WAHT- INF- 042

NHS Worcestershire Acute Hospitals NHS Trust

Department/Service:	Urology
Name:	Worcestershire Acute Hospitals NHS Trust Urinary Catheter Insertion, Care, Management and Removal Policy
Originator:	Helen Worth Lead Urology Clinical Nurse Specialist
Acknowledgements:	Worcestershire Health and Care Trust Continence Team for provision of primary care guidance to ensure health economy management.
Accountable Director:	Chief Nursing Officer
Approved by:	Directorate of Urology
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Review Date:	8th January 2026 Document extended as per Trust agreement 11.02.2021
Related Document	The Management of Urological Catheter Problems SOP
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All healthcare settings where there is the potential for patients with a urinary catheter to receive care or treatment.
Target staff categories	All healthcare staff involved in the care and management of patients with a urinary catheter.

Policy Overview:

This policy is designed to give guidance on the care and management of patients who are either awaiting urinary catheterisation or who have a urinary catheter insitu. It sets out to reduce the incidence and consequence of urinary tract infections associated with short and long term catheters.

Catheter Associated Urinary Tract Infections (CAUTIs) comprise a large proportion of healthcare associated infections and can occur whether a person has either a short term or long term catheter. There is a strong association between duration of urinary catheterisation and risk of infection and these risks are becoming more serious with the continued development of a wide range of multi-resistant bacteria which can cause CAUTIs and associated life threatening complications. Risks are greatly reduced by complying with all parts of the process for patient assessment, safe catheterisation, catheter maintenance and removal as soon as no longer needed. This is important in terms of promoting comfort, safety and infection prevention control measures (NICE 2014).

The policy includes advice on practices to ensure that appropriate management minimises the risk of infection, it reflects EPIC 3 (2013) guidance and NHS Improvement and Infection Prevention Society (2017) High Impact Intervention for Urinary Catheter Care and Management. Guidance is provided on:

- Assessing the need for catheterisation
- Selection of catheter type
- Catheter maintenance and management
- Education of patients, relatives and healthcare workers
- System interventions for reducing risks of infection including audit and competency tools.

Guidelines also meet the requirements of The Health and Social Care Act 2008 (updated 2015). All staff working clinically must be aware of and adhere to the contents of the policy to ensure appropriate assessment care and management of patients with urinary catheters alongside appropriate infection prevention and control precautions.
This policy supersedes WAHT 2008 Guidelines :
Collecting a CSU,MSU, emptying a catheter bag, female urinary catheterisation, intermittent self-catheterisation female/male, guideline for male catheterisation, removal for an indwelling urinary catheter, urinalysis using reagent sticks, supra pubic catheter management.

Key amendments to this document

Date	Amendment	By:
July 2021	Document review date amended as per the Key Documents policy 3 year approval update.	Trust policy
January 2023	Document Reviewed and approved by Governance Lead	Mr Gallagher/Urology Directorate Meeting

QUICK REFERENCE GUIDE

EPIC 3 guidelines provide comprehensive recommendations for preventing Healthcare Associated Infections (HCAIs) in hospital and other care settings based on the best currently available evidence. These national evidence based guidelines are broad principles of best practice and as such are integrated into our Trust policies and audits to reduce variation in practice and promote consistent management of urinary catheters thus supporting minimisation of infections and contributing to the attainment of the national reduction in gram negative bacteraemias whilst enhancing patient care.

Ref. No.	Guideline
Assessing the need for catheterisation	
UC1	Only use a short term indwelling urethral catheter in patients for whom it is clinically indicated, following assessment of alternative methods and discussion with the patient.
UC2	Document the clinical indication(s) for catheterisation, date of insertion, expected duration, type of catheter and drainage system and planned date of removal.
UC3	Assess and record the reasons for catheterisation every day. Remove the catheter when no longer clinically indicated.
Selection of catheter type	
UC4	Assess patient's needs prior to catheterisation in terms of: • Latex allergy. • Length of catheter (standard, female, paediatric). • Type of sterile drainage bag and sampling port (urometer, 2-L bag, leg bag) or catheter valve. • Comfort and dignity.
UC5	Select a catheter that minimises urethral trauma, irritation and patient discomfort, and is appropriate for the anticipated duration of catheterisation.
UC6	Select the smallest gauge catheter that will allow urinary outflow and use a 10-ml retention balloon in adults (follow manufacturer's instructions for paediatric catheters). Urological patients may require larger gauge sizes and balloons.

Catheter maintenance

UC10	Connect a short term indwelling urethral catheter to a sterile closed urinary drainage system with a sampling port.
UC11	Do not break the connection between the catheter and the urinary drainage system unless clinically indicated.
UC12	Change short term indwelling urethral catheters and/or drainage bags when clinically indicated and in line with the manufacturer's recommendations.
UC13	Decontaminate and wear a new pair of clean non sterile gloves before manipulating each patient's catheter. Decontaminate hands immediately following the removal of gloves.
UC14	Use the sampling port and the aseptic technique to obtain a catheter sample or urine.
UC15	Position the urinary drainage bag below the level of the bladder on a stand that prevents contact with the floor.
UC16	Do not allow the urinary drainage bag to fill beyond three quarters full.
UC17	Use a separate clean container for each patient and avoid contact between the urinary drainage tap and the container when emptying the drainage bag.
UC18	Do not add antiseptic or antimicrobial solutions to urinary drainage bags.
UC19	Routine daily personal hygiene is all that is required for meatal cleansing.
Ref. No.	**Guideline**
Education of patients, relatives and healthcare workers	
UC20	Do not use bladder maintenance solutions to prevent catheter associated infection.
UC21	Healthcare workers should be trained and competent in the appropriate use, selection, insertion, maintenance and removal of short-term indwelling urethral catheters.
UC22	Ensure patients, relatives and carers are given information regarding reason for catheter and plan for review and removal. If discharged, the patient should be given written information and shown how to: • Manage the catheter and drainage system. • Minimise the risk of urinary tract infections. • Obtain additional supplies.
System Interventions for Reducing the Risk of Infection	
UC23	Use quality improvement systems to support the appropriate use and management of short-term urethral catheters and ensure their timely removal. These may include: • Protocols for catheter insertion. • Use of bladder ultrasound scanners to assess and manage urinary retention. • Reminders to review the continuing use or prompt the removal of catheters. • Audit and feedback of compliance with practice guidelines. • Continuing professional education.
UC24	No patient should be discharged or transferred with a short term indwelling urethral catheter without a plan documenting the: • Reason for the catheter. • Clinical indications for continuing. • Catheterisation. • Date for removal, or review by an appropriate clinician overseeing their care.

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1. INTRODUCTION

a) Transurethral indwelling catheterisation or urinary catheterisation is defined as passage of a catheter into the urinary bladder via the urethra (urethral catheter). Transurethral indwelling catheterisation is also called urethral catheterisation.

b) Urinary catheterisation is invasive and should not be undertaken without full consideration of the benefits and risks. These guidelines have been developed to standardise practice according to current research and evidence based practice.

c) Healthcare professionals, particularly nurses have a crucial contribution to make in providing effective advice and care to patients with a urinary catheter.

d) When considering catheterisation as a method of care, many decisions need to be made in order to select the optimum equipment and provide effective catheter care. This includes the type of catheterisation, choosing the right catheter (material, size, balloon volume etc) and drainage system. Aspects of catheter care that also require consideration include hygiene, fluid intake, bowel care, collecting specimens of urine, fixation of catheters and sexuality, vigilance for signs of infection and review of need.

2. PURPOSE

a) The purpose of these guidelines are to:

i. Establish a framework for urinary catheter care management for adults;

ii. Prevent inappropriate catheterisation;

iii. Provide healthcare staff with the support, knowledge and evidence of good practice necessary to enable them to insert and/or manage catheter care safely and competently.

3. DEFINITIONS

Key terms and abbreviations used within this guidance include:

Aseptic Technique	This means using practices and procedures to prevent contamination from pathogens. It involves applying the strictest rules to minimise the risk of infection by ensuring that key parts remain sterile.
Autonomic Dysreflexia	Patients with spinal cord injury or neurological conditions may have neurogenic bowel dysfunction, which often means they depend on routine interventional bowel care, including the digital (manual) removal of faeces. Some of these patients, especially those with spinal cord injury above T6, are particularly susceptible to this potentially life-threatening condition autonomic dysreflexia, which is characterised by a rapid rise in blood pressure, risking cerebral haemorrhage and death. See Appendix 2.
Catheter Associated Urinary Tract Infection (CAUTI)	A laboratory confirmed bacteria in the urine, with associated clinical symptoms for which the patient receives treatment. The urinary catheter in situ at time of diagnosis or removed within the previous 48 hours and patient symptomatic of a urinary tract infection.
Catheter Encrustation	The collection of mineral salts which can lead to catheter blockage.
Catheter Maintenance/ Patency Solution	Solutions used to prevent blockage of catheters by encrustation and maintain the patency of the catheter.

Clean Intermittent Self Catheterisation (CISC)	This is used to manage bladders where volume of urine does not drain. It involves the insertion of a small catheter into the bladder enabling the urine to flow out. The tube is then removed and discarded, the patient often undertakes the procedure themselves following appropriate training.
Gram Negative Blood Stream Infection (GNBSI)	A laboratory-confirmed Bloodstream Infection (BSI) is defined as one or more positive blood cultures for a Gram-negative pathogen. A healthcare associated gram-negative BSI has been a laboratory-confirmed positive blood culture for a gram-negative pathogen in patients who had received healthcare in either the community or hospital in the previous 28 days.
Haematuria	The presence of blood in the urine.
Pelvic Floor Exercises (PFE)	Kegel exercise, also known as pelvic floor exercise, consists of repeatedly contracting and relaxing the muscles that form part of the pelvic floor.
Post Void Residuals (PVRs)	This is the amount of urine left in the bladder after an attempt has been made to empty the bladder.
Suprapubic Catheterisation	A procedure involving inserting a catheter through the abdominal wall to drain urine.
Trial Without Catheter (TWOC)	A trial without catheter involves removing a catheter from the bladder and seeing if urine can be passed without it insitu.
Urinary Catheter	A hollow tube which allows urine to drain.
Urethral Catheterisation:	A procedure involving insertion of a catheter into the urethra to drain urine.

4. SCOPE

a) These guidelines are relevant for all healthcare staff working in or on behalf of Worcestershire Acute Hospitals NHS Trust who undertake catheterisations, catheter care and/or teach others as part of their role.

b) It is acknowledged to ensure provision of seamless care and health economy promotion of evidence based best practice that these guidelines will compliment primary care guidance for urinary catheters and ensure that health economy practices are in place to minimise GNBSIs.

5. TRAINING AND COMPETENCE

a) Health care professionals undertaking catheter care must have a theoretical understanding of bladder anatomy, physiology, function and dysfunction and knowledge of current legislation and national guidelines, (RCN 2012). This will be achieved via the initial attendance at a Trust approved internal training course, observed practice and achievement of competency as outlined below.

b) The suggested structure for gaining competence in catheterisation is as follows (RCN 2012):

- **i.** Gain a theoretical knowledge and understanding in aspects of catheterisation;
- **ii.** Observe model/manikin being catheterised;
- **iii.** Practise catheterisation on a model/manikin under supervision until confident;
- **iv.** Observe catheterisation performed by others on actual patients;
- **v.** Be able to catheterise without direct supervision;
- **vi.** Gain experience and become confident;
- **vii.** Become a competent mentor for others;

c) Competence will be achieved through observation, relevant practice and supervision in the clinical setting by a competent assessor and using the competency framework (see associated competency documents included after the reference section.
d) A competent assessor is defined as a health care professional who has undergone training, workplace assessment and who practices the technique as an integral part of their clinical role.
e) Staff who feel confident and competent and are presently performing urethral and suprapubic catheterisation can continue to do so and attend an update including an assessment of competence on a manikin a minimum of every 5 years. It is the individual's personal responsibility to satisfy themselves they are familiar with best practice guidance and Trust recommendations.
f) Staff entering the Trust who have been trained in another Trust or Health Organisation must produce evidence of training and competence and be assessed once using the competency framework.
g) Health care professionals must maintain their competence through clinical practice, retraining and personal study. It is recommended staff refresh their knowledge and skills every 5 years.
h) For support healthcare staff who are providing day to day care and support for management of urinary catheters it will be necessary to ensure competence is achieved through observation, relevant practice and supervision in compliance with care plans and assessments.

6. RESPONSIBILITIES AND DUTIES

a) All practitioners who perform catheter care for patients should be aware of best practice guidance and Trust recommendations.
b) Nurses carrying out catheter care interventions are reminded that they should at all times adhere to the NMC Code of Professional Conduct: standards for conduct, performance and ethics and work within their competence and job description. They also have a responsibility to take account of their patient's informed choices.
c) Registered nurses have a responsibility to ensure they feel confident and competent in the knowledge and skills of practice (NMC 2015) and if they do not feel competent to undertake this role they must inform their immediate manager to discuss training needs.
d) The Line Manager is responsible for ensuring any training required is identified as appropriate and measures taken to ensure that the nurse is able to obtain required competence.
e) Registered nurses who delegate catheter care interventions to health care assistants under specific direction, are reminded that they are at all times accountable for the delegated task.
f) Further information about accountability and delegation is available from RCN (2011).

7. CONSENT

a) Informed consent must be obtained before catheterisation is undertaken (be it initial or renewal) Agreement does not have to be in writing but health records must demonstrate the fact that the patient understands the process of catheterisation, the need for it and consents verbally to the procedure and documentation demonstrates the patients informed consent.
b) If the patient lacks capacity the assessment of this must be documented. The decision to proceed or not with the proposed procedure/intervention on the basis of a best interest decision must also be recorded. The WAHT-CG-752 Trust Policy for Assessing Mental Capacity and Complying with the Mental Capacity Act 2005 must be followed.

8. INDICATIONS FOR CATHETERISATION

a) The clinical decision to undertake initial urethral catheterisation can be made by a competent health care professional in consultation with the patient, other professionals and/or social carer. Initial suprapubic catheterisation will be performed by medical staff.

b) Clear rationale for ongoing use of a catheter is required and it should be removed as soon as possible. Clean Intermittent (self) Catheterisation (CISC) is considered to be the gold standard for urinary drainage however this may not always be suitable. If it is determined that it is unacceptable or unsafe, then indwelling catheterisation might be considered the next best option.

c) Catheterisation has several benefits but also possible complications. Risks associated with catheterisation must be considered and a valid reason for insertion documented.

d) Clinical indications for urinary catheterisation (RCN 2012) include:

i. Pre and post-operative surgery.
ii. Monitoring renal function during critical illness.
iii. Chronic urinary retention, only if symptomatic and/or with renal compromise.
iv. Acute urinary retention.
v. Allowing bladder irrigation.
vi. Bypassing an obstruction.
vii. To allow instillation of medication.
viii. Urodynamics or radiological investigations.
ix. Facilitating continence and maintain skin integrity when all other conservative treatment methods have failed e.g. end of life, disability, unfit for surgery.
x. Where it is viewed as appropriate for patient to use a catheter such as end of life care, disability, unfit surgery, nurses must remember that risks associated with catheter usage are of a serious nature that increasingly may become more difficult to justify.

