

# Urinary Catheter Care in the Community (Adults) Guidelines

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## Summary of Key Points

- The purpose of this guideline is to provide a clear framework of evidence based practice, and a source of reference to support staff to provide safe and competent catheter care in the community.
- It identifies when catheters should be used and the associated benefits and risks. It sets out to reduce the incidence and consequences of urinary tract infections and complications associated with short and long term catheters.
- Risks are reduced by complying with all parts of the process for patient assessment, safe catheterisation, catheter care and removal as soon as no longer needed. This is important in terms of promoting comfort, safety and infection prevention measures. (NICE 2014)
- This guidance includes advice on practices and procedures such as assessing the need for catheterisation, selection of catheter type, catheter maintenance and management, education of patients, relatives and healthcare workers to ensure appropriate management minimises the risk of infection and complications. It reflects EPIC 3 (2013) guidance and NHS Improvement and Infection Prevention Society (2017) High Impact Intervention for urinary catheter care and management.

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## Version History

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V3	30.4.21	Trust Medical Director	-
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V3	30.4.21	Deputy Director of Nursing	Wording regarding who will adopt the guidelines Refresher course is required not recommended If lack capacity refer to consent policy
V3	30.4.21	Lead for Training and Resuscitation	-
V3	30.4.21	Chief Pharmacist	-
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## 1. Introduction

Urinary catheterisation is an invasive procedure 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.

## 2. Purpose of Document

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 for Herefordshire and Worcestershire Health and Care Trust who undertake catheter care and teach others as part of their role. These guidelines also apply to student nurses and trainee nursing associates, under the supervision of a Registered nurse or other Registered Health and Social care professional.
- 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 maintain competence within their role and field of practice and use guidelines to promote and demonstrate good practice (RCN, 2019). They must have attended a training course normally accessed through the Community Continence service. Face to face and online catheter study sessions are available via learning and development.
- 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 2019)
- c. Competence will be achieved through observation, relevant practice and supervision in the clinical setting by a competent assessor and using the competency framework. This competence document can be accessed when attending a catheter course with the continence team and the learning and development unit will keep a record of competent health care professionals.
- 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 that they are familiar with these guidelines.
- f. Staff entering the Trust who has 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. Staff are required to refresh their knowledge and skills every 5 years. Retraining/reresher/update courses 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. NMC registered staff carrying out catheter care interventions are reminded that they should at all times adhere to the NMC Code (2018) and work within their competence and job description. They also have a responsibility to take account of their patient's informed choices and needs. Patients may request a certain gender of nurse to catheterise them or provide catheter care, due to their religious beliefs or personal nature of the procedure. Also some patients may require the option of being catheterised in a setting other than their home environment.
- b. Registered Nurses and Nursing Associates have a responsibility to ensure they feel confident and competent in the knowledge and skills of practice (NMC, 2018) 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 member of staff is able to obtain required competence.
- d. NMC registered staff 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.

## 7. Consent

Verbal or expressed consent is required prior to the procedure/intervention. Interventions must be comprehensively documented in the patient's record and written in such a way that demonstrates the patient's informed consent. If the patient lacks mental capacity regarding catheter insertion/removal/care the assessment of this must be documented in line with the Trusts consent policy. 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.

(RCN, 2019)

## 9. 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
  - History of repeated urinary tract infections
  - Chronic wounds requiring dressings will potentially cross-infect the catheter and drainage system;
  - Organ transplant

(RCN, 2019)

- 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 Enterobacteriaceae (CPE) make it imperative to ensure full patient review and appropriate choice of agent.

- f. Practitioners should be vigilant and understanding regarding issues such as gender realignment or resistance to partake in catheterisation. Practitioners need to enquire about birth gender and preferred gender and also if a female presents with symptoms related to urology/urogynaecology you must ask specifically about female genital mutilation (FGM). In accordance with the new mandatory recording requirements the practitioner should document in patients notes if the patient has undergone FGM, the type, family history and type of procedure carried out. More information is available about FGM in the Trust safeguarding policy CL-194, available via the intranet and RCN Female Genital Mutilation guidance for sexual health care (2020).

## 10. 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, carrier 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 para phimosis
- If urine drained, the amount, colour, smell and if necessary dipstick and record the results
- If no urine drained document what actions were taken
- If urine specimen sent and why
- 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, 2019)

### 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, 2019)

- 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 the clinical record.

## **11. End of Life Care**

- a. Indications for catheterisation 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.
- 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, 2019)

## **12. Acute painful retention**

An approved pathway is in place within Worcestershire for the management of acute retention in males. (See Appendix 2) This includes urgent referral to a GP who will discuss the patient with the on call urologist, patients may subsequently be catheterised in the community, Accident and Emergency or surgical admissions unit. All females with acute retention should be referred urgently to their GP who, if necessary can discuss the patient with the on call urologist or urogynaecologist.

## **13. Trial without catheter (TWOC)**

- a. Trial without catheters are often performed by the acute team who initially inserted it. However there are instances when a planned trial without

catheter may be performed in the community for example acute retention, post trans-urethral resection of prostate, post urethral stricture surgery and general post surgery retention. The health professional must feel confident and competent to perform the procedure and have adequate knowledge why the procedure is being performed. If not, they must contact the medical/nursing team who have been caring for the patient. The use of a bladder scan can help assess the success of the TWOC, but when a scanner is not available fluid balance charting and signs and symptoms of retention and voiding difficulties will be used. It is common for men to be started on an alpha blocker prior to a TWOC.

- b. Community TWOC is not suitable for the following patients:
  - Radical prostatectomy ( usually in the last 3 months)
  - Radical cysto-prostatectomy
  - Known bladder perforation
  - Who have experienced significant previous problems with insertion of catheter
  - Those unable to concord with the guidance
- c. Those patient who may be more likely to fail a TWOC include:
  - Pre existing bladder and bowel problems including constipation
  - Co morbidities and over 75 years
  - Long standing catheters
  - Previously failed TWOCs
  - Supra pubic catheters
  - Large prostate before resection surgery
  - Residuals of over 1000mls when patient was first catheterised
- d. See Appendix 1

## 14. 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 (RCN, 2019). It is a clean procedure and has a reduced infection rate to an indwelling catheter; however caution should be shown with patients following prostatic, bladder neck or urethral surgery, in patients with stent or artificial prosthesis or female genital mutilation. It should be taught by a competent experienced specialist nurse

(RCN, 2019) 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 and be aware of autonomic dysreflexia (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 preference due to needs for comfort and accessibility e.g. wheelchair users, sexual issues
- 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 are usually performed in the Acute Trust by the team who did the initial insertion. If information about this first change is not available on the discharge summary then it should be clarified with the Acute Trust. If a first change is to be performed in the community the health professional must have adequate information about the patients past medical/surgical and urological history and ease with which the initial catheter was inserted and any complications. 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.

- i. First changes should not be within 4 weeks to allow the tract to form (EAUN, 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. Depending on the catheter used, first and subsequent suprapubic catheters changes are usually every 10-12 weeks. However, spinal units usually recommend supra pubic catheter changes in the spinal injured patient to be changed every 6 weeks. This is to reduce calculi formation/encrustation, infection and spasticity within the bladder. Some spinal units recommend filling the bladder before suprapubic catheter changes and more information about this is available from the continence service.
- k. Over granulation can be avoided by preventing friction and adequate securing of the catheter. Haelan tape/cream can be used (Wounds International, 2012) or a foam dressing.
- l. Catheterisation procedures are included in Appendices (4, 5, 6, 7, 8, 9 and 10).

## 15. 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, 2019)
  - 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 is approximately 1.5 -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 2019) 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
  - Instillation of a bladder maintenance solution
- 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, 2020) 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, when 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
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, short/female length and standard/male length. Following a National Patient Safety Agency (2009b) alert regarding caution against use of short female length catheters in males the Trust has decided that only standard/male length catheters must be used for both men and women, UNLESS teams have sought specific guidance around use of a female length catheter from the Continence Team following holistic, individualised assessment. It is recognised that there may be existing patients on caseloads using the female length catheter. In these circumstances care plans must reflect holistic rationale for use and note consultation with the Continence Team. Teams should not hold any stocks

of shorter female catheters. Where required these must be ordered for individual patients and a standard/male catheter used until the shorter/female length is obtained; and preferable changed when the next planned catheterisation is due to reduce infection.

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

### 15.2 Charrier Size

- a. Indwelling catheters are measured in Charrier and the smallest size should be chosen to avoid discomfort, leakage and maintain adequate drainage. A large diameter may cause increased bladder irritability which can result in bladder spasms and catheter bypassing.
- b. Size 12CH – 14CH is suitable for the majority of female patients, 12CH – 16CH for males and 16CH to 18CH are usually used for suprapubic catheterisation.

### 15.3 Balloon Size

- a. The standard balloon is inflated with 10ml of sterile water to keep the catheter in place and this amount is thought to cause less irritation of the bladder mucosa. (Loveday *et al*, 2014) The balloon must only be inflated and deflated once as per manufacturer's instructions. Under inflation of the balloon can cause occlusion of the drainage holes or the catheter becoming dislodged. Over inflation of the balloon risks balloon rupture, bladder spasm and catheter bypassing.
- b. A 30ml balloon should only be used on a three way irrigating catheter i.e. urology patient and would not be used in the community.

### 15.4 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, 2019) (See Appendix 11.)
- b. Those who have had a catheter for over 30 days will have bacteria present in the bladder/urine without an infection. For patients over 65 this asymptomatic bacteriuria is not harmful and although causes a positive urine dipstick, antibiotics are not beneficial. Urine samples should only be taken if the patient is symptomatic of a urine infection and via the needle free port on the drainage bag using an aseptic technique. (Public Health England, 2019).

### 15.5 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.

## 15.6 Bathing with a Catheter

- a. The leg drainage bag should not be disconnected but should be emptied before bathing and ideally 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.

## 15.7 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 are changed every 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. They would not be used if there was urethral reflux, renal impairment, urine infection, following radical prostatectomy, radical cysto-prostatectomy, bladder perforation or neobladder.
- 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. 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 and prescribed 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. (RCN, 2019)
- 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 (Yates, 2018).
- 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. The use of Triclosan antimicrobial solution (Farcofil) to inflate the balloon has the potential to reduce blockages and improve encrustation. (NICE, 2017). However this is not first line treatment. Farcofil should be changed every 28 days and re catheterisation is required to do this. For more information contact the continence service.
- j. Procedure is included in Appendix 12 and competency in Trust documentation library.

## 17. 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 antibiotic prophylaxis may be considered for patients with long term catheters who have a history of recurrent or severe urinary tract infection (RCN, 2019)
- d. Catheters should be changed as soon as possible when a bacterial infection has been confirmed or suspected. The clinical evidence is

limited, but expert opinion recommends this should be immediately (if patient is stable and comfortable) or within 48-72 hours of starting antibiotic treatment (European Association of Urology, 2012; RCN, 2019)

## **18. Changing of Urine Drainage Bags – Day and Night**

- a. Leg bags should be changed every 5 -7 days (DH Drug Tariff, 2020) or when there is accumulation of sediment, leakage, when a new catheter is inserted, or when a maintenance solution has been used.
- b. In a care home setting leg and night drainage bags 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.
- c. A new disposable night bag is used each night.
- d. For patients who are bed bound, a drainable sterile 2 litre drainage bag may be connected directly to the catheter and left in situ for 5-7 days.
- e. See Appendix 13 and 14 for emptying and changing a catheter bag.

## **19. Removal of an Indwelling Catheter**

- a. For procedure see Appendix 5

## **20. 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. Continence Product Formulary**

- a. The Community Continence Product Formulary has been produced to give practitioners advice and support when choosing/prescribing catheters, catheter related equipment and required quantities. The formulary provides guidance to prescribers for first line products and is not intended to restrict patient choice. Copies can be obtained from the community continence service or via the continence intranet page.

