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NHS Trust

Urinary Catheter Care in the Community (Adults) Guidelines

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Unique Identifier	CL-125
Document Purpose	Provide support, knowledge and evidence of good practice necessary to enable staff to manage catheter care safely and competently
Document Author	Elaine Sutcliffe, Continence Nurse Specialist
Target Audience	These guidelines are relevant to all staff undertaking catheter care as part of their role.
Responsible Group	Clinical Policies Group
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Version History

Version	Circulation Date	Job Title of Person/Name of Group circulated to	Brief Summary of Change
V1	2013	Guidelines approved	
V2	30/3/17	Head of Education and Clinical Developement	
V2	30/3/17	Safeguarding Services Manager	Add female genital mutilation
V2	30/3/17	Audit, Research and Clinical Effectiveness Manager	
V2	30/3/17	Lead for Allied Health Professionals	
V2	30/3/17	Chief Pharmacist	
V2	30/3/17	Nurse Consultant Infection Prevention Control	Typing errors. Guidance on antibiotic cover. Use of hand gel, sterile gloves.
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V2	30/3/17	SDU Leads	
V2	30/3/17	Trust Medical Director	
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V2	30/3/17	Specialist Physiotherapist ECH, MCH	
V2	30/3/17	Urology Nurse Specialist Worcester Hospital	
V2	30/3/17	Urogynaecology Nurse Specialist WRH	
V2	30/3/17	Urology Consultant Alexandra Hospital	
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V2	30/3/17	Enhanced Care Redditch and Bromsgrove	
V2	30/3/17	ANP Merstow Green MC	
V2	30/3/17	Community Neurological team lead	

Acessibility

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Training and Development

Worcestershire Health and Care NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

Co-production of Health and Care – Statement of Intent

The Trust expects that all healthcare professionals will provide clinical care in line with best practice. In offering and delivering that care, healthcare professionals are expected to respect the individual needs, views and wishes of the patients they care for, and recognise and work with the essential knowledge that patients bring. It is expected that they will work in partnership with patients, agreeing a plan of care that utilises the abilities and resources of patients and that builds upon these strengths. It is important that patients are offered information on the treatment options being proposed in a way that suits their individual needs, and that the health care professional acts as a facilitator to empower patients to make decisions and choices that are right for themselves. It is also important that the healthcare professional recognises and utilises the resources available through colleagues and other organisations that can support patient health.

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1. Introduction

a. Urinary catheterisation is a common procedure performed in the community but is invasive and should not be undertaken without full consideration of the benefits and risks. These guidelines have been developed to standardise practice according to current research and evidence based practice.

b. Nurses have a crucial contribution to make in providing effective advice and care to patients and clients with a catheter.

2. Purpose of document

a. The purpose of these guidelines are to:

- Establish a framework for urinary catheter care management for adults;
- Prevent inappropriate catheterisation;
- Provide nurses with the support, knowledge and evidence of good practice necessary to enable them to insert and manage catheter care safely and competently.

3. Definitions

- **Urinary Catheter:** A hollow tube which allows urine to drain
- **Urethral Catheterisation:** A procedure involving insertion of a catheter into the urethra to drain urine.
- **Suprapubic Catheterisation:** A procedure involving inserting a catheter through the abdominal wall to drain urine.
- **Catheter Maintenance/Patency Solution:** Solutions used to prevent blockage of catheters by encrustation and maintain the patency of the catheter.
- **Catheter Encrustation:** The collection of mineral salts which can lead to catheter blockage

4. Scope

a. These guidelines are relevant for all staff working on behalf of Worcester Health and Care Trust who undertake catheter care and teach others as part of their role.

b. It is recommended these guidelines may be adopted by independent care homes within Worcestershire, in order to promote best practice.

5. Training/Competencies

a. Health care professionals undertaking catheter care must have a theoretical understanding of bladder anatomy, physiology, function and dysfunction and knowledge of current legislation and national guidelines, RCN 2012. They must have attended a training course normally accessed through the Community

Continence service. Catheter study sessions are available via the Continence Service throughout the year and include practical sessions on catheterisation using a manikin.

b. The suggested structure for gaining competence in catheterisation is as follows:

- Gain a theoretical knowledge and understanding in aspects of catheterisation;
- Observe model/manikin being catheterised;
- Practise catheterisation on a model/manikin under supervision until confident;
- Observe catheterisation performed by others on actual patients;
- Be able to catheterise without direct supervision;
- Gain experience and become confident;
- Become a competent mentor for others; (RCN 2012)

c. Competence will be achieved through observation, relevant practise and supervision in the clinical setting by a competent assessor and using the competency framework. This competence document can be accessed via the Trust clinical competency library. The Learning and Development unit will keep a record of competent health care professionals and it is recommended this is achieved by the following:

	Observed	**Supervised**
Urethral Catheterisation	Two	Two
Suprapubic Catheterisation	Two	Two

d. A competent assessor is defined as a health care professional who has undergone training, workplace assessment and who practice the technique as an integral part of their clinical role.

e. Staff who feel confident and competent and are presently performing urethral and suprapubic catheterisation can continue to do so and attend an update including an assessment of competence on a manikin a minimum of every 5 years. It is the individual's personal responsibility to satisfy themselves they are familiar with these guidelines.

f. Staff entering the Trust who have been trained in another Trust or Health Organisation must produce evidence of training and competence and be assessed once using the competency framework.

g. Health care professionals must maintain their competence through clinical practice, retraining and personal study. It is recommended staff refresh their knowledge and skills every 5 years. Retraining can be accessed through the Trust's Continence Service.

6. Responsibilities and duties

a. All practitioners who perform catheter care for patients should be aware of the contents of these guidelines. Nurses carrying out catheter care interventions are reminded that they should at all times adhere to the NMC Code of Professional Conduct: standards for conduct, performance and ethics and work within their competence and job description. They also have a responsibility to take account of their patient's informed choices.

b. Registered nurses have a responsibility to ensure they feel confident and competent in the knowledge and skills of practice (NMC 2015) and if they do not feel competent to undertake this role they must inform their immediate manager to discuss training needs.

c. The Line Manager is responsible for ensuring any training required is identified as appropriate and measures taken to ensure that the nurse is able to obtain required competence.

d. Registered nurses who delegate catheter care interventions to health care assistants under specific direction, are reminded that they are at all times accountable for the delegated task.

e. Further information about accountability and delegation is available from RCN (2011).

