# Urinary Catheterisation Policy – Adults

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### Equality Impact Assessment (EIA) Disclosure Statement

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<td>i.) Age; ii.) Sex (Male and Female); iii.) Disability (Learning Difficulties/Physical or Sensory Disability); iv.) Race or Ethnicity; v.) Religion and Belief; vi) Sexual Orientation (gay, lesbian or heterosexual); vii) Pregnancy and Maternity; vii) Gender Reassignment (The process of transitioning from one gender to another); viii) Marriage and Civil Partnership.</td>
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2. Introduction and aims

2.1 Introduction

The Royal National Orthopaedic Hospital (RNOHT) aims to provide specialist care to people who have Muscular-Skeletal problems. The RNOHT is a specialist centre which provides care for patients from all over the UK and abroad. The provision of holistic, patient centred care enables effective discharge planning which can often involve multiple agencies and authorities.

Urinary Catheterisation is an intervention to enable bladder emptying by insertion of a catheter. Urinary catheterisation is a frequent intervention during clinical care in hospital affecting a significant number of patients at any one time.

The purpose of this guideline is to outline:

- Expected standards in the insertion, ongoing care and removal of urinary catheters
- The process for patient involvement and education
- Staff education, training and assessment of competence
- The audit process

A patient’s urinary care is interdisciplinary and multidisciplinary. This policy is therefore intended for use by all healthcare professionals to include nurses, doctors, allied health care professionals and health care assistants.

Catheter associated urinary tract infections (CAUTI) is the most common nosocomial infection in hospitals (EPIC 3 guidelines 2014) with urinary tract infections accounting for up to 19% of hospital acquired infections (Smyth 2006). Therefore, indwelling urethral catheters should only be inserted after considering alternative methods of management. A full assessment of the individual and their needs must be carried out before the catheterisation and this must be documented in the patient’s medical and nursing records. Catheterisation of patients who are agitated or cognitively impaired is best avoided where possible.

Healthcare professionals have a duty to safeguard the wellbeing of their patients. An Aseptic Non Touch Technique (ANTT) in inserting indwelling urinary catheters reduces infection rates (EPIC 3 guidelines 2014). An Aseptic Non Touch Technique in intermittent catheterisation must also be practised when done by nurses or doctors (NICE 2012) except when teaching a patient to perform their own self catheterisation whereby a clean technique should be taught (Lapides et al 1972, Wyndaele et al 1990, Vaidyanathan et al 1994 and Perrouin-Verbe et al 1995).
2.2 Aim of Policy

The purpose of this policy is to ensure that patients are protected through the application of evidence-based practice during invasive procedures to reduce risk of harm and infection.

Compliance with this policy will ensure that the procedure of urinary catheterisation is standardised and compliant with current recommended practice and guidelines.

- To ensure a high standard of urinary catheterisation care, including assessment, insertion and maintenance.
- To ensure safe, competent practice by all clinicians performing urinary catheterisation and reduce the risk of complications associated with catheter management.
- To ensure that all practice is evidence based, relevant, appropriate and to minimise harm.
- This policy outlines, step by step, the procedures involved in inserting urinary catheters and applies to all clinical staff involved in the insertion and maintenance of urinary catheters.

3. Definitions

Key words: Indwelling urethral catheterisation, supra-pubic catheterisation and intermittent catheterisation.

ANTT - Aseptic Non Touch Technique
HCP - Health Care Professional
CISC - Clean Intermittent Self Catheterisation
IDUC - Indwelling Urethral Catheter
SPC - Suprapubic Catheter (Indwelling)

4. Duties and Responsibilities

This policy relies on staff taking responsibility for infection prevention and control. The responsibilities necessary for the management and control of infection are outlined below:

- The Chief Executive is ultimately responsible for infection preventions and control and the content of all policies and their implementation. The Chief Executive delegates the day to day responsibility of implementation of the policies to the Director of Infection Prevention and Control and the Infection Prevention and Control Team
• The Infection Control and Prevention Team is responsible for delivering, managing and developing the infection control and prevention service. They assist ward staff, clinical nurse specialists and medical teams in patient risk assessment in the use of urinary catheterisation.
• The Matrons and Director of Nursing are responsible for ensuring that the development of local policies and procedures are implemented and evaluated.
• Healthcare Professionals have a responsibility to be confident and competent when undertaking this clinical procedure (RCN 2015). A registered nurse and medical practitioner must take into consideration:
  o The NMC code of professional conduct: standards for conduct, performance and ethics (NMC 2013)
  o Guidelines for records and record keeping (NMC 2010)
  o Relevant Trust Policies
  o The GMC code of conduct

5. Body of Policy

5.1 Scope of Practice

There is no distinction made between male and female healthcare professionals in their ability and competence to perform male and female urinary catheterisation (RCN 2008)

Patients have the right to request a healthcare professional of the same sex to perform their catheterisation and staff should make every endeavour to meet the patient’s request. However, it must be explained to the patient that their care may be compromised and put them at risk of harm by delaying catheterisation until a same sex healthcare professional is available. This must be clearly documented in the patient’s medical and nursing records.

Catheterisation is a sensitive issue that requires effective communication, diplomacy skills, practitioner confidence and practical skills which will aid patient comfort, safety and dignity.

This statement has been developed to cover all staff involved in the insertion and ongoing care of adult male and female urinary catheters, in all health care settings within the Royal National Orthopaedic Hospital NHS Trust.

It is the responsibility of all health care professionals to be confident and competent when undertaking this clinical procedure (RCN 2015). A registered nurse and medical practitioner must take into consideration:
  • The NMC code of Professional Standards of Practice and Behaviour for Nurses and Midwives (NMC 2015)
• Guidelines for records and record keeping (NMC 2010)
• Relevant trust policies
• The GMC code of conduct

Informed or best practice consent to undertake an initial insertion or changing of a urinary catheter must be obtained verbally from the patient or with written approval from the person with continuing medical responsibility for the patient. This consent should be recorded in the patient notes or other appropriate documentation.

The policy will apply to all health care professionals performing adult urinary catheterisation i.e. indwelling urethral, supra-pubic catheterisation and intermittent catheterisation.

To perform indwelling urethral and supra-pubic catheterisation the healthcare professional must be a registered nurse or doctor.

Registered nurses may delegate changing of indwelling urethral catheters and changing of supra pubic catheters to suitably trained Advanced Reintegration Spinal Injury Practitioners (ARSP), working with spinal cord injured patients that have been identified through their job description, the knowledge and skills framework and assessed as competent to perform this procedure.

Rehabilitation Assistants (RA) and Healthcare assistants (HCA) working with spinal cord injured patients on the Spinal Injury Unit and Angus Mackinnon Ward who have been assessed as competent and working within their job description are able to perform intermittent catheterisation. The registered nurse on duty remains accountable to supervise their practice for this delegated task:

• The ARSP/RA/HCA has received training and assessment of competence in the care of urinary catheters
• The ARSP/RA/HCA undergoes regular supervision to ensure their competence to carry out these tasks and attends relevant study sessions provided by the trust.
• The ARSP/RA/HCA will perform intermittent catheterisation on patients identified by the Registered nurse or doctor as being suitable and the procedure has been delegated by them but they remain accountable.
• The ARSP will only change an indwelling urethral catheter or SPC to a previously identified patient (those with routine, uncomplicated re-catheterisations) under the direct delegation from a registered nurse who is prepared to be accountable for the delegated task.

Advanced spinal reintegration practitioners (ASRP) working in the spinal cord injury centre is allowed to perform indwelling urethral and supra-pubic catheterisation. They follow the same level of continual assessment and competency training as trained nurses and doctors.

In order to perform urinary catheterisation and catheter care, Healthcare Professionals should attend the relevant training, be deemed competent, and be working within their job description. The recording of training and competency assessment of Healthcare Professionals must be recorded locally and remains the responsibility of the ward.
manager or department manager. Nursing Students may insert urethral catheters in adults under direct supervision of a competent registered practitioner providing they meet the standards outlined in this guidance and have been able to demonstrate the appropriate knowledge required to underpin the performance of the procedure. In these instances, responsibility for ensuring safe practice remains with the supervising registered practitioner.

Catheter care may be delegated to non-registered staff, once they have successfully completed the healthcare assistant competency but the registered nurse remains accountable for any care which has been delegated (NMC, 2008).

5.2 Catheterisation Guidelines

Good Practice Statement
Only use indwelling urinary catheters after alternative methods of management have been considered e.g. intermittent self-catheterisation. The Healthcare Professional should consider alternative measures to avoid urinary catheterisation where possible and understand the high level of risk associated with short and long term catheterisation.

Supporting documentation for this policy include the (EPIC 3 2014) for the maintenance of short-term indwelling catheters in acute care and the Infection Control Guidelines (NICE 2003) for care of patients with long term catheters.

5.3 Indications for Catheterisation

A Registered nurse is able, once deemed competent, to perform male and female urethral catheterisation, to change a supra-pubic catheter and perform aseptic intermittent catheterisation. They are also able, once deemed competent, to teach patients how to perform their own clean intermittent self-catheterisation.

Registered nurses working within paediatrics/adolescence and those nurses that are children registered are able, once deemed competent, to perform children and adolescent male and female urethral catheterisation, changing of supra-pubic catheters and aseptic intermittent catheterisation. They are also able, once deemed competent to teach patients (or their parents) how to perform their own clean intermittent self-catheterisation.

General indications for urinary catheterisation include:
- Monitoring of renal function during critical illness
- Intra- and post operatively care
- Acute urinary retention/urethral obstruction
- Chronic urinary retention (if symptomatic or with impaired renal function)
- Bladder irrigation for haematuria and clots
- Investigations (e.g. urodynamic or instillation of medication)
• Unconscious patients to prevent skin break down and monitoring of fluid balance
• Patients undergoing urological surgery
• End of life care, actual skin break down, serious disability and intractable incontinence following thorough clinical assessment involving the multi-disciplinary team.
• To keep perineal areas dry to assist healing
Urethral catheterisation for urinary incontinence needs to be carefully evaluated for the risks and benefits to the patient. Diagnosis and treatment of incontinence must be demonstrated.

5.4 Contra-indications for Catheterisation

There are certain conditions that may contra-indicate or prohibit urethral and supra-pubic catheterisation.

Absolute contra-indications – consult with the Urology team
• Do not change or remove urethral/supra-pubic indwelling catheters if urethral/urology surgery has been performed during the patient’s admission unless written permission has been obtained from the urology medics or the urology/continence clinical nurse specialists.
• Do not change or remove urethral/supra-pubic indwelling catheters if the patient has a symptomatic urinary tract infection until a plan of treatment is agreed and documented

Relative contra-indications (use only after careful discussion with relevant medical Practitioner and Urology team).
• Women who are pregnant or actively trying to get pregnant (increased risk of miscarriage).
• Post pelvic radiotherapy which is symptomatic (risk of urethral or bladder perforation
• Recent fractured pelvis – (potential risk of urethral rupture)

5.5 Patient Consent

Treatment and care should take into account patients’ needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their Healthcare Professionals.

Good communication between Healthcare Professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient’s needs. Treatment and care, and the information patients are given, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.
If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

**Verbal Consent and Documentation**

Verbal consent to insert or change a urinary catheter must be obtained from the patient and documented on the catheterisation label and in the patient’s medical records. The Healthcare Professional must be satisfied that the patient has understood the risks and benefits of the procedure and been given the opportunity to ask further questions or clarify the information given.

Informed or best practice consent to undertake initial insertion or renewal of a catheter must be obtained from the patient or their legal guardian.

- When obtaining consent direct from a patient, then verbal consent is acceptable
- When obtaining consent from a legal guardian then written consent using the RNOHT consent form must be used

The consent must be recorded in the patient’s notes and any correspondence related to the catheterisation.

**5.6 Chaperoning**

It is recommended that a chaperone is present during catheterisation. This must be a member of RNOHT staff and cannot be the patient’s relative, friend or partner alone. It should be offered to the patient and documented in the notes and on the catheter label. Please refer to the RNOHT Chaperoning Policy.

**5.7 Safeguarding Adults**

If patients do not have the capacity to make decisions, healthcare professionals should refer to the RNOHT policy Safeguarding Adults at Risk.

**5.8 Withdrawing Consent**

Patients are able to withdraw consent at any time and the correct policy and procedure for withdrawal of consent to medical treatment must be followed and documented.

**5.9 Prophylactic Antibiotics**

Do not offer prophylactic antibiotics routinely.

Only consider antibiotic prophylaxis in patients who:

- Have a history of symptomatic urinary tract infection after previous catheter changes
• Experienced trauma during catheterisation

Use of Antibiotics
• Microbiology advice should be obtained regarding the need for antibiotics in patients with recent metal work insertion, cardiac valves, cardiac stents, pacemakers and a history of infective endocarditis.

5.10 Catheter Selection
A competent Healthcare Professional can make a clinical decision to undertake an initial urethral catheterisation based on their knowledge and skills of catheterisation. Documentation that consent has been obtained from the patient and that the reason for catheterisation is clearly indicated and documented taking into account the indications and contraindications.

Good Catheter Care (including use of catheter valves)
• The need for the catheter should be assessed on a daily basis. The catheter drainage, condition of the patient and the catheter must be documented in the nursing/medical notes.
• Indwelling catheters should be connected to a sterile closed drainage system or catheter valve.
• Catheter valves should not be used without assessment of bladder function by an appropriate nurse/medical practitioner.
• Contra-indications for use of a catheter valve is indicated in patients with reduced bladder capacity, no bladder sensation, detrusor overactivity, ureteric reflux, renal impairment, cognitive impairment and insufficient manual dexterity to operate catheter valve (Van den Eijkel & Griffiths 2006).
• Healthcare Professionals should ensure that the connection between the catheter, catheter valve and/or urinary drainage system is not broken except for good clinical reasons. For example changing the catheter valve and drainage bag in line with current research and evidence based practice and/or the manufacturer’s recommendations. (NICE 2003).
• Once the drainage bag and/or catheter valve has been disconnected from the catheter, it must be discarded and replaced with a new sterile replacement (NICE 2003).
• Healthcare Professionals must wear an plastic disposable apron and decontaminate their hands using liquid soap and water or alcohol based hand rub. A new pair of clean non sterile gloves must be worn before handling/touching a patient’s catheter.
• Carers and patients managing their own catheters must wash their hands before and after handling/touching the catheter.
• Urine samples must be obtained from a sampling port using an aseptic technique. Never sample directly from the urinary catheter or drainage bag (EPIC 3 2014).
• Drainage bags which attach direct to an indwelling catheter/system must be sterile and may remain in place for 7 days in accordance with the manufacturer’s recommendations or be changed earlier if damaged or leaking or when there is an accumulation of sediment (RCN 2008).

• Healthcare Professionals must record the date of change of the catheter valve and/or drainage bag in the patient’s catheter care document record.

• Urinary drainage bags should normally be positioned below the level of the bladder (the only exception to this being a Sporran Suspension System such as the Rusch Belly Bag which is worn around the waist and is used for some patients with supra pubic catheters).

• No drainage bags used may be in direct contact with the floor.

• A link system should be used to facilitate overnight drainage to keep the original system intact.

• The urinary drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux and should be changed when clinically indicated (EPIC 3 2014).

• The urethral meatus should be washed once a day to assist in the prevention of bacteraemia (EPIC 2014).