## 22. Monitoring Implementation

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

Aspect	Percentage	Exception
<u>Annual Audits</u>		
Inpatient settings: Audit all inpatient beds on a given day to check that every patient who has a catheter has a catheter passport. Y/N	100%	Intermittent self catheterisation
Neighbourhood Teams: Audit all patients on each Neighbourhood Team Caseload with a catheter to determine that each patient has a catheter passport Y/N	100%	Intermittent self catheterisation
One off policy change audit: Neighbourhood Teams will be asked to identify how many patients on their current caseloads have short/female length catheters	100%	None
All qualified staff involved in catheter care have attended training or update in the last 5 years	100%	Exempt staff
In addition all incidents, complaints or patient feedback relating to catheter care will be reviewed by service managers and the continence team	100%	None

## 23. References

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[Yates A \(2018\) Using patency solutions to manage urinary catheter blockage. Nursing Times 114:5,18-21](#) (Accessed 8<sup>th</sup> April 2021)

## 24. Associated Documentation

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 2019
- Loveday et al, EPIC 3 National Evidence Based Guidance for Prevention of Hospital Acquired Infections 2014
- Worcester Health and Care Trust Community Continence Product Formulary
- Worcester Health and Care Trust Urinary Catheter Passport
- Worcester Acute Hospitals NHS Trust Urinary Catheter Insertion, Care, Management and Removal policy WHAT-INF-042
- Wye Valley NHS Trust Policy on the management of indwelling urinary catheters in adults

## 25. Appendices

[Appendix 1 - Trial Without Catheter \(TWOC\)](#)

[Appendix 2 - Management of Acute Retention in Males](#)

[Appendix 3 - Autonomic Dysreflexia](#)

[Appendix 4 - Catheterisation Procedure: requirements](#)

[Appendix 5 - Removal of an Indwelling Catheter](#)

[Appendix 6 - Male Catheterisation](#)

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[Appendix 8 - Suprapubic Catheter Change](#)

[Appendix 9 - Intermittent Self-Catheterisation \(Male\)](#)

[Appendix 10 - Intermittent Self-Catheterisation \(Female\)](#)

[Appendix 11 - Obtaining a Catheter Drainage Specimen of Urine, using needle free port](#)

[Appendix 12 - Using a Bladder Maintenance Solution](#)

[Appendix 13 - Emptying a Urine Drainage Bag](#)

[Appendix 14 - Changing a Urine Drainage Bag](#)

### Appendix 1 - Trial Without Catheter (TWOC)

- TWOC's are likely to be performed in the community following acute retention, post trans urethral resection of prostate, post urethral stricture surgery and general post surgery retention.
- The health professional must feel confident and competent to perform the procedure and have adequate knowledge why the procedure is being performed. If not, they must contact the medical/nursing team who have been caring for the patient.

- The use of a bladder scan can help assess the success of the TWOC, but when a scanner is not available fluid balance charting and signs and symptoms of retention and voiding difficulties will be used.
- It is common for men to be started on an alpha blocker prior to a TWOC.
- Community TWOC is not suitable for the following patients:
  1. Radical prostatectomy (usually in the past 3 months)
  2. Radical cysto-prostatectomy
  3. Known bladder perforation
  4. Who have experienced significant previous problems with insertion of catheter
  5. Those unable to concord with the guidance
- Those patient who may be more likely to fail a TWOC include:
  1. Pre existing bladder and bowel problems including constipation
  2. Co morbidities and over 75 years
  3. Long standing catheters
  4. Previously failed TWOCs
  5. Supra pubic catheters
  6. Large prostate before resection surgery
  7. Residuals of over 1000mls when patient was first catheterised

#### **Prior to TWOC:**

- Ensure hydration levels are good and recommend 1.5-2 litres a day
- Review medications which may cause retention(e.g. Anti cholinergics, opiates)
- In men, consider an alpha blocker 24-48 hours prior to the TWOC
- Check for constipation, defer TWOC if constipation is not rectified
- Check for signs of systemic urine infection – do not do urinalysis
- Where possible ensure a catheter valve has been in situ for 2-4 weeks
- Ensure a spare catheter pack and equipment is available in case TWOC fails
- Advise patient they will need a measuring jug to record urine output post TWOC
- Explore how to promote continence and manage possible incontinence

#### **Day of TWOC**

- Explain the procedure to the patient
- Remove catheter early morning
- Commence an accurate fluid balance chart and encourage intake of 200mls every 1-2 hours
- Ensure patient is aware of signs of retention including:
  - a) Increased frequency
  - b) Passing small volumes of urine
  - c) Rate of urine flow eg dribble
  - d) Lower abdominal pain
  - e) Hesitancy to void
  - f) Feeling of incomplete emptying
- Ensure patient has contact details of the health professional carrying out the TWOC
- Review after 4-6 hours, or before if requested and the health professional will use the above symptoms to determine the outcome of the TWOC
- Voided volumes should ideally be consistently greater than 200mls

**If bladder scanner is not available**

- Review input/output chart and symptoms to assess success of TWOC. Voided volumes of 200mls or more without retention symptoms indicate success. Document the outcome and review the next day if in doubt. Inform professional who requested TWOC and establish if review required. 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 bladder scanner is available**

- If the post void scan is less than 100mls the TWOC is successful. Inform professional who requested TWOC and establish if review required. 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 post void residual bladder scan is 100-300mls and patient is able to void:

- a) Advise double voiding
- b) Only insert catheter if showing signs of retention
- c) Reinforce signs of retention
- d) 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
- e) If scans are consistent review following day and discuss with GP

If post void residual scan is 300-500mls and patient is able to void:

