| Procedure | | Worcestershire Acute Hospitals NHS Trust |
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# The Management of Urological Catheter Problems

Local Procedure

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| **Department / Service:** | Urology |
| **Originator:** | Vincent Koo, Consultant Urology |
| **Accountable Director:** | Tina Wright |
| **Approved by:** | Urology Directorate<br>Division of Surgery Governance meeting |
| **Date of approval:** | 29th April 2025 |
| **Review Date:**<br>**This is the most current document and should be used until a revised version is in place** | 29th April 2028 |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | A&E, all Wards |
| **Target staff categories** | Trust clinicians, junior doctors, nursing staff, Physician Associates |

| **Plan Overview:** |
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| This procedure sets out the key steps necessary to deliver safe care in the management of patients who have urethral catheter or suprapubic catheter problems. |

**Key amendments to this Document:**

| Date | Amendment | By: |
|---|---|---|
| October 2022 | New document approved | Urology Directorate, Surgery Governance |
| 29th April 2025 | No changes to key document, extended for another 3 years | Mr Koo |
| | | |

**Contents page:**

## 1. INTRODUCTION

This document was written to enable staff to follow the correct procedure for catheter problems according to current agreed evidence based clinical practice in the urology department.

## 2. DEFINITIONS AND/OR ABBREVIATIONS

| | |
|---|---|
| Trust | Worcestershire Acute Hospitals NHS Trust |
| Staff | All employees of the Trust including those managed by a third party on behalf of the Trust |
| Invasive procedure | A procedure that has the potential to be associated with a Never Event if safety standards are not set and followed |
| NatSSIPs | National Safety Standards for Invasive Procedures |
| LocSSIPs | Local Safety Standards for Invasive Procedures |
| WHO | World Health Organisation |
| NPSA | National Patient Safety Agency |
| NOAC | Novel Oral Anti-Coagulants |
| LMWH | Low molecular weight heparin |

## 3. Urethral catheter insertion procedure

1) Insert under aseptic conditions and request assistance from nursing staff.
2) Normally use 16F size with a 10mL balloon.
3) In a male pass the catheter all the way in to avoid inflating balloon in the urethra. If the catheter side arm distends as you are filling the catheter balloon, the balloon may be in urethra. Having filled the balloon it should be possible to withdraw the catheter freely several centimetres (a sign that the balloon is in the bladder and not the urethra).
4) Document residual urine volume drained in first 5 minutes.
5) Remember to replace foreskin to prevent paraphimosis.
6) Send a catheter specimen of urine for C & S if urinary tract infection suspected and start empirical antibiotics.
7) In retention perform a digital rectal examination: look specifically for faecal loading, prostate size, prostate consistency, malignancy, tenderness and blood on the glove.
8) Use 22F 3-way catheter, if visible haematuria and clots seen (avoid suprapubic catheterisation with visible haematuria).

### 3.1 Difficult catheter insertion

If difficult some simple tricks include:

1) Try 2 tubes of instillagel.
2) Try a more rigid (silicone) or larger catheter e.g. if using 12-14F, then try 16F.
3) Tiemanns tip catheter (need appropriate training to use).

The following options should only be performed by those with appropriate training:

1) Catheter introducer or attempt catheter insertion over a guide wire.
2) Flexible cystoscopy under LA and insert catheter over a guide wire.
3) Suprapubic catheter insertion (this should be the last local anaesthetic option and avoided where there is haematuria, known bladder cancer history or previous lower abdominal/vascular surgery – requires USS guidance).
4) Cystoscopy and insertion of urethral catheter under general / spinal anaesthesia.

### 3.2 Bypassing catheter

1) Either due to blockage or bladder spasm.
2) Treat as blocked catheter +/- anticholinergic medication.
3) Exclude UTI and treat accordingly.

### 3.3 Blocked catheter

1) Often secondary to debris.
2) Flush catheter with sterile water / saline or replace catheter.

### 3.4 Blocked suprapubic catheter (SPC)

1) Often secondary to debris.
2) Flush catheter using catheter-tip syringe with sterile water / saline.
3) If catheter remains blocked it may need replacing (NB do not remove suprapubic catheter within 6 weeks of insertion or track may be lost, it may be better to insert a urethral catheter temporarily until suprapubic track has matured). Reinsert new SPC quickly after removal, some SPC tracks can close very soon.

### 3.5 Suprapubic catheter has fallen out

1) Attempt re-insertion, use instillagel via tract, with 14 -16F rigid catheter.
2) If this fails attempt to insert a urethral catheter.
3) If this fails seek senior urological advice.

## 4 Implementation

### 4.1 Plan for implementation

As soon as approved at Directorate meeting

### 4.2 Dissemination

Trustwide

### 4.3 Training and awareness

Human Factors Training offered by Worcestershire Acute Hospitals NHS Trust

## 5. Monitoring and compliance

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirement within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks.

Monitoring is normally proactive - designed to highlight issues before an incident occurs – and should consider both positive and negative aspects of a process.
The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

**Monitoring Tool**
This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

| Page/ Section of Key Document | Key control: | Checks to be carried out to confirm compliance with the policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe. | What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.) | Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'. | Who is responsible for the check? Is it listed in the 'duties' section of the policy? Is it in the job description? | Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference. | Use terms such as '10 times a year' instead of 'monthly'. |
| Pg 4-5 | Compliance to Clinician Team responsibilities for pre-procedure and post-procedure follow up. | DATIX records of non-compliance | Yearly | Urology Governance Leads | Directorate Manager | Yearly |
| | | | | | | |

**Contribution List**

This key document has been circulated to the following individuals for consultation;

| Designation |
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This key document has been circulated to the chair(s) of the following committee's / groups for comments;

| Committee |
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| Urology Directorate meeting |
| Surgical Division Governance meeting |
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**Supporting Document 1 - Equality Impact Assessment Tool**
To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | No | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | N/a | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | N/a | |
| **7.** | **Can we reduce the impact by taking different action?** | N/a | |

If you have identified a potential discriminatory impact of this key document, please refer it to Assistant Manager of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Assistant Manager of Human Resources.

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

| | Title of document: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| | Other comments: | |

If the response to any of the above is yes, please complete a business case which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval