Aneurin Bevan Health Board

Urinary Catheterisation Policy

(Does the policy relate to a specific area i.e. Independent contractors) (NO)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.
Contents:

1  Policy Statement .................................................................4
2  Executive summary .............................................................4
2.1  Scope of policy .................................................................4
3  Aims .......................................................................................4
4  Urinary Catheterisation and the risk of infection ..................4
5  Decision to Catheterise ..........................................................5
6  Indications for Catheterisation .............................................6
6.1  Indications for catheterisation include: ..............................6
7  Who can catheterise? Responsibilities, Accountability, Training and Competency ..............................................7
8  Options for Catheterisation ....................................................8
9  Indwelling Urethral Catheterisation .....................................8
10  Intermittent catheterisation (see Intermittent Catheterisation Policy and Procedure for details) .......................9
11  Supra pubic catheterisation (see Supra Pubic Catheterisation Policy and Procedure for details) ............................9
12  Choice of Indwelling Catheter and Drainage System ..........10
12.1  Size ..................................................................................10
12.2  Balloon Size .....................................................................11
12.3  Material .............................................................................11
13  Catheter Change .................................................................11
14  Catheter Valves ....................................................................12
15  Hospital Discharge of Catheterised patients ......................12
15.1  Step 1: Planning Stage .....................................................13
15.2  Step 2: Transfer/Discharge Documentation ......................13
15.3  Step 3: Catheter and Drainage Equipment for Discharge ...13
15.4  Step 4: Clinical Governance and Discharge Quality Control ..14
16  Discharge Check - List for Patient with an Indwelling Urinary Catheter ...........................................................14
17  Infection Control .................................................................15
17.1  Urine Sampling .................................................................15
17.2  Catheter Care and bag emptying ......................................15
17.3  Catheter Maintenance Solutions ......................................16
17.4  Decision to Remove the Catheter .....................................16
18  Audit ....................................................................................16
19  Acknowledgements .............................................................17
20  References ............................................................................17
21  Reading List ..........................................................................18
22  Appendices ...........................................................................19
Appendix 1 - Catheter Care Pathway ......................................19
Appendix 2 - Patient Consent ...................................................22
Appendix 3 - Catheter Selection ...............................................23
Appendix 4 - Catheter Maintenance Solutions .........................24
Appendix 5 - Problem Solving ..................................................25
Appendix 6 - Autonomic Dysreflexia .......................................26
Appendix 7 - Indwelling Catheterised Patient Education Guide ................28
Appendix 8 - Catheterisation Discharge Letter .....................................31
Appendix 9 - Clinical Incident reporting for In-Appropriate Discharge for
Catheterised Patients .................................................................................32
Appendix 10 - Management of Catheterised Patients on Discharge and in
the Community Pathway ........................................................................33
Appendix 11 - Catheter Companies Home Delivery and Prescription Services 37
1  **Policy Statement**

This Policy provides guidance on:

a. Urinary catheterisation, male and female procedures  
b. Supra pubic catheterisation  
c. Intermittent catheterisation

It has been written and developed following a benchmark exercise using the Internet. The process encourages NHS organisations to share policies with other NHS organisations facilitating the sharing of best practice, and preventing duplication. (See reference list)

2  **Executive summary**

This policy emphasises the importance of providing a high standard of clinical care and education to patients in the light of the ever-increasing awareness of the potential complications associated with the use of in-dwelling urinary catheters. It must be used in conjunction with the Organisations continence bladder and bowel care pathway (Appendix 1) and the catheter care pathway.

2.1  **Scope of policy**

This policy applies to adults and children and all Organisation areas where patients are nursed or cared for including patients' own homes, community hospital environments including ward areas, intermediate-care and day-care facilities. It is designed to include all organisation employees including qualified Nurses and competent Health and Social Care Workers. **This policy does not apply to independent care homes.**

3  **Aims**

The aim of the policy is to encourage a best practice approach and highlight specific implications for clinical practice following the publication of the guidelines on urinary catheterisation and infection control (NICE/EPIC (2003)).

4  **Urinary Catheterisation and the risk of infection**

1. Urinary catheterisation is an intervention to enable emptying of the bladder by insertion of a catheter. When considering catheterisation for intractable incontinence, to maintain skin integrity, this intervention should only be considered after all other non-invasive management options have been explored and found to be unsatisfactory.

2. Catheterisation is usually performed by healthcare staff in a variety of settings including acute care, primary care and long term care. General principles of catheterisation and infection control apply to all patient groups; however, some patient will have particular needs, e.g. patients with prosthetic implants, children and patients with spinal injuries. Staff working with these patients must familiarise themselves with their individual needs and localised policies.
3. Recent literature has indicated that considerable variation exists between hospitals in the proportion of patients catheterised in different specialities. Glynn et al (1997) found the overall rate of catheterisation in acute care was 26.3%, with a range of 12-40% dependent on speciality. A local RCP audit in the organisation (2005) demonstrated between 21% and 27% catheterisation rate on wards for incontinence, this is unacceptable practice and improvements must be achieved.

4. The duration of catheterisation is also variable within healthcare settings and is often related to the reason for catheterisation. For example, it can be of short duration (1-7 days) for postoperative patients, intermediate duration (7-30 days) for the measurement of urine output in critically ill patients, or of long duration (more than 30 days) for those patients with complications related to intractable incontinence or those with incomplete emptying of the bladder.

5. The range of reasons for catheterisation and the varied duration of catheterisation indicate a need to address practice-based issues. This is important because patients having a catheter inserted as part of their clinical care are in significant danger of acquiring a urinary tract infection (UTI). The risk of UTI is associated with the method and duration of catheterisation, the quality of catheter care and host susceptibility (NICE/EPIC 2003).

6. UTI is the most common infection acquired in acute hospitals and in long-term care facilities. It accounts for about 30-40% of all healthcare associated infections (HAI) and contributes to the extra mortality and cost associated with these infections.

7. Up to 20% of patients with an indwelling urethral catheter develop asymptomatic bacteriuria, and 2-6% symptomatic UTI. Catheter-associated bacteriuria is the source of organisms for 15% of all healthcare associated bacteraemias. In addition to the 13-30% mortality rate associated with these bacteraemias. It has been suggested that bacteriuric patients have a three-fold increase in mortality compared with non-bacteriuric controls, although the reason for this is not clear.