The use of indwelling catheterisation must not be considered routine in any of these situations.

e) NURSING STAFF SHOULD NOT PERFORM CATHETERISATION IF:

i. The patient has had previous urethral surgery for a stricture.
ii. The patient has haematuria or the patient has suffered urethral trauma, including those who have pulled their catheter out (if a catheter is pulled out re-insertion should not be attempted for 48 hours or until any haematuria subsides).
iii. The patient has suffered trauma to the pelvis.
iv. The patient presents with acute retention (the management of acute retention should be in conjunction with a medical professional).
v. The initial attempt to introduce a catheter is difficult or unsuccessful.

Please note nursing staff should never use catheter introducers.

9 DOCUMENTATION (RCN 2012)

a) A 'Urinary Catheter Assessment and Monitoring Form' must be completed for all patients with indwelling urethral or suprapubic catheters (see Appendix 1 5).

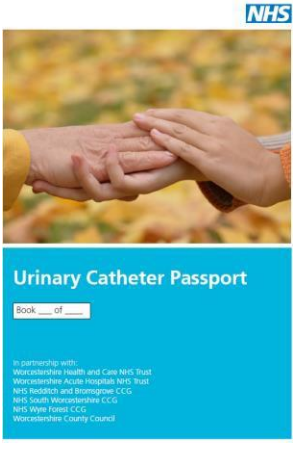
b) Catheter insertion documentation should include:

i. The reason for catheterisation, catheter change and on-going need for a catheter with all its risks;
ii. Consent obtained;

iii. Patient's current health status and result of risk assessment prior to catheterisation;
iv. Date and time of catheter insertion and by whom.
v. Catheter including brand, catheter name, material, catheter length, charriere size and balloon size and expiry date;
vi. Cleaning fluid used;
vii. Lubrication gel type, batch and expiry date;
viii. Amount of sterile water for balloon inflation batch and expiry date;
ix. If the insertion was easy or difficult;
x. Indications to ensure catheter was inserted correctly e.g. amount catheter inserted, urine drained, pain/patient reaction to balloon inflation, resistance to balloon inflation; In men document foreskin replaced to reduce risk of paraphimosis;
xi. If urine drained, the amount, colour, smell and if necessary dipstick and record the results;
xii. If no urine drained document what actions taken;
xiii. If urine specimen sent and why; and
xiv. Date of planned change, re-assessment and expected duration.
xv. A summary of communication with the patient and/or carer and the patient/carer's understanding of what a catheter will mean for them in addition to advice given to them.

c) Catheter removal documentation should include:
i. The length of time the catheter was in situ was appropriate for type being used;
ii. Catheter tip and balloon were intact on removal and balloon deflated easily;
iii. Amount of water in the balloon on deflation;
iv. If removal was painful or difficult to remove;
v. If blood present then where and to what degree;
vi. Any abnormalities around the meatus;
vii. Observations of urine for signs of infection;
viii. If encrustation and to what degree e.g. like consistency of sand, egg shell.

10. URINARY CATHETER PASSPORT



a) Each catheterised patient should have a hand held urinary catheter passport. Patients should be issued with a passport on first catheterisation and then passports that have been issued should be updated with any subsequent catheter interventions. Where a patient was admitted with a urinary catheter insitu, their passport should be requested to ensure completion of information relevant to hospital stay. There is a tick box on the 'Urinary Catheter Assessment and Monitoring Form' to indicate whether a passport has been issued and this must be completed.
b) The passport details all catheter interventions and includes patient information about catheter care and guidance on troubleshooting.
c) Passports are available from IPC Team or Xerox.
d) Personalised care and interventions relating to urinary or suprapubic catheters should be documented using the 'urinary catheter assessment and monitoring form' (Code WR 2230). Any additional information regarding patients care should be documented in their medical record.
e) Urinary catheter passports must remain with the patient, the must be completed appropriately and are not a substitute for Trust documentation.

11. RISK ASSESSMENT

a) Using any catheter has a number of associated risks. It is important that the following risks and other methods of management are considered before a decision to catheterise is made. However there may be instances when an indwelling catheter may be the only choice and then risks will have to be managed.

b) Associated catheter infection risk may be of a serious nature in patients with the following:

i. Artificial heart valve;
ii. Heart defect;
iii. Urinary infections post catheterisation (catheter and drainage system will become colonised by bacteria within 48hours);
iv. Immuno-suppressed;
v. Organ transplants;
vi. Faecal incontinence (high risk of infection);
vii. One kidney (increased risk of renal infection).

c) There are risks of patients developing haematuria in the following cases:

i. Medication such as aspirin and warfarin;
ii. Recent catheter related trauma;
iii. Recent urinary tract surgery;
iv. Known bladder/prostate cancer;
v. Blood clots observed by the patient;
vi. Meatal bleeding observed by patient;
vii. Haematological malignancies and increased risk of bleeding associated with low platelets.

d) Risks factors (RCN 2012) which increase the serious complications associated with catheter related infections include patients who have:

i. Had a hospital admission in the last twelve months;
ii. Had antibiotics in the last six months, increasing the risk of multi resistant infection;
iii. Diabetes;
iv. More than six medications which is indicative of compromised health status;
v. Chemotherapy within the last six months (immune compromised, high infection risk);
vi. Taking steroids (immune compromised, high infection risk);
vii. Underlying renal tract abnormalities;
viii. One functioning kidney – taking antibiotics for urinary tract infection;
ix. Chronic wounds requiring dressings which can potentially cross-infect the catheter and drainage system;
x. Are over 65 years of age which increases vulnerability.

e) Trust Antimicrobial prescribing guidance must be followed for treatment of urinary tract infections, asymptomatic bacteriuria in a catheterised patient does not routinely require treatment. Where infection requires treatment, where available, sensitivity data must be used to inform choice of agent. Prescribers should, where possible, refer back to earlier microbiology to ensure effective choice of agent until current sample result available. The antibiotic, dose and duration must be specified. Nationally, the increase in resistant gram

negative infections including Extended Spectrum Beta Lactamase (ESBL) producing organisms and Carbapenamase Producing Enterobacteriaceae (CPE) make it imperative to ensure full patient review and appropriate choice of agent.

f) Practitioners should be alert to any health issues such as resistance to partake in catheterisation. When a female presents with symptoms related to urology/urogynaecology you must ask specifically about female genital mutilation (FMG). In accordance with the new mandatory recording requirements the practitioner should document in patients notes if the patient has undergone FGM, the type, family history and type of procedure carried out. More information is available about FGM in the Trust policy WAHT-TP-037 Safeguarding Children's Pathway for FGM.

12. END OF LIFE (RCN 2012)

a) Indications for catheterisation at the end of life include:

i. The management or prevention of wound damage e.g. sacral pressure ulcers, fungating wounds or soreness of the anus, perineum, vulva or penis;
ii. Painful physical movements due to frequent change of bed linen caused by incontinence;
iii. Pain or difficulty for patients getting in and out of bed to use commode;
iv. Incontinence associated with obstruction;
v. Urinary retention/distended bladder - excessive oedema of the genitalia making micturition uncomfortable.

b) Nurses must ensure that catheterisation is based upon a balanced decision with more benefits than disadvantages in consultation with the patient, where possible (RCN 2012).

13. ACUTE PAINFUL RETENTION

An approved pathway is in place within Worcestershire for the management of acute retention in males. This includes urgent referral to a GP who will discuss the patient with the on call Urologist, patients may subsequently be catheterised in Accident and Emergency or surgical admissions unit. All females with acute retention should be referred urgently to their GP who, if necessary can discuss the patient with the on call Urologist/Urogynaecologist.

14. TRIAL WITHOUT CATHETER (TWOC) (trial of voiding) (See Appendix 1)

a) Where clinically appropriate, newly inserted urinary catheters should be removed within 48 hours to reduce the risk of urinary sepsis and to promote a return to normal bladder function. Reasons for further assessment before removing a catheter at 48 hours include:

- Obstructive uropathy.
- Lower urinary tract obstruction with acute kidney injury.
- Malignant feeling prostate associated with retention.
- High residual volume – (more than 1000mls, more likely to fail TWOC).
- Grade 3 and above sacral pressure sore.
- End of life care where movement causes pain and distress.
- Acutely ill patient requiring specific fluid management.
- Unresolved constipation.

b) Guidance for inpatient and outpatient trial without catheter is included in Appendix 1. It includes information on the generic procedure in addition to specifics linked to urology, gynaecology, elderly care and primary care patients.

c) A TWOC information handout (BAUS leaflet) should be provided to the patient.

15 URINARY CATHETERISATION

a) Urinary catheterisation is the insertion of a catheter into the bladder using an aseptic technique for the purposes of draining urine, the removal of clots/debris and the instillation of medication.

b) Healthcare workers should be trained and competent in the appropriate use, selection, insertion, maintenance and removal of short-term indwelling urethral catheters.

c)) There are 3 types of catheterisation:

- Intermittent
- Urethral
- Suprapubic

d) **Clean Intermittent self catheterisation** (CISC) is considered to be the gold standard for urine drainage (NICE 2012). It is a clean procedure and has a reduced infection rate to an indwelling catheter, however caution should be displayed with patients following prostatic, bladder neck or urethral surgery and in patients with stent or artificial prosthesis. It should be taught by a competent experienced specialist nurse (RCN 2012) for those individuals who are unable to perform this procedure, then indwelling catheterisation is an option. Urethral catheterisation would usually be considered before suprapubic. Please see Appendix 7 and 8 for information on this procedure.

e) **Urethral catheterisation** Health professionals with appropriate competence are able to perform the first and subsequent urethral catheter changes. They must however have examined associated risks, be aware of potential vasovagal attacks and autonomic dysrelfexia (Appendix 3) and feel confident and competent to complete the procedure. They should have full knowledge of the patient and their past medical/surgical and urological history to make this decision. If they do not feel able to perform the procedure they must discuss with the medical team responsible for this patients care.

f) **Suprapubic catheterisation** Indications for suprapubic catheterisation include:

I. When urethral catheterisation is contraindicated
II. To minimise urethral trauma in long-term catheterised patients
III. Traumatic injury to the lower urinary tract or when the passage of a urethral catheter has not been possible
IV. As a long term solution for patients with neurological conditions
V. Patients who are sexually active

g) Contraindications for suprapubic catheterisation include:

I. Haematuria;
II. Pelvic cancer with or without radiation;
III. Prosthetic devices or material in the lower abdomen.

g) Initial insertion of a suprapubic catheter is performed in hospital under general or local anaesthetic using a percutaneous system. The National Patient Safety Agency (NPSA 2009a) have published a rapid response report stating that the insertion of a suprapubic catheter should be undertaken by an experienced urology staff using ultrasound imaging.

h) On first catheter change, whether in primary or secondary care, the healthcare professional must have completed a risk assessment to include the patients past medical/surgical and urological history. If they lack appropriate skills or feel the patient needs monitoring in secondary care, then they are to contact the surgical team who inserted the catheter. Also

some Urologists specifically request that they/their team perform some first suprapubic catheter changes.

i) First changes should not be within 4 weeks to allow the tract to form (RCN 2012). If the catheter should fall/come out before then, there is usually a window of about 20 minutes to try and replace it. Whether the catheter can be replaced or not, the Doctor/team who initially inserted the catheter should be informed.

j) Over granulation (overgrowth of the tissue from the insertion site), if not causing concern, does not require intervention following the exclusion of malignancy and infection. It may respond to, - Fludroxycortide (Haelan tape) /cream/ointment. (Johnson 2007) or the application of a foam dressing;

k) Catheterisation procedures are included in Appendices (4, 5, 6, 7 and 8).

16. CATHETER SELECTION

16.1

Information on the availability of catheters for use in the Trust and how to access supplies is detailed on the poster below. There has been a Trust decision to use a single universal length catheter to reduce the risk of accidental urethral trauma through inappropriately catheterising a male with a female length catheter. **However female patients admitted with long term catheters who require re-catheterisation before discharge must be re-catheterised with a female length catheter available from the Guardian Box.**

16.2 Charriere Size

a) The charriere is the outer circumference of the catheter in millimetres and is equivalent to three times the diameter. Under normal circumstances a size 12Ch – 14Ch is suitable for the majority of female patients and 12Ch – 16Ch for males. Size 16Ch to 18Ch are usually used for supra pubic catheterisation. Within the Trust 12Ch is the standard for female patients and 14Ch for male patients.

b) To avoid discomfort and leaking choose the smallest sized catheter possible.

c) The general wards within the Trust will only stock size 12Ch and 14Ch. Urology wards and theatres will stock additional sizes and specialist double and triple lumen catheters.

d) Size16Ch and female length long term catheters will be available to wards from the Guardian boxes as indicated on the Catheter Selection Guide (below).

16.3 Balloon Size

a) The majority of catheters require the balloon to be inflated with 10ml of sterile water. This amount is less likely to cause irritation of the bladder mucosa. (Dougherty and Lister 2011, EPIC 3 2014).

b) 30ml balloons were developed to prevent haemorrhage following prostatectomy, which is their intended use only.

16.4 Silver Coated Catheter

a) These may be recommended via urology teams or at the discretion of the clinician for patients at high risk or repeated urinary tract infections for a maximum of three catheter changes and then reviewed. Discuss with Urology Team or Infection Prevention and Control Team if required.

b) Silver coated catheters must be changed every 28 days.

16.5 Guardian Boxes

Guardian Boxes are provided at key locations across the Trust: Urology Ward and A&E (Alex Site) and A&E, Avon 3, Beechand T&O Ward (WRH Site). Additional stocks for urgent top up of boxes in Out of Hours stock IPC offices (Alex/WRH) and Ward 1 KTC. These contain a range of catheter insertion packs for exceptional circumstances. This includes size 16Ch catheter insertion trays in all types of catheter, female length long term catheters and spare stocks of the Statlock stabilisation device for patients requiring a catheter for greater than 7 days. The stocks within these boxes is provided free of charge by the company.

Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospital NHS Trust

Working in Partnership

Worcestershire Health and Care NHS Trust

URINARY CATHETER SELECTION GUIDE

BARD® TRAY with PTFE Catheter
attached to: 500ml Leg Bag or 2000ml Bed Bag (Bed Bound Patients Only) or 350ml Urine Meter (Sizes: 12ch, 14ch)

BARD® TRAY with BIOCATH® Catheter
attached to: 500ml Leg Bag or 2000ml Bed Bag (Bed Bound Patients Only) or 350ml Urine Meter (Sizes: 12ch, 14ch)

BARD® TRAY with LUBRI-SIL® Catheter
attached to: 500ml Leg Bag or 2000ml Bed Bag (Bed Bound Patients Only) or 350ml Urine Meter (Sizes: 12ch, 14ch)

BARD® TRAY with BARDEX® IC Silver Alloy Catheter
attached to: 500ml Leg Bag or 2,000ml Bed Bag (Bed Bound Patients Only) or 350ml Urine Meter (Sizes: 12ch, 14ch)

Size 16ch will be held at the following sites in Guardian Boxes on; Urology Ward and A&E (Alex Site) and A&E, Avon 3, Beech and T&O Ward (WRH Site). Additional stocks for urgent top up of boxes in Out of Hours stock IPC offices (Alex/WRH) and Ward 1 KTC.