• Each patient should have an individual catheter care plan designed to minimize the problems of blockage and encrustation.

• The tendency for catheter blockage should be documented in each catheterised patient.

• All patients with long term catheterisation should have a periodic review of their catheter care plan to monitor effectiveness of the treatment/management. At a minimum this review should be done 3 monthly. This would normally affect outpatients under the care of the RNOHT.

• Bladder instillations or washouts must not be used to prevent catheter associated infection (EPIC 3 2014).

• Catheter/ bladder washouts are only to be performed after a full assessment by Healthcare Professional or after consultation with the Urology/Continence Medical or Nurse Specialists

• Catheters should be changed only when clinically necessary or according to the manufacturer’s current recommendations.

• Prior to a catheter change, the antimicrobial guidelines must be referred to for prophylaxis, and the patient’s infection risk factors considered e.g. MRSA status/clostridium difficile.

**Catheter/Bladder washout**

• Systematic review of the evidence has failed to demonstrate any beneficial effect of bladder instillation, irrigation or washout with a variety of antiseptic or antimicrobial
agents in preventing catheter associated infections. (EPIC 3 2014). Routine catheter washouts using antiseptic solutions should not be undertaken.

- Irrigation, instillations and washouts may be indicated during urological surgery or to prevent catheter drainage blockage. Patients who repeatedly have blocked catheters due to encrustation may benefit from an solution that is instilled into the bladder and left there for 10 minutes maximum e.g. Solution G or Suby-G (EPIC 3 2014) prescribed in accordance with BNF recommendations.

- During office hours (8am to 5pm) urology/continence medical and nurse specialists are available for referral/consultation for patients with urological conditions and complex catheter problems. Contact the Urology department on extension 5593 Urology secretary, air call via switch board for the Urology registrar or Bleep 822 for the CNS for Neuro Urology or Continence.

**Catheter material**

- All silicone catheters contain no latex and are proven to have a lesser encrustation rate than latex based catheters (see Figure 1). They are licenced for urethral and suprapubic use and can stay in for a maximum of 12 weeks (recommended to be changed at 6 weeks for Spinal Cord Injured patients)

![Figure 1 – All silicone catheter](image)

- Open tipped all silicone catheters (LINC Medical Ltd) are licenced for urethral and suprapubic use and are the catheter of choice for those patients prone to catheter blockages (see Figure 2). Licenced to stay in for 12 weeks (must be changed at 6 weeks for Spinal Cord Injured patients). They are also manufactured by Coloplast and Macgregor Healthcare LTD

![Figure 2 Open tipped all silicone catheter](image)
• Silver coated Bardex anti-infective Biocath catheters are licenced for use for 28 days and for indwelling urethral and suprapubic catheterisation (see Figure 3). They have a 35% incidence of reducing Hospital Acquired Catheter Infection.

Figure 3 – Silver coated anti-infective catheter

5.11 Urethral Indwelling Catheterisation

Indwelling urethral catheters should only be used after alternative methods of management have been considered.

All indwelling urinary catheters (IDUC or SPC) are balloon retaining. They can be for short term use, medium term use or long term use, dependent on the anticipated needs of the patients. **The balloon must only be inflated with sterile water to the manufacturer’s recommendation and no more to avoid risk of bursting or misshaping of the balloon that can interfere with drainage. The valve on the catheter or the catheter packaging will indicate the number of mls to be inserted.**

Always check with the patient if they have any allergies including latex or silicone.

The patient’s clinical need for catheterisation should be reviewed daily and the urinary catheter removed as soon as possible.

The type and gauge of an indwelling urinary catheter is based on an assessment of the patient’s individual characteristics (BAUN 1998/1999), including:

- Age
- Allergies or sensitivities to catheter materials
- History of symptomatic urinary tract infection
- Patient preference and comfort
- Previous catheter history
- Reason for catheterisation

**Male – Indwelling Urethral Catheter**
- Length of catheter 43cm*
- Size of catheter 12ch or 14ch

**Female** – Indwelling Urethral Catheter
- We do not recommend using female length catheters (26cm*). These catheters can cause marking of the skin at the level of the inflation valve in those patients who are neuropathic impaired, wheelchair users or with reduced mobility.
- It is recommended that a male length catheter is used
- Size of catheter 10ch or 12ch

*Lengths are approximate, as manufacturers vary.

### 5.12 Suprapubic Indwelling Catheterisation

The initial insertion of a suprapubic catheter will be performed by Urology medical staff via cystoscopy and ultrasound guidance. This is an operative procedure and must only be done by a competent, surgeon in theatres. Trained nurses and doctors who have been deemed competent to perform changes of Suprapubic catheters are allowed to perform this procedure. Only trained nurses and doctors experienced in paediatric care are allowed to perform paediatric changes of Suprapubic catheters.

After the initial insertion of the Suprapubic catheter, there will be a suture in place to secure the catheter to the abdomen which can be removed after 10 days. If permitted, catheter clamping can also begin at this time.

An aseptic non touch technique must be used during initial insertion as well as during subsequent changes of the catheter.

The first change of a Suprapubic catheter is to be done by an Urologist or the Neuro Urology/Continence Clinical Nurse Specialist due to the risk of the Suprapubic tract closing quickly. Subsequent changes can be performed by a competent Healthcare Professional.

The size of the catheter used should be no smaller than a 16ch in adults. Individual choice will be considered by the specialist CNS regarding the length of the catheter inserted according to patient needs.

### Care of the Suprapubic Catheter site

See catheter hygiene procedure appendix 6

If dressings are clinically required then they must be sterile and applied using an Aseptic Non-Touch Technique. The site needs to be reviewed on a daily basis and documented for signs of infection or dilating of the track. Seek advice from the Tissue Viability Nurse Specialists or the Neuro-Urology/Continence Nurse Specialists in cases of infection and dilating of the suprapubic track.

It is acceptable for outpatients to be advised to wash the site daily in the shower with soap and water.
5.13 **Intermittent Self Catheterisation**

Wherever possible, intermittent catheterisation should be the preferred option for bladder drainage compared to an indwelling urinary catheter. This decision will be taken in consultation with the patient and must include:

- Evidence that the patient’s bladder can hold at least 300mls
- Any risk of incontinence has been identified, treated or managed
- Education of the patient and/or carer in how to perform intermittent self-catheterisation is conducted
- The ability to learn to do the procedure themselves independently or with minimal assistance from their carers. Otherwise, an alternative method of bladder management must be considered and discussed.

For the procedure please refer to: Male & Female intermittent catheterisation see appendix 4

5.14 **Catheter Drainage options**

**Leg Bags (500-750mls)**

![Figure 4 – Examples of leg bags for urinary drainage](image)

A leg bag must be used on ambulant patients or wheelchair users. This is to maintain patient dignity and to reduce the risk of the catheter being pulled or traumatised due to the longer tubing on a 2L night bag.

- Leg bags must be sterile and left in situ to minimise the risk of introducing infection between the catheter and the bag connection point.
- Urine drainage bags must have either an anti-reflux valve or anti-reflux chamber to prevent reflux of contaminated urine from the bag into the tubing.
- Urine drainage bags will have sample/access port for the collection of urine specimens while maintaining a closed system, preferable needle free.
- Draining tubing on leg bags is of different lengths, either short tubed or long tubed. Some patients may prefer to have the leg bag attached to their thigh (short tube) and others to their calf (long tube).
- The drainage taps also vary in action from slide action, lever action and clamp taps.
- Urine drainage bags are changed every 5-7 days or more often if indicated (large debris preventing drainage)
- The leg bag must be secured to the leg to avoid drag, damage to the urethra or bladder and to prevent patient discomfort (see section on securing of leg bags)
- The ‘belly bag’ is designed to be placed upon the stomach and if a patient requires this form of urine drainage bag then please contact the Neuro-Urology/Continence Nurse Specialists

Figure 5 – Example of the belly bag

- Speak to the Neuro-Urology/Continence CNS for how to order.
- At night a night bag is attached to the bottom of the leg bag, providing a link system and allowing for greater drainage capacity (Getliffe 2003)
2Litre (Night) Bag

Figure 6 – Example of 2L (Night) bag
- These are sterile and either for long term use continuous drainage use i.e. patient on bed rest and changed every 5-7 days or
- They can be used daily to put onto a leg bag at night and then removed in the morning.
- Non drainable night drainage bags can be used in conjunction with a leg bag and can hold approximately 2-2.6 litres.
- All bags should be secured with an appropriate catheter stand.
- The Trust Infection Control policy should be adhered to when cleaning and storing the catheter stand.

All drainage bags must be positioned above the floor but below the bladder to prevent reflux or contamination. Closed urinary drainage systems must remain intact and should only be changed weekly or more frequently according to clinical need and/or in accordance with manufacturers’ instructions.

Hourly Drainage Bag
An Urometer should be considered for the monitoring of fluid balance in the acutely unwell patient.
15. Securing the Catheter Safely

Catheter securing devices are designed to prevent excessive traction of the catheter against the bladder neck or accidental removal of the catheter.

Recommended devices to secure the catheter tubing include:

- Catheter retaining strap – small/medium and medium/large. These are Velcro straps that go around the thigh to secure the catheter at the Y connection. These are changed only when contaminated or unusable. The skin must be checked daily to avoid any marking and the strap checked to ensure it is not too tight (see pictures below).

Figure 8 Catheter Retaining Strap

- Catheter securing tapes eg Statlock and Clinimed (see pictures below). These are disposable tapes that are designed to anchor/secure the catheter and can be applied direct to the skin. They must be changed daily and the skin checked to identify any marking.

Figure 10 – Statlock and Clinmed securing tapes

16. Catheter Valves and Catheter Clamping

Definition

A catheter valve is a small device that is connected between the catheter and the drainage bag. Closing and opening of the valve allows the bladder to fill and maintain a good bladder capacity (Sheriff et al 1998 and Abrams et al 2004). It can be used...
without the urinary drainage bag to allow the patient to participate in swimming, showering and bathing.

These can be used as an instead of a urinary drainage bag. As well as being discreet, they can help maintain bladder tone and allow the bladder to fill and empty to reflect the ‘normal way’. The use of a valve during the day and continuous drainage at night has been found to be an ideal solution for many catheterised patients.

Advantages
- Maintenance of bladder capacity over a period of time
- Retention of bladder tone and enhanced return to normal pattern of voiding post catheter removal
- May reduce infection rate due to “flushing” action when catheter released
- Discreet in use
- Decreased risk of trauma to the bladder, bladder neck and urethra due to reduction of traction on the catheter from leg bags more than 2/3 full
- Greater freedom in social and leisure activities e.g. swimming, sexual activities

Most useful in:
- Post-operative voiding dysfunction, especially following urological, gynaecological or orthopaedic surgery
- Prior to removal of catheter in short term situation
- Patients capable of self-care regarding bladder drainage
- Patients with suprapubic catheters who find bag positioning problematic
- Patients with spinal cord injury/neurological injury

Catheter Clamping Regime
Most patients will drain their urine directly into a toilet. If using a urinal or other receptacle this must be kept for this purpose alone.

Advice on frequency of drainage should be based on individual need following assessment of bladder function by an appropriate medical/nursing professional, taking into account fluid intake and output. Usual advice is to drain the bladder 2 – 3 hourly if the patient has reduced bladder sensation.

If the catheter and valve is not tucked into underwear, advice should be given on how to secure it to prevent pulling. A catheter retaining strap may be used.

Consideration should be given to the length of urethral catheter in females when using a catheter valve. This is to allow for comfort and ease of drainage to reduce trauma. Overnight drainage bags may be connected if required

Before using catheter valves it is recommended that the relevant medical or nursing staff is contacted - e.g. Neuro urology or Continence CNS.
A spigot is not a suitable alternative to a valve as it has to be removed from the catheter to allow drainage and thereby breaking the closed drainage system.

**Indications for use**

WARNING: USE OF A CATHETER VALVE AND CATHETER CLAMPING SHOULD NOT BE STARTED WITHOUT AN ASSESSMENT OF BLADDER FUNCTION BY AN APPROPRIATE MEDICAL/NURSING PROFESSIONAL

The decision to use a catheter valve must be made by medical/nursing staff. The patient should be fully assessed when considering the use of a catheter valve and must have:

- Cognitive awareness of the need to drain the bladder at regular intervals to avoid over-distension of the bladder
- Sufficient dexterity to manipulate the device
- Sufficient vision to manipulate device
- Ability to comply with manufacturer’s recommendations

NOTE: A PATIENT WITHOUT BLADDER SENSATION OR COGNITIVE AWARENESS MAY HAVE THEIR CATHETER VALVE MANAGED BY A CARER WHO HAS RECEIVED INSTRUCTION ON THE USE OF THE DEVICE FOR THAT INDIVIDUAL PATIENT

**Contra-indications**

- Reduced bladder capacity
- Uncontrolled Detrusor Instability, Overactive bladder, (might cause urinary leakage)
- Ureteric Reflux and/or Renal Impairment
- Severe cognitive impairment (the patient must be able to recognise the need to empty the bladder through sensation or on a timed schedule)
- Small bladder capacity; the valve would have to be opened very often
- Urinary tract infection - symptomatic
- Poor manual dexterity

(EAUN 2012)

**17. Catheter Hygiene Care**

See appendix 6 and 7 Catheter Hygiene Care Record & Documentation
**Indwelling Urethral Catheter**

Catheter care must be performed on all patients with an indwelling urethral catheter on a twice daily basis. This is conducted either by the Healthcare Professional or the patient, after instruction and evaluation by the Healthcare Professional. Soap and water should be used to clean around the urethral meatus and along the indwelling urethral catheter starting at the patient and moving away.

Catheter care performed correctly and on a twice daily basis has been proven to reduce the risk of Catheter Associated Urinary Tract Infection (NICE 2012, RCN 2012, Leaver 2007). This procedure must be documented as completed on a daily basis in the patient’s medical or nursing records.

**Suprapubic Catheter**

The suprapubic catheter site must be clean daily with an Aseptic Non-Touch Technique and appropriate sterile dressing applied (please see section 14 of the policy).

**Intermittent Self Catheterisation**

Hygiene pre and post catheterisation must be performing according to the Procedure outlined in Appendix 4 – Intermittent Self Catheterisation procedure Male and Female.

18. **Taking a sample of urine**

A needle free system should be used. See procedure for collection of a urinary catheter specimen of urine below.

![Figure 11 – Example of needle free port](image)

19. **Catheter Associated Problems and Solutions**

**Blocked Catheter**

It is recommended that if the catheter is blocked then to change it for a new one.

On removal of the catheter make note of the cause of the blockage i.e. encrustation, mucous, blood clot etc. and document in the nursing/medical notes.

Advice to prevent further blockages can include the following:

- Increase oral fluid intake to at least 2-3 litre per day (caution and advice should be sought in patients with pulmonary oedema and renal failure)
- Use of Cranberry Juice orally or in tablet form is not clinically proven but may be of benefit to some patients (not advised in patients on Warfarin as affects levels)
- Use of an all silicone open ended catheter
- Use of bladder washouts and instillations as prevention of blockages but should not be used to unblock a catheter

Encrustation of the Catheter, bladder washouts and instillations
There are a variety of reasons why catheters block and these include both bladder spasms and constipation. However the most common cause of blockage is from urease producing bacteria which deposits bio films and encrustation on the external surface of the catheter and within the lumen of the catheter (Getliffe and Dolman 2003). These deposits not only cause pain and discomfort to the patient, but also contribute to increased nursing costs in time and travel.