5 Decision to Catheterise

1. When catheterisation is being considered as a treatment option, the Aneurin Bevan Health Board catheter care pathway must be utilised and patients must be placed on the pathway (see Appendix 1). An indwelling catheter is a last resort and must not be used by nurses to manage incontinence routinely. Intermittent catheterisation should always be considered for incomplete emptying as the first option rather than indwelling catheterisation, providing this is a safe and acceptable alternative for the individual and carer(s).

2. A full assessment of consent and of the individual and their needs should be carried out using the catheter care pathway by the registered nurse before catheterisation and re-catheterisation in the case of a catheter change. This includes identifying underlying cause(s) for their bladder-emptying problem. There should whenever possible, have been a discussion with the patient.
regarding the necessity for a catheter and consideration of alternatives in relation to their continence needs. (See Appendix 7 to guide practice). The possibility of risks and benefits should be explained and the patient must be able to demonstrate that they have understood. [Indwelling catheters care pathway assessment form is available on the intranet at: http://howis.wales.nhs.uk/sites3/Documents/79/0009056.pdf]

3. Assessment of the patient must include exploration of consent and factors that may contraindicate catheterisation and or pose a risk. These include:

- Consent issues for children and adults; the local consent policy must be adhered to. See Appendix 2 for Guidance
- In cases of male acute retention of urine, the (first) catheterisation should not be undertaken by a nurse these cases should be referred to a doctor and for a urology opinion.
- Ascertaining if the patient has a latex allergy then an all silicone catheter must be used instead of latex.
- Ascertaining if the patient has prosthetic implant as there is a small risk of iatrogenic infection of prosthetic implants after catheterisation (see Male Catheterisation Policy and Procedure - Prophylaxis)
- Mental health or cognitive status of the patient, which may raise questions regarding the patients’ ability to give informed consent and safety. Which would then lead to the activation of a best interest decision following ethical guidelines and adherence to the consent policy. There is evidence suggesting that confused patients may attempt to forcibly remove the catheter, which can lead to urethral trauma and potentially sepsicaemia. (See Appendix 2)
- The patient’s ability and agreement to manage the catheter independently. (See Appendix 7)
- Carer availability and agreement in order to manage/undertake the catheter care for the patient
- Tissue viability and preserving skin integrity

6 Indications for Catheterisation

6.1 Indications for catheterisation include:

- Patients with neurological disease or injury who have difficulty in completely emptying the bladder
- Patients with outlet obstruction who may be unfit for surgical repair
- Patients who are chronically incontinent, often with associated debility or confusion, where other methods are inappropriate or unsuccessful
- Terminally ill patients, where catheterisation allows carers to cope with problems such as pain, frequency of micturition and maintenance of dignity
- Post-operatively, to monitor urine output accurately, or to manage acute urinary retention
- Acute/chronic urinary retention
- For intra-vesical instillation of drugs
- Assistance in maintaining or improving skin integrity
7 Who can catheterise? Responsibilities, Accountability, Training and Competency

1. Any competent registered Nurse can catheterise providing they can demonstrate appropriate training, knowledge and competence. There is no need for community nurses to obtain or request a letter of permission from hospital based doctors or the acute sector to catheterise or take over the re-catheterisation and care in the community.

2. Competent health and social care workers (HSCWs) can re-catheterise patients urethrally **but they cannot carry out the first urethral catheterisation** or routine supra-pubic re-catheterisation (unless there are special agreements in place with managers in the continuing care settings and supported by extended skills and competence).

3. In cases where HSCWs are requested to re-catheterise they are only required and permitted to take on this procedure in specifically identified settings or in circumstances where it is in the patient’s best interest and or if a registered nurse is not available to perform the procedure.

4. An important caveat is the issue of accountability which is held by the registered nurse, for example, the decision to catheterise and the delegation of the procedure rests with a registered nurse. The registered nurse must be confident that the HSCW who is to perform the catheterisation can demonstrate the appropriate knowledge, training and competence to catheterise.

5. In order to access the necessary catheter training study day, registered nurses can book a place directly however, HSCWs have to be nominated by their nurse manager and produce a signed letter agreeing to the training before applying and attending the study day.

6. The theoretical training is provided by the continence service including provision of a competency framework which becomes the responsibility of the individual and their mentor to complete and demonstrate and record competency overtime in line with KSF. Following training it is mandatory that the Catheter Skills Workbook is completed along side the competency framework and kept as a record by the manager in the personnel file. Copies of the catheter skills work book and competency frame work can be downloaded from the Continence Service web pages on the intranet.

7. Competency and practical skills must be gained following the theoretical training by accessing practical demonstrations and supervision from a competent and skilled registered nurse or practice educator. A minimum of 3 supervised catheterisations is required or until the person feels competent and can demonstrate the level of competence. Refresher training must be sought if competence diminishes from lack of regular practice to maintain on going competence. The competency framework document should be used to sign off and record levels of competence in the clinical area. This training and competency arrangement applies to both male, female urethral and supra-pubic catheterisation and applies to both registered nurses and HSCWs.
It is recommended that this knowledge and training should include:

- Policy and awareness of legal issues
- Anatomy and physiology of the urinary tract
- Issues of consent
- Indications for catheterisation
- Contraindications and precautions
- Types of catheterisation i.e., urethral, supra-pubic, intermittent
- Types and sizes of catheters and drainage equipment
- Care of a catheterised patient including minimising risk of catheter-associated infection and catheter blockage.
- How to gain and maintain competence in catheterisation.

8 Options for Catheterisation

- May be inserted into the bladder via the urethra or a supra-pubic cystotomy

9 Indwelling Urethral Catheterisation

1. An aseptic technique using sterile gloves must be used during this procedure.

2. Cleansing of the urethral meatus must be carried out prior to catheterisation

3. Lubricating gel incorporating local anaesthetic from a single-use container should be used for both male and female catheterisation. (see relevant booklets for more detail)

4. Following assessment, as small a catheter as possible should be selected to effect good drainage. During routine indwelling urethral catheterisation catheter sizes 12ch, 14ch, and 16ch can be used for adult male and female patients. Paediatric use is between size 6ch and 10ch. Consideration should be given to user sensitisation when latex products are used.

5. When a Foley catheter is being inserted, the catheter is well advanced into the bladder before the retaining balloon is inflated with sterile water. Urine should be seen to drain from the catheter before the balloon is inflated.

6. Manufacturer’s instructions should always be followed regarding the amount of water required in the balloon. Catheters with 10ml balloons should be used for adults unless otherwise instructed by a Urologist.

