Free Hampstead, London NHS
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- Catheter Care: RCN Guidance for Nurses (2008), Royal College of Nursing
- Kunin, C.M. (1997) — cited for closed drainage systems reducing catheter-related infection risk
- HIQA Draft National Standards for Home Support Services (2024)