It is considered that at least 50% of clients with a long term catheter (defined as a patient who has had a catheter in situ for over 12 weeks) will at some time experience blockage of the catheter due to encrustation of the catheter. (Getliffe and Dolman 2003). For clients whose catheter regularly blocks, that is who have more than 3 emergency catheter changes in 8 weeks due to encrustation, or where visible sediment is seen, then the use of a Catheter Maintenance Solution (formerly called a bladder washout) regime is an acceptable form of management. (Getliffe and Dolman 2003)

Types of Maintenance Solutions
There are a variety of maintenance regimes suggested in the literature. However, it is suggested that catheter closed drainage systems are not opened too often. Therefore, daily washouts would be discouraged in the long term and a 2-3 times a week regime followed where this treatment is considered necessary for a short period of time and then washouts discontinued or used weekly

1. Sterile Normal Saline can be used to irrigate catheters that block with pus, blood clots or debris. It is very effective for clients with reconstructed bladders where there is a large amount of mucous produced. Normal saline will not dissolve encrustation but works by gently washing out the lumen of the catheter. The use of normal saline is not recommended if a catheter is regularly blocking due to encrustation.

2. Solution G (3.2% citric acid) - also known as Suby G - Solution G works by dissolving the crystals formed by urease producing bacteria. Solution G contains Magnesium Oxide which has been incorporated to prevent bladder irritation due to the acidic nature of the solution. This solution has been extensively trialled.

3. Solution R (6% solution of citric acid) Solution R is effective at dissolving severe encrustation due to its acidic nature. This should be used only after Solution G has been tried and has not been effective. It can also be used just prior to catheter removal to dissolve any crystals on the tip of the catheter which may cause trauma on catheter removal. This solution has been extensively trialled. N.B. There are a few patients who cannot tolerate the use of catheter maintenance solutions. These patients usually complain of pain and discomfort on instillation of the solution. For these patients the only option is to change the catheter frequently to prevent encrustation building up. Solution R should only be used after consultation with the Neuro-urology/Continence CNS.
**Autonomic Dysreflexia (Appendix 21)**

Patients with a spinal cord injury at or above the level of T6 can be affected by Autonomic Dysreflexia (exhibiting most commonly hypertension, bradycardia, headache, flushing and seating above the level of the injury) which is a life threatening, medical emergency and must be managed as such. Autonomic Dysreflexia may be caused by urinary retention or an obstructed catheter and this should be considered in the prevention and management of the condition. Refer to the London Spinal Cord Injury Unit at RNOH on call co-ordinator for advice for treatment.

**Catheter Bypassing**

Urine bypassing an indwelling urethral catheter and causing incontinence can be due to the following:

- bladder spasms (overactive bladder/neurogenic detrusor overactivity)
- poor urethral resistance and pelvic floor tone due the cauda equina/lower motor neurone injury or post menopause or multiple vaginal deliveries
- urinary tract infection

It is important to identify the cause of the bypassing and treat accordingly.

**UNDER NO CIRCUMSTANCES SHOULD THE CATHETER SIZE BE INCREASED OR THE WATER IN THE BALLOON INCREASED BEYOND THE MANUFACTURERS LIMIT**

Please contact the Neuro-Urology/Continence Clinical Nurse Specialists or Urology medical team for advice.


Healthcare associated infections are estimated to cost the NHS approximately £1 billion a year and £56 million of this is estimated to be incurred after patients are discharged from hospital. Each infection means additional use of NHS resources, greater patient discomfort and a decrease in patient safety. A no-tolerance attitude is now prevalent in relation to avoidable healthcare-associated infections (NICE 2012)

Catheter associated urinary tract infection (CAUTIs) is the most common nosocomial infection in hospitals (EPIC 3 2014). Bacteraemia develops with every patient who has an indwelling catheter within 30 days, which is usually symptomatic.

**Potential causes of increased risk of serious complications linked to CAUTI**

- Patients aged over 65 years
- History of diabetes
- Suprapubic catheter (may indicate complex urinary tract problems)
- Currently taking steroids
- Single functioning kidney
- Currently taking antibiotics for UTI
- History of UTI while catheterised.

**Patients with an increased risk of possible serious complications from CAUTI**

- Patients with artificial heart valve
• History of UTI while catheterised
• Patients who are immunosuppressed
• Patients who have had organ transplant

Prevention of Infection
The risks of this can be minimised by:
• Limiting the use of catheters
• Maintaining a closed system of drainage and using a link drainage system.
• Good hand washing techniques before and after catheterisation and before and after manipulation of the catheter
• Personal Protective Equipment
• Sterile gloves must be used during insertion of the urinary catheter and clean gloves must be worn when manipulating the catheter
• Disposable apron
• Eye goggles need to be worn when emptying urinary catheter bags

The recording of baseline observations at initial catheterisation (Pulse, Temperature, Respirations, Blood Pressure and Urinalysis) is recommended as good practice to facilitate easier recognition of symptomatic urinary tract infection. Review of the baseline observations should be recorded each time the catheter is replaced or as clinically indicated.

Use of Antibiotics
Please refer to the Microbiology/Infection Control guidelines on treatment or contact them for advice.

Fluid intake
Unless restricted for medical reasons, a fluid intake of between 1 ½ to 2 litres per day is recommended to ensure adequate drainage of urine and potential bacteria.

Bowel Management
There is a higher risk of developing a urinary tract infection if the patient has altered bowel habits. This can be constipation, diarrhoea or related to a neurological condition affecting bowel function or faecal incontinence.

Bowel management must be considered and investigated if a patient develops a urinary tract infection and action taken to resolve it. (RNOHT Continence Policy and MASCIP 2012 Guidelines for the Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions). Ensure perineal hygiene undertaken with soap and water every time the patient has a bowel movement to reduce risk of cross infection.
21. Use of Continuous Bladder Irrigation

See diagram below.

Figure 12 – Continuous Bladder Irrigation

This is usually used post a urological procedure to clear bleeding/clots and prevent a haematoma forming. It will also lessen the risk of catheter blockage following a urology procedure - e.g. SPC insertion, bladder reconstruction.

During continuous bladder irrigation it is not possible to accurately measure urine output. Therefore, renal function has to be evaluated via blood results and examination of the patient.

Irrigation fluid does not need to be prescribed. A fluid balance chart must be maintained to reflect the amount of irrigation being used. Documentation in the medical/nursing notes must include the colour of the urine output i.e. clear/rose/bright red/dark red/blood clots.

Clot retention can still occur. Examination and palpation of the bladder will confirm if bladder full. In this case, please contact the Urologist on call and perform a bladder washout with sterile water or saline.
Three way catheter for bladder irrigation below:

![Three way catheter](image)

Figure 13: Example of a 3-way irrigation catheter (the middle port is for drainage, the outer port is for the irrigation

### 22. Trial Without Catheter (TWOC)

**Definition**
The removal of an indwelling urethral catheter to ascertain voiding function.

Following removal of a catheter, an individual’s urinary output must be closely monitored and evaluated to assess if normal voiding function has returned. Any episodes of incontinence must also be documented.

**Reasons for undertaking TWOC**
To assess if a patient can pass urine without an indwelling urethral catheter. It is the assessment of ability to void.

- A delay in removing an indwelling catheter can mean complications for the patient e.g. infection, blockage, and bypassing.
- If the reason that the catheter was inserted is unclear or the medical status of the patient has changed, e.g. healed pressure sore to sacrum.
- To prevent continued catheter usage when it is no longer needed
- Patient choice
- A risk assessment should be undertaken prior to a TWOC. This should include medical status, infection history, antibiotic indications, skin integrity, diabetes, cardiac status, history of nocturnal polyuria, cognitive status, mobility and dexterity status and social status.
- The patient’s ability to consent/co-operate is an important factor when planning a TWOC

**Preparation of patient for TWOC**
A discussion prior to arranging a TWOC must take place with the patient; this would include why the TWOC has been suggested, outlining benefits, expected outcomes and what the procedure involves, outlining both the nurse and the patient responsibilities.

Consent must be gained from the patient for the procedure to be initiated.
If the patient is discharged home with an indwelling catheter having failed the TWOC whilst an inpatient or has had a procedure which means the catheter must be left in place for longer than the time of the hospital admission then the catheter can be removed in the patient’s home by a community nurse/district nurse.

A TWOC has been found to have a more successful outcome when performed in the patients’ own home in comparison to a hospital setting. It also causes less disruption to the patient. One of the main benefits is the reduction in the risk of a hospital-acquired infection.

Procedure – discuss with the relevant medical team and refer to urology/continence team if appropriate. See procedure for removal of urinary catheter appendix 14.

Bladder scanning - there are portable bladder scanners; situated on the Spinal Cord Injury Unit, Ward 4 and the Paediatric ward. The ultrasound department within X-ray perform ultrasounds of bladder but an ICE request has to be completed by medical team.

**Failure to void following removal of urinary catheter.**
Success or failure of a TWOC should be assessed using a bladder scanner to measure residual urine volume within eight hours of catheter removal.

If the patient develops urinary retention of urine, drain the bladder as soon as possible to prevent anxiety, pain and bladder damage associated with acute/chronic retention of urine.

If the TWOC fails then consider teaching the patient Intermittent Self Catheterisation. Refer to the Urology doctor/Consultant who will discuss with the CNS Neuro urology/continence nurse specialists if support is required.

If the patient has urinary incontinence, a continence assessment should take place and management with the appropriate continence aids should be trialled if possible before discharge. However, the patient may be referred to the local district nursing team, the local continence team or the patient’s local urology services.

**23. Information for Patients**

Patients (and their carers) need to be encouraged to be involved in their own care, which includes being aware of the danger of catheterisation and correct information on general catheter care. It is important that patients (and their carers) know how to identify potential problems and whom to contact for help. See patient information sheet - Appendix 9.

Appropriate leaflets from the manufacturer of the specific intermittent catheter used should be used to ensure that they are relevant, up to date and product specific. It is essential that healthcare professionals document that this information has been given to them.
Patient Information leaflets are available via the internet British Association of Urology Surgeons (BAUS) and they are available via the Neuro Urology/Continence Department at RNOH.

Urethral catheterisation procedure - Male appendix 1 & Female Appendix 2
Suprapubic catheterisation – Appendix 3
Intermitte catheterisation- male/female - Appendix 4

24. Documentation

Use of catheterisation label (pink form) - see Appendix 13

Essential documentation to be put in medical/nursing notes
To ensure that the documentation of the process of urinary indwelling catheterisation is recorded correctly and according to the RCN guidelines, EAUN guidelines and Infection Control Guidelines the following information must be included

- Record patient’s consent and that they have understood the procedure plus allergy status
- Reason for catheterisation
- Type of catheter inserted, size and length
- Manufacturer name, batch number and expiry date
- Date and time of insertion
- Size of balloon and amount of sterile water inserted to inflate
- Cleansing procedure
- Lubricant used – Sterile anaesthetic and chlorhexidine lubricant licensed for use (Optilube Active).
- Any difficulties experienced or clinical observations noted
- Plan of action - i.e. duration of catheterisation/predicted date for change of long-term catheter
- Signed and printed signature by person performing the procedure (NMC 2008b, NMC 2009, NMC 2015, RCN 2015)
- Signed and printed signature of chaperone

25. Catheter Supplies
Catheters must be stored flat and not exposed to extremes of temperatures, and direct sunlight. They must be kept within their packaging or boxes so that the batch number and expiry date can be easily identified.

Ordering information/ Supplies for home/ Home delivery Options - see patient information sheet- Appendix 9

Home delivery
There are numerous companies who provide a home delivery service as listed below but this list is not exhaustive.

The patient may already be registered with a home delivery service or they may prefer to pick up supplies from their local pharmacy. Always obtain their informed consent to the service.
For advice please contact the Neuro-Urology/Continence department for further details.

Examples of Home Delivery Companies. This list is not exhaustive:
- Charter Healthcare
- Fittleworth
- Wellspect Healthcare
- Spinal Injuries Association
- Emerald

26. Discharging a Patient Home

The Registered nurse for all patients discharged with a urinary indwelling catheter or performing intermittent self-catheterisation must be documented in the patient’s notes. The patient should be given enough equipment to last them one week to enable them to get a delivery at home either via the GP/district nurse or a home delivery service. The GP must be informed of the setup of delivery service.

Adequate follow up must be arranged by the medical team that is responsible for the patient. A referral to the GP/ District nurse must be made by the Nurse or Doctor.

If the Urology team at the RNOHT are involved in the patient's care then they will refer the patient to their local continence team or GP as appropriate for support/advice and ongoing care of the catheter or future catheter changes. A district nurse referral must still be done by the ward nurses.

If the patient requires a Trial without Catheter (TWOC), for example a patient who is admitted and discharged following an episode of acute retention, or a change of catheter in hospital, a referral must be made to the Urology Consultants at RNOHT and they will advise if external referral to the patient's local urologist at the patient's local District General Hospital is required. The Urology CNS or Continence CNS may be contacted for further advice.

27. Competencies and Skills to Perform Catheterisation

Statement
It is expected that the healthcare professional will have up to date knowledge of the related anatomy and physiology in relation to catheterisation. This can be achieved through the recommended online training (see section Online catheterisation competency or by reading the following material):

- Royal College of Nursing (2012). Catheter Care. RCN Guidance
Skills for Health Competencies.
The following National Occupational Standard were developed by Skills for Health in partnership with the Royal College of Nursing in December 2007. These standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004):
CC01 - Assess bladder and bowel dysfunction
CC02 - Insert and secure urethral catheters
CC03 - Care for individuals with urethral catheters
CC04 - Manage suprapubic catheters
CC05 - Undertake trial without catheter
CC06 - Enable individuals to carry out intermittent catheterisation
CC07 - Review catheter care
CC08 - Care for individuals using containment products
CC09 - Enable individuals to effectively empty their bowels
CC10 - Assess residual urine by use of portable ultrasound
CC11 - Implement toileting programmes for individuals
CC12 - Enable individuals to undertake pelvic floor muscle exercises
CC13 - Enable individuals with complex pelvic floor dysfunction to undertake pelvic floor muscle rehabilitation
CHS4 - Identify the individual whose skin integrity is at risk and undertake the appropriate risk and tissue viability risk assessment

Indwelling Urethral Catheterisation – see appendices and also documentation regarding competencies and care.

Suprapubic Catheterisation and Intermittent Self Catheterisation Competencies can be done by a Registered Nurse competent to perform these procedures and holds a teaching and assessing/ mentorship certificate. Please contact the Neuro-Urology/Continence Nurse Specialist

28. Documentation of Competencies and Skills

Educational RNOHT study sessions
The Neuro-Urology and Continence Nurse Specialists conduct regular study sessions throughout the year on Indwelling Urethral Catheterisation in Adults. This study session can be accessed through the RNOHT training or booked via the Grapevine Online Training system. All Healthcare Professionals who are expected to perform this task must have undertaken this study day with an update every 2yrs (RCN 2012)

Instructions and documentation for achieving competency in insertion of adult male and female indwelling urethral catheterisation will be given to participants (Appendix 16, 17, 18). The RCN recommends that Healthcare Professionals perform at least 12 catheterisations per year to maintain their competency. This can be achieved on patients and the catheterisation models. The Neuro-Urology and Continence Nurse Specialists can lend the models to wards for practice on request.