7. When catheterisation is complete, the catheter is connected to the closed drainage system of choice. Catheters and attached drainage systems should be properly secured in a comfortable position for the individual after insertion.
10 Intermittent catheterisation (see Intermittent Catheterisation Policy and Procedure for details)

1. Intermittent self-catheterisation is the preferred alternative to indwelling catheters for individuals in whom bladder emptying is incomplete, providing they or the carer have the dexterity, ability and desire to manage the procedure.

2. Intermittent catheterisation can be carried out by carers/partners or healthcare workers after appropriate training, and with patient consent, if the patient is unable to self-catheterise.

3. Where the procedure is being carried out independently by the patient, the use of sterile gloves is not necessary. (See Female Urethral Catheterisation for more details on procedure)

4. Advice should be given, including supporting literature, to patients and carers on frequency of catheterisation, size of catheters to be used and on any documentation that requires completion regarding volumes obtained.

5. Individuals carrying out intermittent catheterisation as a way of managing urethral strictures should be given guidance on the frequency of catheterisation and size of catheter to be used. Guidance must be sought from the urologist.

6. Where paid carers or healthcare professionals are taught to carry out intermittent catheterisation this technique is carried out as an aseptic procedure. If partners and close family members are carrying out the procedure on a one-to-one basis for the patient, this is a clean procedure.

11 Suprapubic catheterisation (see Supra Pubic Catheterisation Policy and Procedure for details)

1. For some patients an indwelling catheter inserted supra-pubically through the abdominal wall into the bladder may offer advantages. The technique may be used following pelvic or urethral trauma, and occasionally for urinary retention or voiding problems. Advantages include no risk of urethral trauma or necrosis, greater comfort, access for cleaning and management and greater freedom for expressing sexuality.

2. Contra-indications include patients with haematuria of unknown origin or with carcinoma of the bladder. Supra-pubic catheterisation may also be inappropriate for patients who are very obese.

   An aseptic technique is used during the initial insertion of the catheter as well as during subsequent changes of the catheter.

3. NB. To avoid closure of the tract during changes re-catheterisation should take place within 10 minutes, if a supra-pubic catheter falls out and it is not possible to reinsert the supra-pubic catheter the patient should be seen by the on call urology team as an emergency so that the catheter can be replaced as soon as possible.
4. The size of catheter used should be no smaller than 16ch in adults with 10ml balloon unless otherwise specified by the appropriate specialist. After further clinical assessment, some adult patients may require larger lumen catheters. Children should be managed with 3ml balloon catheters and lumen size should be determined by assessment of the child.

5. The manufacturer’s guidelines should be followed regarding the choice of catheter licensed as suitable for use in the supra-pubic route. Foley catheters with retaining balloons provide easier management during changing.

6. Individual choice should be considered regarding the length of the catheter inserted supra-pubically.

7. Lubricating gel should be used at time of catheter changes.

8. The drainage and suspensory systems used should be manageable for individuals and carers where appropriate.

9. The choice of appliance should be regularly re-assessed.

12 Choice of Indwelling Catheter and Drainage System


1. Re-assessment of initial choice of equipment takes place at mutually agreed times.

2. Individuals (and carers where appropriate) are involved in decision-making regarding type of catheter and drainage systems. Catheter valves and drainage bags of all types should be considered to suit the patient’s lifestyle and needs. Not all patients are suitable for valve usage and manufacturer’s instructions for use/contraindications should be followed. A ‘belly bag’ can be considered for patients with Foley-type catheters. See Appendix 7.

12.1 Size

1. The choice of catheter should be the smallest Charriere (Ch) size possible, which will allow for the adequate drainage of urine. A size 12-14 Ch is generally sufficient for men and women. Catheters of size 16-18 Ch should only be used if the patient has debris or mucous in the urine or blood clots and haematuria which may occlude smaller lumens. Smaller sizes (6-10 Ch) are available for children.

2. Standard length catheters are recommended in hospital settings for male and female patients for short-term usage. In community settings female patients with long-term urinary catheters may benefit from shorter (female) length catheters. However they are not recommended in the case of wheel chair bound or women with obese thighs. Female length catheters are not available for routine use in acute hospital settings.
12.2 Balloon Size

1. The balloon size should, in most instances, be 10ml for adults and 2.5-5 ml balloons for children. Larger balloon sizes should be avoided, as there is an increased risk of urethral damage if balloons are expelled. A larger balloon will sit higher within the bladder, allowing greater residual urine which may cause leakage and provide a reservoir for infection.

2. Catheter balloons should be inflated with the correct amount of sterile water, as stated on the catheter and packaging. Both over and under inflation can result in balloon distortion, allowing the catheter tip to angle to one side which could result in pressure ulceration of the bladder wall.

12.3 Material

1. Catheters are available in different materials designed for short, medium and long-term use. Catheter material selection should be made to ensure a high rate of patient comfort/tolerance as well as a low rate of infection and rejection. Nurses should also be aware of any allergies/intolerance to materials such as latex (possibility of allergic reaction to coated catheters). Within the Organisation PTFE are recommended for short term use (4wks only) ‘biocath’ (hydrogel coated) is recommended for long term use (12wks) and must be used when patients are discharged home with a catheter (see section 15 for policy on catheter discharge). Silver coated catheters are not for routine use but may be helpful for patients who are high risk or prone to developing infections (discuss with the continence advisers)

2. Nurses should be aware of the range of catheters available and their different functions.

13 Catheter Change

1. Catheter change should be a planned event according to the type of catheter selected and the patients' previous history where a catheter is already in situ. Monitoring catheter change history can establish a pattern for any recurrent problems such as encrustation leading to blockage, and can allow changes to be planned prior to problems developing.

2. When a catheter change (or initial catheterisation) is to be performed in the patients home, the nurse should assess the patient using the catheter care pathway with reference to all known precautions (RCN, 1997) and seek medical advice in case of doubt.

3. A catheter (pathway) record should be completed (see Appendix 1) following insertion of catheter and following each catheter change. This information should be documented:
   - Date of catheter insertion/reason for insertion
   - Batch no of catheter: (see packaging)
   - Batch No of Gel used
   - Date of next planned catheter change
• Catheter :
• Expiry Date
• Make and description
• Balloon size
• Size (Charriere) and length
• Leg bags/catheter valve
• Make and description
• Volume and tube length
• Night drainage bag – Make and description
• Straps/Holster – Make, description and volume

4. The nurse should also record on the pathway/nursing document any comments or problems encountered during or prior to the catheter change, for example, encrustation, adverse reactions, bypassing and the actions taken.