For short term use up to 28 days
If due for catheter change within 1 week or if patient requires long term catheter, re-catheterise with the appropriate catheter prior to discharge. A supply of these should be ordered and held in each department.

A Hydrogel Coated Catheter for long term use up to 12 weeks
A supply of these will be held at the following Guardian Boxes; Urology Ward (Alex) and A&E, Avon 3, Beech, T&O Ward (WRH) and Ward 1 KTC.
N.B Use female length catheter if replacing existing long term female catheter prior to discharge.

A latex-free silicone Catheter for use with latex sensitised patients. For long term use up to 12 weeks
A supply of these will be held at the following Guardian Boxes; Urology Ward (Alex) and A&E, Avon 3, Beech, T&O Ward (WRH) and Ward 1 KTC.
N.B Use female length catheter if replacing existing long term female catheter prior to discharge.

A Silver Alloy Coated Catheter for use with patients who have an increased risk of developing UTI.
Please discuss with Urology or Infection Prevention and Control prior to using. A supply of these will be held at the following Guardian Boxes; Urology Ward (Alex) and A&E, Avon 3 Beech, T&O Ward (WRH) and Ward 1 KTC.

All of the above catheters are available in a universal (e.g. male length) range of sizes and catheter drainage bag types. (Urology/theatre specialties ONLY will stock catheters above a 16 gauge.) Please ensure to complete your Urinary Catheter Assessment and Monitoring Form (WR2230)

NO FEMALE CATHETERS TO BE STOCKED IN CLINICAL AREAS EXCEPT FOR MATERNITY

NB. For pre-connect catheters the drainage bag can stay in-situ for up to 14 days if the seal is unbroken. Once the seal is broken new drainage bag can remain in-situ for up to 7 days. Don't forget the Catheter Passport! If admitted with a catheter, ask for it. If discharging with a catheter, make sure the Catheter Passport is filled out and sent home with the patient.

For further advice please contact the relevant Urology Nurse Specialist for your site via switchboard

SHARON BANYARD - ALEXANDRA SITE (ALEX)
PENNY TEMPLEY - KIDDERMINSTER SITE (KTC)
LISA HAMMOND – WORCESTERSHIRE ROYAL SITE (WRH)

For Infection Control advice please contact
WRH EXT 38752 / ALEX 44744

NHS

16.5 Urine Samples

a) Urine samples should be obtained aseptically from the needle free port on the drainage bag and never from the catheter itself. (EPIC 3 2014, RCN 2012). (See Appendix 9 which details recognised procedure for standard sampling and also specific procedure for use with urine monovette devices).
b) Samples from catheterised patient to identify infection are only indicated if patients are symptomatic of a urinary tract infection.
c) Routine MRSA screens must include a CSU if a urinary catheter is insitu, if a suyora pubic catheter this should also include a swab from around the site in addition to the CSU,
d) CPE screens in addition to three rectal swabs/faecal samples each at least 48 hours apart, should include a CSU if a urinary catheter is insitu. This is in addition to a single swab for any wounds or invasive device sites.
e) Further CCG guidance in place within Worcestershire and was approved in April 2018 it can be viewed (not sure where it is on acute website) and provides a guide to: Urinalysis in the Older Adult/Care Home Environment.

17. CATHETER SECURING DEVICES

a) It is preferable to use a catheter securing device to anchor the catheter to the patient's thigh/leg/abdomen. This prevents the catheter pistoning and subsequent trauma. Stat locks are promoted for this.
b) Position the urinary drainage bag below the level of the bladder, if in bed use a stand that prevents contact with the floor.
c) Do not allow the urinary drainage bag to fill beyond three quarters full.

18. CATHETER VALVES

a) A catheter valve allows the bladder to fill and empty. Therefore:
   - They help maintain an intact bladder wall;
   - They allow the bladder to expand and fill with urine;
   - They maintain blood and nerve supply to the bladder wall;
   - They provide the sensation to want to pass urine;
   - Catheter valves should be opened on average every 2 – 3 hours;
   - At night an overnight drainage bag may be attached;
   - Catheter valves can stay in place for 5 – 7 days.
b) Catheter valves are only suitable for patients who have good cognitive function, sufficient manual dexterity to manipulate the valve and adequate bladder capacity.
c) When possible a catheter valve should be used before a trial without catheter. If the catheter has been in place for several months, it is suggested the catheter valve be used for approximately 1 - 2 weeks before trial without catheter is attempted.
d) When used, the lot number and expiry date of the valve should be documented in the patient's notes.

19. CATHETER MAINTENANCE SOLUTIONS (PROCEDURE IS INCLUDED IN APPENDIX 11)

a) Some patients who have a long term indwelling urinary catheter and suffer from encrustation may benefit from the use of a catheter maintenance solution to prolong the life of their catheter. Do not use bladder maintenance solutions to prevent catheter associated infection.

b) Bladder lavage is not included in this procedure and is defined as the manual washing out of the bladder with sterile fluid.
c) Bladder irrigation is not included in this procedure and is defined as the continuous washing out of the bladder with sterile fluid, usually 0.9% normal saline.
d) Catheter maintenance solutions are defined as pre-packaged sterile solutions ready for administration. Catheter maintenance solutions include Citric acid 3.23% (Solution G or Suby G) or Citric acid 6% (Solution R). Where assessment indicates that a catheter maintenance solution may be beneficial, the solution used must be appropriate for the condition being treated.
e) Chlorhexidine maintenance solutions are no longer considered effective due to previous overuse and past incidence of allergy, and should not be used (EPIC 3 2014).
f) Catheter maintenance regimes should be based on individual need, after appropriate assessment and as part of a treatment plan. Their effect should be reviewed regularly and on-going care planned accordingly, with the aim to reduce and stop using the solutions as soon as possible.
g) Catheter maintenance solutions are not to be used prophylactically or to attempt to unblock a non-draining catheter. They are treatment preparations for dissolving encrustation only.
h) The best way to determine encrustation is to visually examine the removed catheter both externally and internally by cutting the catheter lengthways. If there is no visible evidence of encrustation on the catheter when rolled between fingers or does not feel gritty then it is safe to assume that catheter maintenance/patency solutions are not indicated. (EPIC 3 2014, Cochrane review, 2010, European Association of Urology Nurses 2012).

20. CATHETER CHANGE

a) If a catheter continues to drain adequately, it should remain undisturbed until it is due for change (e.g. 28 days or 12 weeks) unless it requires changing due to a specific problem such as obstruction or malfunction.
b) **Do not routinely offer prophylactic antibiotics when changing long term catheters.**
c) Consider antibiotic prophylaxis for patients who:
   - Have a history of symptomatic urinary tract infection after catheter change;
   - have an underlying health reason which indicates the need for prophylaxis e.g. endocarditis (RCN, 2012).
d) If a patient is prescribed antibiotics to treat a catheter associated urinary tract infection, the catheter should be changed during the course of treatment (treatment must be based on sensitivity data or prescribing guidance if this is not available). Removal of the urinary catheter during the course of treatment will ensure bacteria in biofilm is minimised on catheter change and ensure that a new catheter is inserted under antibiotic therapy thus reducing the risk of infection. If the patient does not require a urinary catheter then this should be removed on presentation or suspicion of infection and the need for further treatment assessed.

21. CHANGING OF URINE DRAINAGE BAGS – DAY AND NIGHT

a) If a 'Pre connect' catheter is in use the drainage bag can stay insitu for 14 days if the seal is unbroken. Once the seal is broken replace drainage bag every 7 days.
b) On catheters which are not 'Preconnect' or where the first change of bag has occurred the drainage bag (whether a leg bag or overnight drainage bag) that is connected directly to the catheter must be changed every 7 days. (DH Drug Tarriff 2016).

c) The bag should also be changed when there is an accumulation of sediment, leakage, when a new catheter is inserted, or when a maintenance solution has been used.
d) The changing of bags connected to the catheter on a daily basis incurs unnecessary expense and disconnection of the system more often than is necessary increases risk of infection.
e) Position the urinary drainage bag below the level of the bladder on a stand that prevents contact with the floor.
f) Drainage bags should be emptied when indicated to prevent traction on the catheter.
g) If discharging patients out to care home settings, please note:
    - In a care home setting a disposable night drainage bag should be emptied, and disposed of as offensive waste if infection is not suspected. If infection is suspected it should be treated as infected waste and put in an orange or yellow waste bag. In patients own home empty used bags should be double bagged and be disposed of in normal household waste unless there is already a pre-existing hazard waste collection in place.
    - A new disposable night bag is used each night.
    - For patients who are bed bound, a sterile non disposable drainable 2 litre drainage bag may be used only if connected directly to the catheter and left in situ for 5-7 days.
h) See Appendix 12 and 13 for emptying and changing a catheter bag.

22. REMOVAL OF AN INDWELLING CATHETER - For procedure see Appendix 13

23. PATIENT ADVICE AND EDUCATION

a) Patients and carers should be educated and trained in techniques of hand decontamination, the risk of cross infection and catheter management before discharge from hospital as well as being aware of any additional support they will receive linked to their urinary catheter.
b) Follow up training and ongoing support of patients and carers should be available for the duration of long-term catheterisation and appropriate referrals to community teams should be made to ensure that this occurs.
c) Patients and where relevant their carers should be aware of possible signs and symptoms of infection and actions to take. Healthcare staff must ensure patients, relatives and carers are given information regarding reason for catheter and plan for review and removal. If discharged, the patient should be given written information and shown how to:
    - Manage the catheter and drainage system.
    - Minimise the risk of urinary tract infections.
    - Obtain additional supplies.
d) Information on catheter care and management is also contained within the Worcestershire Urinary Catheter Passport and this can be used as a basis for discussions. Healthcare staff must ensure that patients who are newly catheterised and discharged with a urinary catheter insitu are provided with a Urinary Catheter Passport and are aware of the need to ensure that patient is aware of the need to share this passport with relevant healthcare professionals.
e) No patient should be discharged or transferred with a short term indwelling urethral catheter without a plan documenting the:
    - Reason for the catheter.
    - Clinical indications for continuing.
    - Catheterisation.
    - Date for removal, or review by an appropriate clinician overseeing their care.

23.1 Personal Hygiene

a) The following applies for patients with a urethral or supra pubic indwelling catheter:
   - With urethral catheterisation the genital area should be thoroughly cleansed at least once daily with unscented soap and water, and repeated after every bowel movement. Routine daily personal hygiene is all that is required for meatal cleansing.
   - Following defecation, patients should be reminded to use soft toilet tissue, wiping from front to back. Moist toilet wipes may be useful for this purpose.
   - Supra pubic sites initially require a dressing but should be removed when the insertion site has healed (7-10 days). Dressing should be changed aseptically. Once healed the site can be cleaned with soap and water and a clean cloth and left clean and dry (RCN 2012).
   - In and out movement of the catheter should be avoided by securing the catheter and connection tubing. Drainage bags should remain below the level of the patients bladder and be emptied regularly to prevent traction on the catheter.

b) The leg drainage bag or urine drainage bag connected directly to the catheter should not be disconnected, however the catheter bag should be emptied before bathing and can either be immersed in the bath or placed on a suitable surface at the edge of the bath.

c) The use of showers is strongly recommended, since there is less risk of infection.

23.2 Everyday advice for patients on catheter management:

- Patients should always wash their hands before and after any procedure.
- Carers should always wash their hands and wear non sterile gloves when emptying or changing the drainage bag, please note this relates to carers who have a professional responsibility and not family who are supporting a patient.
- Men should ensure they wash under the foreskin.
- Drinking plenty of mixed fluids may help to flush the catheter and help the catheter to drain
- Consider individuals medication i.e. Diuretics, Warfarin and discuss their affects on urine.
- Avoid constipation.
- Do not kink or clamp the catheter tubing.
- Always attach the catheter to the chosen drainage bag or catheter valve
- Empty the drainage system regularly and do not allow to become overfull, however do not empty if not necessary. • Keep a closed system of drainage.

How do I advise patients about sex?

- Intercourse is usually possible for both men and women with a urethral catheter. For women the catheter should be taped out of the way along the abdomen. Men can tape the catheter along the penis and apply a condom.
- The drainage bag should be emptied before sexual activity.
- A suprapubic catheter may make sexual intercourse easier.

Escalation advice to tell the patient:

This will depend on the patient, but usually help should be sought if any of the following occurs:

- The catheter blocks.
- There is no urine in the bag after 2–3 hours.
- The catheter falls out.
- Urine keeps leaking from around the catheter.
- Urine is cloudy, smelly or feels as if it is burning and this does not improve after drinking more fluids.

- The patient has acute lower abdominal pain.
- The urine is suddenly blood stained or discoloured.

24. MONITORING TOOL

a. In addition to audits undertaken by urology and/or infection prevention and control, settings are encouraged to complete DH (2017) High Impact Interventions for Urinary Catheters (see Appendix 14).

b. Healthcare staff can also refer to the quick reference guide included in this policy and measure practices against EPIC (2014) criteria.

c. Use of quality improvement systems to support the appropriate use and management of short-term urethral catheters and ensure their timely removal can include:
   - Protocols for catheter insertion.
   - Use of bladder ultrasound scanners to assess and manage urinary retention.
   - Reminders to review the continuing use or prompt the removal of catheters.
   - Audit and feedback of compliance with practice guidelines.
   - Continuing professional education.

25. BACKGROUND

25.1 Equality Requirements

There are no implications for equality following completion of the Equality Impact Assessment.

25.2 Financial Risk Assessments

No financial risks are identified following completion of Financial Risk Assessment.

25.3 Consultation

Key individuals involved in developing the document

Name	Designation
Julie Booth	Lead Infection Prevention and Control Nurse
Helen Worth	Lead Urology Clinical Nurse Specialist
Emma Sneed	Commissioning Lead Nurse Infection Prevention and Control
Kerrie Howles	Infection Prevention and Control Nurse Advisor
Mr Vincent Koo	Consultant Urologist
Members of the Health Economy UTI/CAUTI Working Group	

Committee

Name	Designation
TIPCC	All members of Trust Infection Prevention and Control Committee

Circulated to the chair of the following committees / groups for comments

Name	Committee / Group

Acknowledgment to the Health and Care Trust Continence Team for the use of their Trust Guidelines to support the development of this document to facilitate seamless urinary catheter care across our health economy.