7. Consent

a. The Consent where this is possible will always need to be obtained prior to the procedure/intervention being initiated. The interventions in these guidelines would not be classified as requiring written consent however verbal, expressed consent would be required. Therefore all interventions must be comprehensively documented in the patient's record and written in such a way that demonstrates the patient's informed consent when this can be obtained. If the patient lacks capacity the assessment of this must be documented. The decision to proceed or not with the proposed procedure/intervention on the basis of a best interests decision must also be recorded in line with the Trust Mental Capacity Act 2005 summary and guidance for staff.

8. Indications for Catheterisation

a. Catheterisation has several benefits but also possible complications. Risks associated with catheterisation must be considered and a valid reason for insertion documented. A clear rationale for on-going use of a catheter is required and it should be removed as soon as possible. Intermittent catheterisation is considered to be the gold standard for urinary drainage however this may not always be suitable.

b. Clinical indications for urinary catheterisation include:

- Pre and post-operative surgery;
- Monitoring renal function during critical illness;

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

(RCN 2012)

9.0 **Risk Assessment**

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

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

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

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

- Medication such as aspirin and warfarin;
- Recent catheter related trauma;
- Recent urinary tract surgery;
- Known bladder/prostate cancer;
- Blood clots observed by the patient;

- Meatal bleeding observed by patient;
- Haematological malignancies and increased risk of bleeding associated with low platelets.

d. Risks factors which increase the serious complications associated with catheter related infections include patients who have:

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

(RCN 2012)

e. Primary Care Prescribing Guidance for Worcestershire should be followed for treatment of urinary tract infections, where available, sensitivity data must be used to inform choice of agent. Prescribers should, where possible, refer back to earlier microbiology to ensure effective choice of agent until current sample result available. The antibiotic, dose and duration must be specified.

   Nationally, the increase in resistant gram negative infections which can present amongst community patients including Extended Spectrum Beta Lactamase (ESBL) producing organisms and Carbapenamase Producing Enterobacteriacea (CPE) make it imperative to ensure full patient review and appropriate choice of agent.

f. Practitioners should be vigilant to any health issues such as resistance to partake in catheterisation. When a female presents with symptoms related to urology/urogynaecology you must ask specifically about female genital mutilation (FMG). In accordance with the new mandatory recording requirments the practitioner should document in patients notes if the patient has undergone FGM, the type, family history and type of procedure carried out. More information is available about FGM in the Trust safeguarding policy CL-194, available via the intranet.

10.0 Documentation

a. Catheter insertion documentation should include:

- The reason for catheterisation, catheter change and on-going need for a catheter with all its risks;
- Consent obtained;
- Patient's current health status and result of risk assessment prior to catheterisation;
- Date and time of catheter insertion and by whom.
- Catheter including brand, catheter name, material, catheter length, charriere size and balloon size and expiry date;
- Cleaning fluid used;
- Lubrication gel type, batch and expiry date;
- Amount of sterile water for balloon inflation batch and expiry date;
- If the insertion was easy or difficult;
- Indications to ensure catheter was inserted correctly e.g. amount catheter inserted, urine drained, pain/patient reaction to balloon inflation, resistance to balloon inflation;
- In men document foreskin replaced to reduce risk of paraphimosis;
- If urine drained, the amount, colour, smell and if necessary dipstick and record the results;
- If no urine drained document what actions taken;
- If urine specimen sent and why; and
- Date of planned change, re-assessment and expected duration.
- A summary of communication with the patient and/or carer and the patient/carer's understanding of what a catheter will mean for them.
- Advice to patient/carer

(RCN 2012)

b. Catheter removal documentation should include:

- The length of time the catheter was in situ was appropriate for type being used;
- Catheter tip and balloon were intact on removal and balloon deflated easily;
- Amount of water in the balloon on deflation;
- If removal was painful or difficult to remove;
- If blood present then where and to what degree;

- Any abnormalities around the meatus;
- Observations of urine for signs of infection;
- If encrustation and to what degree e.g. like consistency of sand, egg shell;

(RCN 2012)

c. Each catheterised patient should have a hand held Trust catheter passport. This details all catheter interventions and includes patient information about catheter care and guidance on troubleshooting. Patients should also have a personalised care plan. Staff should record a summary of catheter intervention on carenotes.

11.0 End of Life Care

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

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

(RCN 2012)

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

(RCN 2012)

12.0 Acute Painful Retention

a. The pathway for male acute retention is detailed in Appendix 1 and has been approved and implemented by South Worcestershire CCG. At the time of these guidelines being updtaed, Redditch and Bromsgrove and Wyre Forest CCG's were in the process of adopting this pathway. Until that time it is recommended that patients who present with acute painful retention in R&B and WF are referred urgently to the GP who can discuss the patient with the on call Urologist and the patient catheterised in Accident and Emergency or surgical admissions unit.

b. All females with acute retention should be referred urgently to the GP who, if necessary can discuss the patient with the on call Urologist/Urogynaecologist.

13.0 Trial Without Catheter (TWOC)

a. There are instances when a planned trial without catheter may be performed in the community e.g. post-surgery, post-acute urinary retention or following changes in general condition which had predisposed the need for a catheter. The nurse must feel confident and competent to perform the procedure and have adequate knowledge about the patient and why the procedure is being performed. If not, they must contact the medical/nursing team who have been caring for the patient. It is common for men to be started on an alpha blocker prior to a trial without catheter.

b. Refer to Appendix 2 for trial without catheter guidance and documentation.

14.0 Urinary Catheterisation

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

b. There are 3 types of catheterisation:

- Intermittent
- Urethral
- Suprapubic

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

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

e. **Suprapubic catheterisation** Indications for suprapubic catheterisation include:

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

f. Contraindications for suprapubic catheterisation include:

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

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

h. First catheter changes can take place in the community, however the health professional must have completed a risk assessment to include the patients past medical/surgical and urological history. If they lack appropriate skills or feel the patient needs monitoring in secondary care, then they are to contact the surgical team who inserted the catheter. Also some Urologists specifically request that they/their team perform some first suprapubic catheter changes.

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

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

k. Catheterisation procedures are included in Appendices (4, 5, 6, 7, 8 and 9).