The need for the catheter should be reviewed at agreed intervals throughout the period of catheterisation. [Catheter review form is available on the intranet at: http://howis.wales.nhs.uk/sites3/Documents/79/0009057.pdf]

5. The initial decision to catheterise should always involve the individual and carer(s) where appropriate (see Appendix 2 for consent issues).

14 Catheter Valves

1. Catheter valves can be used as an alternative to a drainage system. Valves are inserted into the end of the catheter, allowing bladder filling and intermittent drainage. However catheter valves may be inappropriate for patients with:

• Poor Dexterity
• Cognitive impairment and confusion
• Poor bladder capacity
• Detrusor over activity
• Ureteric reflux
• Renal impairment

2. Patients need to be able to manipulate the valve and empty the bladder regularly to avoid leakage (especially with suprapubic catheters), overfilling and subsequent back flow to the upper urinary tract. A spigot is not an alternative to a catheter valve, as it requires removal to allow drainage. There is significant evidence of the benefits of patient comfort and independence with the use of valves. However, the use of a valve should be a multidisciplinary decision involving the patients GP, DN, Urologist or CNS Continence where appropriate.

15 Hospital Discharge of Catheterised patients

1. The following section has been developed to encourage the implementation of consistent policies for the transition of catheterised patients between hospital and the community. Bard (2004)
Please familiarise yourself with the information below, however for ease of accessibility all documents required and a guide to discharge has been placed on the Continence Service web page. Please click on the link [http://howis.wales.nhs.uk/sites3/page.cfm?orgId=79&pid=25765](http://howis.wales.nhs.uk/sites3/page.cfm?orgId=79&pid=25765) and on the Map of Medicine:

15.1 Step 1: Planning Stage

- Before transfer, ensure patient has the appropriate type and size of catheter in situ.
- Confirm that patients and his/her carer understand basic catheter care requirements (refer to Patient Education Guide included in this booklet, Appendix 7).
- Inform patient/carer of date of proposed transfer (ideally this should be more than 24 hours in advance of the discharge).
- Make arrangements and refer to the local District Nurses. Ensure that all legally-required documentation has been completed including the patient’s catheter care history details (refer to Catheterisation Transfer of Care form included in this booklet, Appendix 8).
- Query with patient/carer how he/she would like to receive their products after they have been discharged (e.g. home delivery service, community pharmacist or dispensing GP)
  - On presentation of prescription items dispensed (3-4 days on average)
  - Products dispatched directly to your home within 24 hours

15.2 Step 2: Transfer/Discharge Documentation

- When the patient is transferred into the community, or transferred to another hospital, telephone the district nurse or relevant healthcare professional, care home or community hospital giving all essential patient information (refer to Catheterisation Transfer of Care form included in this booklet, Appendix 8).
- Give the completed Catheterisation Transfer of Care form to the patient/carer to pass on to the district nurse (or other nominated health care professional).
- **It is vitaly important to provide a catheter care patient information leaflet/guide.**
- The leaflet provided must be recorded and signed confirmation must be given

15.3 Step 3: Catheter and Drainage Equipment for Discharge

- Ensure patient/carer has sufficient supply of product for a minimum of 7 days use (The current contracter (Bard) supply a starter pack free of charge). 7 days supply should include:
- One spare leg bag/night bag or a catheter valve
- A community prescription for the provision of a spare catheter at the earliest opportunity is essential (the spare catheter should be prescribed rather than supplied by the hospital as hospital stock is supplied in boxes of 5 and would not have the fully protected packaging. This means that it could be damaged and no longer sterile).
- A buffer stock of catheter equipment will be available for district nurses to access in the case of emergency this to enable catheter changes to be carried out in the community avoiding admission to hospital. The spare catheter should be prescribed and forward planning is necessary to replace any catheters used so that a spare is always available.

- It is vital to record the way in which the patient/carer would like their products to be supplied (e.g. home delivery service (see appendix 11 for list), community pharmacist or dispensing GP).
- Ensure that patient/carer is given contact details for their provider of continence products.

15.4 Step 4: Clinical Governance and Discharge Quality Control

- Once a patient has been discharged home District nurses must be informed to take over the management. Catheter changes are to be carried out in the community; patients should not routinely be admitted to hospital for catheterisation or catheter management. Forward planning is necessary so that patients are not sent to hospital due to the lack of equipment ensure a spare is always available.
- An incident reporting system is in place to monitor patient safety incidents and complaints and to ensure seamless transfer of care so that action is taken in the event of any problems. (see Appendix 9)
- When inappropriate Discharge/Transfer of Care from hospital wards has been identified the district nurse (Appendix 9) should contact the ward and inform them this will ensure timely feedback. In addition, the District Nurse should complete an incident form and return it to the Risk Management Support Team at Llanfrechfa Grange as soon as possible. These incidents are very important to record and report as a patient safety issue.
- Information on the number of such incidents can then be collated with the quarterly divisional incident feedback reports and broken down into incidents per ward. The information provided to the wards and senior nurses will enable lessons to be learned. The trend associated with clinical incidents will also be discussed in the community learning group.

16 Discharge Check-List for Patient with an Indwelling Urinary Catheter

Refer to Flow Chart, Appendix 10

Please ensure that each patient has:

• Always been referred to the District Nurses
An appropriate urinary catheter in situ
- Catheter valve or leg bag
- Suitable night bag and any catheter accessories e.g. retainer straps and leg sleeves
- A drainage bag stand
- A community prescription
- Patient information leaflet
- One starter pack (7 days’ supply)
- Completed Catheterisation Transfer of Care form
- Patient Education Guide
- Telephone contact number
- Details of where they can obtain products on prescription
- Copy of the Flow Chart for the management of catheterised patients on discharge

### 17 Infection Control

1. Catheter equipment should be stored unopened in boxes according to manufacturer’s instructions in a dry, cool, dark place. Advice should be given to patients/carers on storing catheter equipment appropriately in their own home.

2. Hand decontamination should be appropriate for care.

3. Products conducive to effective hand decontamination should be used, and effective hand-drying carried out before catheter procedures.