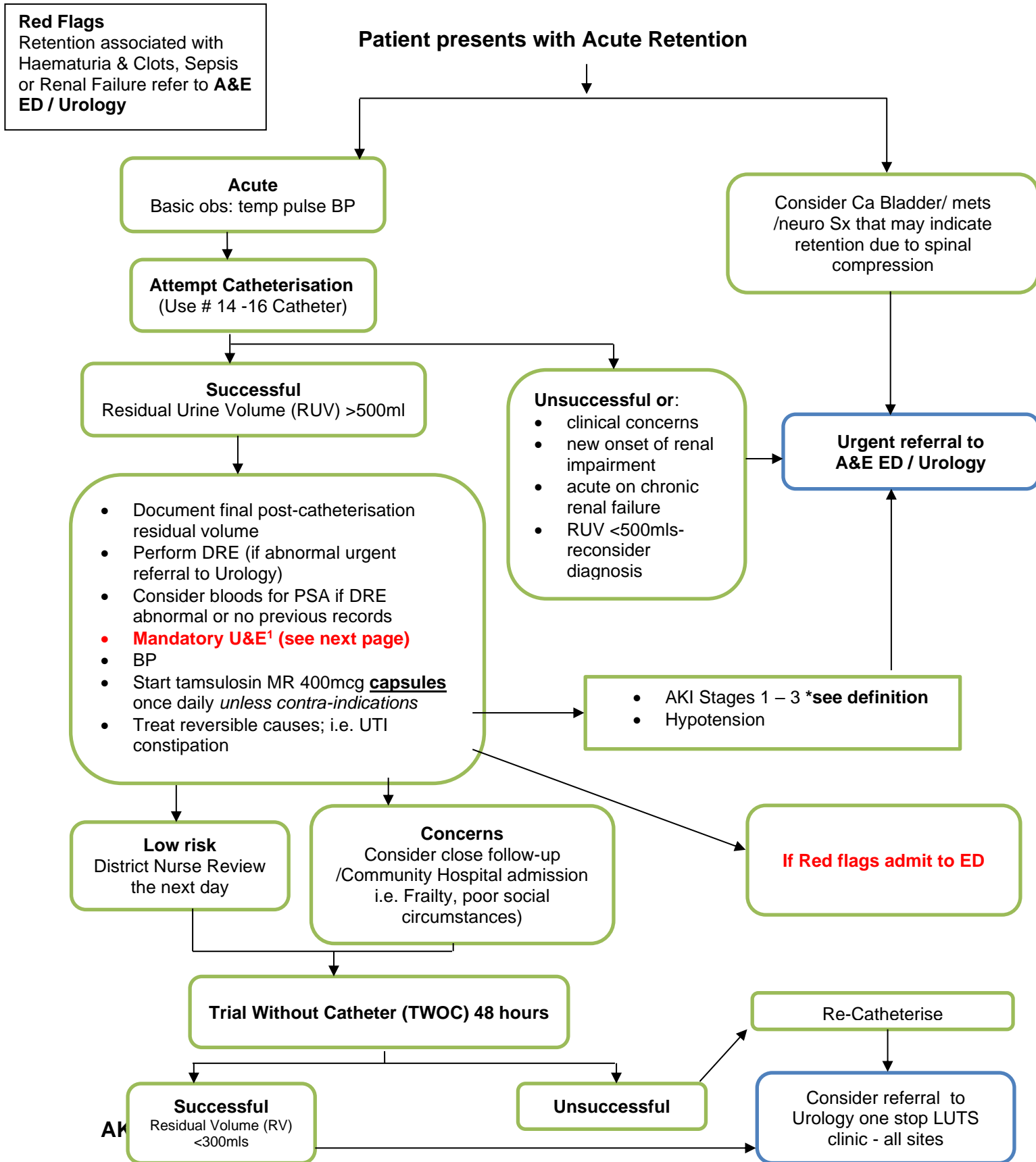
- a) Consider intermittent self catheterisation or re catheterisation if demonstrating signs of retention.
- b) Give the patient advice about healthy bladder advice, symptoms of a urinary tract infection and what to do if they are concerned or develop voiding difficulties.
- c) Discuss with GP

If post void residual scan is 300-500mls and patient is unable to void or has signs of retention:

- a) Reinsert catheter
- b) Discuss with GP, inform professional who requested TWOC and arrange follow up

These guidelines follow latest recommendations as referenced in the main catheter guideline document.

Appendix 2 - Management of Acute Retention in Males



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  $\geq 355$  AND increased to  $\geq 1.5$  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<sup>1</sup>**

**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**

[National Institute for Health and Clinical Excellence \(NICE\). The management of lower urinary tract symptoms in men. London: NICE; 2010.](#)

Map of Medicine (MoM) Clinical Editorial team and Fellows. London: MoM; 2010.

### Appendix 3 - 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 patients 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.

#### Treatment

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

Hypertension can be reduced by returning the patient to bed or sitting upright. Check blood pressure every 2-5 minutes. Administer prescribed anti hypertensives eg GTN or Nifedipine.

If symptoms do not resolve quickly medical attention should be sought or transfer to hospital for further assessment and management.

*RCN (2019) Bowel Care Management of Lower Bowel Dysfunction, including Digital Rectal Examination and Digital Removal of Faeces*

#### Appendix 4 - 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 - Removal of an Indwelling Catheter

##### Equipment Required:

- Vesica catheterisation pack includes pack for catheter removal
- Alternatively - 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.
Catheters can be removed at any time. However, it is sensible to remove them early in the morning if they are not being immediately replaced.	So that any retention problems can be dealt with during the day, thus avoiding delays in re catheterisation if required

Explain and discuss the procedure and gain consent. Inform them of potential post-catheter symptoms, such as urgency, frequency and discomfort, which are often caused by irritation of the urethra by the catheter.	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
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.

*The Royal Marsden Hospital Manual of Clinical Nursing Procedures; 10th Edition 2020.*



- 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

### Appendix 6 - Male Catheterisation

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

Procedure.	Rationale.
Explain and discuss procedure with patient, including consideration of a chaperone and obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Check for allergies 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 The Code 2018).  Please note that patients with spinal cord injury at T6 and above may be prone to autonomic dysreflexia.
Prepare the patient, maintaining their dignity ( procedure sheet underneath and underwear removed)	To enable good access to genital area To maintain patients privacy and dignity.
Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.	To avoid over reaching and reduce the risk of infection. To ensure correct catheter/equipment is used.
Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy. Put on disposable plastic apron	To reduce the risk of infection.
Open catheterisation pack onto clean work surface.	To reduce the risk of infection.
Using an aseptic technique open supplementary pack. Prepare bag for waste disposal, slide the catheter from the packaging onto the sterile area, pour sodium chloride solution into receiver, open sterile anaesthetic gel from packaging.	To ensure items remain sterile.