15.0 Indwelling Catheters

a. The following applies for patients with a urethral or suprapubic indwelling catheter:

- With urethral catheterisation the genital area should be thoroughly cleansed at least once daily with unscented soap and water, and repeated after every bowel movement.
- Following defecation, patients should be reminded to use soft toilet tissue, wiping from front to back. Moist toilet wipes may be useful for this purpose.
- Suprapubic sites initially require a dressing but should be removed when the insertion site has healed (7-10 days). Dressing should be changed aseptically. Once healed the site can be cleaned with soap and water with a clean cloth and left clean and dry (RCN 2012)
- A closed drainage system for urinary collection is essential, minimising the risk of ascending infection. (see section below)
- In and out movement of the catheter should be avoided by securing the catheter and connection tubing with a securing device.
- Drainage bags should remain below the level of the patient's bladder and be emptied regularly to prevent traction on the catheter.
- When clinically appropriate it is recommended that fluid intake be approximately 2 litres and patients avoid constipation.

b. There is a clear correlation between the number of times the drainage system is disconnected and the rate of infection. (RCN 2012) It is important, therefore, to maintain a closed drainage system. The bag should only be disconnected from the catheter in the following instances:

- The bag requires changing, routinely every 5-7 days;
- Catheter valve change, routinely every 5-7 days;
- The catheter becomes blocked and bladder maintenance solution is required.

c. The patient's clinical need for catheterisation should be reviewed regularly/at each catheter change and the urinary catheter removed as soon as possible. Each patient should have an up to date catheter care plan.

d. Healthcare workers must decontaminate their hands in accordance with the five moments of hand hygiene (WHO 2009) and also removal of personal protective equipment. Alcohol hand gel can be used on visibly clean hands as long as the patient does not have diarrhoea and /or vomiting soap and water or a skin cleansing wipe are recommended. A single use disposable apron and non sterile gloves must be worn before manipulation of the catheter system.

15.1 Choice of Catheter

a. The choice of catheter used should be governed by allergies and length of time the catheter is likely to remain in situ, taking into account the reason for catheterisation.

Single use coated	In/out catheter	Used in Intermittent self-catheterisation
Silver coated	Medium term	Up to 28 days (for a maximum of 3 consecutive months and then review)
PTFE coated latex	Medium term	Up to 28 days
Hydrogel coated latex/all silicone	Long term	Up to 12 weeks

b. There are 2 lengths of catheters, female and standard/male length. The health professional must always check the length of catheter being inserted and never insert a female length catheter in a male. National Patient Safety Agency (2009b).

c. Standard length catheters may be used in women who are obese or use wheelchairs.

d. Standard length catheters are used for suprapubic catheterisation in both men and women.

15.2 Charriere Size

a. The charriere is the outer circumference of the catheter in millimetres and is equivalent to three times the diameter. Under normal circumstances a size 12CH – 14CH is suitable for the majority of female patients and 12CH – 16CH for males. Size 16CH to 18CH are usually used for suprapubic catheterisation.

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

15.3 Balloon Size

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

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

15.4 Silver Coated Catheter

a. To be used at the discretion of the clinician for patients at high risk or repeated urinary tract infections for a maximum of three catheter changes and then reviewed. Discuss with Continence Advisor or Infection Control team if required.

15.5 Urine Samples

a. Urine samples should be obtained aseptically from the needle free port on the drainage bag and never from the catheter itself. (Loveday et al, 2014, RCN 2012) (See Appendix 10.)

15.6 Catheter Securing Devices

a. It is preferable to use a catheter securing device to anchor the catheter to the patient's thigh/leg/abdomen. This prevents the catheter pistoning and subsequent trauma.

15.7 Bathing with a Catheter

a. The leg drainage bag should not be disconnected but should be emptied before bathing and can either be immersed in the bath or placed on a suitable surface at the edge of the bath.

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

15.8 Catheter Valves

a. A catheter valve allows the bladder to fill and empty. Therefore :

- They help maintain an intact bladder wall;
- They allow the bladder to expand and fill with urine;
- They maintain blood and nerve supply to the bladder wall;
- They provide the sensation to want to pass urine;
- Catheter valves should be opened on average every 2 – 3 hours;
- At night an overnight drainage bag may be attached;
- Catheter valves can stay in place for 5 – 7 days.

b. Catheter valves are only suitable for patients who have good cognitive function, sufficient manual dexterity to manipulate the valve and adequate bladder capacity.

c. When possible a catheter valve should be used before a trial without catheter. If the catheter has been in place for several months, it is suggested the catheter valve be used for approximately 1 - 2 weeks before trial without catheter is attempted.

d. When used, the lot number and expiry date of the valve should be documented in the patient's notes.

16.0 Catheter Maintenance Solutions

a. Some patients who have a long term indwelling urinary catheter and suffer from encrustation may benefit from the use of a catheter maintenance solution to prolong the life of their catheter.

b. Bladder lavage is not included in this procedure and is defined as the manual washing out of the bladder with sterile fluid.

c. Bladder irrigation is not included in this procedure and is defined as the continuous washing out of the bladder with sterile fluid, usually 0.9% normal saline.

d. Catheter maintenance solutions are defined as pre-packaged sterile solutions ready for administration. Catheter maintenance solutions include Citric acid 3.23% (Solution G or Suby G) or Citric acid 6% (Solution R). Where assessment indicates that a catheter maintenance solution may be beneficial, the solution used must be appropriate for the condition being treated.

e. Chlorhexidine maintenance solutions are no longer considered effective due to previous overuse and past incidence of allergy, and should not be used (Loveday et al, 2014)

f. Catheter maintenance regimes must be based on individual need, after appropriate assessment and as part of a treatment plan. Their effect should be reviewed regularly and on-going care planned accordingly, with the aim to reduce and stop using the solutions as soon as possible.

g. Catheter maintenance solutions are not to be used prophylactically or to attempt to unblock a non-draining catheter. They are treatment preparations for dissolving encrustation only.

h. The best way to determine encrustation is to visually examine the removed catheter both externally and internally by cutting the catheter lengthways. If there is no visible evidence of encrustation on the catheter when rolled between fingers or does not feel gritty then it is safe to assume that catheter maintenance/patency solutions are not indicated. (Loveday et al 2014, Cochrane review, 2010, European Association of Urology Nurses 2012).

i. Procedure is included in Appendix 11.

17.0 Catheter Change

a) Catheters need changing only if they become obstructed or a malfunction occurs. If a catheter continues to drain adequately, it should remain undisturbed until it is due for change. (28 days or 12 weeks)

b) Do not routinely offer prophylactic antibiotics when changing long term catheters.

c) However consider antibiotic prophylaxis for patients who:

- Have a history of symptomatic urinary tract infection after catheter change;
- have an underlying health reason which indicates the need for prophylaxis e.g. endocarditis (RCN, 2012)

d) If a patient is prescribed antibiotics to treat a catheter associated urinary tract infection (CAUTI), the catheter should be changed during the course of treatment (treatment must be based on sensitivity data or prescribing guidance if this is not available). Removal of the catheter during the course of treatment will ensure bacteria in biofilm is minimised on catheter change and ensure that a new catheter without biofilm is inserted under antibiotic therapy thus reducing the risk of infection. If the patient does not require a urinary catheter then this should be removed and need for further treatment assessed.