4. Alcohol hand rub may be used for the rapid decontamination of visibly clean hands.

5. Personal protective equipment, such as aprons and gloves, should be selected following assessment of the level of risk associated with catheterisation/catheter care procedure.

#### 17.1 Urine Sampling

1. Urine samples should only be taken from catheters for a valid reason, such as suspected infection.

2. Samples are collected from the bag sample port; the closed system should not be broken in order to collect urine samples.

3. Prior to obtaining a catheter sample of urine, the port should be cleaned with an isopropyl alcohol 70% impregnated swab and allowed to dry thoroughly.

#### 17.2 Catheter Care and bag emptying

1. Indwelling catheters are connected to a closed drainage system. The closed system is maintained as much as possible.

2. Urine drainage bags are emptied regularly (when three quarters full or once a day if there is low urine output) and positioned below the level of the bladder.
Body worn drainage bags are changed weekly. Bedside type drainage bags should be supported above floor level.

3. In ward settings, a separate clean container must be used for each individual at the time of bag emptying. Contact between drainage tap and container is avoided. Gloves are worn to empty drainage bags and changed after hand washing between each individual. Leg bags may also be emptied directly into the toilet but must not come into contact with it.

4. When an overnight bag is required, a single use drainable 2 litre bedside bag should be used and emptied each morning.

5. When closely monitoring urine output, empty the urine bag, observe and measure before recording in the documentation.

**17.3 Catheter Maintenance Solutions**

1. Catheter maintenance solutions should only be used following thorough assessment.

2. Where assessment indicates that a catheter maintenance solution may be beneficial, the solution prescribed should be appropriate to the condition being treated (Appendix 4). Where a catheter maintenance solution is used, the effect of the treatment should be systematically assessed and ongoing care planned accordingly.

**17.4 Decision to Remove the Catheter/Trial with out**

1. Catheters should only be removed following thorough assessment of the individual's ongoing condition and after joint discussion with patient /carer and healthcare team. The catheter care pathway should be used to assist staff in deciding when to remove a catheter. Catheter review form is available on the intranet at:


2. Where an assessment indicates a catheter may be safely removed, the individual's condition including residual urine measurement after removal is carefully monitored and reported with action taken if problems arise. A trial with out catheter reference guide can be obtained from the urology day case unit or downloaded from the continence service web page on the intranet.

**18 Audit**

Nursing teams will be called upon to periodically audit catheter care across the Organisation to monitor practice, improvement and the overall catheterisation rate. This policy will be used as a marker of best practice and as the standard outcome measure.
19 Acknowledgements

Grateful thanks go to the following staff and external organisations for their contribution in the development of this policy:

Denise Ballard
Clare Eaton
Coral Seymour
Stephanie James
Vicky Coghlan

Brent NHS Trust
Cambridge city and South Cambridgeshire Primary care Trust

20 References


BARD (2004) Guidelines for the transfer of care between and community care settings for patients with a urinary catheter Bard

Brent NHS Trust Policy and protocol for indwelling catheterisation

Cambridge City, South Cambridgeshire Primary Care Trust Catheter Care Policy
## 21 Reading List

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Journal Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downey P, Dean M, Hayes J, (1997)</td>
<td>Perfect timing</td>
<td>Nursing Times Jan 29, 93; 5; 89-90</td>
</tr>
<tr>
<td>Woodward S (1997)</td>
<td>Complications of allergies to latex urinary catheters</td>
<td>British Journal of Nursing Vol 6, No 14, 786-792</td>
</tr>
</tbody>
</table>
# Appendix 1 - Catheter Care Pathway

## PLEASE TICK WHERE APPROPRIATE

<table>
<thead>
<tr>
<th>NAME</th>
<th>CONSULTANT</th>
<th>ADDRESS</th>
<th>GP/DYCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>PRACTICE ADDRESS</th>
<th>TELEPHONE</th>
<th>ASSESSING NURSE</th>
<th>CONTACT NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## REASON FOR CATHETERISATION

<table>
<thead>
<tr>
<th>Reason for Catheterisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drainage</td>
</tr>
<tr>
<td>Retention - Acute</td>
</tr>
<tr>
<td>Retention - Chronic</td>
</tr>
<tr>
<td>Surgical/Trauma</td>
</tr>
<tr>
<td>Medical</td>
</tr>
</tbody>
</table>

## ACTION TAKEN

<table>
<thead>
<tr>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation</td>
</tr>
<tr>
<td>Treatment</td>
</tr>
<tr>
<td>Intractable Incontinence</td>
</tr>
</tbody>
</table>

## CONSENT

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient has no contraindications to catheterisation</th>
<th>Doctor has consented to catheterisation</th>
<th>Patient has given informed consent to catheterisation</th>
<th>Met</th>
<th>Unmet</th>
<th>Variance from standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## DATE | GENERAL ASSESSMENT | STANDARD | ACTION PLAN | MET | UNMET | VARIANCE FROM STANDARD | REVIEW DATE |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess fluid intake</td>
<td>If patient drinks volumes outside parameters of fluid matrix, advise them to drink appropriate amount</td>
<td>Weight ________ stones/Kgs Should drink approximately ________ cups/mugs in 24hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urinalysis performed: Glucose Ketone S. Gravity Blood PH Protein Nitrite Leucocytes</td>
<td>If leucocytes/nitrite, or symptoms of UTI present, take MSU (CSU) and refer to doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Status: Issue 2 rev 1  
Approved by: Clinical Standards & Policy Group  
Issue date: 08 August 2011  
Review date: 08 August 2013  
Expire date: 08 August 2014
### Ask patient if they have a problem with bowel function
- If patient has problems with their bowels, patient given appropriate advice

### Does the patient experience difficulty with:
- Mobility
- Dressing
- Access to bathroom/toilet
- If patient has mobility, dexterity or environment problems, record any action taken

### Does the patient suffer from reduction/restriction or poor co-ordination
- If patient has signs of cognitive dysfunction seek specialist advice

<table>
<thead>
<tr>
<th>DATE</th>
<th>GENERAL ASSESSMENT continued</th>
<th>STANDARD</th>
<th>ACTION PLAN</th>
<th>MET</th>
<th>UNMET</th>
<th>VARIANCE FROM STANDARD</th>
<th>REVIEW DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is sexually active/function satisfactory</td>
<td>If patient is sexually active, patient given advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ask patient if they have an allergy</td>
<td>Patient does not have an allergy to latex, soap or anaesthetic gel</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the patient self-caring</td>
<td>Patient is able to self-care, or has carer support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ROUTE OF CATHETERISATION