Remove cover that is maintaining patient's dignity. Position a disposable pad under patient's buttocks and thighs.	To ensure patient dignity is maintained for as 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.
Apply sterile gloves.	To reduce the risk of infection.
Place sterile drape across patient's thighs, ensuring the scrotal area is covered. Place the receiver between the patient's legs.	To create a sterile field.
Wrap a sterile swab around the penis and with the same non touch technique, retract the foreskin if present. Clean the urethral meatus with 0.9% sodium chloride.	To reduce the risk of introducing infection into the urinary tract during catheterisation.
Position the penis at 90° angle to the patient's thigh, extending the penis forward.	To aid insertion.
Prime the syringe of the anaesthetic gel, then squeeze a small amount onto the tip of the urethra.	To minimise discomfort.
Insert the nozzle of the lubricating gel (as per manufacturer's guidelines) into the urethra. Instil all 11mls of gel slowly, remove nozzle and discard.  Squeeze the penis and wait 3-5 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 gel from escaping and take full effect.
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.
Remove catheter packaging from the end and attach sterile drainage bag ( optional)	To aid insertion.

Free packaging form catheter tip. Re position penis at 90° and insert the catheter into the urethra for 15-25cm, ensuring the fingers do not touch the glans penis. If resistance is felt at the external sphincter, ask the patient to cough or strain gently as if trying to pass urine.	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.
When urine begins to flow, advance the catheter a further 2-5cm	Advancing the catheter ensures it is correctly positioned in the bladder.
Slowly inflate the balloon, according to manufacturer's guidelines and observing the patient at all times – if discomfort is displayed stop and recheck the catheter's position. Withdraw the catheter slightly and check it remains secure.	The male urethra is approximately 18-22cm long. Inadvertent inflation of the balloon into the urethra causes pain and trauma/bleeding.
Ensure glans penis is clean and foreskin repositioned and patient comfortable and dry.	This is to prevent para phimosis occurring
Observe the colour and measure the amount of urine drained. Collect a sample if required.	Observe for signs of urine infection.
Dispose of equipment including gloves and apron. Secure the drainage system to the patient considering use of leg bag straps, thigh straps and leg bag sleeves.	To prevent environmental contamination.
Wash hands using soap and water	To reduce risk of infection.
Record information in relevant documents this should include, consent, 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, review date and catheter care instructions given.	To provide a point of reference or comparison in the event of later queries.

*RCN (2019) Catheter Care RCN Guidance for Health Care Professionals*

### Appendix 7 - Female Catheterisation

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

Procedure.	Rationale.
<p>Explain and discuss procedure with patient, including consideration of a chaperone and obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Check for allergies e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport</p>	<p>To ensure that the patient fully understands the procedure and gives valid consent (NMC The Code 2018).  Please note that patients with spinal cord injury at T6 and above may be prone to autonomic dysreflexia.</p>
<p>Prepare the patient, maintaining their dignity ( procedure sheet underneath and underwear removed)</p>	<p>To enable good access to genital area To maintain patients privacy and dignity.</p>
<p>Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.</p>	<p>To avoid over reaching and reduce the risk of infection.  To ensure correct catheter/equipment is used.</p>
<p>Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy. Put on disposable plastic apron</p>	<p>To reduce the risk of infection.</p>
<p>Open catheterisation pack onto clean work surface.</p>	<p>To reduce the risk of infection.</p>
<p>Using an aseptic technique open supplementary pack. Prepare bag for waste disposal, slide the catheter from the packaging onto the sterile area, pour sodium chloride solution into receiver, open sterile anaesthetic gel from packaging.</p>	<p>To ensure items remain sterile.</p>
<p>Remove cover that is maintaining patient's dignity. Position a disposable pad under patient's buttocks and thighs.</p>	<p>To ensure patient dignity is maintained for as long as possible.  To ensure urine does not leak onto bedclothes.</p>

Decontaminate hands or use alcohol hand gel.	Hands may become contaminated while opening outer packs or preparing patient for catheterisation.
Apply sterile gloves.	To reduce the risk of infection.
Place sterile drape across patient's thighs and place the receiver between the patient's legs.	To create a sterile field.
Using the sterile swabs, part the labia minora so the urethral meatus can be seen- one hand should be used to maintain labial separation until catheterisation is completed.	To identify urethral opening.
Clean around the meatus with sterile saline – use separate single downward strokes (firstly the labia majora, then the labia minora and the urethral meatus).	To reduce the risk of introducing infection into the urinary tract during catheterisation.
Prime the syringe of the anaesthetic gel, then squeeze a small amount onto the tip of the urethra.	To minimise discomfort.
Insert the nozzle of the lubricating gel (as per manufacturer's guidelines) into the urethra. Instil all 6mls of gel slowly, remove nozzle and discard.  Wait 3-5 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 allow gel to take full effect.
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.
Remove catheter packaging from the end and attach sterile drainage bag ( optional)	To aid insertion.

Free packaging from catheter tip. Introduce the tip of the catheter into the urethral orifice in an upward and backward direction. Advance the catheter until 5-6cm has been inserted.	To aid insertion.
When urine begins to flow, advance the catheter a further 2-5cm	Advancing the catheter ensures it is correctly positioned in the bladder.
Slowly inflate the balloon, according to manufacturer's guidelines and observing the patient at all times – if discomfort is displayed stop and recheck the catheter's position. Withdraw the catheter slightly and check it remains secure.	Inadvertent inflation of the balloon into the urethra causes pain and trauma/bleeding.
Ensure meatal area is clean and the patient is comfortable and dry.	Ensure comfort and dignity.
Observe the colour and measure the amount of urine drained. Collect a sample if required.	Observe for signs of urine infection.
Dispose of equipment including gloves and apron. Secure the drainage system to the patient considering use of leg bag straps, thigh straps and leg bag sleeves.	To prevent environmental contamination.
Wash hands using soap and water	To reduce risk of infection.
Record information in relevant documents this should include, consent, 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, review date and catheter care instructions given.	To provide a point of reference or comparison in the event of later queries.