ANTT for catheterisation- appendix 22
29. Dissemination

The Royal National Orthopaedic Hospital NHS Trust has made staff aware of the policy through:
- RNOHT Intranet site
- Nursing Advisory Committee
- Staff meetings
- Study days
- In house training
- Screen saver

30. Audit

This policy will be audited by monitoring incident forms received by the Clinical Risk Department. This will take into account numbers, types and occasions of incidents reported. Numbers of attendees to urinary catheterisation training sessions will also be audited. This audit will be undertaken annually and feedback will go through the Annual Risk Management Report.

31. References


12. MASCIP 2012 Guidelines for the Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions


   www.guidnace.nice.org.uk/cg40


17. NICE(2015) Urinary incontinence in women: management CG171)

   www.guidance.nice.org.uk/cg97

   www.guidance.nice.org.uk/cg139


23. Royal College of Nursing (2012). *Catheter Care*. RCN Guidance


6. Monitoring and the effectiveness of this policy

Feedback via staff meetings.
Feedback via adult indwelling catheterisation Study days
It will be audited by monitoring the incident forms via clinical risk department. This will take into account numbers, types and occasions of incidents reported
Appendix 1:  Glossary of Terms

**Key words:** Indwelling urethral catheterisation, supra-pubic catheterisation and intermittent catheterisation.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ANTT</td>
<td>Aseptic Non Touch Technique</td>
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<tr>
<td>HCP</td>
<td>Health Care Professional</td>
</tr>
<tr>
<td>CISC</td>
<td>Clean Intermittent Self Catheterisation</td>
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<tr>
<td>IDUC</td>
<td>Indwelling Urethral Catheter</td>
</tr>
<tr>
<td>SPC</td>
<td>Suprapubic Catheter (Indwelling)</td>
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### Appendix 2: Other linked trust policies and guidelines

<table>
<thead>
<tr>
<th>Document</th>
<th>Location</th>
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<tbody>
<tr>
<td>Safer handling policy</td>
<td>K;Corporate\policies\Clinical Governance\section 4 G-H</td>
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<tr>
<td>Safer handling of heavy patients Policy</td>
<td>K;Corporate\policies\Clinical Governance\section 4 G-H</td>
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<tr>
<td>Consent policy</td>
<td>K;Corporate\policies\Clinical Governance\section 4 G-H</td>
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<tr>
<td>Policy for the Management of Latex Sensitivity in Employees and Patients</td>
<td>K;Corporate\policies\Clinical Governance\section I-L</td>
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<tr>
<td>Incident Reporting Policy</td>
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<td>Medicines Policy</td>
<td>K;Corporate\policies\Clinical Governance\section 6 M-O</td>
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<tr>
<td>Safeguarding adults at risk policy and procedure</td>
<td>K;Corporate\policies\Clinical Governance\section</td>
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<tr>
<td>Infection control policy</td>
<td>K;Corporate\policies\Clinical Governance\section</td>
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<tr>
<td>ANTT – Aseptic Non Touch Technique</td>
<td>K;Corporate\policies\Clinical Governance</td>
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</table>
Appendix 3: Extra sources of information and support

Bladder and Bowel Foundation
British Society of Urogynaecology
Pelvic Obstetrics and Gynaecology physiotherapy
Royal College of general practitioners
Royal College of Nursing
Royal College of Obstetricians and gynaecologists
Primary Care Women’s health forum
United Kingdom Continence Society
This policy is available on request in large print and alternative languages. It is a manager’s responsibility to ensure employees are aware of these options.

* The following policies must be sent for review to the Local Counter Fraud Specialist:

- Fraud and Bribery
- Standard Financial Instructions
- Declaration of Interests
- Gifts and Hospitality
- Whistleblowing
- Disciplinary
- IT
- Anti-Money Laundering
- Managing Sickness Absence
- Secondary Employment
- Expenses
- Overpayment
- Financial Redress
- TOIL (Time off in Lieu)
- Code of Conduct/Standards of Business Conduct
- Data Protection
- Lone Worker
- Patient Transport
- Commercial Sponsorship
- Overseas Visitors
- Disclosure
Appendix 1

URETHRAL INDWELLING CATHETERISATION - ADULT MALE

Equipment

- Apron
- Sterile Catheter or wound dressing pack
- Normal Saline 25ml sachet x 2
- Sterile gloves x 2 pair
- Sterile anaesthetic disinfecting lubricant containing lignocaine and chlorhexidine (11mls)
- Catheter - size and type to be determined
- Sterile drainage bag – either 2L drainable (immobilised patients) or leg bag (ambulant patients)
- Catheter bag stand or holder or catheter retaining straps/leg straps to secure catheter
- 10ml syringe x 1 (2 x 10ml syringe if removing an existing catheter first)
- 10mls of sterile water for injection
- Bactericidal hand rub
- Disposable/procedure pad

Action

1. Clean trolley as per infection control Policy. Place equipment on bottom of trolley
   Rationale: To prevent cross infection.

2. Explain and discuss the procedure with the patient.
   Verbal consent to be obtained and Documented. Offer chaperone.
   Rationale: To ensure that the patient understands the procedure and gives their valid consent

   Screen the bed area
   Rationale: To ensure patient's privacy

3. Wash hands using bactericidal soap and water
   Rationale: To reduce risk of infection

4. Put on disposable plastic apron
   Rationale: To reduce the risk of cross infection

5. Assist the patient to get into a supine position
   Cover with a sheet until ready to perform catheterisation
   Rationale: To access to the urethra to facilitate a first attempt at catheterisation

   To aid patient comfort

6. Place a disposal pad under the patient's penis.
   Rationale: To prevent contamination of bed
7. Wash hands using bactericidal soap and water or bactericidal hand gel
   To reduce risk of infection

8. Open catheter pack, place on top shelf of trolley and open.
   To prepare equipment

9. Using an aseptic non touch technique, open the supplementary equipment and place on sterile field
   To reduce the risk of introducing infection into the bladder

10. Don sterile gloves.
    Non touch procedure.

11. Inflate sterile catheter with 10mls of sterile water then deflate.
    To check balloon not faulty and Prevent cross contamination.

12. Clean penis and surrounding area with gauze and normal saline ensuring to pull back foreskin. Discard gloves.
    To prevent introduction of infection when catheterising.

13. Wash hands with antibacterial soap or alcohol hand rub.
    To decrease risk of microbiological contamination.

    Non touch technique.

15. Place sterile dressing towel under penis.
    To prevent contamination during catheterisation process.

16. Open one piece of gauze and place under penis to create a sling effect.
    Non touch technique.

17. Insert lignocaine gel into urethra then occlude penis using sling. Hold for a minimum of 5 mins.
    Lubricate urethra and aid comfort due to its local anaesthetic properties.

18. Insert catheter into urethra until very end (Y junction).
    Ensuring catheter tip is in bladder

19. Check for urine drainage or ask patient to cough and check the catheter end for urine.
    Ensuring catheter tip is in bladder

20. Inflate balloon slowly with 2mls of sterile water. If resistance is felt within the first 2mls of water then stop and check position of catheter if no resistance is felt.
    Preventing inflation of balloon in urethra or prostatic bed.

21. Draw catheter out until balloon is felt against bladder neck.
    Ensuring correct catheter position.
22. Pull forward foreskin back over the glans. Prevent swelling.

23. Attach drainage bag.

24. Secure catheter by tape to top of thigh. To prevent undue traction on catheter. To prevent urethral trauma.

25. Wash hands after correct disposal of equipment Decrease risk of microbiological contamination.

26. Check drainage bag 15mins later for urine drainage. Ensuring catheter is patent.

If removing an existing catheter prior to reinsertion, check catheter tip for encrustation, stones etc and document.

**Record make of catheter, size, batch number, expiry date, amount of water in balloon, and when next due to be changed or reviewed on the catheterisation record label and insert in the nursing kardex or medical notes.**

*(In accordance with the Safety Information Bulletin No.38, SIB (88) 7 January 1998. “Foley catheters and urethral strictures/urethritis”)*

**Spinal Cord Injury (SCI).**

**T12 and above spinal cord injuries** - Some difficulty in catheterising may be experienced when the catheter reaches the external sphincter or bladder neck. This is due to sphincter spasm in reaction to the procedure. Using a Lignocaine based lubricating gel prior to insertion is beneficial in relaxing the sphincter allowing the catheter to be passed into the bladder. Unstable bladder contractions can be caused by a 10ml balloon irritating the trigone and the catheter may be expelled urethrally with the balloon inflated causing urethral trauma. Seek advice from the urology team. They may recommend that the balloon of the catheter is inflated with 10mls sterile water and to then withdraw 5mls leaving 5mls of water only.

**Types of catheters**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Use</th>
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<tbody>
<tr>
<td>PVC/latex</td>
<td>Orange/brown in colour.</td>
<td>For short term (0-2 weeks)</td>
</tr>
<tr>
<td>PTFE-coated</td>
<td>Orange/brown in colour.</td>
<td>Medium term use (0-4 weeks)</td>
</tr>
<tr>
<td>Bardex Biocath Anti infective</td>
<td>Silver coated (Latex) Grey in colour</td>
<td>Medium term use up to max 29 days</td>
</tr>
<tr>
<td>Biocath (Latex)</td>
<td>Grey in colour</td>
<td>Long term use (0-3 months) Change 6 weekly in SCI</td>
</tr>
</tbody>
</table>

43
<table>
<thead>
<tr>
<th>Material</th>
<th>Colour</th>
<th>Use Duration</th>
<th>Change Frequency</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>All silicone</td>
<td>Blue, Green/clear</td>
<td>Long term (0-3 months)</td>
<td>Change 6 weekly in SCI patients</td>
<td></td>
</tr>
<tr>
<td>Argyle</td>
<td>Blue in colour</td>
<td>Long term (0-3 months)</td>
<td>Change 6 weekly in SCI patients</td>
<td>100% latex free</td>
</tr>
</tbody>
</table>
Appendix 2

URETHRAL INDWELLING CATHETERISATION FEMALE ADULT

Aim

To provide continuous bladder drainage.

Equipment

- Apron
- Disposal pad
- Sterile Catheter pack or wound dressing pack
- Normal Saline 25ml sachet x 2
- Sterile gloves x 2 pair
- Sterile lubricant with lignocaine and chlorhexidine (6mls or more)
- Catheter size and type to be determined
- Sterile Drainage bag – either 2L drainable (immobilised patients) or leg bag (ambulant patient)
- Catheter stand or holder and leg straps
- 10ml syringe x 1 (2 x 10mls syringe if removing an existing catheter first)
- 10mls of sterile water for injection
- Bactericidal hand rub
- Tape to secure catheter or catheter retaining strap
<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clean trolley as per hospital policy - clean with detergent solution. Place equipment on base of trolley.</td>
<td>To prevent cross infection. To protect the patient from infection / contamination.</td>
</tr>
<tr>
<td>2. Explain and discuss the procedure Verbal consent to be obtained and Documented. Screen the bed area.</td>
<td>To ensure that the patient understands the procedure To ensure patient’s privacy</td>
</tr>
<tr>
<td>3. Wash hands using bactericidal soap and water</td>
<td>To reduce risk of infection</td>
</tr>
<tr>
<td>4. Put on disposable plastic apron</td>
<td>To reduce the risk of cross infection</td>
</tr>
<tr>
<td>5. Position patient carefully, to ensure</td>
<td>To aid patient comfort and co-operation</td>
</tr>
<tr>
<td>6. Place a disposable pad under the patient’s buttocks to prevent contamination of bed covers. Cover with a sheet until ready to perform catheterisation.</td>
<td>To access the urethra to facilitate comfort – semi-recumbent position allows attempt at catheterisation. To reduce risk of infection</td>
</tr>
<tr>
<td>7. Wash hands using bactericidal soap and water or bactericidal hand gel</td>
<td>Non touch procedure</td>
</tr>
<tr>
<td>8. Open catheter pack, place on top. To prepare equipment shelf of trolley and open using aseptic non touch technique.</td>
<td>To reduce the risk of introducing an infection into the bladder Non touch procedure</td>
</tr>
<tr>
<td>9. Using an aseptic non touch technique, open the supplementary equipment and place on a sterile field</td>
<td>To check the balloon and see if it is faulty</td>
</tr>
<tr>
<td>10. Don sterile gloves</td>
<td>To prevent introduction of infection when catheterising</td>
</tr>
<tr>
<td>11. Inflate sterile catheter with 10mls of water then deflate</td>
<td></td>
</tr>
<tr>
<td>12. Clean perineum and surrounding area with normal saline soaked gauze. Discard gloves</td>
<td></td>
</tr>
<tr>
<td>13. Wash hands with anti-bacterial solution or alcohol hand rub</td>
<td>To decrease risk of microbiological contamination</td>
</tr>
<tr>
<td>14. Don sterile gloves using non touch technique.</td>
<td>To prevent contamination</td>
</tr>
<tr>
<td>15. Place sterile dressing towel below under perineum during catheterisation process.</td>
<td>Adequate lubrication helps to prevent urethral trauma</td>
</tr>
<tr>
<td>16. Anaesthetise the urethra with 6mls of the local anaesthetic gel by instilling it slowly and evenly into the urethra. Warn the patient that he/she may experience slight stinging.</td>
<td>Ensuring catheter tip is in bladder</td>
</tr>
<tr>
<td>17. Insert catheter into urethra 6-8cm or until the Y junction</td>
<td>Ensuring catheter tip is in bladder</td>
</tr>
<tr>
<td>18. Check for urine drainage or ask patient to cough and check the catheter for urine.</td>
<td>Preventing inflation of the balloon in the urethra</td>
</tr>
<tr>
<td>19. Inflate balloon slowly with 2mls of sterile water. If resistance is felt within the first 2mls of water then stop and check position of catheter. Then increase to the 10mls when reassured it is in the bladder.</td>
<td>Ensuring correct catheter position.</td>
</tr>
<tr>
<td>21. Attach drainage bag, take urine sample as necessary.</td>
<td>To prevent undue traction of the catheter</td>
</tr>
<tr>
<td>22. Secure catheter to top of thigh with tape or catheter retaining strap</td>
<td>To prevent urethral trauma</td>
</tr>
<tr>
<td>23. Wash hands after correct disposal of equipment contamination.</td>
<td>Decrease the risk of microbiological contamination</td>
</tr>
<tr>
<td>24. Check drainage bag 15 minutes later for urine drainage. Measure and document.</td>
<td>Ensuring catheter is in the correct position</td>
</tr>
</tbody>
</table>

If removing an existing catheter prior to reinsertion, check catheter tip for encrustation, stones etc. and document. Always check for latex allergy prior to insertion of urinary catheter.

Record make of catheter, size, batch number, expiry date, amount of water in balloon, and when next due to be changed or reviewed on the catheterisation
record label and insert in the nursing kardex or medical notes according to local policy.
(In accordance with the Safety Information Bulletin No.38, SIB (88) 7 January 1998. “Foley catheters and urethral strictures/urethritis”)

Spinal Cord Injury (SCI)

T12 and above complete SCI - Unstable bladder contractions can be caused by a 10ml balloon and the catheter may be expelled urethrally with the balloon inflated causing urethral trauma. Seek advice from the urology team. It may be recommended that in future the patient may require inflation of the balloon to 10mls and then withdraw 5mls leaving 5mls of water only. Urology Consultants at RNOH recommend that urinary catheters are changed every 6 weeks in patients with neurological conditions.