25.4 Approval Process

Approval for this policy is via TIPCC following consultation with all members and others cited in section 25.3.

25.5. Policy Review

The policy will be reviewed within three years of the date of approval or sooner in light of new national best practice guidance.

26. REFERENCES

Department of Health (2016) Drug Tariff Prescribing Services.

Department of Health. (2015). *The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.* London. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Dougherty L, Lister S (Eds) (2011), The Royal Masden Hospital Manual of Clinical Nursing Procedures. Seventh Edition Wiley – Blackwell, Oxford.

EPIC 3. (2014). EPIC 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection* S1–S70. https://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

European Association of Urology Nurses (2012) Evidence Based Guidelines for Best Practice in Urological Health Care. Catheterisation Indwelling Catheters in Adults Urethral and Suprapubic. EAUN. Arnhem.

National Patient Safety Alert (2009a) Minimising risk of supra pubic catheter insertion

National Patient Safety Alert (2009b) Female urinary catheters causing trauma to adult males

NHS Improvement 2018 Preventing healthcare associated Gram-negative bacterial bloodstream infections – an improvement resource. https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/

Nursing and Midwifery Council (NMC) (2015), The Code: Standards of Conduct Performance and ethics for nurses and midwives. London

Nursing and Midwifery council (NMC) (2012) record Keeping Guidance. London.

Royal College of Nursing (2009) Guidelines for the management of neurogenic bowel dysfunction after spinal cord injury.

Royal College of Nursing (2011) Accountability and Delegation: What you need to know.

Royal College of Nursing (2012) Catheter Care RCN Guidance for Nurses.

Assessment of Competency for Insertion of Urethral Catheter (Female)

Assessment Specification

The candidate should be able to demonstrate competence in urethral catheterisation using the following knowledge and performance criteria.

Competence is achieved through observation, relevant practice and supervision in the classroom and clinical setting by a competent assessor. A competent assessor is defined as practitioners who have undergone training, workplace assessment and who practice the procedure as an integral part of their clinical role.

It is recommended an individual observes 2 catheterisations and is supervised performing 2 catheterisations to achieve competence. Observed and supervised practice is recorded and countersigned. The action plan can be used to identify learning needs in order to achieve competence.

Signature log for observation and supervision

Assessors Name	Initials	Designation

Completion of Competency

The candidate has been assessed and achieved the competence overleaf:

Name of Candidate *(please print)* .....

Candidate Signature .....

Candidate Job Title .....

Base/Ward .....

Date Competence Achieved .....

Name of Assessor *(please print)* .....

Assessor Signature .....

Completed forms should be kept in the member of staffs portfolio.

Performance Criteria

	Competency Statement	Observation 1	Observation 2	Supervised 1	Supervised 2
		Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date
1.	Demonstrate knowledge of anatomy and physiology of the female urinary tract and its function in relation to urethral catheterisation.				
2.	Demonstrate knowledge and importance of a full risk assessment of urethral catheterisation including potential risks prior to, during and post procedure.				
3.	Demonstrate knowledge of Trust policies in relation to urethral catheterisation e.g. infection control, consent, chaperone and respecting patient dignity, privacy, wishes and beliefs.				
4.	Discuss short and long term health implications of catheterisation and actions to take if problems occur.				
5.	Demonstrate knowledge of the Trust catheterisation policy and catheters and equipment on the formulary. Explain when alternative products may need to be used.				
6.	Demonstrate the ability to perform the procedure according to Trust policy.				
7.	Discuss information the patient/carer should be given regarding catheter care.				
8.	Discuss elements of a catheter review and the frequency with which this would take place.				

With thanks to Worcestershire Health and Care Trust Continence Team for use of their Competency Documents.

References:

Skills for Health. (2008). Continence Care Suite available from www.skillsforhealth.org.uk

Royal College of Nursing. (2012). Catheter Care RCN Guidance for Nurses.

Assessment of Competency for Insertion of Urethral Catheter (Male)

Assessment Specification

The candidate should be able to demonstrate competence in male urethral catheterisation using the following knowledge and performance criteria.

Competence is achieved through observation, relevant practice and supervision in the classroom and clinical setting by a competent assessor. A competent assessor is defined as practitioners who have undergone training, workplace assessment and who practice the procedure as an integral part of their clinical role.

It is recommended an individual observes 2 catheterisations and is supervised performing 2 catheterisations to achieve competence. Observed and supervised practice is recorded and countersigned. The action plan can be used to identify learning needs in order to achieve competence.

Signature log for observation and supervision

Assessors Name	Initials	Designation

Completion of Competency

The candidate has been assessed and achieved the competence overleaf:

Name of Candidate *(please print)* .....

Candidate Signature .....

Candidate Job Title .....

Base/Ward .....

Date Competence Achieved .....

Name of Assessor *(please print)* .....

Assessor Signature .....

Completed forms should be kept in the member of staffs portfolio.

Performance Criteria

	Competency Statement	Observation 1	Observation 2	Supervised 1	Supervised 2
		Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date
1.	Demonstrate knowledge of anatomy and physiology of the male urinary tract and its function in relation to urethral catheterisation.				
2.	Demonstrate knowledge and importance of a full risk assessment of urethral catheterisation including potential risks prior to, during and post procedure.				
3.	Demonstrate knowledge of Trust policies in relation to urethral catheterisation e.g. infection control, consent, chaperone and respecting patient dignity, privacy, wishes and beliefs.				
4.	Discuss short and long term health implications of catheterisation and actions to take if problems occur.				
5.	Demonstrate knowledge of the Trust catheterisation policy and catheters and equipment on the formulary. Explain when alternative products may need to be used.				
6.	Demonstrate the ability to perform the procedure according to Trust policy.				
7.	Discuss information the patient/carer should be given regarding catheter care.				
8.	Discuss elements of a catheter review and the frequency with which this would take place.				

With thanks to Worcestershire Health and Care Trust Continence Team for use of their Competency Documents.

References:

Skills for Health. (2008). Continence Care Suite available from www.skillsforhealth.org.uk

Royal College of Nursing. (2012). Catheter Care RCN Guidance for Nurses.

Assessment of Competency for Change of a Supra Pubic Catheter

Assessment Specification

The candidate should be able to demonstrate competence in supra pubic catheterisation using the following knowledge and performance criteria. It is noted initial catheterisation is performed under ultrasound guidance in the hospital under consultant care.

Competence is achieved through observation, relevant practice and supervision in the classroom and clinical setting by a competent assessor. A competent assessor is defined as practitioners who have undergone training, workplace assessment and who practice the procedure as an integral part of their clinical role.

It is recommended an individual observes 2 catheter changes and is supervised performing 2 catheter changes to achieve competence. Observed and supervised practice is recorded and countersigned. The action plan can be used to identify learning needs in order to achieve competence.

Signature log for observation and supervision

Assessors Name	Initials	Designation

Completion of Competency

The candidate has been assessed and achieved the competence overleaf:

Name of Candidate *(please print)* .....

Candidate Signature .....

Candidate Job Title .....

Base/Ward .....

Date Competence Achieved .....

Name of Assessor *(please print)* .....

Assessor Signature .....

Completed forms should be kept in the member of staffs portfolio.

Performance Criteria

	Competency Statement	Observation 1	Observation 2	Supervised 1	Supervised 2
		Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date	Sign/Countersign and date
1.	Demonstrate knowledge of anatomy and physiology of the male and female urinary tract and its function in relation to supra pubic catheterisation.				
2.	Discuss why supra pubic catheterisation is required and complete a risk assessment of supra pubic catheterisation including potential risks prior to, during and post procedure.				
3.	Demonstrate knowledge of Trust policies in relation to supra pubic catheterisation e.g.. infection control, consent, chaperone and respecting patient dignity, privacy, wishes and beliefs.				
4.	Discuss short and long term health implications of catheterisation and actions to take if problems occur.				
5.	Can discuss how to manage the cystostomy site and over-granulation.				
6.	Demonstrate knowledge of the Trust catheterisation policy and catheters and equipment on the formulary. Explain when alternative products may need to be used.				
7.	Demonstrate the ability to perform the procedure according to Trust policy.				
8.	Discuss information the patient/carer should be given regarding catheter care.				
9.	Discuss elements of a catheter review and the frequency with which this would take place.				

With thanks to Worcestershire Health and Care Trust Continence Team for use of their Competency Documents.

References:

Skills for Health. (2008). Continence Care Suite available from www.skillsforhealth.org.uk

Royal College of Nursing. (2012). Catheter Care RCN Guidance for Nurses.

APPENDIX 1

TRIAL WITHOUT CATHETER (TWOC) - PROCEDURE AND GUIDANCE

INTRODUCTION

Infection prevention and control and continence guidelines specify that **newly inserted urinary catheters should be removed, where appropriate, within 48 hours** to reduce the risk of urinary sepsis and promote return to normal bladder function. The majority of catheters can be removed promptly. **Reasons for further assessment before removing a catheter at 48 hours:**

- Obstructive uropathy.
- Lower urinary tract obstruction with acute kidney injury.
- Malignant feeling prostate associated with retention.
- High residual volume – (more than 1000mls, more likely to fail TWOC).
- Grade 3 and above sacral pressure sore.
- End of life care where movement causes pain and distress.
- Acutely ill patient requiring specific fluid management.
- Unresolved constipation.

BEFORE DOING A TWOC (refer to specialty specific section on following pages to note exception prior to commencement of TWOC)

- Supply a TWOC information handout (BAUS leaflet).
- Review medication that may cause retention (e.g. anti-cholinergics, opiates).
- Check for constipation.
- In men consider giving an uro-selective alpha blocker 24-48 hours prior to TWOC
  a. Patient has symptoms of benign prostatic enlargement (lower urinary tract symptoms - LUTS).
  b. Residual greater than 1000mls.
  c. Patient will tolerate postural hypotension (avoid if there is a history of falls).
- Antibiotic prophylaxis is **NOT** indicated, unless it is traumatic or there is a history of urosepsis. (See trust antibiotic prophylaxis policy).
- DO NOT give prophylaxis if the patient has:
  a. Allergies.
  b. Receiving current antibiotic therapy.
  c. Or has a resistant organism to preferred prophylaxis (discuss with microbiology).
  d. Have renal failure (discuss with pharmacy).
- A bladder scanner should be available – this can be performed by staff who have been shown and deemed competent by experienced staff.
- Perform TWOC without delay.
- Keep a record of fluid balance and post void residuals.

If the patient has specific urological or gynaecological reason for retention, refer to SPECIALITY SPECIFIC INFORMATION

TWOC PROCEDURE FOR PATIENT WITH NO REASON TO FAIL

Patient with:

- **Urethral catheter for less than 72 hours.**

- **Catheter post-surgery (no pre-existing LUTS or episodes or retention).**
- **No significant co-morbidities (e.g. poor mobility, chronic conditions).**

1. Explain the TWOC procedure to the patient.
2. Obtain and document verbal consent to remove the catheter.
3. Ensure the patient is aware of the signs of urinary retention.
   a. Increase frequency.
   b. Passing small volumes of urine.
   c. Lower abdominal pain.
   d. Hesitancy to void.
   e. Feeling of incomplete bladder emptying.
4. Remove the urinary catheter in accordance with the Trust catheter policy.
5. Encourage the patient to drink 200mls of fluids every hour.
6. Once the patient has passed 2 volumes of 200mls or more without retention symptoms, scan their bladder.
7. If the residual is less than 100mls – the TWOC has been successful.
8. Document the outcome and any additional follow-up.
9. Advise patient of risk of future episodes of urinary retention and who they should report to in this instance.

TWOC PROCEDURE FOR PATIENTS WITH A REASON TO FAIL

Patients with:

- **Pre-existing bladder or bowel problems.**
- **Co-morbidities.**
- **Long standing catheters.**
- **Previously failed TWOCS.**
- **Supra-pubic catheters.**
- **Check if possible previous documented post void residuals.**

Follow the procedure above, also follow post void scanning and manage residuals as below.

- **If post void residuals on bladder scanning (PVRs) are below 100mls:** it can be considered that the patient has passed their TWOC and discharge as above with follow-up.
- **If PVRs are 100-300mls:**
  - Advise double voiding.
  - Do not reinsert the catheter, unless the patient demonstrates the signs of retention (patient could a small capacity bladder).
  - Reinforce signs of urinary retention.
  - Perform a further scan after further voiding.
  - If these scans are consistent, discharge the patient with follow-up and reinforce the signs of urinary retention and where to obtain help should it occur.
  - Document the outcome of the TWOC.
- **If PVRs are 300-500mls and patient is able to void:**
  - Discuss with the patient the risks/merits of clean intermittent self catheterisation (CISC) if they are consistently high.
  - If unable to perform CISC, discuss re-catheterisation if the patient is demonstrating signs of urinary retention.

- If patient declines advise about further episodes of urinary retention and where to obtain help.
- Document the outcome of the TWOC and arrange follow-up.
- Refer to community continence team/neighbourhood teams (if patient housebound), if performing CISC or has indwelling catheter. **Ensure that all patients with an indwelling catheter are given a catheter passport on discharge home.**

- **If PVRs are 300-500mls and the patient is unable to void or has signs of urinary retention reinsert a long term catheter:**
  - Obtain consent to re-catheterise, as per Trust catheter policy.
  - Secure catheter with a stabilising device (e.g. G strap, Stat-lock, clinifix) to reduce shunting and traction on the catheter.
  - Discuss use of catheter valve as an alternative (NOT FOR PATIENTS WITH RECENTLY RECONSTRUCTED BLADDER NECK OR RISK OF BLADDER PERFORATION).
  - **Complete a catheter passport.**
  - Refer to community teams, explain outcome of TWOC.
  - Arrange outpatient TWOC:
    a. Alex – UIC, Claire Franks – via email.
    b. WRH – Helen Worth / Sam White – via email.
    c. KTC – Penny Templey /Jayne Cox – via email.
  - For patients being discharged with a catheter provide a home from hospital pack, and if required a spare valve. Refer to relevant community team.

SPECIALITY – SPECIFIC INFORMATION

UROLOGY

- Inpatient TWOC – any issues contact on call team.

Outpatient

- Request TWOC as above.

Acute Urinary Retention

- Men should be assessed for TURP or alternative lower urinary tract surgery. To be discussed with medical team.

Post Radical Prostatectomy/Radical Cysto-Prostatectomy and formation of neo-bladder/Patients with known bladder perforation.

TWOC only to be done by urology team. **DO NOT RECATHETERISE – refer back to urology.**
NO CATHETER VALVES TO BE USED IN THESE PATIENTS.

- Catheters must remain on free drainage.
- Nurse performing TWOC must ensure that a cystogram is not required.
- Consultants may request antibiotic cover for some patients.
- On discharge give discharge pack with continence products.
- Re-inforce pelvis floor exercises (PFE's).