*RCN (2019) Catheter Care RCN Guidance for Health Care Professionals*

## Appendix 8 - Suprapubic Catheter Change

Only appropriately trained staff who are competent and confident should change suprapubic catheters.

Procedure.	Rationale.
<p>Explain and discuss procedure with patient, including consideration of a chaperone and obtain and document valid consent. Discuss any problems that have been experienced with previous catheterisations. Check for allergies e.g. latex or anaesthetic gel (Chlorhexidine). Commence or review catheter passport</p>	<p>To ensure that the patient fully understands the procedure and gives valid consent (NMC The Code 2018). Please note that patients with spinal cord injury at T6 and above may be prone to autonomic dysreflexia.</p>
<p>Assist the patient to get into the supine position with the legs extended on the bed. Remove any necessary clothing and use a towel to cover the patient's thighs and genital area</p>	<p>To enable good access to supra pubic site. To maintain patients privacy and dignity.</p>
<p>Prepare a clean working surface near patient. Prepare necessary equipment. Check choice of catheter is correct and in date.</p>	<p>To avoid over reaching and reduce the risk of infection. To ensure correct catheter/equipment is used.</p>
<p>Wash hands using soap and water or decontaminate hands using alcohol gel in accordance with local trust policy. Put on disposable plastic apron.</p>	<p>To reduce the risk of infection.</p>
<p>Open catheterisation pack onto clean work surface.</p>	<p>To reduce the risk of infection.</p>
<p>Using an aseptic technique open supplementary pack. Prepare bag for waste disposal, slide the catheter from the packaging onto the sterile area, pour sodium chloride solution into receiver, open sterile anaesthetic gel from packaging if required.</p>	<p>To ensure items remain sterile.</p>
<p>Remove cover to expose catheter exit site.</p>	<p>To ensure patient dignity is maintained for as long as possible.</p>

Decontaminate hands or use alcohol hand gel.	Hands may become contaminated while opening outer packs or preparing patient for catheterisation.
Apply sterile gloves.	To reduce the risk of infection.
On the sterile field, place the catheter into the sterile receiver with the drainage bag attached (optional) and place sterile drape across patient's thighs	To create a sterile field.
Observe the current suprapubic site for the lie of the catheter, angle of insertion and length of catheter exposed outside the body as this will aid insertion of the new catheter.	To assist with reinsertion of the suprapubic catheter.
Clean around the insertion site with 0.9% sodium chloride, holding the indwelling catheter using a gauze swab.	To reduce the risk of introducing infection.
Put on new sterile gloves and place a new sterile drape over the change site.	To minimize infection risk with sterile gloves during insertion of the new catheter and maintain a sterile field.
Deflate the balloon and remove the existing catheter. Cover the change site with sterile gauze.	A two-person approach can be adopted at this stage with one person remaining 'aseptic' to insert the new catheter.
Instil 5–10 mL of water-soluble lubricant or anaesthetic gel into the suprapubic tract if required.	Adequate lubricant reduces trauma to the tissues, helping to glide the catheter along the existing tract.
Advance the catheter into the tract 3 cm deeper than it was prior to removal. If no urine drains, press gently on the patient's lower abdomen to elicit urine drainage.	Further advancement can inadvertently pass the catheter into the proximal urethra, leading to tissue damage on balloon inflation.
Inflate the catheter balloon, after ensuring that urine is draining, then gently withdraw the catheter.	To ensure the balloon is inflated and maintains adequate urine drainage.
Secure the catheter. Ensure that the catheter does not become taut when the patient is mobilizing. Ensure that the	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken when applying securing devices



catheter lumen is not occluded by the fixation device.	to ensure these do not interfere with drainage of the catheter by being applied too tightly. Leg straps must not impair circulation.
Assist the patient into a comfortable position and ensure that drainage is aided by gravity and area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur.
Observe the colour and measure the amount of urine drained. Collect a sample if required.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance if clinically indicated. It is not necessary to measure the amount of urine if the patient is having a routine suprapubic catheter change.
Dispose of equipment including gloves and apron.	To ensure correct and safe disposal of clinical waste.
Wash hands using soap and water.	To reduce the risk of infection.
Record information in relevant documents this should include, consent, 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, review date and catheter care instructions given.	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 catheter.

## Appendix 9 - 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 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 2018). To enable the patient to feel as comfortable as possible.
Wash hands using soap and water.	To reduce the risk of cross-infection.
Stand in front of a toilet, or (if easier) in front of a low bench with a suitable container, such as a jug or bottle. Standing in front of a mirror is helpful for patients with a large abdomen. Alternatively the procedure can be performed lying on the bed.	To catch urine.  For ease of observation.
Clean the glans penis with water or 0.9% sodium chloride. If the foreskin covers the penis, it will need to be held back during the procedure.	To reduce risk of infection and ease insertion of catheter.
Wash hands using soap and water or alcohol based hand rub.	To reduce risk of infection.
Ask the patient to prepare the catheter as per manufacturer's instructions.	Ensure correct use of product.
Hold the penis, with the non-dominant hand, upwards towards the stomach.	To straighten the penile urethra and prevent trauma to the penoscrotal junction
Hold the catheter with the dominant hand, being careful not to touch the part of the catheter entering the body, and gently insert it into the opening of the urethra. Advance the catheter into the	To reduce the risk of introducing an infection