18.0 Changing of Urine Drainage Bags – Day and Night

a. Leg bags should be changed every 5 -7 days. (DH Drug Tarriff 2016)

b. The bag should also be changed when there is an accumulation of sediment, leakage, when a new catheter is inserted, or when a maintenance solution has been used.

c. The changing of leg bags on a daily basis incurs unnecessary expense and disconnection of the system more often than is necessary increases risk of infection.

d. In a care home setting a disposable night drainage bag should be emptied, and disposed of as offensive waste if infection is not suspected. If infection is suspected it should be treated as infected and put in an orange or yellow waste bag. In patients own home empty used bags should be double bagged and be disposed of in normal household waste unless there is already a pre-existing hazardous waste collection in place.

e. A new disposable night bag is used each night.

f. For patients who are bed bound, a drainable sterile 2 litre drainage bag may be used only if connected directly to the catheter and left in situ for 5-7 days.

g. See Appendix 12 and 13 for emptying and changing a catheter bag.

19.0 Removal of an Indwelling Catheter

a. For procedure see Appendix 14

20.0 Patient Advice and Education

a. Patients and carers should be educated and trained in techniques of hand decontamination, the risk of cross infection, and catheter management before discharge from hospital.

b. Follow-up training and on-going support of patients and carers should be available for the duration of long-term catheterisation.

c. This education will be offered by the practitioner directly responsible for catheter care and is included in the Worcestershire Catheter Passport.

21.0 Contience Product Formulary

a. The Community Continence Product Formulary has been produced to give Practitioners advice and support when choosing/prescribing catheters and catheter related equipment and quantities to be prescribed. The formulary provides guidance to prescribers for first line products only and is not intended to restrict patient choice. Copies can be obtained from the community continence service or via the continence intranet page located under useful documents, where a prescription form and formulary can also be downloaded.

22.0 Monitoring Implementation

The following tool will be used to monitor the implementation of these guidelines.

Aspect	%	Exceptions
Monthly audit completed by community staff: 1. Reason for catheter recorded i.e Pre/post operative surgery Monitoring renal function Chronic/acute urinary retention Allowing bladder irrigation/lavage Investigative purposes e.g. Urodynamics Instillation of medication Where it is viewed as 'better' for the patient to use a catheter or is unfit for surgery 2. If no, how many of these patients have catheters that do not fit above criteria? 3. Re catheterisation or review date recorded? 4. Do all patients with an indwelling catheter have an up to date care plan?	100	None

How will monitoring be carried out?	Questionnaire
When will monitoring be carried out?	Monthly with quality metrics
Who will monitor compliance with the guideline?	Clinical Governance team

23.0 References

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24.0 Associated Documentation

a. These guidelines cross reference with the following Worcester Health and Care NHS Trust policies and national guidance:

- Consent to Treatment Policy
- Infection, Prevention and Infection Control Guidelines
- Nurse Prescribing
- Safeguarding Adults Policy
- Being Open Duty of Candour Guidance
- Worcestershire Guidelines for Primary Care Antimicrobial Prescribing
- RCN Catheter Care guidance for nurses 2012
- Loveday et al, EPIC 3 National Evidence Based Guidance for Prevention of Hospital Acquired Infections 2014
- WHCT Community Continence Product Formulary
- WHCT Urinary Catheter Passport
- WHCT Community Quality Nursing Metrics

Appendix 1 Management of Acute Retention in Males

Red Flags
Retention associated with Haematuria & Clots, Sepsis or Renal Failure refer to **A&E ED / Urology**

Patient presents with Acute Retention

Acute
Basic obs: temp pulse BP

Attempt Catheterisation
(Use # 14 -16 Catheter)

Consider Ca Bladder/ mets /neuro Sx that may indicate retention due to spinal compression

Successful
Residual Urine Volume (RUV) >500ml

Unsuccessful or:
- clinical concerns
- new onset of renal impairment
- acute on chronic renal failure
- RUV <500mls- reconsider diagnosis

Urgent referral to A&E ED / Urology

- Document final post-catheterisation residual volume
- Perform DRE (if abnormal urgent referral to Urology)
- Consider bloods for PSA if DRE abnormal or no previous records
- **Mandatory U&E[1] (see next page)**
- BP
- Start tamsulosin MR 400mcg **capsules** once daily *unless contra-indications*
- Treat reversible causes; i.e. UTI constipation

- AKI Stages 1 – 3 ***see definition**
- Hypotension

Low risk
District Nurse Review the next day

Concerns
Consider close follow-up /Community Hospital admission i.e. Frailty, poor social circumstances)

If Red flags admit to ED

Trial Without Catheter (TWOC) 48 hours

Consider referral to Urology one stop LUTS clinic - all sites

Successful
Residual Volume (RV) <300mls

Unsuccessful

Re-Catheterise

AKI Definition

The biochemistry laboratory will define the AKI stage for given Creatinine, using a computerised algorithm based on the AKI definition by KDIGO, which is summarised below:

AKI Stage 1 = Creatinine increased to 1.5 – 1.99 x previous baseline

AKI Stage 2 = Creatinine increased to 2 – 2.99 x previous baseline

AKI Stage 3 = Creatinine increased to > 3 x previous baseline

Or

Creatinine > 355 AND increased to > 1.5 x previous baseline

AKI Red flags - consider for hospital admission or specialist advice:

- IV fluids needed
- Hypotensive (symptomatic)
- AKI – unclear cause / not improving
- Rare but relevant: Suspected vasculitis / scleroderma / nephrotic
- K > 6.0 mmol/L
- AKI 3
- Renal transplant

Mandatory U&E[1]

if attending GP does not have a reasonable expectation that the urgent U&E result will be received before the normal surgery hours then please place an alert on the Adastra system that the patient has experienced AUR and urgent U&E are expected. *(This will change when OOH will be able use Emis)*

Disclaimer

This pathway is intended to guide and facilitate the care of patients, it is not intended to replace individual assessment and personalised treatment of the patient.

References

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Appendix 2

Worcestershire Health and Care NHS
NHS Trust

Trial without Catheter

Worcestershire Community Continence Advisory Service

Trial without Catheter (TWOC)
Community Protocol

Referral made to District Nursing Service for TWOC

- A qualified/competent healthcare professional should remove the catheter early morning on the day for TWOC
- The healthcare professional will instruct the patient to record fluid intake and output on the attached form
- An emergency contact telephone number should be given to the patient if they experience voiding difficulties during the day.
- Re-visit patient mid-afternoon and review patient inout and output record and how the patient is feeling.
- If frequency and output volumes satisfactory inform health professional who requested the TWOC. If the patient does not already have a review appointment, eastablish if they require one. Give the patient advice about healthy bladder advice, symptoms of a urinary tract infection and what to do if they are concerned or develop voiding difficulties
- If symptoms indicate retention, re catheterise and instruct GP to see if a new referral or referral back to Urology/other consultant is necessary.