Other Urology TWOC Patients

- Teach Pelvic Floor Exercises (PFE's)/bladder re-training.
- Teaching of CISC to be considered before indwelling catheter.
- FOR ADVICE CONTACT UROLOGY CNS's via switchboard or email.

GYNAECOLOGY

Inpatient TWOC

- If a patient fails her TWOC re-catheterise and refer to the uro-gynaecology CNS team.
- Women with acute urinary retention should be assessed by the uro-gynaecology team.
- Patient can be taught CISC if able, as an option if unsuccessful TWOC.
- Refer to community team for further support.

ELDERLY CARE/MEDICINE/OTHER SURGERY

- Patients can be referred as above if they have an unsuccessful inpatient TWOC.

COMMUNITY TWOC

- For patients living in Worcestershire who are not under any speciality service, refer to the Neighbourhood Teams for assessment and possible TWOC.
- If the patient is out of area and requires community follow-up contact the GP or Community Team.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Please attach patient sticker her or record

Name:

NHS No:

Hosp No:

D.O.B: D D M M Y Y Male Female

NHS
Worcestershire
Acute Hospitals
NHS Trust

Trial Without Catheter (TWOC)Chart

DATE_____ TIME	FLUID INTAKE (mls)	URINE PASSED (mls)	CONTINENT (YES/NO)	POST VOID RESIDUAL (bladder scan)	SIGNED
Time of TWOC 24 hr HH:MM _____					
Time post TWOC + 1 hour _____					
+ 2 hours _____					
+ 3 hours _____					
+4 hours _____					
+5 hours _____					
+6 hours _____					
+ 7 hours _____					
+ 8 hours _____					
+ 9 hours _____					
+ 10 hours _____					
Total					

APPENDIX

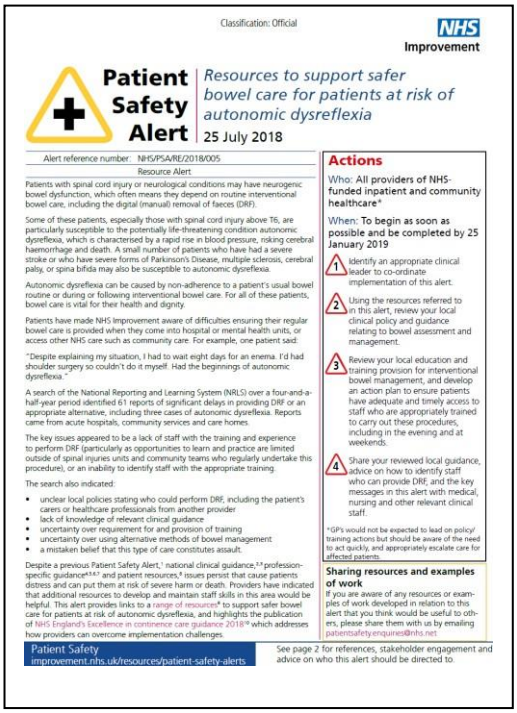
Autonomic Dysreflexia

Autonomic Dysreflexia is a serious life threatening condition that affects people with spinal cord injury at or above level of the six thoracic vertebrae. The syndrome develops secondary to a noxious stimulus below the level of injury as signals cannot pass normally to the brain due to damage to the spinal cord. As a result the body produces exaggerated abnormal nerve signals causing problems above and below the level of the spinal cord injury. This leads to an elevation of blood pressure. Hypertension may be severe enough to lead to seizures, or ultimately death if not addressed.

Symptoms may be mild or severe in severity and patient may present with one or more of the following

- Pounding headache.
- Flushing and or blotching above the level of cord damage.
- Pallor below the level of injury.
- A slow heart rate.
- Profuse sweating above the level of injury.
- Elevated blood pressure.
- Blurred vision or seeing spots before your eyes.

NHS Improvement has collated resources to support safer bowel care for patients at risk of autonomic dysreflexia which can be accessed on https://improvement.nhs.uk/resources/resources-to-support-safer-bowel-care-for-patients-at-risk-of-autonomic-dysreflexia/ in addition to this there is also a Patient Safety Alert that has been issued signposting resources to support safer provision of bowel care for patients at risk of autonomic dysreflexia that can be accessed on https://improvement.nhs.uk/documents/3074/Patient_Safety_Alert_-_safer_care_for_patients_at_risk_of_AD.pdf



Classification: Official

NHS Improvement

Patient Safety Alert

Resources to support safer bowel care for patients at risk of autonomic dysreflexia

25 July 2018

Alert reference number: NHS/PSA/RE/2018/005

Resource Alert

Patients with spinal cord injury or neurological conditions may have neurogenic bowel dysfunction, which often means they depend on routine interventional bowel care, including the digital (manual) removal of faeces (DRF).

Some of these patients, especially those with spinal cord injury above T6, are particularly susceptible to the potentially life-threatening condition autonomic dysreflexia, which is characterised by a rapid rise in blood pressure, risking cerebral haemorrhage and death. A small number of patients who have had a severe stroke or who have severe forms of Parkinson's Disease, multiple sclerosis, cerebral palsy, or spina bifida may also be susceptible to autonomic dysreflexia.

Autonomic dysreflexia can be caused by non-adherence to a patient's usual bowel routine or during or following interventional bowel care. For all of these patients, bowel care is vital for their health and dignity.

Patients have made NHS Improvement aware of difficulties ensuring their regular bowel care is provided when they come into hospital or mental health units, or access other NHS care such as community care. For example, one patient said:

"Despite explaining my situation, I had to wait eight days for an enema. I'd had shoulder surgery so couldn't do it myself. Had the beginnings of autonomic dysreflexia."

A search of the National Reporting and Learning System (NRLS) over a four-and-a-half-year period identified 61 reports of significant delays in providing DRF or an appropriate alternative, including three cases of autonomic dysreflexia. Reports came from acute hospitals, community services and care homes.

The key issues appeared to be a lack of staff with the training and experience to perform DRF (particularly as opportunities to learn and practice are limited outside of spinal injuries units and community teams who regularly undertake this procedure), or an inability to identify staff with the appropriate training.

The search also indicated:

- unclear local policies stating who could perform DRF, including the patient's carers or healthcare professionals from another provider
- lack of knowledge of relevant clinical guidance
- uncertainty over requirement for and provision of training
- uncertainty over using alternative methods of bowel management
- a mistaken belief that this type of care constitutes assault.

Despite a previous Patient Safety Alert,[1] national clinical guidance,[2,3] profession-specific guidance[4,5,6,7] and patient resources,[8] issues persist that cause patients distress and can put them at risk of severe harm or death. Providers have indicated that additional resources to develop and maintain staff skills in this area would be helpful. This alert provides links to a range of resources[8] to support safer bowel care for patients at risk of autonomic dysreflexia, and highlights the publication of NHS England's Excellence in continence care guidance 2018[9] which addresses how providers can overcome implementation challenges.

Patient Safety improvement.nhs.uk/resources/patient-safety-alerts

See page 2 for references, stakeholder engagement and advice on who this alert should be directed to.

Actions

Who: **All providers of NHS-funded inpatient and community healthcare***

When: **To begin as soon as possible and be completed by 25 January 2019**

1. Identify an appropriate clinical leader to co-ordinate implementation of this alert.
2. Using the resources referred to in this alert, review your local clinical policy and guidance relating to bowel assessment and management.
3. Review your local education and training provision for interventional bowel management, and develop an action plan to ensure patients have adequate and timely access to staff who are appropriately trained to carry out these procedures, including in the evening and at weekends.
4. Share your reviewed local guidance, advice on how to identify staff who can provide DRF, and the key messages in this alert with medical, nursing and other relevant clinical staff.

*GPs would not be expected to lead on policy/training actions but should be aware of the need to act quickly, and appropriately escalate care for affected patients.

Sharing resources and examples of work

If you are aware of any resources or examples of work developed in relation to this alert that you think would be useful to others, please share them with us by emailing patientsafety.enquiries@nhs.net

Treatment

Identify the source of noxious stimulus for example this could be due to a blocked catheter, defective drainage system, constipation or a urinary tract infection. The stimulus needs to be removed for the symptoms to settle.

Some patients may have prescribed medication for this condition which will help lower blood pressure.

Hypertension can be reduced by returning the patient to bed or placing in the sitting position.

If symptoms do not resolve quickly patient should be admitted immediately to hospital for further assessment and management.

RCN (2009) *Guidelines for the management of neurogenic bowel dysfunction after spinal cord injury.*

CATHETERISATION PROCEDURE: REQUIREMENTS

Access to hand hygiene facilities

The Bard IC Comprehensive Care Foley Tray, contains everything required to catheterise or re-catheterise a patient. It should be used in sequential order with care taken to ensure asepsis is maintained. The pack contains:

- One empty 10ml syringe to deflate the balloon during re-catheterisation.
- One prefilled 10ml syringe of sterile water to inflate the newly inserted catheter balloon.
- BARD Catheter of choice and 'Preconnect' system for your chosen drainage system.
- Protective waterproof sheet and fenestrated drape.
- Two pairs of latex free gloves.
- Cleansing solution and gauze.
- Apron for the healthcare professional.
- STATLOCK® Foley Stabilisation Device *.
- Syringe of lubricating gel.

Consider need for spare catheter if procedure does not go to plan.

Spare non sterile gloves/single use disposable apron.

Patient's notes including access to prior microbiology results and allergy status. Caution always check allergy status, document and act upon information provided.

If indicated consider use of local anaesthetic, antimicrobial lubricating gel *(Instillagel*). Take care to use the right product (6ml female; 11ml male) and ensure patient is not allergic to any components of the product. Caution some may contain chlorhexidine.

*The STATLOCK® is a strap free device which locks the catheter in position, stabilising it and eliminating any chance of a sudden pull. It is a latex free product that is hypoallergenic, breathable, waterproof securement pad with a 360° swivel retainer clip which allows the catheter to move with the patient. It can be worn for up to seven days and is designed to be changed when a bag change occurs.

APPENDIX 4

URINARY CATHETERISATION MALE

Equipment

- Bard IC Comprehensive Care Foley Tray

If not available consider need for:

- sterile pack containing gallipots, receiver, gauze swabs, disposable towels
- Disposable pad
- 0.9% sodium chloride
- Alcohol hand gel
- Stat Lock for tethering of catheter
- Sterile gloves
- Sterile water
- Selection of appropriate catheters
- Syringe and needle (as required to obtain any urine samples)
- Sterile anaesthetic lubricating gel
- Single use disposable plastic apron
- Universal specimen container
- Drainage bag and stand or holder

Pre-Procedure

No	Action	Rationale
1	Explain and discuss the procedure with the patient. Discuss any problems that have been experiences with previous catheterisations. Consider and check for any allergies the patient may have e.g latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport.	To ensure that the patient understands the procedure and gives his valid consent (NMC 2013 Consent). Please note that patients with spinal cord injury at T6 and above may be prone to Autonomic Dysreflexia and some patients may be at risk of a vasovagal attack when lay in a supine position.
2	Screen the bed.	To ensure patient's privacy. To allow dust and airborne organisms to settle before the sterile field is exposed (Fraise and Bradley 2009).
3	Prepare the trolley, placing all equipment required on the bottom shelf.	The top shelf acts as a clean working surface.
4	Take the trolley to the patient's bedside, disturbing the screens as little as possible.	To minimise airborne contamination (Fraise and Bradley 2009).
5	Assist the patient to get into the supine position with the legs extended on the bed.	To ensure the appropriate area is easily accessible.
6	Remove underpants or pyjama trousers and preserve patients dignity by covering the patient's thighs and genital area.	To maintain patient's dignity and comfort (NMC 2015 The Code).
7	Cleanse hands using bactericidal soap and water or Alcohol Hand Gel.	To reduce risk of infection (Fraise and Bradley 2009).
8	Put on a single use disposable plastic	To reduce risk of cross-infection from micro-

	apron.	organisms on uniform (Fraise and Bradley 2009).

Procedure

No	Action	Rationale
9	Open the outer cover of the catheterization pack and slide the pack onto the top shelf of the trolley.	To prepare equipment.
10	Using an aseptic technique, open the sterile/catheter pack. Open an appropriately sized catheter onto the sterile field.	To reduce the risk of introducing infection into the bladder (NICE 2012).
11	Remove cover from the patient's genital area, maintaining the patient's privacy, and position a disposable pad under the patient's buttocks and thighs.	To ensure urine does not leak onto bedclothes.
12	Cleanse hands with a alcohol hand gel.	Hands may have become contaminated by handling the outer packs (Fraise and Bradley 2009).
13	Put on sterile gloves.	To reduce risk of cross-infection (NICE 2012).
14	On the sterile field, place the catheter into the sterile receiver.	
15	Place a sterile towel across the patient's thighs.	To create a sterile field.
16	With one hand, wrap a sterile topical swab around the penis. Use this to retract the foreskin, if necessary, and with the other hand clean the glans penis with either cleansing solution or 0.9% sodium chloride or sterile water.	To reduce the risk of introducing infection to the urinary tract during catheterization.
17	Insert the nozzle of the lubricating jelly into the urethra. Squeeze the gel into the urethra, remove the nozzle and discard the tube. Massage the gel along the urethra using the barrel of the syringe.	Adequate lubrication helps to prevent urethral trauma. (Use of a local anaesthetic minimizes the discomfort experienced by the patient (Bardsley 2005)).
18	Squeeze the penis and wait approximately 5 minutes.	This is to prevent anaesthetic gel from escaping. To allow the anaesthetic gel to take effect, only required if used.
19	Depending on technique, gloves can be removed hands gelled and sterile gloves re applied and or a no touch technique of the key parts of the catheter maintained.	To enable aseptic technique.
20	With one hand hold the penis firmly behind the glans, raising it until it is almost totally extended. Maintain this hold of the penis until the catheter is inserted and urine flowing.	This manoeuvre straightens the penile urethra and facilitates catheterization (Stoller 2009). Maintaining a grasp of the penis prevents contamination and retraction of the penis.