bladder.	
There will be a change of feeling as the catheter passes through the prostate gland and into the bladder. It may be a little sore on the first few occasions only. If there is any resistance, do not continue. Withdraw the catheter and contact a nurse or doctor.	The prostate gland surrounds the urethra just below the neck of the bladder and consists of much firmer tissue. This can enlarge and cause an obstruction, especially in older men
Drain the urine into the toilet or a suitable container. When the urine stops flowing, slowly remove the catheter, halting if more urine starts to flow.	To ensure that the bladder is completely emptied.
Before removing the catheter from the urethra, put a finger over the funnel end of the catheter and then remove the catheter from the urethra. Ensure the foreskin is drawn back over the glans of the penis.	To trap urine in the catheter and prevent spillage onto clothing or the floor.  This is to prevent para phimosis occurring.
Hold the catheter over the toilet or a suitable container and remove finger from the funnel end to release the trapped urine.	To prevent urine spillage.
Dispose of the catheter in a bag in household waste if in own home or according to local trust policy if in communal care setting.	To prevent environmental contamination.
Wash hands with soap and water or alcohol-based hand rub.	To reduce 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 10 - 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 wash their 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 2018). To enable the patient to feel as comfortable as possible.
Wash hands using soap and water.	To reduce the risk of cross-infection.
Take up a comfortable position, depending on mobility (e.g. sitting on toilet or standing with one foot placed on toilet seat). Alternatively the procedure can be performed lying on the bed.	To catch urine.  For ease of observation.
Wash genitalia from front to back, with soap and water or 0.9% normal saline solution, then dry.	To reduce risk of infection and ease insertion of catheter.
Wash hands using soap and water or alcohol based hand rub.	To reduce risk of infection.
Ask the patient to prepare the catheter as per manufacturer's instructions.	Ensure correct use of product.
Find the urethral opening above the vagina. A mirror can be used to help identify it. Gently insert the catheter into the urethra, taking care not to touch the part of the catheter entering the body.	To reduce the risk of introducing infection.
Drain the urine into the toilet or a suitable container. When the urine stops flowing, slowly remove the catheter, halting if more urine starts to flow.	To ensure that the bladder is completely emptied.

Before removing the catheter from the urethra, put a finger over the funnel end of the catheter and then remove the catheter from the urethra.	To trap urine in the catheter and prevent spillage onto clothing or the floor.
Hold the catheter over the toilet or a suitable container and remove finger from the funnel end to release the trapped urine.	To prevent urine spillage.
Dispose of the catheter in a bag in household waste if in own home or according to local trust policy if in communal care setting.	To prevent environmental contamination.
Wash hands with soap and water or alcohol-based hand rub.	To reduce 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 11 - Obtaining a Catheter Drainage Specimen of Urine, using needle free port

#### Equipment Required:

- Personal protective equipment including sterile gloves
- Sterile 5 ml syringe with tip
- Sterile urine specimen container with boric acid
- Alcohol based swab
- Non traumatic clamp
- Laboratory request card and bag

Procedure	Rationale
Explain procedure to patient and obtain consent.	So that the patient is fully informed.
If no urine visible in catheter tubing: wash/decontaminate physically clean hands with alcohol rub, don apron and	To reduce risk of infection

apply non-sterile gloves prior to manipulating the catheter tubing.	
Apply non-traumatic clamp a few centimetres below the sampling port. Use the drainage bag tubing for this purpose, never the catheter.	To ensure sufficient sample has collected to allow for accurate sampling.
Wash hands or decontaminate physically clean hands with hand sanitizer and put on gloves.	To reduce risk of infection
Wipe sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allow to dry for 30 seconds	To decontaminate sampling port and prevent false-positive results.
In a needleless system: insert syringe/Monovette firmly into centre sampling port (according to manufacturer's guidelines), aspirate the required amount of urine and remove syringe.	To reduce the risk of sharps injury
Transfer an adequate volume of the urine specimen (approx. 10 mL) into a sterile container immediately if not using Monovette.	To allow adequate collection of urine for analysis.
Wipe the sampling port with an alcohol wipe and allow to dry for 15 seconds.	To reduce contamination of access port and reduce the risk of cross-infection
Unclamp tubing.	To allow drainage to continue.
Remove gloves and wash/cleanse hands	To reduce the risk of cross-infection
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. If using the 'Urine Monovette' this is stable at room temperature for 48 hrs between sampling and analysis.	To allow accurate analysis
Record information in patients notes.	To ensure timely and accurate record keeping

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## Appendix 12 - Using a Bladder Maintenance Solution

### Equipment Required :

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

Procedure	Rationale
Explain the procedure to the patient and gain consent.	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, 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.
Instil maintenance solution, following manufacturer's instructions.	To ensure patient safety and comfort.
Remove connector from catheter and re-connect to new 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 patient's documentation.	To provide a point of reference or comparison in the event of later queries.

### Appendix 13 - Emptying a Urine Drainage Bag

#### Equipment Required:

- Plastic Apron
- Non sterile gloves
- Suitable Receptacle e.g. jug, urinal  
In hospital settings single use or processed through an 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 and gain consent.	To ensure that the patient understands the procedure and gives their valid consent (NMC 2018)
Wash hands using soap and water. Apply apron and gloves.	To reduce the risk of cross-infection
Open outlet valve and allow the urine to drain into appropriate 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.
Remove gloves and apron and wash hands with soap and water.	To reduce risk of infection.
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 14 - 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 Required:**

- Plastic Apron
- Sterile gloves
- Sterile urine drainage bag

Procedure	Rationale.
Explain and discuss the procedure with the patient and gain consent.	So that the patient is fully informed.
Release leg support.	To aid removal of bag
Protect bed and patient.	To promote comfort and dignity.
Wash hands, apply apron and gloves	To reduce risk of infection.
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.	To prevent infection and ensure secure fitting.
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.	Reduce risk of infection and identify problems.
Remove gloves and apron.	To prevent infection.
Wash hands and record intervention and any problems in patient's documentation.	To provide point of reference or comparison in event of later queries.





## 26. Equality Analysis

### Herefordshire and Worcestershire ICS - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

**Section 1 - Name of Organisation** (mark with an 'X' in the right-hand column)

Herefordshire & Worcestershire ICS	
Worcestershire Acute Hospitals NHS Trust	
Herefordshire & Worcestershire Health and Care NHS Trust	X
Herefordshire Council	
Worcestershire County Council	
Wye Valley NHS Trust	
Herefordshire & Worcestershire CCG	
Other (please state)	

Name of lead for activity	<u>Name</u>	<u>Job title</u>	<u>Email address</u>
Details of individual(s) completing this assessment, please include name, job title and email contact	Elaine Sutcliffe	Continenence Advisor	elainesutcliffe@nhs.net
	Vicci Hickson Downes	Continenence Advisor	Vicci.hickson-downes@nhs.net
Date assessment completed	23rd April 2021		

**Section 2**

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Catheter care guidelines for adults
What is/are the aim, purpose and/or intended outcomes of this activity?	Review of present guidelines

**Who will be affected by the development & implementation of this activity?** (Mark with an 'X' in the right-hand column)

Service user	X
Patient	X
Carers	X
Staff	X
Communities	X
Other (please state)	



This is a... (Mark with an 'X' in the right-hand column)

Review of an existing activity	X
New activity	
Planning to withdraw or reduce a service, activity or presence?	