TRIAL WITHOUT CATHETER (TWOC) COMMUNITY PROTOCOL

NAME:_____DOB_____

DATE UNDERTAKEN:_____TIME CATHETER REMOVED:_____

PATIENT INSTRUCTIONS

1. Please drink at regular intervals through out the day to comfortably fill your bladder.

2. Please measure and record all fluids drunk and all urine passed on the chart below.

3. **If at anytime during the day you cannot pass urine and it becomes uncomfortable, please contact the District Nurse on the emergency number given.**

TIME	INTAKE	OUTPUT	TIME	INTAKE	OUTPUT
08:30			**13:30**		
09:00			**14:00**		
09:30			**14:30**		
10:00			**15:00**		
10:30			**15:30**		
11:00			**16:00**		
11:30			**16:30**		
12:00			**17:00**		
12:30			**17:30**		
13:00			**18:00**		

Health Care Professional to complete this section

Overall Outcome

- ☐ Discharged successfully without catheter
- ☐ Re catheterised with referral back to GP/Consultant
- ☐ Treatment of urinary symptoms post TWOC eg; Alphablockers , UTI
- ☐ Other – Specify

Signature of Nurse_____

Date _____

Appendix 3

Worcestershire Health and Care NHS
NHS Trust

Autonomic Dysreflexia

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

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

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

<u>Treatment.</u>

Identify the source of noxious stimulus for example this could be due to a blocked catheter, defective drainage system, constipation or a urinary tract infection. The stimulus needs to be removed for the symptoms to settle. Some patients may have prescribed medication for this condition which will help lower blood pressure.

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

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

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

Appendix 4

Worcestershire Health and Care NHS
NHS Trust

Catheterisation Procedure: requirements

Sterile Catheterisation Pack
Protection for bed
Normal saline /0.9%sodium chloride (in catheter pack)
Catheter
Sterile gloves (in catheter pack)
Drainage bag and holder (in catheter pack)
Catheter straps and securing device (in catheter pack)
Lubricating gel (for male and female catheterisation)
10ml Syringe (in catheter pack)
10ml sterile water or prefilled catheter (in catheter pack)
Apron (in catheter pack)
Patient's notes

Appendix 5

Worcestershire Health and Care NHS
NHS Trust

Male Catheterisation

Only appropriately trained staff who are competent and confident should carry out male catheterisation.

Procedure.	Rationale.
Explain and discuss procedure with patient, obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Consider and check for any allergies patient may have e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport	To ensure that the patient fully understands the procedure and gives valid consent (NMC 2015). Please note that patients with spinal cord injury at T6 and above may be prone to Autonomic Dysreflexia and some patients may be at risk of a vasovagal attack when lay in a supine position.
Assist patient into the semi recumbant position with legs extended. Do not expose patient at this stage of the procedure.	To enable good access to genital area To maintain patients privacy and dignity.
Ensure a good light source	To enable genital area to be seen clearly to aid procedure.
Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy.	To reduce the risk of infection.
Put on disposable plastic apron	To reduce the risk of infection.
Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.	To avoid over reaching and minimise airborne contamination. To ensure correct catheter is used.
Using an aseptic technique open catheterisation pack.	To ensure items remain sterile.
Remove cover that is maintaining patients dignity. Position a disposable pad under patient's buttocks and thighs.	To ensure patient dignity is maintained for a long as possible. To ensure urine does not leak onto bedclothes.
Decontaminate hands or use alcohol hand gel.	Hands may become contaminated while opening outer packs or preparing patient for

	catheterisation.
Put on sterile gloves.	To reduce the risk of infection.
Appropriately place sterile drape around penis.	To create a sterile field.
With one hand wrap a sterile towel around the penis. Retract the foreskin if necessary, with the other hand cleanse the glans penis with 0.9% sodium chloride.	To reduce the risk of introducing infection into the urinary tract during catheterisation.
Remove gloves and decontaminate hands with soap and water or use alcohol hand rub	To reduce the risk of cross infection.
Put on sterile Gloves	To reduce the risk of cross infection.
Holding the penis upright insert the nozzle of the lubricating gel (as per manufacturers guidelines) into the urethra. Instill gel slowly, remove nozzle and discard. Wait 5 minutes (as per manufactures instructions) before continuing with procedure.	Adequate lubrication helps prevent urethral trauma and infection. Use of a local anaesthetic minimises the discomfort experienced by the patient. To prevent anaesthetic gel from escaping. To allow gel to take full effect.
Remove gloves and apron and wash hands. Apply pair of sterile gloves and apron from catheterisation pack. Place receiving bowel between patients legs	To reduce the risk of cross infection To provide a temporary container for urine as it drains
Proceed with catheterisation holding the penis at angle of 45 degrees from abdomen, and extending slightly, expose the tip of the catheter from the inner wrapping insert the catheter into the urethra pushing gently and slowly, and simultaneously remove wrapping until urine appears.	Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter. The prostate gland surrounds the urethra just below the neck of the bladder and consists of much firmer tissue. This can enlarge and cause obstruction, especially in older men.
If resistance is felt do not force the catheter, encourage the patient to relax and try to pass urine. If resistance continues, medical advice should be	Resistance may be due to insufficient anaesthesia or muscle spasm. Asking the patient to breathe deeply can help overcome spasm.

sought.	
When urine drains advance catheter almost to its bifurcation. Gently inflate balloon according to manufactures guidance. Withdraw catheter slightly and apply drainage bag and catheter securing device. Ask the patient to report any discomfort and observe closely for signs of distress	Advancing the catheter ensures it is correctly positioned in the bladder. The male urethra is approximately 18-22cm long. Inadvertent inflation of the balloon into the urethra causes pain and trauma/bleeding.
When the catheter is in situ, the foreskin must be drawn back over the glans penis	This is to prevent paraphimosis occurring
Make the patient comfortable and ensure catheter is draining adequately	To promote patient dignity. To reduce the risk of urethral and bladder neck trauma
Dispose of equipment according to local policy, remove personal protection equipment and wash hands	To prevent environmental contamination
Record information in relevant documents this should include, consent given, reasons for catheterisation, date and time of catheterisation, catheter type, length and size, batch number, amount of water instilled into balloon, manufacturer and batch number of anaesthetic gel used and any problems during the procedure	To provide a point of reference or comparison in the event of later queries

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

Appendix 6

Worcestershire Health and Care NHS
NHS Trust

Female Catheterisation

Only appropriately trained staff who are competent and confident should carry out male catheterisation.