**Types of catheters**

<table>
<thead>
<tr>
<th>Material</th>
<th>Use Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVC/latex</td>
<td>For short term (0-2 weeks)</td>
<td>Orange/brown in colour.</td>
</tr>
<tr>
<td>PTFE-coated</td>
<td>Medium term use (0-4 weeks)</td>
<td>Orange/brown in colour.</td>
</tr>
<tr>
<td>Biocath (Latex)</td>
<td>Medium term use up to max</td>
<td>Anti-infective Silver coated 29 days</td>
</tr>
<tr>
<td>Bardex I.C</td>
<td>Long term use (0-3 months)</td>
<td>Grey in colour Change 6 weekly in SCI patients.</td>
</tr>
</tbody>
</table>
| All silicone      | Long term use (0-3 months) | clear in colour.
| Argyle/Dover/     | Long term use (0-3 months) | Blue in colour. 100% latex free |
|                   | Change 6 weekly in SCI patients. |
Appendix 3
SUPRAPUBIC INDWELLING CATHETERISATION PROCEDURE

Aim

To provide continuous bladder drainage.

Equipment

- Apron
- Trolley/ ANTT procedure tray
- Disposable pad/ procedure pad
- Catheter pack or dressing pack
- Normal saline 25ml sachet x 1
- 1 pair of non-sterile gloves
- Sterile gloves x 2 pair
- Sterile anaesthetic lubricating disinfectant gel 11mls
- Catheter size and type to be determined (check expiry date) check for allergies
- Drainage bag (if not on bed rest, a leg bag, short or long tube – patient preference)
- Catheter valve(dependent on patient discuss with medical team)
- 10ml syringe x 2
- 10mls of sterile water for injection to fill the catheter balloon (prefilled syringe with sterile water supplied with catheter dependent on manufacturer)
- Bactericidal hand rub
- Catheter retaining strap and or catheter securing device
- Mepore dressing or appropriate absorbent dressing(check for allergies)
- Clinical Waste disposal bag
- If patient has been incontinent Clinell continence wipes

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clean trolley as per hospital policy - clean with detergent solution daily. Wipe with alcohol before and after use.</td>
<td>To prevent cross infection</td>
</tr>
<tr>
<td>Place equipment on base of trolley.</td>
<td>To protect top shelf from contamination</td>
</tr>
<tr>
<td>Inform patient of the procedure and gain informed consent. Check for allergies</td>
<td>To gain co-operation to facilitate procedure</td>
</tr>
<tr>
<td>Position patient carefully, ensure comfort</td>
<td>To gain co-operation to facilitate procedure</td>
</tr>
<tr>
<td>Wash hands with liquid soap</td>
<td>Decrease risk of microbiological contamination</td>
</tr>
<tr>
<td>Don apron</td>
<td>Decrease risk of microbiological contamination</td>
</tr>
<tr>
<td>Open catheter pack, place on top shelf of trolley and open other equipment necessary and place opened on top of</td>
<td>Maintain non touch technique to decrease risk of contamination</td>
</tr>
<tr>
<td>Step</td>
<td>Purpose</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>the sterile sheet. This may include a 10ml prefilled syringe if not then draw up once</td>
<td>prevents cuffing of the balloon of the catheter</td>
</tr>
<tr>
<td>sterile gloves on and do not touch the ampule of sterile water.</td>
<td></td>
</tr>
<tr>
<td>Using the first 10ml syringe deflate the previous catheter balloon by allowing it to</td>
<td>prevents cuffing of the balloon of the catheter</td>
</tr>
<tr>
<td>deflate naturally</td>
<td></td>
</tr>
<tr>
<td>Use hand gel then don sterile gloves using non touch technique</td>
<td>To check balloon of catheter and valve not faulty</td>
</tr>
<tr>
<td>Inflating the sterile catheter with the 10mls of water in the syringe, then deflate</td>
<td></td>
</tr>
<tr>
<td>naturally. If it does not deflate then gently pull back the syringe to encourage</td>
<td></td>
</tr>
<tr>
<td>deflation</td>
<td></td>
</tr>
<tr>
<td>Place the sterile dressing towels over patient’s abdomen and under supra pubic site to</td>
<td>To prevent contamination</td>
</tr>
<tr>
<td>cover pubis</td>
<td></td>
</tr>
<tr>
<td>Clean around suprapubic catheter site with normal saline soaked gauze. Place in the</td>
<td>To prevent introduction of infection when catheterising</td>
</tr>
<tr>
<td>waste bag</td>
<td></td>
</tr>
<tr>
<td>Check balloon of catheter in situ, catheter deflated by gently pulling on syringe</td>
<td>To ensure catheter in correct position</td>
</tr>
<tr>
<td>ensuring all of previous water has been withdrawn.</td>
<td></td>
</tr>
<tr>
<td>Remove gloves and wash hands with hand gel</td>
<td>To reduce risk of microbiological contamination</td>
</tr>
<tr>
<td>Draw up 10mls of sterile water or use prefilled syringe and keep it</td>
<td></td>
</tr>
<tr>
<td>Lubricate the first 2-3cm of catheter with gel from trolley and squeeze small amount</td>
<td>To aid insertion of the catheter and ease the catheterisation of the patient</td>
</tr>
<tr>
<td>around the site</td>
<td></td>
</tr>
<tr>
<td>Using gauze with a piece pf gauze on abdomen next to SPC site remove old catheter in</td>
<td>Non touch technique</td>
</tr>
<tr>
<td>non-dominant hand. Withdominant hand put the lubricant into the tract and then pick up</td>
<td></td>
</tr>
<tr>
<td>the new catheter in its plastic sleeve and insert into track. Advance 6cm.</td>
<td></td>
</tr>
<tr>
<td>With dominant hand put the lubricant into the tract and then pick up the new</td>
<td>To prevent closure of track</td>
</tr>
<tr>
<td>catheter in its plastic sleeve and insert into track. Advance 6cm.</td>
<td></td>
</tr>
<tr>
<td>Check for urine drainage or ask patient to cough</td>
<td>Ensuring catheter tip is in bladder</td>
</tr>
<tr>
<td>Inflate balloon slowly with 2mls sterile water via syringe initially. If resistance is</td>
<td>Preventing inflation of balloon in the urethra or outside of bladder wall.</td>
</tr>
<tr>
<td>felt within first 2mls of water then stop and check position of catheter. Then put in</td>
<td></td>
</tr>
<tr>
<td>the remaining 8mls of water.</td>
<td></td>
</tr>
<tr>
<td>Draw catheter out until balloon is felt against bladder wall</td>
<td>Ensuring correct catheter position</td>
</tr>
<tr>
<td>Task</td>
<td>Reason</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Attach drainage bag and valve and or catheter bag. Check catheter bag</td>
<td>Prevent traction of catheter. To prevent trauma/erosion of site.</td>
</tr>
<tr>
<td>and secure catheter to abdomen or thigh.</td>
<td></td>
</tr>
<tr>
<td>Place the appropriate dressing around the suprapubic site</td>
<td>Protect against oozing and contamination</td>
</tr>
<tr>
<td>Remove gloves and dispose of them in waste bag. Wash hands after</td>
<td>Decrease risk of microbiological contamination</td>
</tr>
<tr>
<td>disposal of the equipment.</td>
<td></td>
</tr>
<tr>
<td>Check drainage bag 15 minutes later and measure and document.</td>
<td>Ensuring catheter position is correct</td>
</tr>
</tbody>
</table>

When removing an existing catheter prior to reinsertion, check catheter tip for encrustation, stones etc. and report/record in notes/kardex. Record on the pink RNOHT catheter label and in the indwelling catheter procedure documentation. The information documented should be:
- make of catheter, size (charriere) and length, batch number, expiry date, amount of water in balloon, type of anaesthetic lubricant disinfectant gel used and when next due to be changed or reviewed.

**Spinal Cord Injury**

Suprapubic catheters are normally used as a long term drainage system for the neuropathic bladder instead of urethral indwelling catheters. Ideally, to preserve bladder capacity the drainage tubing must be clamped daily for a maximum of 3 hours or to a capacity of 500mls thereby allowing the bladder muscle to expand and then empty, preserving elasticity. However, this must be in discussion with the medical team and the patient may have to have video-urodynamics prior to this happening and may also need to be on bladder suppressant medication. Also if the patient has a symptomatic urinary tract infection the catheter will not be clamped for a period of time.

**Types of catheters used for Suprapubic procedure**

- **Bard Biocath**
  - Long term use (0-3 months)
  - Grey in colour
  - Change 6 weekly in spinal cord injured patients.

- **All silicone**
  - Long term use (0-3 months)
  - Green/clear in colour.
  - Change 6 weekly in spinal cord injured patients.

- **Argyle/Dover**
  - Long term use (0-3 months)
  - Blue in colour
  - Change 6 weekly in spinal cord injured patients.

- **Bardex Biocath Anti-infective**
  - Medium term use (4 weeks only) licensed for 29 days.
  - Silver alloy coating
  - Grey in colour

All silicone open tipped catheters are licensed for suprapubic use and are all silicone. Always check the catheter is licenced for suprapubic use. Also note, report and record any moisture lesions and continence associated dermatitis. See RNOH Continence policy and also RNOHT wound care formulary.
Appendix 4        Intermittent Catheterisation Procedure Male/Female

The aseptic technique is the preferred (and recommended) method for catheterisation. Aseptic non touch technique (ANTT) means that the catheter, which is inserted into the urethra and bladder, has no direct contact with the practitioner. This “no touch” method reduces the potential of external contamination from an intermittent urinary catheter. In practice, this means inserting the catheter with sterile gloves or tweezers or holding only outside packaging of the catheter. The technique to hold the catheter in areas which have no contact with the urethra is also recommended. Methods may vary depending on the catheter or catheter system, as recommended by the Neuro urology/ Continence CNS.

CLEAN INTERMITTENT CATHETERISATION USING A HYDROPHILIC COATED CATHETER. MALE/ FEMALE

Aim

To provide intermittent bladder drainage.

Equipment

- Apron
- Procedure pad or disposable pad
- Non sterile gloves x 1 - powder free non latex
- Catheter size and type to be determined
- Drainage bottle or catheter drainage bag attached to catheter
- Bowl of warm water if not using moistened non perfumed wipes
- Wipes
- ANTT Tray or catheterisation tray/trolley
- Mirror for females – to aid teaching. Hand grip – if required
- Clinical waste bag
- Access to hand washing facilities if staff performing catheterization/ sterile gloves and catheterization pack/ normal saline sachet
- Bactericidal hand rub
<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Wash hands with liquid soap</td>
<td>Reduce risk of microbiological contamination.</td>
</tr>
<tr>
<td>Don apron</td>
<td>Reduce risk of microbiological contamination.</td>
</tr>
<tr>
<td>Clean tray and bowl as per hospital policy. Single patient use only.</td>
<td>Prevent cross infection</td>
</tr>
<tr>
<td>Assemble equipment on tray. Check catheter is correct size and length. Check expiry date of catheter.</td>
<td>To avoid harm to patient</td>
</tr>
<tr>
<td>Inform patient of procedure and gain verbal informed consent. Check allergies.</td>
<td>To gain co-operation to facilitate procedure</td>
</tr>
<tr>
<td>Place disposable pad under covers/chair/penis/perineum</td>
<td>To prevent contamination of bed/cushion</td>
</tr>
<tr>
<td>Position patient carefully, ensure comfort</td>
<td>To gain co-operation to facilitate procedure</td>
</tr>
<tr>
<td>Lubricate catheter/hydrate according to manufacturer’s instructions. Open catheter package to just below the funnel or as per manufacturers guidelines</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>Clean hands with alcohol/wash hands with soap and water</td>
<td>Reduce risk of microbiological contamination</td>
</tr>
<tr>
<td>Don powder free non latex gloves</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>Wash perineum/penis with warm water/wipes or using non perfumed wipes. Ensure that the male foreskin is retracted to allow for thorough cleansing</td>
<td>To prevent a moist environment. To reduce a risk of microbiological contamination</td>
</tr>
<tr>
<td>Position urinal to catch urine when catheter in situ or use product with bag attached.</td>
<td>To prevent spillage/contamination</td>
</tr>
<tr>
<td>Take catheter out of packet by funnel or use packaging/sleeve to hold catheter or grip provided</td>
<td>To prevent contamination. Enable good grip</td>
</tr>
<tr>
<td>Hold catheter with your dominant hand. Avoiding touching the catheter as much as you can</td>
<td>To prevent contamination</td>
</tr>
<tr>
<td>With the non-dominant hand, part the labia or hold the penis</td>
<td>To view the urethra</td>
</tr>
<tr>
<td>Insert the catheter into the urethra</td>
<td>To facilitate passage through the urethra</td>
</tr>
<tr>
<td>If obstruction is felt, then stop. Withdraw the catheter 1 cm and then try again</td>
<td>To prevent urethral trauma</td>
</tr>
<tr>
<td>Advance the catheter until urine drains. Place funnel end in the bottle</td>
<td>To ensure that the catheter is in the bladder. To prevent contamination of the environment</td>
</tr>
<tr>
<td>When urine stops draining. Check catheter has not slipped out of the bladder into the urethra by pushing it in 1 cm and asking the patient to take deep breaths</td>
<td>To ensure bladder is empty</td>
</tr>
</tbody>
</table>
breaths or cough. If no further urine drains then withdraw the catheter.

<table>
<thead>
<tr>
<th>Action</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>On removal, pinch the end of the catheter or remove catheter downwards flowing</td>
<td>To prevent urine caught in catheter from contaminating environment and the urine back into the bladder</td>
</tr>
<tr>
<td>Place catheter back in package or dispose in clinical waste bag.</td>
<td>To allow procedure to be completed</td>
</tr>
<tr>
<td>Wipe perineum/ penis with a wipe. In men ensure the foreskin is pulled forward</td>
<td>To remove any lubricant residual. In men - to prevent paraphimosis</td>
</tr>
<tr>
<td>Make patient comfortable</td>
<td></td>
</tr>
<tr>
<td>Dispose of equipment in orange clinical waste bag. Wash bowl and tray with appropriate solution/wipe</td>
<td>To prevent cross infection</td>
</tr>
<tr>
<td>Wash hands with soap and water</td>
<td>Reduce risk of microbiological contamination</td>
</tr>
<tr>
<td>Document volume of urine on patient’s fluid balance chart. Take other action as appropriate</td>
<td>Legal requirements/ professional requirement</td>
</tr>
</tbody>
</table>
Patient admitted with a catheter Yes/ No  Date of catheter change:..............................

Patient informed of why they need to be catheterised- Yes/ No Catheter(pink catheter label to be put in medical notes and catheter label on pink form)

If no specify why consent was not obtained.............................................................................. - Urethral catheter □ Suprapubic catheter □

Date when next change due.......................Does the patient need a catheter? Avoid if possible.