What information and evidence have you reviewed to help inform this assessment? (Please name sources, e.g. demographic information for patients / services / staff groups affected, complaints etc.)	Demographics and presenting complaint of patients, feedback from community practitioners and care home staff, learnings from incidents and complaints. National patient safety alerts.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Engagement has been with staff and patients during clinical consultations, education sessions, teaching, patients groups. Feedback has been encouraged and recognised. Comments from Friends and Family, complaints and incidents have been acknowledged and changed accordingly. Recommendations from National patient safety alerts have been implemented.
Summary of relevant findings	Relevant changes made to guidelines in accordance with engagement or consultation

### Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale.** Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential <u>positive</u> impact	Potential <u>neutral</u> impact	Potential <u>negative</u> impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		Applies to a wide age group. Specifically adults – legal definition is 18 years and above



Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
<b>Disability</b>	x			Catheter problems can occur in people with disabilities such as spinal cord injuries and neurological conditions. Support, advice and extra time for explanations/interventions would be given to those who require it at a location suitable to them eg home.
<b>Gender Reassignment</b>	x			Consideration to birth gender and preferred gender has been considered in the guidelines.
<b>Marriage &amp; Civil Partnerships</b>		x		Acknowledged recent changes in the law regarding civil partnership and implications for practice
<b>Pregnancy &amp; Maternity</b>		x		Both mother and child welfare would be assessed and specialist advice sought if necessary
<b>Race including Traveling Communities</b>		x		Considered on an individual basis and during catheter assessment and planned treatments
<b>Religion &amp; Belief</b>	x			Considered on an individual basis and during catheter assessment and planned treatments
<b>Sex</b>	x			Consideration and guidance is given regarding both genders within the guidance
<b>Sexual Orientation</b>		x		Guidelines take into consideration sex and sexuality
<b>Other Vulnerable and Disadvantaged Groups</b> (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		Access to the service for assessment is broad and includes self referral and from health professionals and carers. There is flexibility regarding venues, timings of appointments and interventions irrespective of individual circumstances
<b>Health Inequalities</b> (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)	x			Consideration has been given this in the guidelines. It is recommended these guidelines are adopted by safe working on behalf of WHCT, private care agencies and independent care homes to promote best practice



**Section 4**

**What actions will you take to mitigate any potential negative impacts?**

Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
Potential difficulties of travelling communities accessing clinics	Clinic locations x 8 throughout the county Flexibility regarding the discharge process. No automatic discharge following DNA in this group Ways of communicating patient information eg Easy read	Elaine Sutcliffe	6 months

How will you monitor these actions?	Uptake of services from travelling communities
When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	During the service redesign planned over the next year

**Section 5 - Please read and agree to the following Equality Statement**

**1. Equality Statement**

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc., and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.



1.4 Our organisations are expected to use the appropriate interpreting, translating or preferred method of communication for those who have language and/or other communication needs. Practitioners will need to assess that the Catheter care guidelines for adults is fair and equitable for all groups covered under the Equality Act 2010 and that they are implementing the Accessible Information Standard and have considered health inequalities.

1.5. Herefordshire and Worcestershire Health and Care NHS Trust must meet its statutory duty to reduce inequalities of access and outcomes, as set out in the NHS Act 2006 (as amended). As a result, the Herefordshire and Worcestershire Health and Care NHS Trust aims to design and implement policy documents that seek to reduce any inequalities that already arise or may arise from any new policy. Therefore, Herefordshire and Worcestershire Health and Care NHS Trust will consciously consider the extent to which any policy reduces inequalities of access and outcomes.

1.6. Any change to a service will require a conscious effort from the author(s) of that change to actively consider the impact that this will have on any Protected group(s) and act due diligently. Where an impact on any of the Equality groups is realised after the implementation of the Project/Service, the commissioners and or Providers, who are implementing the said Project and or service will seek to minimise such an impact and simultaneously carry out a full review.

<b>Signature of person completing EIA</b>	
<b>Date signed</b>	14 <sup>th</sup> May 2021
<b>Comments:</b>	
<b>Signature of person the Leader Person for this activity</b>	
<b>Date signed</b>	14 <sup>th</sup> May 2021
<b>Comments:</b>	

### **Human Rights Consideration:**

NHS organisations must ensure that none of their services, policies, strategies or procedures infringes on the human rights of patients or staff. You should analyse your document using the questions provided to determine the impact on human rights. Using human rights principles of fairness, respect, equality, dignity and autonomy as flags or areas to consider is often useful in identifying whether human rights are a concern.



Can you please answer the following Human Rights screening questions:

	<b>Human Rights</b>	<b>Yes/No</b>	<b>Please explain</b>
<b>1</b>	Will the policy/decision or refusal to treat result in the death of a person?	no	
<b>2</b>	Will the policy/decision lead to degrading or inhuman treatment?	no	
<b>3</b>	Will the policy/decision limit a person's liberty?	no	
<b>4</b>	Will the policy/decision interfere with a person's right to respect for private and family life?	no	
<b>5</b>	Will the policy/decision result in unlawful discrimination?	no	
<b>6</b>	Will the policy/decision limit a person's right to security?	no	
<b>7</b>	Will the policy/decision breach the positive obligation to protect human rights?	no	
<b>8</b>	Will the policy/decision limit a person's right to a fair trial (assessment, interview or investigation)?	no	
<b>9</b>	Will the policy/decision interfere with a person's right to participate in life?	no	

If any Human Rights issues have been identified in this section please get in touch with your Equality and Inclusion lead who will advise further and a full Human Rights Impact Assessment maybe required to be completed.