Procedure.	**Rationale.**
Explain and discuss procedure with patient, obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Consider and check for any allergies patient may have e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport	To ensure that the patient fully understands the procedure and gives valid consent (NMC 2015). Please note that patients with spinal cord injury at T6 and above may be prone to Autonomic Dysreflexia and some patients may be at risk of a vasovagal attack when lay in a supine position.
Lie patient in semi-recumbent position with knees bent and abducted to either side as far as possible. Alternatively, if the meatal opening is concealed, it may be easier to find with the patient in the left lateral position, with her knee drawn up to her chest. Do not expose patient at this stage of the procedure.	To enable good access to genital area To maintain patients privacy and dignity.
Ensure a good light source	To enable genital area to be seen clearly to aid procedure.
Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy.	To reduce the risk of infection.
Put on disposable plastic apron	To reduce the risk of infection.
Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.	To avoid over reaching and minimise airborne contamination. To ensure correct catheter is used.
Using an aseptic technique open catheterisation pack.	To ensure items remain sterile.
Remove cover that is maintaining patients dignity. Position a disposable pad under	To ensure patient dignity is maintained for a

patient's buttocks and thighs.	long as possible. To ensure urine does not leak onto bedclothes.
Decontaminate hands or use alcohol hand gel.	Hands may become contaminated while opening outer packs or preparing patient for catheterisation.
Put on sterile gloves.	To reduce the risk of infection.
Clean genital area downwards with normal saline (0,9% sodium chloride) and cotton wool. Separate labia whilst cleaning, using gauze swabs.	To reduce the risk of infection.
Remove gloves and decontaminate hands with soap and water or use alcohol hand rub	To reduce the risk of cross infection.
Put on sterile Gloves	To reduce the risk of cross infection.
Insert the nozzle of the lubricating gel (as per manufacturers guidelines) into the urethra. Instill gel slowly, remove nozzle and discard. Wait 5 minutes (as per manufactures instructions) before continuing with procedure.	Adequate lubrication helps prevent urethral trauma and infection. Use of a local anaesthetic minimises the discomfort experienced by the patient. To prevent anaesthetic gel from escaping. To allow gel to take full effect.
Remove gloves and apron and wash/cleanse hands. Apply pair of sterile gloves from catheterisation pack. Place receiving bowel between patients legs	To reduce the risk of cross infection To provide a temporary container for urine as it drains
Expose the tip of the catheter from the inner wrapping insert the catheter into the urethra pushing gently and slowly, and simultaneously remove wrapping until urine appears. Advance the catheter approximately 5-6 cm.	The direction of insertion and the length of catheter inserted should relate to the anatomical structure of the area
When urine drains advance catheter a little further. Gently inflate balloon according to manufactures guidance. Withdraw catheter slightly and apply drainage bag and catheter securing device. Ask the patient to report any discomfort and observe closely for signs of distress	Advancing the catheter ensures it is correctly positioned in the bladder. Inadvertent inflation of the balloon into the urethra causes pain and trauma/bleeding.

Make the patient comfortable and ensure catheter is draining adequately	To promote patient dignity. To reduce the risk of urethral and bladder neck trauma
Dispose of equipment according to local policy, remove personal protection equipment and wash/cleanse hands	To prevent environmental contamination
Record information in relevant documents this should include, consent given, reasons for catheterisation, date and time of catheterisation, catheter type, length and size, batch number, amount of water instilled into balloon, manufacturer and batch number of anaesthetic gel used and any problems during the procedure	To provide a point of reference or comparison in the event of later queries

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

Appendix 7

Worcestershire Health and Care NHS
NHS Trust

Suprapubic Catheter Change

Only appropriately trained staff that are competent and confident should change a suprapubic catheter.

Procedure	Rationale.
Explain and discuss procedure with patient, obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Consider and check for any allergies patient may have e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport	To ensure that the patient fully understands the procedure and gives valid consent (NMC 2015). Please note that patients with spinal cord injury at T6 and above may be prone to Autonomic Dysreflexia and some patients may be at risk of a vasovagal attack when lay in a supine position.
Assist patient to lie flat on the bed and bed protection placed in situ.	To ensure the appropriate area is easily accessible To maintain patient's privacy and dignity.
Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy.	To reduce the risk of infection.
Put on disposable plastic apron	To reduce the risk of infection.
Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.	To avoid over reaching and minimise airborne contamination. To ensure correct catheter is used.
Using an aseptic technique open catheterisation pack.	To ensure items remain sterile.
Wash hands and put disposable plastic apron on and apply sterile gloves. Prepare equipment required. Do not remove inner wrapper from catheter at this stage.	Hands washed to reduce the risk of cross-infection. Disposable apron used to reduce the risk of cross-infection from micro-organisms on uniform. (Laveday et al, 2014).
Cleanse around the insertion site with normal saline	To reduce the risk of infection.
Gently attach syringe nozzle to the valve on the inflation channel of the catheter	Make a mental note of the length of catheter removed from the abdomen as this is the amount

and deflate the balloon without forceably pulling back on the syringe	that needs replacing.
Remove catheter	
Insert the new catheter to the length of catheter that was removed and when urine drains advance it a little further. You may need to gently corkscrew the catheter in. Gently inflate balloon according to manufactures guidance. Withdraw catheter slightly and apply drainage bag and catheter securing device if required. Ask the patient to report any discomfort and observe closely for signs of distress	The new catheter needs to be inserted within approximately 10mins. It should be the same size catheter as the one initially inserted.
Make the patient comfortable and ensure catheter is draining adequately	To promote patient dignity. To reduce the risk of urethral and bladder neck trauma
Dispose of equipment according to local policy, remove personal protection equipment and wash hands	To prevent environmental contamination
Record information in relevant documents this should include, consent given, reasons for catheterisation, date and time of catheterisation, catheter type, length and size, batch number, amount of water instilled into balloon, manufacturer and batch number of anaesthetic gel used and any problems during the procedure	To provide a point of reference or comparison in the event of later queries

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NOTES:

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

Appendix 8

Worcestershire Health and Care NHS
NHS Trust

Intermittent Self-Catheterisation (Male)
Guidance for teaching self catheterisation to male clients

Equipment Required:

- Appropriately sized catheter
- Mirror (optional)