<table>
<thead>
<tr>
<th>Standard</th>
<th>Action Taken</th>
<th>Met</th>
<th>Unmet</th>
<th>Variance from standard statement /reasons</th>
<th>Initial</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient catheterised with urethral catheter or Patient catheterised with suprapubic catheter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INDWELLING CATHETER SELECTED

- Patient catheterised with short-term or long term catheter in accordance with policy
- Catheter record completed
- Initial catheterisation: DATE:
- Re-catheterisation: DATE:
- Patient referred as appropriate
**CATHETER INSERTION**

<table>
<thead>
<tr>
<th>Catheter inserted without difficulty</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter is draining Urine within 30 minutes</td>
<td>If <strong>NOT</strong> seek medical advice</td>
</tr>
</tbody>
</table>

**PATIENT AND CARER ADVICE**

| Patient / carer instructed in catheter care and given written information. (see page 30 of booklet) |  |
| Patient / carer given contact name and number |  |
| Patient given catheter supplies on discharge according to local policy |  |

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Designation</th>
<th>Signature</th>
<th>Initials</th>
<th>Date</th>
</tr>
</thead>
</table>

**COMMENTS:**

---

Status: Issue 2 rev 1
Approved by: Clinical Standards & Policy Group
Issue date: 08 August 2011
Review date: 08 August 2013
Expiry date: 08 August 2014
Appendix 2 - Patient Consent and Catheterisation

Informed patient consent must be obtained before catheterisation is carried out, a consent form is not required for catheterisation. Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds.

Consent should be seen as a process, not a single event. Patients can change their minds and withdraw their consent at any time.

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds.

An important issue about consent is that the patient understands and agrees to the healthcare intervention. The nature of this agreement will depend on the nature of the proposed intervention and on local policies. Agreement does not necessarily need to be in writing but health records must document the fact that the patient understands the process of catheterisation and the need for it and consents verbally to the procedure.

Patients are entitled to request that the procedure of catheterisation be carried out by a specific gender of healthcare professional to fit in with their cultural or personal preferences.

These issues should be addressed at the time of obtaining consent and information giving.

If the patient is 18 or over and is not legally competent to give consent, you should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so.

A patient will not be legally competent to give consent if they are unable to comprehend and retain information material to the decision and or they are unable to believe, weigh and use this information in coming to a decision

See Aneurin Bevan Health Board Consent Policy for further detailed information.
Appendix 3 - Catheter Selection

Catheters should be comfortable, easy to insert and remove, and must minimise secondary complications such as tissue inflammation, encrustation and colonisation by micro-organisms. Recent research has shown no significant difference in the incidence of bacteriuria comparing latex with silicone catheters, however many practitioners have strong preferences for one type of catheter over another. This is often based on good clinical experience and wide usage of different catheter materials (EPIC Guidelines, 2001). The smallest gauge catheter suitable for patients’ needs should be used and, if Foley-type catheters are used balloons should only be of 10ml size.

Studies comparing the use of silver-coated (silver alloy or silver oxide) catheters with silicone hydro gel or Teflon latex suggest that silver alloy coated catheters on reducing the incidence of UTIs has been shown to be from 30-70% (Liedberg & Lundberg, 1990; Lai & Fontecchio, 2002). These catheters are now available in the UK and are designed to be used for a maximum of 28 days.

<table>
<thead>
<tr>
<th>Catheter Material</th>
<th>Recommended Usage</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyvinyl chloride(PVC)</td>
<td>Short-term only</td>
<td>Large internal diameter</td>
<td>Uncomfortable for long term use.</td>
</tr>
<tr>
<td></td>
<td>Maximum of 7 days</td>
<td>Allows good drainage</td>
<td>Rigid and inflexible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postoperatively</td>
<td>Must be rinsed thoroughly after use for ICSC.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suitable for single use for administration of instillation</td>
<td>Soap deposits can cause urethral irritation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyvinyl chloride non-balloon</td>
<td>Intermittent catheterisation, can</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>be reused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teflon coated (PTFE) with latex</td>
<td>Short-term, up to 28 days.</td>
<td>Smoother on external surfaces for insertion – reduces tissue damage.</td>
<td>If left in situ too long Teflon coating may wear thin.</td>
</tr>
<tr>
<td>core*</td>
<td></td>
<td>More resistant to encrustation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silicone</td>
<td>Long-term, up to 12 weeks, follow</td>
<td>Wide lumen for drainage. Suitable for patients with latex allergy.</td>
<td>‘Cuffing’ of balloon can occur on deflation can be more difficult to remove</td>
</tr>
<tr>
<td></td>
<td>manufacturer’s recommendations</td>
<td></td>
<td>suprapubically.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrogel coated latex</td>
<td>Long-term use, up to 12 weeks</td>
<td>More compatible with body tissue, less trauma</td>
<td>Does contain latex – unsuitable for patients allergic to latex.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silicone elastomer</td>
<td>Long term, up to 12 weeks, follow</td>
<td>Wide lumen for drainage. Suitable for patients with latex allergy.</td>
<td>‘Cuffing’ of balloon can occur on deflation can be more difficult to remove</td>
</tr>
<tr>
<td></td>
<td>manufacturer’s recommendations</td>
<td></td>
<td>suprapubically.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrogel coated latex</td>
<td>Long-term use, up to 12 weeks</td>
<td>More compatible with body tissue, less trauma</td>
<td>Does contain latex – unsuitable for patients allergic to latex.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silicone elastomer-coated latex</td>
<td>Long term, up to 12 weeks</td>
<td>May help to reduce potential for encrustation</td>
<td>Unsuitable for patients allergic to latex.</td>
</tr>
<tr>
<td>(silicone bonding to outer and inner surfaces)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrogel coated silicone</td>
<td>Long-term use, up to 12 weeks</td>
<td>Suitable for patients with latex allergy</td>
<td>Rigid; may be uncomfortable for patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silver coated silver alloy latex</td>
<td>short-term use, up to 28 days</td>
<td>Suitable for patients more prone to (CAUTI) infection</td>
<td>Cost</td>
</tr>
<tr>
<td>silver alloy/hydrogel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The use of uncoated latex catheters is not recommended even in short-term use. Latex has been shown to cause discomfort and tissue trauma due to what can become an unsmooth surface. Also, the incidence of latex allergies seems to be increasing in both patients and staff who may have been exposed to latex products.
Appendix 4 - Catheter Maintenance Solutions

Clinical evidence for the use of catheter maintenance solutions is limited. Many of the research papers involve a small number of patients, raising questions about the general application of findings to wider patient groups. However, catheter maintenance solutions have undergone the rigorous trials necessary to obtain their product licences and are available on prescription for use in treating specific conditions.