<table>
<thead>
<tr>
<th>Reason for catheter insertion.................................</th>
<th>Catheter information</th>
<th>Aseptic non touch technique used □ Appropriate catheter used □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies...................................................................</td>
<td>100% silicone □ PTFE coated latex □</td>
<td>Sterile Normal saline used for meatal cleansing □ If not what cleansing agent used......................</td>
</tr>
<tr>
<td>Balloon size... mls water  Length .........................</td>
<td>Balloon size...... mls water  Length ...........................</td>
<td>Sterile anaesthetic disinfectant lubricant gel used.........................................................</td>
</tr>
<tr>
<td>Charriere size(ch)..............</td>
<td>Charriere size(ch)..........................</td>
<td>CSU taken and sent for MC&amp;S date.................................</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bladder scan done or required? Yes/ No</th>
<th>Residual urine drained mls............</th>
<th>Sensitivities to............................................................</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date ...... Bladder scan volume mls.....</td>
<td>Colour of urine..........................</td>
<td>Resistant to...............................................................</td>
</tr>
<tr>
<td>Type of bag attached.........................</td>
<td>Easy insertion yes/ No. if no why?..................................</td>
<td>Treatment prescribed..................................................</td>
</tr>
<tr>
<td>Catheter clamp attached......................</td>
<td>Urinalysis done yes/ no..................</td>
<td>Print Name of chaperone...............................................</td>
</tr>
</tbody>
</table>

Review daily and document need for catheterisation. Hygiene care plan twice a day.

Date of removal/ replacement..............................

Name and signature of person inserting catheter .................................................................

Print Name of chaperone

Signature ..........................................................

Appendix 5 – Catheter Care Plan – Urethral and Suprapubic Catheter
Do you need to change the catheter or remove?

<table>
<thead>
<tr>
<th>Catheter removal (Trial without catheter - TWOC)</th>
<th>Discharge arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date............................................. Time........................................</td>
<td></td>
</tr>
<tr>
<td>Bladder scan(after urination/ voiding).............mls</td>
<td></td>
</tr>
<tr>
<td>If residual more than 100mls requires referral by doctors to Urology medical team via switch board or air call</td>
<td></td>
</tr>
<tr>
<td>District nurse referral made YES/NO</td>
<td></td>
</tr>
<tr>
<td>Patient information given YES /NO</td>
<td></td>
</tr>
<tr>
<td>Neuro Urology and Continence Clinical Nurse Specialist bleep 822</td>
<td></td>
</tr>
<tr>
<td>Products given to patient YES/NO Registered for patient direct delivery if so which company..................................................</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6

CATHETER HYGEINE PROCEDURE

**DEFINITION**- Cleansing of catheter entry site to reduce risk of infection

**AIM** To reduce risk of hospital acquired urinary tract infection

**REQUIREMENTS**

- Disposable apron
- Non-sterile latex free disposable gloves as per infection control policy
- Warm water, unperfumed soap
- Towel
- Washing cloth/ disposable wipes/ or non-perfumed wipes or continence wipes.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain procedure to patient and gain informed consent</td>
<td>Ensure patient understands procedure</td>
</tr>
<tr>
<td>Provide privacy to patient</td>
<td>Maintain patient comfort and dignity</td>
</tr>
<tr>
<td>Wash and dry hands thoroughly</td>
<td>To reduce risk of cross-infection</td>
</tr>
<tr>
<td>Put on disposable gloves and plastic apron</td>
<td>To reduce risk of cross-infection</td>
</tr>
<tr>
<td>Wash around and away from the entry site of catheter with soap and water, rinse and dry thoroughly. Do same procedure if using wipes.</td>
<td>To reduce risk of cross-infection</td>
</tr>
</tbody>
</table>

**N.B.**

**Male**- Gently retracting the foreskin, wash and dry. Pull foreskin back into its normal position.

**Female**- Wash or wipe from front to back to ensure bacteria from anus does not contaminate urethra.
**Suprapubic** - if dressing required please follow the dressing procedure using aseptic non touch technique.

A daily bath or shower is recommended.

**Warnings** do not use creams or powder unless prescribed.

<table>
<thead>
<tr>
<th>Action</th>
<th>Purpose</th>
</tr>
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<tbody>
<tr>
<td>Remove and dispose of apron, gloves and wipes if used as per RNOHT waste policy</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Wash and dry hands thoroughly</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Check for any trauma, moisture lesions or incontinence associated dermatitis (see tissue viability formula and)</td>
<td>To reduce risk of skin break down</td>
</tr>
</tbody>
</table>

Ref - RCN 2012 catheter care - RCN guidance for nurses

**Indwelling Urethral Catheters**

Daily hygiene requirements a minimum of once a day as follows:

1. Always gain informed consent to the care of the catheter and document prior to performing the care. Ask patient if they require a chaperone as it is an intimate procedure.

2. Patients and carers should wash their hands before and after any procedure relating to the urinary catheter.

3. The area around the catheter should be washed at least twice each day with mild soap and warm water or non-perfumed wipes/continence wipes. Use disposable wipes and discard after use. If the catheter tubing needs cleaning then use mild soapy water and disposable wipes. Clean from the patient’s urethra along the tubing but never wipe towards the patient.

4. Men should be taught to wash under their foreskin. Women should ensure that when they clean they wipe in a downward motion from the top of the vulva to the vagina, keeping away from the anus. If the patient has been incontinent of faeces, catheter care should be repeated afterwards.

5. Empty the urine bag regularly wearing an apron and gloves. Also, this will prevent the catheter being pulled, preventing a dragging effect and erosion of the point of entry of the catheter.
6. Maintain a closed drainage system and change the bags according to the manufacturer’s instructions at 5-7 days. Document when changed and also write on the bag the date when it was changed. When emptying, wear new apron and gloves. Wipe the drainage port with a Clinell wipe or antibacterial wipe to prevent cross infection and also spillage of urine.

**Suprapubic catheters**

Daily hygiene requirements as follows whilst in hospital

1. Clean area around with normal saline using aseptic non touch technique

2. Observe for signs of infection and erosion/moisture lesions. Take and send swab for MC&S.

3. If there is a discharge from around the catheter site, then a small dry dressing can be applied to prevent soiling of clothing. Check again for allergies.

4. Ensure there is a 2cm clearance of pubic hair around the catheter site to prevent irritation of the suprapubic entry site and reduce discharge. Gain consent from patient if this can be done.

When patients are discharged they can wash the site with soap and water and a dressing may not be required around the site.
Daily Urinary Catheter Care Hygiene Record (Appendix 7)

Insert patient label…………………………………………………..Ward…………………………

Name ………………………………………DOB                     NHS no……………………

**Indwelling Urethral Catheters**

Daily urinary catheter care hygiene requirements **once a day to reduce cross infection**. Always gain informed consent to the care of the catheter and document prior to performing the care. Ask patient if they require a chaperone as it is an intimate procedure. See urinary catheter care hygiene procedure.

<table>
<thead>
<tr>
<th>Date/ time</th>
<th>Meatal hygiene performed Catheter care given. Ensure foreskin placed back over glans (men) Yes/ No</th>
<th>Catheter still required? Yes/No</th>
<th>Issues identified and interventions Documented.</th>
<th>Print name and Signature of nurse</th>
</tr>
</thead>
<tbody>
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</table>

60
<table>
<thead>
<tr>
<th>Date/ time</th>
<th>Meatal hygiene performed</th>
<th>Catheter still required</th>
<th>Issues identified and interventions documented</th>
<th>Print name and signature of the nurse</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Date/ time</td>
<td>Meatal hygiene/ catheter care performed</td>
<td>Catheter still required</td>
<td>Issues identified &amp; interventions documented</td>
<td>Printed name signature of nurse</td>
</tr>
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</tbody>
</table>

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Appendix 8

Urethral Catheterisation Procedural Checklist

Generic Guidelines specific is colour coded below:

- **Male & Female**

<table>
<thead>
<tr>
<th>Task</th>
<th>√</th>
<th>x</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform hand wash.</td>
<td></td>
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</tr>
<tr>
<td>Collect and prepare required equipment.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Check identity of patient and the reasons for catheterisation</td>
<td></td>
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</tr>
<tr>
<td>Explain procedure to the patient and obtain informed consent.</td>
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<tr>
<td>Establish patient allergies (especially latex).</td>
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<tr>
<td>Ensure patient privacy; offer chaperone.</td>
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<tr>
<td>Assist the patient into a comfortable position and ensure not unduly exposed.</td>
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<tr>
<td>Place protective sheet under the patient’s buttocks and adjust lighting as necessary.</td>
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<tr>
<td>Put on apron.</td>
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<tr>
<td>Perform hand wash.</td>
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</tr>
<tr>
<td>Open catheterisation pack – open up all other catheterisation equipment onto the sterile field using the aseptic non touch technique. Then apply first pair of sterile gloves.</td>
<td></td>
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<tr>
<td>Apply the sterile drapes appropriately over the patient.</td>
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</tbody>
</table>

*An aseptic non touch technique using sterile gloves is used during the procedure*

**MALE -** Retract the foreskin (if present) and cleanse the glans and urethral meatus with saline solution, swabbing away from the urethral orifice.

Hold the penis gently and laterally behind the glans with a gauze swab.
Before applying gel, check with the patient regarding any previous allergies/ reactions.

Anaesthetise the urethra with 11ml of local anaesthetic lubricating disinfecting gel, instilling slowly.

Gently squeeze the end of the penis to prevent the anaesthetic lubricating disinfecting gel escaping from the urethra.

FEMALE - Using saline cleanse the vulval area swabbing from above downwards. Identify the urethral meatus. Insert 6 mls lubricating disinfecting gel into the urethra.

Allow 5 minutes to elapse to let gel take effect.

Remove first pair of gloves.

Wash or use hand gel and put on second pair of gloves.

Position receptacle for urine.

Pick up catheter in dominant hand and peel back plastic packaging.

MALE - Using the gauze swab, hold the penis at 90 degree angle from the penis.

FEMALE - Introduce catheter into meatus about 6-8cm or further if no urine flows.

MALE - Introduce the catheter up to the Y junction. Once urine flows, insert the catheter a further few centimetres more.

Inflate the balloon with sterile water, initially with 2mls and if any resistance is felt do not inflate the balloon further. Readjust the catheter and try again. Add amount of water as per manufacturer’s guidelines or patient treatment plan.

Withdraw the catheter slightly until resistance is felt. Measure urine drained. It may take a few minutes for urine to drain due to the gel inserted.

Attach catheter to urinary drainage system and/or catheter valve.

MALE - Ensure the foreskin (if present) is placed back over the glans.
<table>
<thead>
<tr>
<th>Collect urine sample as required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure the patient is comfortable and hygiene needs attended to if necessary.</td>
</tr>
<tr>
<td>Dispose of apron and equipment as per local hospital policy.</td>
</tr>
<tr>
<td>Perform hand wash.</td>
</tr>
<tr>
<td>Document procedure in patient’s notes/care plan/ fluid chart, including reason for catheterisation/procedure using the RNOHT pink catheter label. The size, type, batch number, volume of water in the balloon, anaesthetic gel used and any problems encountered. Ensure signature and name stamp used.</td>
</tr>
<tr>
<td>Next change and review of catheter to be clearly documented.</td>
</tr>
<tr>
<td>Catheter care to be undertaken twice a day and documented in catheter care plan.</td>
</tr>
</tbody>
</table>

Please refer to the Urinary Catheterisation Aseptic Non Touch technique, catheterisation procedure and the catheter hygiene document. Appendix 1& 2, 6, 22.
PATIENT CATHETER INFORMATION

THE CATHETER:

Urine (water) is produced by the kidneys and passed down the two ureters (small tubes) to be collected in the bladder. When the bladder is full an urge to pass urine is felt.

Urine is then passed through the urethra (the canal from the bladder to the outside of the body) to be expelled. Sometimes this does not happen and a catheter is inserted into the bladder to help drain the urine.

There are two ways of inserting a catheter into the bladder.
1. Through the urethra – see above.
2. Through the abdominal wall – below the navel but above the pubic bone. (It is called a suprapubic catheter) see below (male diagram see below)

A catheter is a fine hollow, flexible tube that is inserted in the bladder. To prevent it from falling out, a small balloon near the tip of the catheter is inflated.

The most common reasons for using a catheter are;
1. Before or after surgery, especially on the bladder, prostate or other part of the urinary system.
2. Obstruction to the flow of urine.
3. The bladder does not function as well as it did because of a medical condition or injury.

The type of catheter you have been given will depend on whether it is for short or long-term use.

Your catheter may be connected to a drainage system that collects your urine. This system consists of a leg drainage bag or valve, which is emptied at regular intervals during the day and a night drainage bag, which is removed each morning. A catheter valve is suitable for some people instead of a drainage system. It allows for regular emptying of the bladder. It can be connected to a drainage bag overnight.

**LIVING WITH YOUR CATHETER**

Having a catheter should not restrict your social or leisure activities or prevent you from going on holiday, particularly if using a catheter valve. For some it may be the start of more freedom and improving their health.

**CHANGING THE CATHETER**

The nurse will usually carry this out although some people learn to change their own.

**DIET AND FLUIDS**

A well-balanced diet and adequate fluid intake are very important in minimising the risk of infection, preventing constipation and avoiding catheter blockage.

Eat a well-balanced diet to help prevent constipation. This will include fresh fruit, vegetables, fibre and carbohydrates. Constipation or a loaded bowel may press on the catheter and prevent urine from draining. The aim is to achieve a regular bowel movement without having to strain.

To ensure a good drainage of urine it is advisable to drink at least 2 litres/4pints of fluid each day. This can include: diluted juices, decaffeinated tea and coffee.

**EXERCISE**

Regular exercise such as walking will help to maintain free drainage of your urine.

**MAKING LOVE – SEXUAL HEALTH**

Females with a urethral catheter are able to have penetrative sex by taping the catheter to their abdomen. A catheter valve may also be used instead of the catheter bag. To prevent pulling or friction on the catheter and vulva, a soluble lubricant such as KY Jelly should be use. **Do not use** petroleum jelly as it may react with the catheter material. For both males and females who are sexually active, they should consider the alternatives to a urethral catheter. The options include being educated on how to perform intermittent self-catheterisation. The other option available is to have a supra-pubic catheter inserted through the abdominal wall. These alternatives will allow more sexual freedom especially around the genital area.

Please do not feel embarrassed to talk to your nurse or doctor for further information or advice if you are having concerns regarding your catheter and sexual intercourse.

**RNOHT Useful Tel Numbers:-**

Neuro Urology Clinical Nurse Specialist – 0208 909 5854. Bleep 822
Continence Clinical Nurse Specialist – 0208 909 5261, Bleep 822
Urology Secretary – 0208 909 5593
Continence secretary – 020 8909 5313
PERSONAL CARE:
Good personal hygiene is very important to avoid infection
1. **Always wash and dry your hands thoroughly** before doing anything that involves your catheter or drainage system.
2. Either have a daily shower, bath or daily wash. You can do this with an empty drainage bag attached to your leg, pay particular attention to the area where the catheter enters the body. Wash with unperfumed soap and warm water, rinse thoroughly. Avoid the use of talcum powder, creams or antiseptics unless they have been prescribed.
3. **FEMALES** – ensure you wash from ‘front to back’ to keep the bacteria from the anus (back passage) away from the catheter. Dry in the same way.
4. **MALES** – carefully draw back the foreskin and wash the exposed skin, replace the foreskin.
5. **FEMALE/MALE** - any discharge from where the catheter enters your body should be reported to your healthcare professional.
6. **SUPRAPUBIC** – ensure the area where the catheter enters your body is kept clean and dry. A small dressing may be required but this is optional.
7. **CARERS** – **always wash and dry your hands thoroughly** before doing anything that involves the catheter - e.g. emptying or changing a drainage bag. You should also wear non-sterile disposable gloves in the community.