No	Action	Rationale
21	With the free hand, place the receiver containing the catheter or the entire pre connect system between the patient's legs. Take the catheter and insert it into the penis for 15–25 cm until urine flows.	The male urethra is approximately 18 cm long (Bardsley 2005).
22	If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to cough gently. Do not force the catheter, encourage the patient to relax and try to pass urine. If resistance continues, medical advice should be sought.	Some resistance may be due to spasm of the external sphincter. Coughing gently helps to relax the external sphincter. Resistance may be due to insufficient anaesthesia or muscle spasm. Asking the patient to breathe deeply can help overcome spasm.
23	When urine begins to flow, advance the catheter almost to its bifurcation.	Advancing the catheter ensures that it is correctly positioned in the bladder.
24	Gently inflate the balloon according to the manufacturer's direction, having ensured that the catheter is draining properly beforehand. Ask the patient to report any discomfort and observe closely for signs of distress.	Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma (Getliffe and Dolman 2007).
25	Withdraw the catheter slightly and if necessary attach it to the drainage system.	To ensure that the balloon is inflated and the catheter is secure.
26	Support the catheter, if the patient desires, either by using a specially designed support, for example Statlock Foley Stabilisation Device.. Ensure that the catheter does not become taut when patient is mobilizing or when the penis becomes erect. Ensure that the catheter lumen is not occluded by the fixation device.	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken in using adhesive tapes as they may interact with the catheter material (Fillingham and Douglas Urological Nursing; Pomfret 1996).
27	Ensure that the glans penis is clean and dry and then extend the foreskin	Retraction and constriction of the foreskin behind the glans penis (paraphimosis) may occur if this is not done (Pomfret 2002)

Post procedure

No	Action	Rationale
28	Assist the patient to replace underwear and pyjamas and replace bed cover. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur (Pomfret 2002).
29	Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed (Pomfret 2002).
30	Dispose of equipment including gloves and single use disposable plastic apron into the appropriate waste bag and seal the bag before moving the trolley.	To prevent environmental contamination. (DH 2005).
31	Draw back the curtains.	
32	Dispose of clinical waste bag in a larger bin.	To prevent environmental contamination (Fraise and Bradley 2009).
33	Cleanse hands thoroughly with bactericidal soap and water.	To reduce risk of infection (Fraise and Bradley 2009).
34	Record information in relevant documents; including urinary catheter passport. Documentation should include: • reasons for catheterization • date and time of catheterization • catheter type, length and size • amount of water instilled into the balloon • batch number • manufacturer • any problems negotiated during the procedure • a review date to assess the need for continued catheterization or date of change of catheter.	To provide a point of reference or comparison in the event of later queries (NMC 2010).

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URINARY CATHETERISATION FEMALE

Equipment

- Bard IC Comprehensive Care Foley Tray

If not available consider need for:

- Sterile catheterization pack containing gallipots, receiver, gauze swabs, disposable paper towel
- Alcohol hand gel
- Strap to tether catheter (stat lock)
- Sterile water
- Syringe and needle
- Disposable plastic apron
- Drainage bag and stand or holder
- Clean privacy cover
- Disposable pad
- Sterile gloves
- Selection of appropriate catheters
- Sterile anaesthetic lubricating gel

Pre-Procedure

No	Action	Rationale
1	Explain and discuss the procedure with the patient. Obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Consider and check for any allergies patient may have e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport.	To ensure that the patient understands the procedure and gives her valid consent (NMC 2015).
2	Screen bed space.	To ensure patient's privacy. To allow dust and airborne organisms to settle before the sterile field is exposed (Fraise and Bradley 2009).
3	Prepare the trolley, placing all equipment required on the bottom shelf.	To reserve top shelf for clean working surface.
4	Take the trolley to the patient's bedside, disturbing screens as little as possible.	To minimize airborne contamination (Fraise and Bradley 2009).
5	Remove patient's underwear. Assist patient to get into the supine position with knees bent, hips flexed and feet resting about 60 cm apart.	To enable genital area to be seen.
6	Place cover over the patient's thighs and genital area.	To maintain the patient's dignity and comfort (NMC 2013).
7	Ensure that a good light source is available.	To enable genital area to be seen clearly.
8	Cleanse hands.	To reduce risk of cross-infection (Fraise and Bradley 2009).

No	Action	Rationale
9	Put on a single use disposable plastic apron.	To reduce risk of cross-infection from micro-organisms on uniform (Bardsley and Kyle 2008; Fraise and Bradley 2009).

Procedure

No	Action	Rationale
10	Open the outer cover of the catheterization pack and slide the pack on the top shelf of the trolley.	To prepare equipment.
11	Using an aseptic technique, open sterile pack. Then open appropriately-sized catheter and place on sterile field.	To reduce risk of introducing infection into the urinary tract.
12	Remove cover, maintaining the patient's privacy, and position a disposable pad under the patient's buttocks.	To ensure urine does not leak onto bedclothes.
13	Cleanse hands with alcohol hand gel.	Hands may have become contaminated by handling of outer packs, and so on (Fraise and Bradley 2009).
14	Put on sterile gloves.	To reduce risk of cross-infection (NICE 2012).
15	Place sterile towels under the patient's buttocks.	To create a sterile field.
16	Using gauze swabs, separate the labia minora so that the urethral meatus is seen. One hand should be used to maintain labial separation until catheter is inserted and urine flowing.	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter.
17	Clean around the urethral orifice with 0.9% sodium chloride using single downward strokes.	Inadequate preparation of the urethral orifice is a major cause of infection following catheterisation. To reduce the risk of cross-infection (Fraise and Bradley 2009).
18	Insert the nozzle of the lubricating gel (as per manufacturer's guidelines) into the urethra. Instil gel slowly, remove nozzle and discard. Wait 5 minutes (as per manufacture'rs guidelines) before continuing procedure. Or place a small amount of the lubricating gel/anaesthetic gel onto the tip of the catheter (as per manufacturer's guidelines).	Adequate lubrication helps to prevent urethral trauma. Use of a local anaesthetic minimises the patient's discomfort. Five minute wait to allow gel to take effect. (Baston 2011; Woodward 2005).
19	Depending on technique gloves can be removed, hands gelled and sterile gloves re applied and/or a no touch technique of the key parts of the catheter maintained.	To enable asepsis.

No	Action	Rationale
20	Place the catheter, in the sterile receiver, between the patient's legs.	To provide a temporary container for urine as it drains.
21	Introduce the tip of the catheter into the urethral orifice in an upward and backward direction. Advance the catheter until 5–6 cm has been inserted.	The direction of insertion and the length of catheter inserted should relate to the anatomical structure of the area.
22	If there is no urine present, remove the catheter gently and start procedure again. If urine is present, advance the catheter 6–8 cm.	This prevents the balloon from becoming trapped in the urethra.
23	Inflate the balloon according to the manufacturer's directions, having ensured that the catheter is draining adequately.	Inadvertent inflation of the balloon within the urethra is painful and causes urethral trauma (Getliffe and Dolman 2007).
24	Withdraw the catheter slightly and connect it to the drainage system.	To ensure that the balloon is inflated and the catheter is secure.
25	Support the catheter, if the patient desires, either by using a specially designed support, for example Statlock Foley Stabilisation Device. Ensure that the catheter does not become taut when patient is mobilising. Ensure that the catheter lumen is not occluded by the fixation device.	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken in using adhesive tapes as they may interact with the catheter material (Pomfret 1996).

Post Procedure

No	Action	Rationale
26	Assist the patient to replace underwear and pyjamas and replace bed cover. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur (Pomfret 1996).
27	Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed (Pomfret 1996).
28	Dispose of equipment including gloves and single use disposable plastic apron into the appropriate waste bag and seal the bag before moving the trolley.	To prevent environmental contamination. (DH 2005).
29	Draw back the curtains.	
30	Dispose of clinical waste bag in a larger bin.	To prevent environmental contamination (Fraise and Bradley 2009).
31	Cleanse hands thoroughly.	To reduce risk of infection (Fraise and Bradley

		2009).

No	Action	Rationale
32	Record information in relevant documents; including urinary catheter passport. Documentation should include: • reasons for catheterization • date and time of catheterization • catheter type, length and size • amount of water instilled into the balloon • batch number • manufacturer • any problems negotiated during the procedure • a review date to assess the need for continued catheterization or date of change of catheter.	To provide a point of reference or comparison in the event of later queries (NMC 2010).

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APPENDIX 6

SUPRAPUBIC CATHETER CHANGE

Equipment

- Bard IC Comprehensive Care Foley Tray

If not available consider need for:

- Sterile catheterization pack containing gallipots, receiver, gauze swabs, disposable paper towel
- Alcohol hand gel
- Sterile water
- Syringe
- Disposable plastic apron
- Drainage bag and stand or holder
- Clean privacy cover
- Disposable pad
- Sterile gloves
- Selection of appropriate catheters

Only appropriately trained staff that are competent and confident should change a supra-pubic catheter.

No	Action	Rationale
1	Explain and discuss procedure with patient, obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Consider and check for any allergies patient may have e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport.	To ensure that the patient fully understands the procedure and gives valid consent (NMC 2015). Please note that patients with spinal cord injury at T6 and above may be prone to Autonomic Dysreflexia and some patients may be at risk of a vasovagal attack when lay in a supine position.
2	Assist patient to lie flat on the bed and bed protection placed in situ.	To ensure the appropriate area is easily accessible To maintain patient's privacy and dignity.
3	Cleanse hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy.	To reduce the risk of infection.
4	Put on single use disposable plastic apron.	To reduce the risk of infection.
5	Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.	To avoid over reaching and minimise airborne contamination. To ensure correct catheter is used.
6	Using an aseptic technique open catheterisation pack.	To ensure items remain sterile.
7	Cleanse hands and put disposable plastic apron on and apply sterile gloves. Prepare equipment required. Do not remove inner wrapper from catheter at this stage.	Hands washed to reduce the risk of cross-infection. Disposable apron used to reduce the risk of cross-infection from micro-organisms on uniform. (EPIC 3 2014).
8	Cleanse around the insertion site with	To reduce the risk of infection.

	normal saline.	
No	**Action**	**Rationale**
9	Gently attach syringe nozzle to the valve on the inflation channel of the catheter and deflate the balloon without forcibly pulling back on the syringe.	Make a mental note of the length of catheter removed from the abdomen as this is the amount that needs replacing.
10	Remove catheter.	
11	Insert the new catheter to the length of catheter that was removed and when urine drains advance it a little further. You may need to gently corkscrew the catheter in. Gently inflate balloon according to manufactures guidance. Withdraw catheter slightly and apply drainage bag and catheter securing device if required. Ask the patient to report any discomfort and observe closely for signs of distress.	The new catheter needs to be inserted within approximately 10mins. It should be the same size catheter as the one initially inserted.
12	Make the patient comfortable and ensure catheter is draining adequately.	To promote patient dignity. To reduce the risk of urethral and bladder neck trauma.
13	Dispose of equipment according to local policy, remove personal protection equipment and cleanse hands.	To prevent environmental contamination.
14	Record information in relevant documents this should include, consent given, reasons for catheterisation, date and time of catheterisation, catheter type, length and size, batch number, amount of water instilled into balloon, manufacturer and batch number of anaesthetic gel used and any problems during the procedure.	To provide a point of reference or comparison in the event of later queries.

Reference

Mallett, J (2015) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures.* 9th Edition. Blackwell Sciences. Oxford

NOTES:

- Nurses worry about getting the catheter in the peritoneal space rather than in the bladder. If the catheter is not far enough into the bladder, resistance will be felt when attempting to fill balloon, and patient will feel pain. A small amount of blood may be apparent at supra pubic catheter changes, but this should stop in the next 24 hours.
- Discomfort due to bladder spasm may also occur.
- Unlike urethral catheterisation, lubricating gel is not required routinely when inserting a supra pubic catheter.

APPENDIX 7

URINARY CATHETERISATION CLEAN INTERMITTENT SELF CATHERISATION (CISC) MALE

Equipment

- Appropriately sized catheter
- Mirror (optional)
- Alcohol hand gel
- Waste bag
- Single use disposable apron and sterile/non sterile gloves in case of need
- Suitable container (clean heat disinfected or disposable pulp product)

It is noted this is a clean procedure if the patient is catheterising themselves, but an aseptic technique if a health professional is catheterising the patient.

It is advisable that the patient has a bath or shower on the day they will catheterise or wash their genitalia prior to catheterisation.

No	Action	Rationale
1	Explain and discuss the procedure with the patient using written information booklet or DVD.	To ensure that the patient understands the procedure and gives his valid consent (NMC 2015). To enable the patient to feel as comfortable as possible.
2	Cleanse hands, don single use disposable plastic apron if actively assisting in procedure and ensure access to sterile/non sterile gloves in case of need.	To reduce the risk of cross-infection (Fraise and Bradley 2009).
3	Ask the patient to prepare the catheter as per manufacturer's instructions.	Ensure correct use of product (Barton 2000).
4	If required clean the glans penis and wash hands. If the foreskin covers the penis it will need to be retracted during the procedure.	To reduce risk of infection and ease insertion of catheter.
5	Ensure the patient is in a comfortable position e.g. either sitting on toilet; standing upright or lying on the bed.	To facilitate insertion of the catheter.
6	The penis should be held straight at an angle of 45 degrees towards the abdomen. A stand up mirror is helpful for patients with a large abdomen	To prevent trauma to the penoscrotal junction.
7	Ask the patient to insert the catheter into the urethra, using aseptic non-touch technique. NB: There may be a change of feeling as the catheter passes through the prostate gland and into the bladder. Explain if a lot of resistance is felt, DO NOT continue; withdraw and seek medical advice.	The prostate gland surrounds the urethra just below the neck of the bladder and consists of much firmer tissue. This can enlarge and cause obstruction, especially in older men.

No	Action	Rationale
8	Drain urine into the toilet or measuring container if possible. When the urine stops flowing slowly remove the catheter, halting if more urine starts to flow.	It is useful to record the volume of residual urine drained to ascertain the frequency with which self-catheterisation is required. To ensure that the bladder is completely emptied.
9	Explain they should slowly remove the catheter when the flow has ceased and the foreskin drawn back over the glans of the penis.	This is to prevent paraphimosis occurring
10	Dispose of the catheter into the appropriate waste stream.	To reduce risk of environmental contamination
11	Remove PPE if worn and cleanse hands.	To reduce the risk of infection.
12	Record information in relevant documents including catheter type, size and batch number and any problems during the procedure	To provide a point of reference or comparison in the event of later queries

References

Barton, R. (2000) Intermittent self-catheterisation. Nursing Standard, 15(9), 47–55. Pubmed link

Fraise, A. P. & Bradley, T. (2009) Aycliffe's Control of Healthcare-associated Infections: A Practical Handbook, 5th edn. London: Hodder Arnold.

Mallett, J (2015) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures.* 9th Edition. Blackwell Sciences. Oxford

APPENDIX 8

URINARY CATHETERISATION CLEAN INTERMITTENT SELF CATHERISATION (CISC) FEMALE

Equipment

- Appropriately sized catheter
- Mirror (optional)
- Alcohol hand gel
- Waste bag
- Single use disposable apron and sterile/non sterile gloves in case of need
- Suitable container (clean heat disinfected or disposable pulp product)

It is noted this is a clean procedure if the patient is catheterising themselves, but an aseptic technique if a health professional is catheterising the patient.

It is advisable that the patient has a bath or shower on the day they will catheterise or to wash genitalia prior to catheterisation.