Antibiotic solutions are not effective in treating catheter-associated urinary tract infection (see notes/cautions). However, for some patients there may be benefit in using catheter maintenance solutions to prolong the life of their catheter, thereby avoiding the trauma of re-catheterisation. The appropriate solution should be chosen by identifying the likely cause of the blockage. In a first time blockage, where there is no evidence of the cause of the blockage, the catheter should be removed, examined, and the urine tested to explore the possible causes of blockage. The findings should be recorded. This will give a basis for obtaining a prescription for an appropriate catheter maintenance solution. [Catheter record card is available on the intranet at: http://howis.wales.nhs.uk/sites3/Documents/79/0009486.pdf]

Where a catheter has blocked with struvite crystals, formed in alkaline urine, regular pH monitoring should be undertaken, to predict future blockages. An individual maintenance programme can then be planned.

Caution should be exercised in the use of any catheter maintenance solution as there is evidence that all solutions increase the shedding of epithelial cells within the bladder.

<table>
<thead>
<tr>
<th>Solution</th>
<th>Product Licence</th>
<th>Practice Notes/Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citric acid 3.23% (pH 4)</td>
<td>For the dissolution of struvite crystals which form on the catheter tip under alkaline conditions (pH 7.5-9.5)</td>
<td>Charting of urinary pH over time will allow development of an individual catheter care plan</td>
</tr>
<tr>
<td>Citric acid 6% (pH 2)</td>
<td>Stronger citric acid solution for more persistent crystallisation</td>
<td>Strongly acidic – potential mucosal irritation</td>
</tr>
<tr>
<td>Mandelic acid 1% (pH 2)</td>
<td>For the reduction of micro-organisms which produce urease creating alkaline conditions (mostly proteus species). Acidic pH also counters the effect of proteus on the urinary pH.</td>
<td>Strongly acidic – potential mucosal irritation. Evidence shows that 19 days treatment of twice daily instillations are required to effect treatment, but the licence is for maximum 14 days use.</td>
</tr>
<tr>
<td>Sodium chloride 09%</td>
<td>For the washing of debris (blood, mucus, pus) from the catheter</td>
<td>Will not dissolve crystal formation</td>
</tr>
<tr>
<td>Chlorhexidine 0.02%</td>
<td>For the treatment of pseudomonas infections</td>
<td>Limited value as the infections will exist in a biofilm which resists surface washing of antibiotics. Likely to lead to flourishing of resistant organisms.</td>
</tr>
</tbody>
</table>

Footnote: Catheter maintenance solutions should not be routinely used in patients with spinal injury due to the possibility of autonomic dysreflexia (however can be used with caution if necessary).
## Appendix 5 - Problem Solving

<table>
<thead>
<tr>
<th>Catheter Problem</th>
<th>Possible Reasons</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine not draining into bag</td>
<td>Incorrectly sited catheter, it may be in the urethra and not fully into the bladder.</td>
<td>Deflate retaining balloon and gently reposition.</td>
</tr>
<tr>
<td></td>
<td>Incorrect positioning of the drainage bag above the level of the bladder can prevent good flow of urine.</td>
<td>Check tubing and ensure drainage bag is below level of bladder.</td>
</tr>
<tr>
<td></td>
<td>Drainage tubing may be kinked</td>
<td>Gentle flush of catheter with sterile water or saline solution.</td>
</tr>
<tr>
<td></td>
<td>Catheter may be blocked by debris</td>
<td></td>
</tr>
<tr>
<td>Haematuria</td>
<td>Trauma post-catheterisation infection</td>
<td>Observe output and document severity of haematuria. Seek medical advice if haematuria persists</td>
</tr>
<tr>
<td></td>
<td>Prostatic enlargement</td>
<td>Encourage fluid intake</td>
</tr>
<tr>
<td></td>
<td>Calculi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinoma</td>
<td></td>
</tr>
<tr>
<td>Bypassing of urine around catheter</td>
<td>May indicate present of infection</td>
<td>Obtain a catheter specimen of urine using the sampling port.</td>
</tr>
<tr>
<td></td>
<td>Bladder spasm/instability</td>
<td>Consider use of anti-cholingergic medications</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>Increase fluid intake and dietary fibre intake</td>
</tr>
<tr>
<td></td>
<td>Incorrect positioning of drainage system</td>
<td>Check drainage bag is in correct position, ie, below level of the bladder</td>
</tr>
<tr>
<td>Pain or discomfort</td>
<td>The ‘eyelets’ of the catheter may be occluded by urothelium due to hydrostatic suction</td>
<td>Raise the drainage bag above the level of the bladder for 10-15 seconds only.</td>
</tr>
<tr>
<td></td>
<td>May be indication of infection</td>
<td>Obtain catheter specimen above the level of the bladder</td>
</tr>
<tr>
<td>Catheter retaining balloon will not deflate</td>
<td>Valve port and balloon inflation channel may be compressed</td>
<td>Check no external compression problems.</td>
</tr>
<tr>
<td></td>
<td>Faulty valve mechanism</td>
<td>Valve port should always be aspirated slowly. If done forcefully, the valve mechanism may collapse.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deflation can sometimes be achieved by injecting an additional small volume of sterile water then slowly aspirating again.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If attempts fail, medical advice must be sought. Cutting of the catheter along its length is not safe practice and may result in retraction of the catheter into the bladder.</td>
</tr>
</tbody>
</table>

### Key Challenge –

Patients with a spinal cord lesion above the mid-thoracic level can be affected by a syndrome known as autonomic dysreflexia. If this is not recognised early enough or left untreated it can be fatal. One of the most common causes of this syndrome is a distended bladder mainly due to catheter blockage. This must be relieved as soon as possible and the patient placed in an upright sitting position and their blood pressure monitored at five minute intervals.

*NB: Please see Appendix 6 for further help and advice regarding this condition*
Appendix 6 - Autonomic Dysreflexia

Autonomic dysreflexia (also known as autonomic hyperreflexia) is one of the most serious life threatening conditions that affect people with spinal cord injury at or above the level of the 6th thoracic vertebrae.