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

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

Procedure	Rationale
Explain and discuss the procedure with the patient using written onformation booklet or DVD.	To ensure that the patient understands the procedure and gives his valid consent (NMC 2015). To enable the patient to feel as comfortable as possible.
Wash hands using soap and water.	To reduce the risk of cross-infection.
Ask the patient to prepare the catheter as per manufacturers instructions.	Ensure correct use of product
If required clean the glans penis and wash hands. If the foreskin covers the penis it will need to be retracted during the procedure.	To reduce risk of infection and ease insertion of catheter.
Ensure the patient is in a comfortable position. E.g., either sitting on toilet; standing upright or lying on the bed.	To facilitate insertion of the catheter.
The penis should be held straight at an angle of 45 degrees towards the abdomen. A stand up mirror is helpful for patients with a large abdomen	To prevent trauma to the penoscrotal junction.
Ask the patient to insert the catheter into the urethra, using aseptic non-touch	The prostate gland surrounds the urethra just below the neck of the bladder and consists of

technique. NB: There maybe a change of feeling as the catheter passes through the prostate gland and into the bladder. Explain if a lot of resistance is felt, DO NOT continue; withdraw and seek medical advice.	much firmer tissue. This can enlarge and cause obstruction, especially in older men.
Drain urine into the toilet or measuring container if possible. When the urine stops flowing slowly remove the catheter, halting if more urine starts to flow.	It is useful to record the volume of residual urine drained to ascertain the frequency with which self-catheterisation is required. To ensure that the bladder is completely emptied.
Explain they should slowly remove the catheter when the flow has ceased and the foreskin drawn back over the glans of the penis.	This is to prevent paraphimosis occurring
Dispose of the catheter in a bag in household waste in if own home or according to local trust policy if in communal care setting.	To reduce risk of environmental contamination
Wash hands using soap and water.	To reduce the risk of infection.
Record information in relevant documents including catheter type, size and batch number and any problems during the procedure	To provide a point of reference or comparison in the event of later queries

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Appendix 9

Worcestershire Health and Care NHS
NHS Trust

Intermittent Self-Catheterisation (Female)
Guidance for teaching self catheterisation to female clients

Equipment Required:

- Appropriately sized catheter
- Mirror (optional)

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

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

Procedure	Rationale
Explain and discuss the procedure with the patient using written information booklet or DVD.	To ensure that the patient understands the procedure and gives his valid consent (NMC 2015). To enable the patient to feel as comfortable as possible.
Wash hands using soap and water.	To reduce the risk of cross-infection.
Ask the patient to prepare the catheter as per manufacturers instructions.	Ensure correct use of product
Ensure the patient is in a comfortable position. Eg, either sitting on toilet; standing upright or lying on the bed.	To facilitate insertion of the catheter.
Using a mirror, if required, ask the patient to locate and spread the labia to expose the urethra. If required the meatus and labia are cleaned from front to back using soap and water and then wash hands.	To enable the urethra being found easier. To reduce the risk of infection.
Using less dominant hand ask the patient to find the urethral opening above the vagina. A mirror can be used to help identify	To reduce the risk of introducing an infection.

anatomy. Gently insert the catheter into the urethra using dominant hand, maintaining an aseptic no touch technique.	
Drain the urine into the toilet or suitable measuring container. When the urine stops flowing, slowly remove catheter, halting if more urine starts to flow.	It is useful to record the volume of residual urine drained to ascertain the frequency with which self catheterisation is required. To ensure that the bladder is completely emptied.
Dispose of the catheter in a bag in household waste in if own home or according to local trust policy if in communal care setting.	To reduce risk of environmental contamination.
Wash hands using soap and water.	To reduce the risk of infection.
Record information in relevant documents including catheter type, size and batch number and any problems during the procedure	To provide point of reference or comparison in event of later queries.

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Appendix 10

Worcestershire Health and Care NHS
NHS Trust

Obtaining a Catheter Drainage Specimen of Urine, using needle free port

Equipment:

- Plastic Apron
- Sterile gloves
- Sterile 5 ml syringe with tip
- Sterile urine specimen container with boric acid
- Laboratory request card and bag

Procedure	Rationale
Explain procedure to patient	So that the patient is fully informed.
Wash and dry hands and apply sterile gloves and apron	To reduce risk of infection
Insert syringe to needle free port	To allow urine to be drawn up
Aspirate approximately 5mls and place the urine in the sterile container.	To allow adequate collection of urine for analysis.
Remove gloves and wash/cleanse hands	
Label specimen, complete request card and send to laboratory. The specimen should be kept in a fridge if it is not sent for testing within 4 hours.	To allow accurate analysis
Record information in patients documentation	

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Appendix 11

Worcestershire Health and Care NHS
NHS Trust

Using a Bladder Maintenance Solution

Equipment:

- Plastic Apron
- Non sterile gloves
- Sterile gloves
- Appropriate maintenance solution
- Sterile urine drainage bag

Procedure	Rationale
Explain the procedure to the patient	So that the patient is fully informed
Protect bed or chair	
Prepare solution in accordance with manufacturer's instructions	The solution should be at body temperature to prevent discomfort.
Wash hands and put on plastic apron and apply non sterile gloves, empty urine drainage bag and dispose of urine according to local policy.	To reduce the risk of infection.
Position comfortably, ensuring ease of access to the catheter. Remove gloves.	Maintain privacy and dignity through procedure.
Wash/cleanse hands and put on sterile gloves.	Handling of the irrigation system and catheter should be performed aseptically.
Disconnect leg bag or flip flow valve Holding catheter 3 cm from end, insert solution connector into catheter.	To ensure good connection and prevent urine leakage.
Perform irrigation, following manufacturer's instructions.	To ensure patient safety and comfort.

Remove connector from catheter and re-connect to sterile drainage bag.	To reduce the risk of infection.
Remove gloves, apron and wash hands. Dispose of equipment according to trust policy	To reduce risk of infection.
Record procedure and any problems in patients documentation.	To provide a point of reference or comparison in the event of later queries.

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Appendix 12

Worcestershire Health and Care NHS
NHS Trust

Emptying a Urine Drainage Bag

Equipment:

- Plastic Apron
- Non sterile gloves
- Suitable Receptacle e.g. jug, urinal (single use or processed through approved washer in In hospital settings this should be single use or processed through approved washer.
  In community settings (patient's own home) this must be single patient use and left clean and dry
- 70% Isopropyl Alcohol Swab

(Use of a 70% isopropyl alcohol swab is recommended only in health care settings)

Procedure	Rationale
Explain and discuss the procedure with the patient.	To ensure that the patient understands the procedure and gives their valid consent (NMC 2012)
Wash hands using soap and water. Apply apron and gloves.	To reduce the risk of cross-infection (Loveday et al, 2014)
Open outlet valve and allow the urine to drain into appropiate measuring jug.	To empty drainage bag and accurately measure volume of contents.
Close the outlet valve and wipe with alcohol swab	To prevent leakage of urine.
Cover the receptacle and dispose of contents, having noted the amount of urine if this is requested for fluid balance records.	To reduce the risk of environmental contamination (Loveday 2014)
Remove gloves and apron and wash hands with soap and water.	To reduce risk of infection (Loveday 2104)
Record output and any problems in patient's documentation.	To provide point of reference or comparison in event of later queries.