TYPES OF DRAINAGE BAGS:
**Daytime bags**
This is usually worn on the leg, (leg bag) and is only disconnected from the catheter when it is changed every 5-7 days. If you have a catheter valve you will not need a daytime leg bag.

ATTACHING THE LEG DRAINAGE BAG:
This is attached to either your calf or thigh by a pair of straps, a sleeve or a special holster. Ask your Healthcare Professional for details. How you wear the leg bag depends on what feels comfortable for you. The choice and size of the leg bag and the length of the tubing depend on where you want to wear it, your size and urinary output. If you wear trousers, the long-tubed leg bag is more convenient, as it is possible to roll up the bottom of the trouser leg and access the tap at the base of the bag for emptying the urine. Short-tubed leg bags can be worn on the thigh and are discreet under skirts.

EMPTYING THE LEG DRAINAGE BAG:
This will need to be emptied at regular intervals during the day. It is best to empty it when it is two thirds full. This will prevent the bag pulling on your catheter and causing discomfort.

**Wash and dry your hands before and after emptying this bag.**
You may need to remove the straps/sleeve from the leg drainage bag before you empty it. Open the outlet tap on the bag over the toilet and allow the urine to drain. If you cannot get to the toilet the urine can be emptied into a suitable container kept solely for this purpose. Wash the container with soap and water and dry after each use. After emptying the bag close the tap and wipe the outlet with a clean tissue or toilet paper and dispose of this in the toilet.

CHANGING THE LEG DRAINAGE BAG:
The Department of Health recommends that the leg bags should be changed once a week (7 days).
Wash and dry your hands before and after changing your leg bag. Avoid touching the end of the catheter or the connecting end of the new bag that goes into the catheter. Carefully remove the ‘old’ bag to prevent urine escaping. Remove the protective cap from the leg bag and immediately insert the connecting end of the new bag into the catheter.

NIGHT DRAINAGE BAGS:
This bag is attached to the bottom of the leg drainage bag. It can hold more urine so you don’t need to get up during the night to empty your bag. After connecting the night bag, ensure the tap on your leg drainage bag is in the open position to allow the urine to flow into the night bag. You can now either loosen the straps of your leg drainage bag leaving it attached to your leg or remove the leg drainage bag from your leg and lay the bag on the bed ensuring it is below the level of your bladder. If you have a catheter valve connect your night bag to the outlet of the valve. Ensure the tap of the valve is in the open position to allow the urine to drain into the night bag. The night bag should be well supported on a stand or hanger - not placed on the floor. These can be obtained from your Healthcare Professional.

Night bags
This is used in conjunction with the daytime bag or catheter valve if necessary for the extra capacity of urine produced overnight.

REMOVING THE NIGHT DRAINAGE BAG:
This bag is connected to either the leg drainage bag or the catheter valve and is disposed of each morning.
1. Wash and dry your hands before and after emptying this bag.
2. Close the tap on the leg drainage bag or catheter valve.
3. Disconnect the night drainage bag from the leg drainage bag or catheter valve. Wipe the end of the tap with a clean tissue or toilet paper and dispose of this in the toilet.
4. Empty the night drainage bag by opening the one way tap and disposing of the urine in the toilet.
5. Dispose of the empty night drainage bag by double wrapping in either paper or plastic bags before placing into the domestic dustbin.

CATHETER VALVES:
They are connected to the catheter and allow you to empty your bladder at regular intervals without wearing a daytime leg drainage bag. They are not suitable for everyone that has a catheter; your Healthcare Professional will advise you on this product.

CHANGING YOUR CATHETER VALVE:
The Department of Health recommends that valves should be changed once a week. It is important that the connection between the catheter and the valve remains unbroken except when valve is changed.
1. Wash and dry your hands before and after changing your valve.
2. Open the packaging of the valve to expose the outlet tap.
3. Carefully remove the ‘old’ valve to prevent urine from escaping.
4. Remove the ‘new’ valve from the packet by holding the outlet tap; do not touch the end that goes into the catheter.
5. Insert immediately into the catheter.
6. Ensure the tap is in the closed position.
YOUR HEALTHCARE PROFESSIONAL WILL GIVE YOU HELP AND ADVICE ON THE PROBLEMS BELOW.
1. Bladder spasm or cramp – this may cause urine leakage around the outside of the catheter (bypassing).
2. Leg bag not staying in place securely (slipping down your leg).
3. Catheter pulling.
4. The feeling that you need to pass urine.
5. Difficulty in emptying/changing your drainage bags.
6. No urine in your leg bag. See helpful advice below.

IF NO URINE IS DRAINING, HERE ARE SOME THINGS YOU CAN DO BEFORE CONTACTING YOUR NURSE.
1. Ensure there are no kinks in the catheter or drainage tubing.
2. Check the drainage bag is below the level of the bladder.
3. The straps of the leg bag are NOT over the inlet valve at the top of the bag.
4. Ensure the catheter is not being pulled tight by the position of the leg bag.
The use of a leg bag sleeve or strap or abdominal strap for a suprapubic catheter may help prevent this.
5. Make sure you are drinking enough fluid - at least 2 litres a day if possible.
6. Move around if possible. This may help to relieve a blockage.

CONTACT YOUR HEALTHCARE PROFESSIONAL IF:
1. You have prolonged pain.
2. Urine is not draining.
3. There is blood in your urine.
4. Your urine is cloudy, smelly and you feel unwell.
5. Urine keeps leaking around the catheter.

HEALTHCARE PROFESSIONAL DETAILS:
Name………………………………………………………………………………
Contact number……………………………………………………………………
G.P…………………………………………………………………………………
Telephone number………………………………………………………………

CATHETER DETAILS:
Type……………………. Size…………… Balloon size…………
Code for ordering………………………………

DRAINAGE BAG DETAILS:
LEG BAGS
Make…………………………. Code for ordering…………………………
Capacity………………………… Tubing length…………………………

NIGHT BAGS
Make…………………………… Code for ordering…………………………

VALVES
Make……………………………… Code for ordering…………………………

SLEEVE
Make……………………………… Code for ordering…………………………
Size………………………………

LEG STRAP
Make……………………………… Code for ordering…………………………
Size………………………………
Catheter securing devices…………………………………………………

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Appendix 10

CHANGING A URINARY DRAINAGE BAG

DEFINITION
To replace the existing Urinary Drainage Bag

INDICATIONS
1. To comply with manufacturer’s recommendations
2. To reduce risk of infection

REQUIREMENTS
• Disposable plastic apron
• Non-sterile disposable gloves
• Sterile Urinary Drainage Bag
• Tissue/Paper towel/clinel wipe
• Disposal bag as per Waste Policy

<table>
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<tr>
<th>PROCEDURE</th>
<th>RATIONALE</th>
</tr>
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<tbody>
<tr>
<td>Explain procedure to patient</td>
<td>Ensure the patient understands the procedure and gives consent</td>
</tr>
<tr>
<td>Provide privacy to patient</td>
<td>Maintain patient comfort and dignity</td>
</tr>
<tr>
<td>Wash and dry hands thoroughly</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Put on plastic apron and apply disposable gloves</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Open the drainage leg bag pack</td>
<td>To allow change of drainage bag</td>
</tr>
<tr>
<td>Remove catheter straps/sleeve/stand</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Place tissue/paper towel on flat surface under urine drainage bag</td>
<td>Prevent leakage of urine onto bed/chair</td>
</tr>
<tr>
<td>Remove cap from sterile bag</td>
<td>Prepare for re-connection of drainage bag</td>
</tr>
<tr>
<td>Disconnect bag from catheter – lay on tissue</td>
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</tr>
<tr>
<td>Immediately attach sterile drainage bag ensuring that there is no hand contact with exposed end of catheter</td>
<td>To reduce the risk of cross-infection</td>
</tr>
<tr>
<td>Ensure the tap is in the closed position</td>
<td>Reduce environmental contamination</td>
</tr>
<tr>
<td>Secure the urine bag using straps/sleeve/stand</td>
<td>Reduce risk of urethral and bladder neck trauma</td>
</tr>
<tr>
<td>Make patient comfortable</td>
<td>Provide patient comfort and dignity</td>
</tr>
<tr>
<td>Measure urine if required and record on completion of procedure. Document date of bag change</td>
<td>Provide legal record</td>
</tr>
<tr>
<td>Remove gloves and apron and dispose in clinical waste bin</td>
<td>To reduce the risk of cross infection</td>
</tr>
</tbody>
</table>
### Procedure for Inserting/Changing a Catheter Valve

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain procedure to patient</strong></td>
</tr>
<tr>
<td><strong>Encourage patient to empty bladder before procedure</strong></td>
</tr>
<tr>
<td><strong>Provide privacy to patient</strong></td>
</tr>
<tr>
<td><strong>Assist patient into a suitable position.</strong></td>
</tr>
<tr>
<td><strong>Wash and dry hands thoroughly</strong></td>
</tr>
<tr>
<td><strong>Put on disposable plastic apron and gloves</strong></td>
</tr>
<tr>
<td><strong>Release the valve and empty urine into jug or urinal</strong></td>
</tr>
<tr>
<td><strong>Measure amount of urine if necessary</strong></td>
</tr>
<tr>
<td><strong>Dispose of urine as per healthcare waste policy</strong></td>
</tr>
<tr>
<td><strong>Remove and dispose of gloves</strong></td>
</tr>
<tr>
<td><strong>Wash and dry hands thoroughly</strong></td>
</tr>
<tr>
<td><strong>Put on second pair of gloves</strong></td>
</tr>
<tr>
<td><strong>Open the catheter valve pack from the outlet end</strong></td>
</tr>
<tr>
<td><strong>Do not remove</strong></td>
</tr>
<tr>
<td><strong>Remove the old valve. Discard onto paper or into disposal bag as per healthcare waste guidelines</strong></td>
</tr>
<tr>
<td><strong>Immediately insert the new valve into the end of the catheter ENSURING THAT NO HAND CONTACT IS MADE WITH END BEING INSERTED</strong></td>
</tr>
<tr>
<td><strong>Ensure the valve is left in the closed position</strong></td>
</tr>
<tr>
<td><strong>Remove and dispose of gloves, apron and valve as per healthcare waste policy</strong></td>
</tr>
<tr>
<td><strong>Wash and dry hands thoroughly</strong></td>
</tr>
<tr>
<td><strong>Record the urine drained, date of change, type of valve and valve batch/lot no. and expiry date in patient record</strong></td>
</tr>
<tr>
<td><strong>Ensure the patient (or carer) has written information and Health Care Professional’s contact number</strong></td>
</tr>
<tr>
<td><strong>Follow manufacturer’s guidelines and ensure patient or carer knows how to operate and maintain valve</strong></td>
</tr>
</tbody>
</table>
PROCEDURE FOR COLLECTION OF A URINARY CATHETER SPECIMEN OF URINE

Breaking the closed drainage system to obtain a urine sample increases the risk of catheter related infection. The use of drainage bags incorporating a sample port removes the need to break the closed system. A needle-less port should be used to reduce the risk of sharps injury to patient and member of staff.

DEFINITION
The collection of a specimen for examination from a patient with an indwelling urinary catheter.

INDICATIONS
1. To exclude infection
2. Routine urinalysis

REQUIREMENTS
• Disposable plastic apron
• 1 pair of non-sterile gloves as per Interim Glove Guidelines
• Specimen bag and plastic urine pot
• Medicated swab
• Syringe
• Needle
• Sharps box (If not using a needless port)

PROCEDURE | RATIONALE
--- | ---
Explain procedure to patient | Ensure patient understands procedure and gives consent
Provide privacy to patient | Ensure patient comfort and dignity
Wash and dry hands thoroughly | Reduce risk of cross-infection
Put on disposable plastic apron and non-sterile gloves | Reduce risk of cross-infection
Clean the access point with a swab saturated with 70% Isopropyl Alcohol allow to dry for 30 seconds – thoroughly | Reduce risk of cross-infection
Follow manufacturer’s instructions a. If a leg bag has a needle sampling port a syringe may be inserted into the port and urine obtained. b. | To obtain sterile specimen
THE ABOVE IS WHAT SHOULD BE USED
b. If using a needle and syringe aspirate the required amount of urine from the access point on the leg bag.
Dispose of apron and gloves and wash hands. | Reduce risk of cross infection
Catheter label- pink in colour to be stuck and inserted in the notes.

<table>
<thead>
<tr>
<th>Catheterisation Record Label (to be put in patients hospital notes)</th>
<th>Insert catheter label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>Hospital Number</td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
</tr>
</tbody>
</table>

**Date/ time of change/ insertion**

<table>
<thead>
<tr>
<th>Consent from patient (circle)</th>
<th>Verbal</th>
<th>Written</th>
<th>Witnessed</th>
<th>Other -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Catheterisation (circle)</td>
<td>1st insertion</td>
<td>1st change</td>
<td>Routine</td>
<td>Blocked catheter</td>
</tr>
</tbody>
</table>

**Aseptic non touch technique**

Yes/No

**Type of Sterile lubricant used**

Type of catheter

**No of mls in the balloon**

<table>
<thead>
<tr>
<th>5mls</th>
<th>10mls</th>
<th>30mls</th>
<th>Other -</th>
</tr>
</thead>
</table>

**Residual Urine drained**

mls

**Antibiotics given**

Yes/No

**Chaperone Name and Signature**

Name + Signature of person performing the catheterisation

**Date of next change/review**

Planned date of removal/ review

Signature
Appendix 14-PROCEDURE FOR REMOVAL OF URINARY CATHETER

There is no evidence to suggest that any time of day is more beneficial for removing a urinary catheter, (see catheter policy.)

**Equipment**

Trolley with:-
1. Dressing pack containing galley pot and gauze and absorbent pad
2. Disposable gloves/PPE
3. Needle and syringe for urine specimen, specimen pot if CSU is indicated.
4. Syringe for deflating balloon
5. Sterile saline for cleaning
6. Clinical waste bag

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient and inform him or her of potential post catheter symptoms, i.e. urgency, frequency and discomfort which may be caused by irritation of the urethra by the catheter. Explain the fluid requirements once the catheter has been removed. Ensure the patient is not constipated. Check documentation to determine the amount of water in the catheter balloon.</td>
<td>To fully inform the patient and obtain informed consent to the procedure. The patient will know what to expect post catheter and plan daily activity For adequate flushing of the bladder especially to dilute and expel debris and infected urine If present, constipation may prevent the patients from voiding successfully. To ensure correct amount of water is obtained prior to catheter removal.</td>
</tr>
<tr>
<td>2. Prepare the clinical room or bed area. Ensuring patient’s privacy and dignity is maintained at all times.</td>
<td></td>
</tr>
<tr>
<td>3. Wash hands and wear PPE</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>Step</td>
<td>Task Description</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td>Correctly position patient on bed and adjust clothing as necessary. Place absorbent pad under buttocks.</td>
</tr>
<tr>
<td>5</td>
<td>Wearing PPE as per catheter policy, take a catheter specimen of urine if appropriate</td>
</tr>
<tr>
<td>6</td>
<td>Clean the urethral meatus using sterile saline as per catheter insertion procedure</td>
</tr>
<tr>
<td>7</td>
<td>Release the support from the leg drainage bag if appropriate</td>
</tr>
<tr>
<td>8</td>
<td>Using syringe withdraw water from catheter balloon</td>
</tr>
<tr>
<td>9</td>
<td>Ask patient to breathe in then out; as patient exhales, gently but quickly, remove the catheter. Male patients should be warned of discomfort as the deflated balloon passes</td>
</tr>
<tr>
<td>10</td>
<td>Clean meatus, make patient comfortable and tidy away equipment as per Trust policy</td>
</tr>
</tbody>
</table>

**Symptoms** should resolve over the following 24–48 hours. If not, further investigation may be needed. Encourage patient to exercise and to drink 2–3 litres of fluid per day.