No	Procedure	Rationale
1	Explain and discuss the procedure with the patient using written information booklet or DVD.	To ensure that the patient understands the procedure and gives his valid consent (NMC 2015). To enable the patient to feel as comfortable as possible.
2	Cleanse hands.	To reduce the risk of cross-infection (Fraise and Bradley 2009).
3	Ask the patient to prepare the catheter as per manufacturer's instructions.	Ensure correct use of product and to ease insertion (Barton 2009).
4	Ensure the patient is in a comfortable position. eg, either sitting on toilet; standing upright or lying on the bed.	To facilitate insertion of the catheter.
5	Using a mirror, if required, ask the patient to locate and spread the labia to expose the urethra. If required the meatus and labia are cleaned from front to back using soap and water and then wash hands.	To enable the urethra being found easier. To reduce the risk of infection.
6	Using less dominant hand ask the patient to find the urethral opening above the vagina. A mirror can be used to help identify anatomy. Gently insert the catheter into the urethra using dominant hand, maintaining an aseptic no touch technique.	To reduce the risk of introducing an infection.
7	Drain the urine into the toilet or suitable measuring container. When the urine stops flowing, slowly remove catheter, halting if more urine starts to flow.	It is useful to record the volume of residual urine drained to ascertain the frequency with which self catheterisation is required. To ensure that the bladder is completely emptied.

No	Procedure	Rationale
8	Dispose of the catheter in a bag in household waste in if own home or according to local trust policy if in communal care setting.	To reduce risk of environmental contamination.
9	Remove PPE if worn and cleanse hands.	To reduce the risk of infection.
10	Record information in relevant documents including catheter type, size and batch number and any problems during the procedure	To provide point of reference or comparison in event of later queries.

References

Barton, R. (2000) Intermittent self-catheterisation. Nursing Standard, 15(9), 47–55. Pubmed link

Fraise, A. P. & Bradley, T. (2009) Aycliffe's Control of Healthcare-associated Infections: A Practical Handbook, 5th edn. London: Hodder Arnold.

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APPENDIX 9

URINE SAMPLING – CATHETER SPECIMEN OF URINE – See page 44

Equipment

- Dependent upon technique either sterile or non sterile gloves
- Apron
- Monovette
- Non-traumatic clamps
- Appropriate documentation/forms
- 70% alcohol with 2% chlorhexidine (hard surface disinfection wipe)

Pre-Procedure

No	Action	Rationale
1	Explain and discuss the procedure with the patient.	To ensure the patient understands the procedure and gives valid consent (NMC 2012).
2	Ensure a suitable, private location.	To maintain patient privacy and dignity (Gilbert 2006).
3	Prepare equipment and place on sterile trolley.	To prepare equipment for use.

Procedure

No	Action	Rationale
4	*If no urine visible in catheter tubing*: wash/decontaminate physically clean hands with alcohol rub, don apron and apply non-sterile gloves prior to manipulating the catheter tubing.	To minimize the risk of cross-infection (Pellowe 2009; RCN 2012).
5	Apply non-traumatic clamp a few centimetres distal to the sampling port.	To ensure sufficient sample has collected to allow for accurate sampling (Higgins 2013).
6	Cleanse hands; either cleanse hands or cleanse visibly clean hands with alcohol hand gel and single use disposable plastic apron and gloves.	To prevent cross-contamination (Fraise and Bradley 2009; RCN 2012).
7	Wipe sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allow drying for 30 seconds.	To decontaminate sampling port and prevent false-positive results (DH 2007a).
8	*If using needle and syringe*: using a sterile syringe and needle, insert needle into port at an angle of 45° and aspirate the required amount of urine, then withdraw needle. *Or in a needle-less system*: insert syringe firmly into centre sampling port (according to manufacturer's guidelines), aspirate the required amount of urine and remove syringe.	To enable safe inoculation of urine specimen and to minimize the risk of penetration of the wall of the catheter tubing (2006). Reduces the risk of sharps injury (DH 2006; European Biosafety Network 2010).
9	Transfer an adequate volume of the urine specimen (approx. 10 mL) into a sterile container immediately.	To avoid contamination and to allow for accurate microbiological processing (HPA 2014j).

No	Action	Rationale
10	Discard needle/syringe into sharps bin.	To prevent the risk of needlestick injury.
11	Wipe the sampling port with an alcohol wipe and allow to dry.	To reduce contamination of access port and to reduce risk of cross-infection (DH 2007a).

Post Procedure

No	Action	Rationale
12	Unclamp catheter tubing.	To allow drainage to continue.
13	Dispose of waste, remove apron and gloves and cleanse hands.	To ensure correct clinical waste management and reduce risk of cross-infection (DH 2006a)
14	Label sample, complete microbiological request form including relevant clinical information, such as signs and symptoms of infection, antibiotic therapy.	To maintain accurate records and provide accurate information for laboratory analysis (NMC 2010; Weston 2008).
15	Dispatch sample to laboratory immediately (within 4 hours) or refrigerate at 4°C.	To ensure the best possible conditions for microbiological analysis and to prevent micro-organism proliferation (HPA 2014j).
16	Document the procedure (including urinary catheter passport).	To ensure accurate record keeping (NMC 2010)

References

DH (2006a) Safe Management of Healthcare Waste. London: Department of Health.

DH (2007a) Saving Lives: Reducing Infection, Delivering Clean and Safe Health Care. High Impact Intervention No.6: Urinary Catheter Care Bundle. London: Department of Health. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/prod_consum_dh

European Biosafety Network (2010) *Prevention of Sharps Injuries in the Hospital and Healthcare Sector*. European Union. Available at: www.europeanbiosafetynetwork.eu/EU%20Sharps%20Injuries%20Implementation%20Guidance.pdf

Fraise, A.P. & Bradley, T. (2009) Ayliffe's Control of Healthcare-associated Infection: A Practical Handbook, 5th edn. London: Hodder Arnold.

Gilbert, R. (2006) Taking a midstream specimen of urine. Nursing Times, 102(18), 22–23.

Hampson, G.D. (2006) Practice Nurse Handbook, 5th edn. Oxford: Blackwell Publishing. Cross Ref link

Higgins, C. (2013) Understanding Laboratory Investigations for Nurses and Health Professionals, 3rd edn. Oxford: Blackwell Publishing.

HPA (2014j) Investigation of Urine: BSOP 41: Issue 7. Wales: Health Protection Agency. Available at: www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1317132858791

NMC (2010) Record Keeping: Guidance for Nurses and Midwives. London: Nursing and Midwifery Council. Available at: www.nmc-uk.org/Documents/NMC-Publications/NMC-Record-Keeping-Guidance.pdf

NMC (2012) Chaperoning. London: Nursing and Midwifery Council. Available at: www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Chaperoning/

Pellowe, C. (2009) Using evidence-based guidelines to reduce catheter related urinary tract infections in England. Journal of Infection Prevention, 10(2), 44–49. Cross Ref link

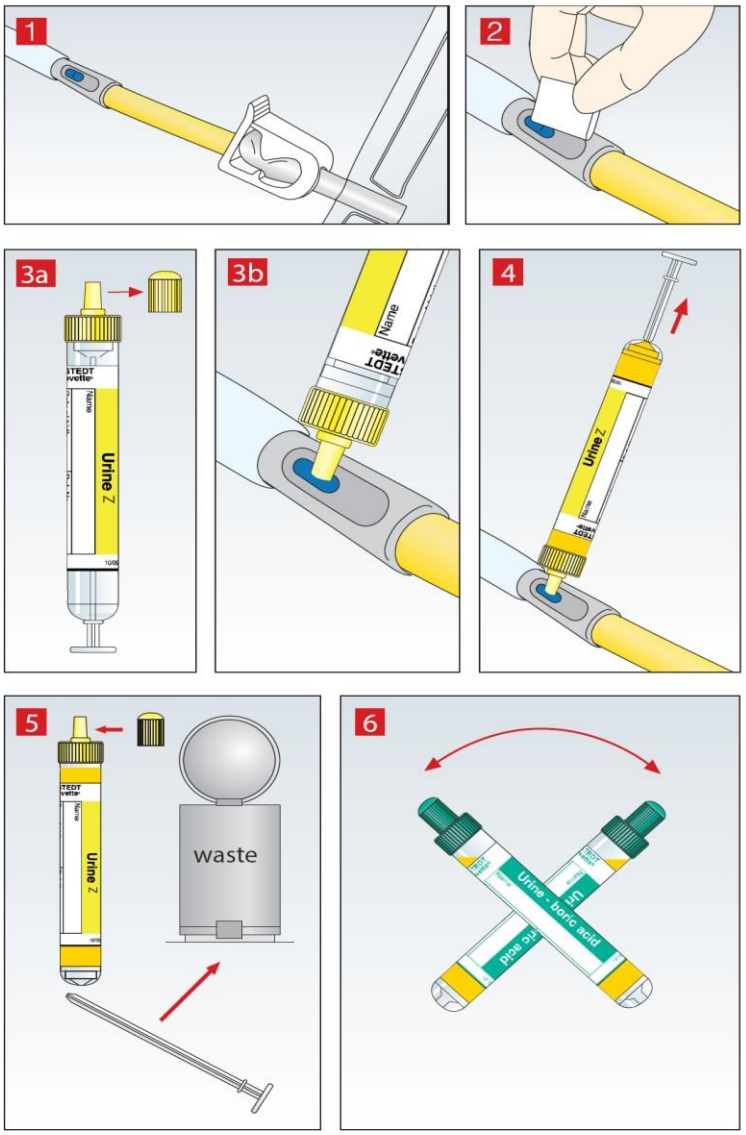
RCN (2012) Wipe It Out: Essential Practice for Infection Prevention and Control: Guidance for Nursing Staff . London: Royal College of Nursing.

Royal Marsden Hospital Manual of Clinical Nursing Procedures (2015) Ninth Edition, (Online). (Accessed March 2018) Weston, D. (2008) Infection Prevention and Control: Theory and Clinical Practice for Healthcare Professionals. Oxford: John Wiley & Sons. Cross Ref link

Pre-Procedure for Urine Sampling with a Monovette

No	Action	Rationale
1	Explain and discuss the procedure with the patient.	To ensure the patient understands the procedure and gives valid consent.
2	Ensure a suitable, private location.	To maintain patient privacy and dignity.
3	Prepare equipment and place on disposable tray.	To prepare equipment for use.
4	Cleanse hands, don single use disposable plastic apron and gloves.	To prevent cross-contamination.

Urine-Monovette Procedure for Obtaining a CSU:



1) If necessary, clamp the tubing a few centimetres distal to the sampling site. The sampling segment must be filled with urine.

2) Disinfect the sampling site on the catheter according to institutional guidelines.

3a) Remove the stopper of the Urine-Monovette® and keep for later use.

3b) Pierce the centre of the membrane at the sampling site with the Luer tip of the sterile Urine-Monovette®.

4) Fill the Urine-Monovette® with urine by completely withdrawing the plunger.

5) Break off the plunger and throw away.
Replace the stopper.

6) If using the Urine-Monovette® with boric acid, mix well after sample collection
(tilt approximately 5 times).

Follow post procedure for specimen collection actions 13, 14 and 16.

APPENDIX 10

USING A BLADDER MAINTENANCE SOLUTION

Equipment:

- Single use disposable plastic apron
- Depending on technique sterile or non sterile gloves
- Appropriate maintenance solution
- Sterile urine drainage bag
- Access to hand hygiene facilities/alcohol hand gel

No	Procedure	Rationale
1	Explain the procedure to the patient	So that the patient is fully informed
2	Protect bed or chair	
3	Prepare solution in accordance with manufacturer's instructions	The solution should be at body temperature to prevent discomfort.
4	Cleanse hands, put on single use disposable plastic apron and non sterile gloves, empty urine drainage bag and dispose of urine according to local policy.	To reduce the risk of infection.
5	Position comfortably, ensuring ease of access to the catheter. Remove gloves.	Maintain privacy and dignity through procedure.
6	Cleanse hands and put on sterile gloves.	Handling of the irrigation system and catheter should be performed aseptically.
7	Disconnect leg bag or flip flow valve Holding catheter 3 cm from end, insert solution connector into catheter.	To ensure good connection and prevent urine leakage.
8	Perform irrigation, following manufacturer's instructions.	To ensure patient safety and comfort.
9	Remove connector from catheter and re-connect to sterile drainage bag.	To reduce the risk of infection.
10	Remove gloves, apron and cleanse hands. Dispose of equipment according to trust policy	To reduce risk of infection.
11	Record procedure and any problems in patients documentation (including urinary catheter passport).	To provide a point of reference or comparison in the event of later queries.

References

Mallett, J (2015) *The Royal Marsden Hospital Manual of Clinical Nursing Procedures.* 9th Edition. Blackwell Sciences. Oxford

Royal Marsden Hospital Manual of Clinical Nursing Procedures (2015) Ninth Edition, (Online). (Accessed March 2018)

APPENDIX 11

URINARY CATHETER BAG EMPTYING

Equipment

- Disinfectant wipe
- Single use disposable plastic apron
- Non sterile gloves
- Container (jug or urine bottle), either heat disinfected or single use pulp product
- Paper towel to cover the jug
- Access to hand hygiene facilities/alcohol hand gel

NOTE If urine requires frequent measuring for an accurate fluid balance consider use of bag with integral measuring chamber to minimise number of times the closed system is opened.

Pre-Procedure

No	Action	Rationale
1	Explain and discuss the procedure with the patient.	To ensure that the patient understands the procedure and gives their valid consent (NMC 2013).
2	Cleanse hands, put on single use disposable plastic apron and non sterile gloves.	To reduce risk of cross-infection (Fraise and Bradley 2009).

Procedure

No	Action	Rationale
3	Open the catheter valve. Allow the urine to drain into the jug.	To empty drainage bag and accurately measure volume of contents.
4	Close the outlet valve and clean it with an alcohol wipe.	To reduce risk of cross-infection (Fraise and Bradley 2009).
5	Cover the jug and dispose of contents in the sluice, having noted the amount of urine if this is requested for fluid balance records.	To reduce risk of environmental contamination (DEFRA 2005).
6	Remove non sterile gloves and single use disposable plastic apron and dispose of in appropriate waste stream, and cleanse hands .	To reduce risk of infection (Fraise and Bradley 2009).

References

DEFRA (2005) Hazardous Waste Regulations: List of Wastes Regulations 2005. London: Department for Environment, Food and Rural Affairs.

Fraise, A. P. & Bradley, T. (2009) Aycliffe's Control of Healthcare-associated Infections: A Practical Handbook, 5th edn. London: Hodder Arnold.

NMC (2013) Consent. London: Nursing and Midwifery Council. Available at: www.nmc- uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/consent/

Royal Marsden Hospital Manual of Clinical Nursing Procedures (2015) Ninth Edition, (Online). (Accessed March 2018)

CHANGING A URINE DRAINAGE BAG

The bag should be changed when there is an accumulation of sediment, leakage, and a new catheter is inserted, or when the bladder has been irrigated. Bags should last for at least 5 to 7 days.

Equipment:

- Single use disposable plastic apron
- Non sterile gloves
- Sterile urine drainage bag
- STATLOCK® stabilisation device if required
- Access to hand hygiene facilities/alcohol hand gel

NOTE It is imperative that key parts which are required to be sterile are not touched with non sterile gloves.

No.	Action	Rationale.
1	Explain and discuss the procedure with the patient.	So that the patient is fully informed.
2	Release leg support.	To aid removal of bag.
3	Protect bed.	
4	Cleanse hands do single use disposable plastic apron and non sterile gloves.	To reduce risk of infection (EPIC 3 2014).
5	Loosen cap of new catheter tubing. Pinch the catheter 3-5 cm from its end and disconnect old drainage bag, raising the end of the tubing to drain residual urine into the bag.	To prevent infection and prevent urine leaking from tubing. Do not touch end of catheter to ensure aseptic non touch technique of key parts.
6	Holding new bag tubing 3-5 cm from its end, connect to catheter.	To minimise contamination and maintain aseptic non touch technique.
7	Secure catheter to body using a stabilisation device, STATLOCK® and bag to leg or to stand. Make patient comfortable.	To prevent urethral trauma.
8	Remove used bag and measure and record volume of urine if required	
9	Dispose of used bag, remove non sterile gloves and single use disposable plastic apron.	To prevent infection (EPIC 3 2014).
10	Cleanse hands, record intervention and any problems in patient documentation (including urinary catheter passport).	To provide point of reference or comparison in event of later queries.

APPENDIX 13

URINARY CATHETER REMOVAL

Equipment

- Single use disposable plastic apron
- Non sterile gloves
- Syringe for deflating catheter balloon
- Access to hand hygiene facilities/alcohol hand gel

In patients with a long term catheter where encrustation is suspected, a citric acid washout solution may be recommended prior to removal.

Once a balloon has been deflated, long term catheterised patients may prefer to remove their own catheter under supervision.

Pre-Procedure

No	Action	Rationale
1	Explain procedure to the patient and inform them of possible symptoms, such as urinary urgency, frequency and discomfort (caused by inflammation of the urethra following prolonged catheterisation).	So that patient knows what to expect, and can plan daily activity.
2	Cleanse hands, put on single use disposable apron and gloves.	To reduce risk of cross-infection (EPIC 3 2014).

Procedure

No	Action	Rationale
3	Release leg support.	For easier removal of catheter.
4	Having checked volume of water in balloon (see patient documentation), use syringe to deflate balloon.	To confirm how much water is in the balloon. To ensure balloon is completely deflated before removing catheter.
5	Ask patient to breathe in and then out; as patient exhales, gently (but firmly with continuous traction) remove catheter. Male patients should be warned of discomfort as the deflated balloon passes through the prostate gland.	To relax pelvic floor muscles. It is advisable to extend the penis as per the process for insertion to aid removal.

Post Procedure

No	Action	Rationale
6	Encourage patient to exercise and to drink 2–2.5 litres of fluid per day.	To prevent urinary tract infections.
7	Dispose of equipment in appropriate waste stream. Remove gloves and single use disposable plastic apron disposing of appropriately.	To prevent environmental contamination. Orange is the recognized colour for clinical waste (DEFRA 2005).
8	Cleanse hands.	To reduce risk of infection.
9	Record summary of removal, including	To provide a point of reference or

	where relevant details in urinary catheter passport	comparison in the event of later queries (NMC 2010).

References

DEFRA (2005) Hazardous Waste Regulations: List of Wastes Regulations 2005. London: Department for Environment, Food and Rural Affairs.

Fraise, A. P. & Bradley, T. (2009) Aycliffe's Control of Healthcare-associated Infections: A Practical Handbook, 5th edn. London: Hodder Arnold.

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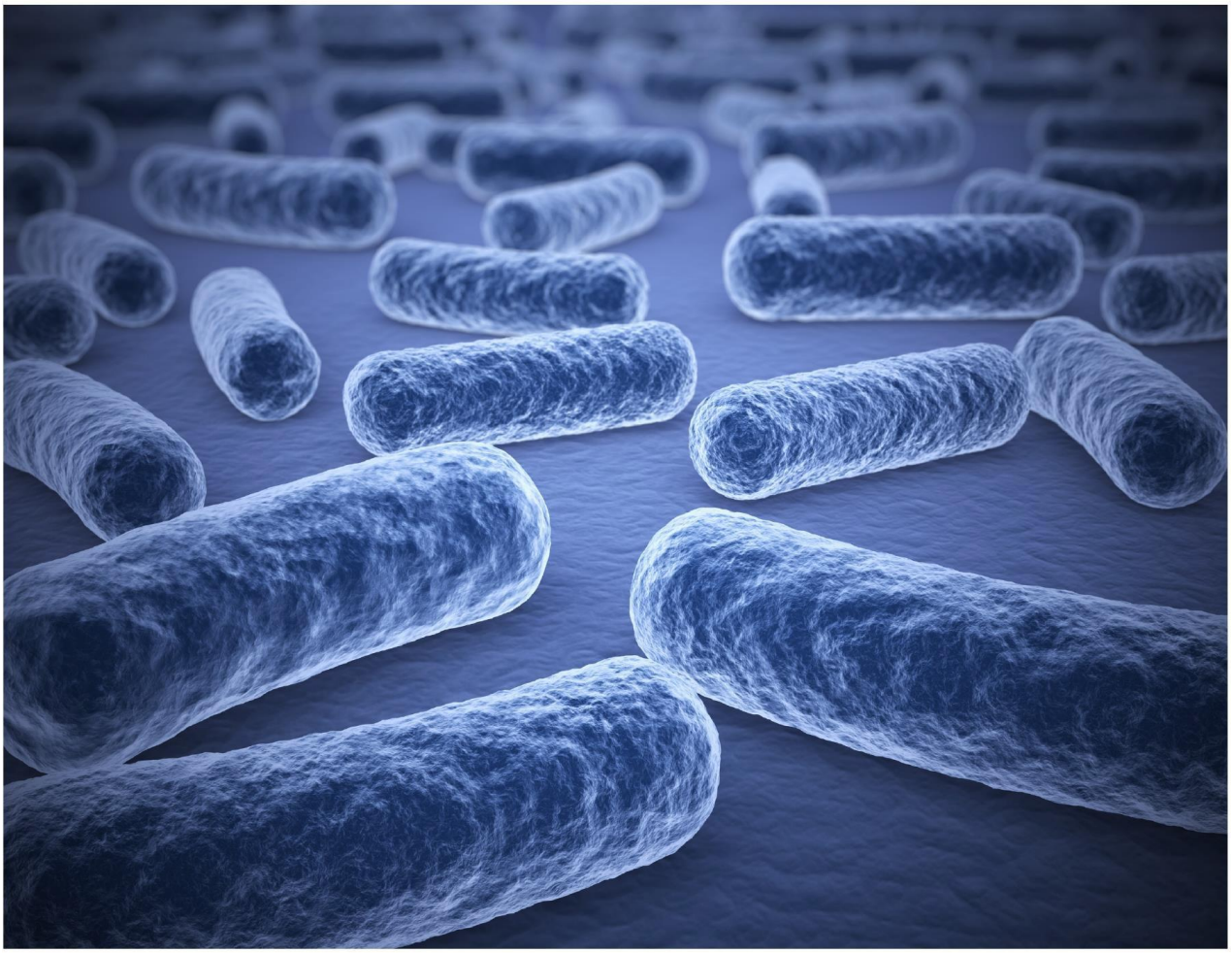
Infection Prevention Society

NHS Improvement



High Impact Interventions

Care processes to prevent infection

4th edition of Saving Lives: High Impact Interventions

April 2017

NHS Improvement
IPS Infection Prevention Society

High Impact Interventions to prevent catheter associated urinary tract infection

Aim

To reduce the incidence and consequences of urinary tract infection associated with both short and long term urethral catheters.

Why use the high impact intervention?

Catheter associated urinary tract infections comprise a large proportion of healthcare associated infections and occur whether a person has either a short term catheter or long term catheter. There is a strong association between duration of urinary catheterisation and risk of infection and these are becoming more serious with the continued development of a wide range of multi-resistant bacteria which can cause catheter associated urinary tract infections and associated life threatening complications (RCN 2012). Risks are greatly reduced complying with all parts of the process for safe catheterisation, maintenance, and removal as soon as no longer needed. This is important in both terms of promoting comfort, safety and infection prevention control measures. (NICE guidelines 2014).

Elements of the care process

There are two sets of actions outlined below as good practice.

a. Insertion phase
b. Routine maintenance and assessment for continuing indication phase

Insertion phase
1. Assessment for catheter indication Assessment of the need of the catheter is to be documented ensuring a clear clinical indication which includes exploring alternative options [1-3].
2. Aseptic procedure Catheterisation should follow an aseptic procedure including hand hygiene and is documented [1-3].
3. Urethral meatus The meatus should be cleaned with normal saline prior to insertion. Use a lubricant gel from a sterile single use sachet/syringe to minimise urethral trauma [1-3].
4. Catheter insertion documentation Document as a minimum the following: • date of insertion, • indication for catheterisation • catheter size • type of catheter and planned date for removal [1-3]

Routine maintenance and assessment for continuing indication phase
1. Hand hygiene Hands are decontaminated immediately before and after each episode of patient contact using the correct hand hygiene technique [1-3].
2. Personal protective equipment Wear personal protective equipment only when indicated and in accordance with local policy [1-3].
3. Assessment Daily assessment of the need of the short term urinary catheter needs to be clearly documented. Long term catheters should be reviewed regularly, at least every catheter change and documented [1-3].
4. Catheter hygiene Routine daily personal hygiene is required for meatal cleaning [1-3].
5. Routine maintenance • Do not break the connection between the catheter and the urinary drainage system unless clinically indicated. Use a separate clean/disposable container when emptying the drainage bag. • Document on the drainage bag when last changed and should be changed in line with the manufacturer's recommendation. The urinary catheter tubing and leg bag should be fixed to the patient's leg using a leg strap [1-3].
6. Patient information Ensure patients and carers are given information regarding the reason for the catheter and the plan for review and removal e.g. indwelling urinary catheter passport [1-3].

References

1. EPIC 3 Loveday H,P.,Pratt R.J., Wilson J.A., et al EPIC 3 National Evidence Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals. Available at https://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

2. Nice guideline 2014 available at https://www.nice.org.uk/guidance/qs61/chapter/quality-statement-4-urinary-catheters

3. Royal College of Nursing 2012 Catheter care – RCN guidance for Nurses.

Please attach patient sticker her or record

Name: _____

NHS No:

Hosp No:

D.O.B: D D M M Y Y Male ☐ Female ☐

Worcestershire Acute Hospitals NHS Trust

SITE: ALX ☐ KTC ☐ WRH ☐

Ward: _____

URINARY CATHETER ASSESSMENT AND MONITORING FORM FOR ALL PATIENTS WITH INDWELLING URETHRAL OR SUPRAPUBIC CATHETERS

(if patient re-catheterised commence new form)

TO BE COMPLETED BY STAFF WHO ARE COMPETENT AND TRAINED TO INSERT CATHETERS

The risk of catheter associated urinary tract infection (CAUTI) increases by 5% for each day the device remains insitu. The catheter and drainage system is to be reviewed at least daily.

Urethral Catheter ☐ Suprapubic Catheter ☐

Date of insertion: _____ Inserted prior to admission ☐

By Whom: Print Name _____ Signature: _____

Trust policy followed for correct insertion: YES ☐ NO ☐

If NO, state reason _____

_____

AFFIX CATHETER LABEL HERE OR COMPLETE

Catheter Size . . . . . CH

Male ☐

Lot No: . . . . . Expiry Date: . . . . . .

CATHETER TYPE (please tick)

PTFE short term use up to 28 days

HYDROGEL (BIOCATH) ☐ long term use up to 12 weeks

LUBRISIL ☐ long term use up to 12 weeks

☐

REASON FOR INSERTION:

Fluid Management – Monitoring renal function during critical illness ☐

Instillation of medication ☐

Pre/Post surgery ☐

Retention – Acute onset ☐

Retention – Chronic (only if symptomatic And/or renal compromise) ☐

Incontinence – Explain reason below ☐

If YES, was bladder scan done? YES ☐ NO ☐

Date: _____ Result: _____

_____

Other (please specify) _____

_____

Specify Sterile Closed Drainage system used :

Leg Bag ☐ 2L Bed Bag ☐ Urine Meter ☐

Statlock applied at insertion

YES ☐ NO ☐

Signature: _____ Print Name: _____

Designation: _____ Date: _____

Please attach patient sticker her or record

Name: _____

NHS No: | | | | | | | | | | |

Hosp No: | | | | | | | | | | |

D.O.B: D D M M Y Y Male ☐ Female ☐

PLEASE INDICATE:
✓ = YES
X = NO

Catheter Passport has been issued on insertion
Date……
Yes ☐
Already has passport ☐
Not issued state reason ☐
……

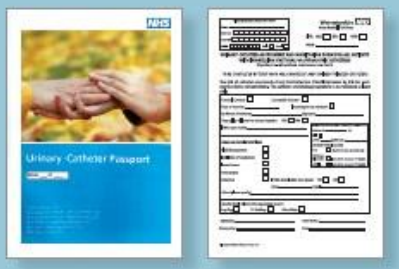
Date/ Time	Catheter still required (if no, date removed)	Meatal/ Suprapubic site hygiene performed?	Catheter tube secured safely?	Drainage Bag positioned above floor and below bladder	Drainage Bag changed? (unless clinically indicated, change after 14 days)	Statlock changed? (change every 7 days)	Is patient pyrexial or experiencing signs of UTI? If YES, perform urinalysis	C.S.U sent? If YES, date sent	Print Name & Designation
DAY 1									
DAY 2									
DAY 3									
DAY 4									
DAY 5									
DAY 6									
DAY 7					CHANGE BAG TODAY IF NO PRE-CONNECT SEAL IN SITU				
DAY 8									
DAY 9									
DAY 10									
DAY 11									
DAY 12									
DAY 13									
DAY 14					CHANGE BAG TODAY				
DAY 15									
DAY 16									
DAY 17									
DAY 18									
DAY 19									
DAY 20									
DAY 21					CHANGE BAG TODAY				
DAY 22									
DAY 23									
DAY 24									
DAY 25									
DAY 26									
DAY 27									
DAY 28	CHANGE PTFE CATHETER								

APPENDIX 16

NHS Worcestershire Acute Hospitals NHS Trust

Catheter Discharge Checklist

Community services use Prosys®



Provide or update a Urinary Catheter Passport, inserting a copy of the Urinary Catheter Assessment and Monitoring Form.

Has the patient been referred to the community nursing team as appropriate?

Does the patient require a urology clinic appointment?

Has the patient been provided with a hospital single patient use bag stand and Hospital to Home discharge pack?

Has the patient/carer been given verbal and written instruction on catheter care?

For more information or Hospital to Home discharge packs contact

Louise Patterson on: **07793 443349**

Email **louise.patterson@clinisupplies.co.uk** or **0208 863 4168**

Clinisupplies HEALTHCARE SOLUTIONS

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