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Appendix 13

Changing a Urine Drainage Bag

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

Equipment:

- Plastic Apron
- Sterile gloves
- Sterile urine drainage bag

Procedure	**Rationale.**
Explain and discuss the procedure with the patient.	So that the patient is fully informed.
Release leg support	To aid removal of bag
Protect bed	
Wash hands, apply apron and gloves	To reduce risk of infection (Loveday 2104)
Loosen cap of new catheter tubing. Pinch the catheter 3-5 cm from its end and disconnect old drainage bag, raising the end of the tubing to drain residual urine into the bag.	To prevent infection and prevent urine leaking from tubing.
Holding new bag tubing 3-5 cm from its end, connect to catheter.	
Secure catheter to body and bag to leg. Make patient comfortable.	To prevent urethral trauma
Remove used bag and measure and record volume of urine if required	
Remove gloves and apron.	To prevent infection (Loveday 2014)
Wash hands and record intervention and any problems in patient's documentation.	To provide point of reference or comparison in event of later queries.

Appendix 14

Worcestershire Health and Care NHS
NHS Trust

Removal of an Indwelling Catheter

Equipment:

- Dressing pack including :
  Non-sterile gloves
  Plastic Apron
  Gallipot
  Gauze swabs
- Normal saline sachet
- 10 ml syringe
- Citric Acid 6% (e.g Solution R) if appropriate
- Suitable receptacle for collection

A citric acid washout solution may be used prior to removal, if encrustation is suspected in long-term catheterised patients.

Once the balloon has been deflated, the patient may remove his own catheter under supervision.

Procedure	**Rationale.**
Explain procedure to patient and inform them of potential post catheter removal symptoms. Which can include urgency, frequency, discomfort and urinary tract infection.	To obtain valid consent. Removal or change of catheter can cause irritation of urethra from the catheter.
Wash hands using soap and water. Put on disposable gloves.	To reduce risk of cross infection (Loveday et al, 2014)
Protect bed. Using normal saline clean the meatus swabbing away from the catheter and urethral opening. Note: in women, never clean from the perineum/vagina towards the urethra.	To reduce the risk of infection. To help reduce the risk of bacteria from the vagina and perineum contaminating the urethra.
Release leg support	For easier removal of catheter.
Having checked volume of water in balloon (see patient documentation), use syringe to deflate balloon.	To confirm how much water is in the balloon. To ensure balloon is completely deflated before removing catheter. Note if the catheter has been in place for several weeks you may not get exactly the same volume of water back due to osmosis. Usually about 1-3 mls less.

Ask patient to breathe in and then out; as patient exhales, gently (but firmly with continuous traction) remove catheter. Male patients should be warned of discomfort as the deflated balloon passes through the prostate gland.	To relax pelvic floor muscles.
Make patient comfortable and dispose of equipment according to local policy. Remove personal protection equipment and wash hands.	To maintain patient comfort and dignity. To prevent environmental contamination
Record information in relevant documentation including any problems with the procedure.	To provide a point of reference or comparison in the event of later queries To prevent urinary tract infections.

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

- Inspect catheter on removal for encrustation, damage etc., and establish future catheter selection and optimum time for next catheter change
- If standard deflation procedure fails, it is NOT recommended the inflation channel is cut off or the balloon is re-inflated.
- If unsuccessful, refer for medical advice

Equality Analysis

Worcestershire Health and Care NHS
NHS Trust

Title of Policy/Function (Function Includes: Services; Projects; Strategy; Processes; Systems; Practices; Procedures; Protocols; Guidelines; Care Pathways etc..) Catheter Care Guidelines (Adults)	New	Existing/Revised Revised
Short description of Policy/Function (aims and objectives, is the policy/function aimed at a particular group if so what is the intended benefit): Establish a framework for catheter care management and provide nurses working in Worcester Health and Care Trust with the support, knowledge and evidence of good practice necessary to enable them to manage catheter care safely and competently.		

Name of Lead/Author(s)	Job Title	Contact details
Elaine Sutcliffe	Continence Team Leader	01905 681522

When the policy/function involves patients/staff/partners/stakeholders etc please where possible include them in the Equality Analysis to demonstrate openness, transparency and inclusion and particularly by those who this policy/function is most likely to have impact.

Does this Policy/Function have any potential or actual impact that is positive(+), neutral (N) or negative (-) impact on the following protected characteristics please indicate:				
	+	N	-	**Please provide a rational/justification for <u>each</u> of the following regardless of impact**
Age		x		Applies to a wide age group. Specifically adults – legal definition is 18 years and above
Disability	x			Adapt practice to individual need. This was demonstrated when teaching a visually impaired patient to do intermittent self catheterisation. Additional support and explanation was given
Gender Reassignment		x		Caution may be needed and necessary specialist advice and support sought when needed
Pregnancy & Maternity		x		Both mother and child welfare would be assessed and specialist advice sought if necessary. Selection of appropriate catheters and close monitoring would be necessary
Race		x		Information about care and interventions would be given in a way informed consent could be obtained. Other bladder management options would be considered if consent withheld
Religion & Belief		x		Plan of care and treatment plan would be discussed to ensure informed consent is given
Sex		x		Gender neutral

Sexual orientation		x		Guidelines take into consideration sex and sexuality
Marriage & Civil Partnership		x		

Other Groups who could experience inequality, eg carers, homeless, travelling communities, unemployed, people resident within deprived areas, different socio/economic groups eg low income families, asylum seekers/refugees, prisoners, people confined to closed institutions or community offenders, people with different work patterns eg part-time, full-time, job-share, short-term contractors or shift workers - *Access, location and choice of venue, timings of events and activities. Support with caring responsibilities*

Most interventions done at home irrespective of individual circumstances

Analysis conducted by: (minimum of 3 people)			
	Name	Job Title	Contact details
1	Elaine Sutcliffe	Continence Team Leader	01905 681522
2	Tracey Walker	Continence Advisor	01905 681601
3	Kim Brant	Continence Nurse	01905 681601

Reference/Version: 2	Date Equality Analysis completed:	D	D	M	M	Y	Y
		3	0	0	3	1	7

If you have identified a potential discriminatory impact on the policy/function please refer it to the author together with suggestions to avoid or reduce the impact.

A copy of the completed Equality Analysis must be attached to the policy/function and a copy sent to:

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