If patient is unable to void, contact medical staff, discuss options for treatment, re-catheterisation or intermittent catheterisation may be necessary.

To encourage voiding

To relieve urinary retention and prevent damage to upper urinary tracts.

To relieve pain and discomfort for the patient
| Discuss treatment plan with medical staff and patient or carer and refer to appropriate services if necessary |  |
Appendix 15 - Moisture associated Skin Damage Pathway

Moisture Associated Skin Damage Pathway

Assessment

General Criteria
- Infection
- Swelling
- Moisture or oozing
- Frequent skin excoriation

MAD Specific
- Incontinence
- Oozing
- Skin breakdown

Skin is intact but regular reassessment required

There is evidence of skin breakdown

Differential Diagnosis

1. Urine or fecal incontinence
2. Excessive moisture from sweating
3. Wound oozing
   (Exclude pressure damage as a cause (M&I Differentiation Guide))
4. Stoma leakage

Incontinence Associated Dermatitis (MAD)
- Signs of MAD
  - Urine or fecal incontinence

- Erythema: inflammation of the skin, usually amenable to flowing down or dripping moisture
  - Redness under the incontinence pad
  - Redness over the skin

Interstitial Dermatitis (MAD Within Skin Folds)
- Signs of MAD
  - Pus formation

- Irritant dermatitis: inflammation of skin within 4 cm of wound edge, may show desquamation or erosions

Management

Implement Skin Care Regimen

- Clean skin leads to normal bacterial flora
- Reduce exposure to wet skin
- Ensure dampness and urinary leakage

Include patient in all decisions relating to treatment

Complete an assessment and care plan in all instances

Reassessment & Evaluation: Record outcomes

If no improvement or deterioration in condition, refer to M&I guidelines for advice.
## Assessment of Skill Acquisition

<table>
<thead>
<tr>
<th>Assessor: ____________________</th>
<th>Status:___________________</th>
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</thead>
<tbody>
<tr>
<td>Practitioner:________________</td>
<td>Status:___________________</td>
</tr>
<tr>
<td>Clinical Skill:______________</td>
<td>Date:______________</td>
</tr>
<tr>
<td>Number of Supervised Evaluation:______</td>
<td></td>
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</tbody>
</table>

Practitioners should be assessed until competence is achieved in all domains OR If competence is achieved on first attempt they must undergo a minimum of 3 observations. Competence is achieved when all criteria are met in all domains. Assessors should indicate if competence has been achieved in each domain by circling ‘YES’ or ‘NOT YET’. Feedback should be entered in each remark box, identifying criteria to be achieved or demonstrated.

### 1. Professional Criteria

- applies ethical principles to inform decision making
- involves patient in decision making process
- Practices in accordance with professional code
- demonstrates autonomy and initiative
- maintains accurate record keeping

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<thead>
<tr>
<th>Remarks</th>
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</table>

<table>
<thead>
<tr>
<th>Competence Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/Not yet</td>
</tr>
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</table>

### 2. Patient Assessment Criteria

- Assesses patient suitability for the procedure
- Selects equipment (providing rationale for choice)
- Discusses the potential psychological impact with the patient
- Critically analyses potential risks

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<th>Remarks</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Competence Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/Not yet</td>
</tr>
</tbody>
</table>

### 3. Knowledge and Application Criteria

- Demonstrates knowledge of relevant A&P
- Provides appropriate patient information
- Discusses indication and contraindications with patient
- Seeks information from appropriate sources when necessary

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<tr>
<th>Remarks</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Competence Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/Not yet</td>
</tr>
</tbody>
</table>

### 4. Communication Criteria

- Skill explained to patient/significant others to obtain Informed consent
- Practitioner demonstrates accurate and legible Documentation of skill

<table>
<thead>
<tr>
<th>Remarks</th>
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</table>

<table>
<thead>
<tr>
<th>Competence Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/Not yet</td>
</tr>
</tbody>
</table>
Appendix 17  

Record of Completion of Competencies (Urinary Catheterisation)

All staff must complete and return this form to their line manager.

Full Name: ____________________________________________

Profession: ____________________________________________

Job Title: ______________________________________________
Clinical Area: ____________________

Directorate:____________________________________________

Please circle which type of catheterisation the practitioner has achieved competence in

Male Urethral  |  Female Urethral  |  Supra-pubic

| Attendance at simulated practice session | Signature (Practitioner) | Signature (Assessor/Facilitator) | Date |
| Completion of theoretical assessment    |                           |                                 |      |
| Completion of practical assessment      |                           |                                 |      |
| Competence to perform urinary catheterisation |                       |                                 |      |

Practitioners will not be deemed competent until all the assessments have been completed and is signed off by their line manager.

A copy of this form should be included in the practitioners PREP folder and in their personal record.
### Nursing Competencies – Urinary Catheterisation

<table>
<thead>
<tr>
<th>Competency Standard</th>
<th>Performance</th>
</tr>
</thead>
</table>
| **Understands and debates professional issues in relation to urinary catheterisation** | • Applies ethical principles and guidelines to inform decision making in practice  
• Actively involves the patient in the decision making process  
• Demonstrates the ability to work in accordance with legal and statutory guidelines  
• Exercises autonomy and initiative  
• Demonstrates responsibility and accountability for own, and applicable others’ practice  
• Maintains accurate record keeping                                                                                                                                 |
| **Performs accurate assessment of patient requiring an urinary catheterisation**     | • Demonstrates knowledge of the anatomy and physiology of male/female urinary system  
• Identifies and analysis the appropriateness of urinary catheterisation  
• Provides patient education regarding urethral or suprapubic catheterisation to aid decision-making  
• Recognises when assistance is required from specialists  
• Selects appropriate catheter (size and type) with rationale for choice  
• Awareness of psychological impact of urinary catheterisation for the patient  
• Discusses the indications of urinary catheterisation  
• Details contra-indications of urinary catheterisation                                                                                                                                 |
| **Demonstrates competence in the procedure of urinary catheterisation**              | • Obtains consent and prepares the patient for the procedure  
• Assembles necessary equipment, in accordance with devised checklist  
• Practises skill competently (see checklist)  
• Justifies the skill/procedural checklist of catheterisation using evidence (published and other sources)  
• Critically analyses the clinical risks associated with urinary catheterisation and takes appropriate action to manage risks  
• Recognises fundamental differences of catheterisation in children compared to adults and the need for specialist assistance |
| Engages in evaluation and critical analysis post procedure | • Responds promptly and appropriately to complications  
• Takes action to prevent commonly known associated complications of urinary catheterisation  
• Adequately prepares patient for discharge with a urinary catheter in place  
• Recognises limitations and accesses assistance as required  
• Reflects on attitude, behaviour (skill) and cognitions post procedure  
• Appraises context in which skills were practiced  
• Identifies learning which has occurred to influence future practice  
• Identifies area/enquiries for further learning  
• Draws on a range of resources for further learning/reading |
Appendix 19  BLADDER WASHOUT

This procedure is based on the Marsden manual and can be used as a guide only. Please refer to your Standard precautions and principles of aseptic non touch technique (ANNT) to be used.

**Equipment required**

- Sterile bladder washout or dressing pack
- Isopropyl Alcohol 70% wipes x 2
- One pair of sterile gloves and one pair non-sterile gloves
- Alcohol-based hand rub
- Catheter clamp if available
- Drainage bag
- Disposable waterproof sheet/pad
- 60 ml bladder syringe
- Water or normal Saline - 500 ml - warmed
- Sterile kidney dish/jug

**Procedure**

1. Perform hand hygiene
2. Discuss procedure with patient and gain verbal consent
   a. Ensure patient privacy and keep warm at all times
   b. The patient may require some pain control/antispasmodic medication prior to procedure, due to discomfort secondary to bladder spasm
3. Position your patient with catheter and drainage bag connection point exposed
   a. Place waterproof sheeting between nurse and patient
4. Wash hands with antimicrobial liquid soap or alcohol-based hand rub (ABHR)
5. Put on plastic apron and gloves
6. Prepare equipment - if using trolley place, all equipment required on bottom shelf
7. Open up pack using an aseptic non touch technique (ANNT)
   a. Add sterile equipment-gloves, 60 ml syringe, sterile kidney dish/container and Isopropyl alcohol 70% swab onto the top of the trolley on sterile field
8. Warm sterile saline or sterile water 500ml and pour into sterile jug
   b. keep empty saline bottle beside dressing table for collection of bladder washout fluid
9. Clean catheter and drainage bag connection point with swab saturated with 70% Isopropyl Alcohol using firm friction and allow to air dry
10. Wash hands with antimicrobial liquid soap or alcohol-based hand rub (ABHR) and
put on sterile gloves

1. Clamp the outlet end of catheter below bifurcation junction with “quick” clamp or using sterile swab pinch shut using fingers and thumb

2. Disconnect catheter from bag and wipe catheter outlet with Isopropyl Alcohol 70% swab and keep this in place in between instillations

3. Using 60 ml syringe draw up 60 ml of warmed normal saline, ejecting any air in syringe

14. Attach syringe to catheter outlet

15. Release clamp of catheter and gently instil 60mls saline

16. Then gently withdraw 30 ml saline (ensuring 30 ml remains in bladder)

17. Draw up 60 ml of warmed normal saline and attach syringe to catheter outlet

18. Gently instil sterile saline 60ml into bladder and then gently withdraw 60ml

19. Continue this process, until urine runs clear or patient indicates

20. With final instillation leave 30ml in bladder

21. Swab connection with Isopropyl Alcohol 70% wipe and attach drainage to catheter

22. Remove gloves and dispose of equipment in a yellow biohazard bag

23. Wash hands with antimicrobial liquid soap or alcohol-based hand rub

24. Document procedure and any abnormalities in patient’s notes
**Observational Audit of ANTT: Urinary Catheterisation**

**Please use one sheet per procedure. See the reverse of this tool for guidance or to add further comment.**

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Date</th>
<th>Observer</th>
<th>Staff grade observed</th>
<th>Surgical or Standard-ANTT? (Please circle)</th>
</tr>
</thead>
</table>

**Organisation**

<table>
<thead>
<tr>
<th>Was equipment available and to hand in the preparation area?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the prep area conducive to aseptic preparation?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were contraindicated activities (such as bed making, dusting etc) occurring in close proximity to the aseptic procedure?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hand Cleaning**

<table>
<thead>
<tr>
<th>Were hands cleaned prior to each new aseptic procedure?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes: Was the hand cleaning always in accordance with local policy for hand hygiene?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Aseptic Field Usage**

<table>
<thead>
<tr>
<th>Aseptic field(s) used: Plastic tray</th>
<th>Paper tray</th>
<th>Worktop</th>
<th>Sterile Drape</th>
<th>None Used</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If used, were plastic trays cleaned effectively before each procedure?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, cleaned with what?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Glove Usage**

<table>
<thead>
<tr>
<th>Gloves used: Sterile</th>
<th>Non-sterile</th>
<th>No gloves</th>
<th>Was this glove selection appropriate for the procedure?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If contaminated during the procedure were gloves changed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no, why not?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key-Part and Key-Site Management**

<table>
<thead>
<tr>
<th>Were non-active Key-Parts protected during prep and the procedure?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the genitilia (Key-Site) cleaned according to local policy</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If no, what happened?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the Key-Site allowed to dry before use?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were Key-Parts or the Key-Site touched by the operator during preparation or the procedure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, when?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Decontamination**

<table>
<thead>
<tr>
<th>After the procedure, was all equipment disposed of cleanly and safely?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no, why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were hands cleaned immediately after glove disposal (i.e. before the environment is touched)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was reusable equipment effectively cleaned prior to storage?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cleaned with what?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Autonomic Dysreflexia (AD) is a medical emergency specific to individuals with Spinal Cord Injury (SCI) at the neurological level of T6 or above. It is usually caused when a painful irritation occurs below the level of your spinal cord injury. It can present with a variety of signs / symptoms which can vary from mild to severe discomfort. As a SCI individual you need to have a good understanding of AD and be familiar with signs and symptoms and immediate management of this potentially life threatening condition. It must be addressed immediately because if it is untreated it may progress to cause a seizure, stroke or death. (Atrens Prestice 1998).

**How do I get Autonomic Dysreflexia?**

1. Irritation below the level of SCI such as a full bladder sends signals up the spine

2. Constriction of blood vessel

3. Causing high blood pressure

4. Attempted compensation message cannot pass through the spinal cord and blood pressure continues to rise

5. Slow pulse and dilatation of blood vessels above the injury level as an attempt to compensate for the rise in blood pressure causing symptoms

**Signs & Symptoms**

- BP 20-30mmHg above normal
- SWEATING
- POUNDING HEADACHE
- FLUSHED
- TIGHT CHEST & STUFFY NOSE
- BLURRED VISION

**Emergency Treatment for Autonomic Dysreflexia**

- Signs / Symptoms of Autonomic Dysreflexia
- Call for assistance
  - Sit upright and lower legs
  - Loosen any tight clothing / leg straps
  - Monitor BP until symptoms have resolved
- Common causes to exclude / treat first are:
  1. Bladder Distension
  2. Constipation
- If symptoms persist and cause is unknown:
  - Take prescribed medication
  - Nifedipine 10mg capsule “bite and swallow” method
  - If BP not settling and cause not identified
  - Contact your GP or Accident / Emergency Department

**Conclusion**

It is essential for you, family members or carers to recognise and understand the potential causes, prevention and treatment of AD. If an episode of AD is identified quickly, and treated immediately the symptoms may then subside, thus removing the likelihood of complications.
Indwelling urinary catheterisation – male or female

1. Clean hands with soap & water
2. Clean trolley according to Trust policy
3. Gather equipment onto bottom shelf

4. Clean hands
5. Apply apron
6. Open equipment onto critical aseptic field using non-touch technique (ANTT)

7. Clean hands
8. Apply sterile gloves
9. Prepare equipment using non-touch technique (ANTT)
10. Apply aseptic field drapes over genitae & between legs
11. Clean urethral orifice with normal saline & gauze
12. Insert lubricating gel
13. Dispose gloves
14. Insert catheter

14. Inflate balloon using ANTT
15. Attach collection bag using ANTT if not preconnect catheter
16. Dispose of waste & gloves
17. Clean hands with soap & water immediately after glove removal
18. Clean trolley also wipe if visibly clean/ChloroxClean if any body substances
19. Clean hands soap & water

Principles of ANTT: Protect key-parts & sites at all times by:
- Risk assessment
- Effective hand cleaning
- Non-touch technique
- Using appropriate infective precautions.