The syndrome develops secondary to any noxious stimulus below the level of injury. As the spinal cord is damaged, signals cannot pass normally to the brain, therefore, the body produces exaggerated abnormal nerve signals which cause problems above and below the level of the spinal injury. Below the injury, blood vessels go into spasm causing the blood pressure to rise. Above the level of injury, the body senses the high blood pressure and tries to relax the blood vessels (can only influence the blood vessels above the level of injury) which causes flushing and blotchiness of skin and pounding headache.

Symptoms may be mild or severe 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
- Slowed heart rate
- Profuse sweating (above level of injury)
- Palpitations
- Goosebumps
- Blurred vision or seeing spots before your eyes
- Stuffy nose
- Feeling of doom and gloom, anxiety apprehension
- Elevated blood pressure

NB: Under normal circumstances a tetraplegic person may have a low blood pressure (e.g. 90/60). A rise of 20mmHg can be quite significant; therefore if the BP rises to 120/80 mmHg it could become an emergency situation. Hypertension may be severe enough to lead to seizures, strokes or ultimately death.

Bladder problems are the most common cause of autonomic dysreflexia.

- Overfull bladder
- Kidney or bladder stones
- High pressure voiding
- Urinary tract infection
- Blocked catheter
- Defective drainage system (e.g., kinked tubing or leg bag too full)
Treatment

Identify the source of the noxious stimulus. Removing the stimulus will cause the symptoms to settle.

Reduce the blood pressure by returning the patient to bed and place in a sitting position. (If bladder problems suspected only sit patient to 45 degrees. Sitting at 90 degrees may cause increased pressure on the full bladder).

Check Bladder

If patient is not catheterised and bladder appears full, catheterise immediately and leave on free drainage. Catheter should be lubricated with an anaesthetic gel prior to insertion.

If catheterised, empty leg bag and untwist any kinked tubing. If catheter appears blocked, change catheter immediately, DO NOT ATTEMPT A BLADDER WASHOUT; this will only distend the bladder further with potentially fatal consequence.

If infection is suspected commence antibiotic therapy.

Check bowel and check for other potential causes and treat appropriately.
Appendix 7 - Indwelling Catheterised Patient Education Guide

This guide serves as a check list for patients/carers and health care professionals alike to check that all essential information relating to catheterisation are covered. The document should be completed prior to transfer and revisited during ongoing assessment. Both the health care professional and the patient should sign the form to demonstrate that both parties are satisfied that all the necessary information and advice has been imparted.

Patients Name: ____________________________

Reason for Catheterisation: ____________________________

Date & day Indwelling Catheter Inserted: ____________________________

Type of Catheter: ____________________________

Nurse's Name & Contact Number: ____________________________

Date Patient/Carer received copy of this document: ____________________________

<table>
<thead>
<tr>
<th>Date &amp; Time Commenced</th>
<th>Actions</th>
<th>Tick Once Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Section 1 - Why You Have Been Catheterised</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Understanding why you need a catheter to pass urine.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Appreciate how an indwelling catheter drains the bladder.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Sample of a catheter shown.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Section 2 – Equipment</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Be aware of the equipment that is needed and understand the difference between catheter valves, legs, bags, daytime and night time bed bags plus catheter accessories and how closed drainage systems can reduce the risk of infection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Be given a supply of drainage devices to last until you obtain your own supply, ensure user guide is completed with prescription details and know why a prescription is required to obtain supplies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Avoid running out of supplies and know what to do if you do. Be aware that chemists may not have stock of your equipment and know how to use a home delivery system if preferred.</td>
<td></td>
</tr>
</tbody>
</table>
Section 3 – Using Catheters & Bags

- a. Identify good hygiene practices prior to changing any equipment. (Through hand washing and drying is vital).
- b. Discuss and identify if a catheter valve or a leg bag is best to suit your lifestyle and discuss what the best size and way to wear these is for you.
- c. Understand how to wear your leg bag or catheter valve and bed bag in bed, how to position the bed bag and discuss equipment that can be used to support the bed bag.
- d. Understand when and how to drain your leg bag or catheter valve and how to dispose of your drainage bags in household rubbish in a safe way.
- e. Agree the frequency of when to change the catheter and keep records of this.

Section 4 – Troubleshooting

- a. Know how much fluid you need to drink to ensure your catheter drains well, be aware of the implications of a full bowel and know what food to eat in order to avoid constipation.
- b. Be able to identify the signs and symptoms of a urinary tract infection and initiate self help remedies and know when to contact your GP.
- c. Know what action to take if blood is seen on a regular basis or the bleeding worries you.
- d. Know what action to take if no urine drains from your catheter.

Section 5 – Holidays & Travelling Abroad

- a. Understand the importance of carrying a letter from your doctor or nurse with you and why.
### Date & Time Commenced

<table>
<thead>
<tr>
<th>Actions</th>
<th>Tick Once Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider with your GP the need for a standby course of antibiotics.</td>
<td>□</td>
</tr>
<tr>
<td>b. Appreciate the need to carry medicines and equipment with you in your hand luggage and consider the implications of lost luggage and the importance of carrying appropriate forms when in Europe.</td>
<td>□</td>
</tr>
<tr>
<td>c. Appreciate the need to consider hygiene in the foreign country you visit.</td>
<td>□</td>
</tr>
</tbody>
</table>

### Section 6 – Health Education

a. Received an individual care plan. □

b. Received an information booklet on indwelling catheters, leg bags, catheter valves, etc. □

c. Received written information on fluid intake. Discuss with Health Professional if cranberry juice is good for you. □

d. Received information or advice for catheterised patients about sex. □

e. Received a copy of this patient education guide. □

f. Received information on local and national user groups including In Contact. □

g. Received written information about your local services. □

h. Received written information about out of hours action to take in an emergency. □

i. Received written information about follow up appointments (medical and nursing). □

---

Patient/Carer Signature: ___________________________________________

Health Care Professional ____________________________________________

Signature: _________________________________________________________
Appendix 8 - Catheterisation Discharge Letter

Discharge Letter From
Hospital:
Ward/Department:

To: ________________________________ Addressograph

____________________________________

____________________________________

____________________________________

____________________________________ Consultant

Dear Colleague

____________________________________ is being discharged home with a urethral/suprapubic catheter. Would you be so kind as to take over this patient with regards to catheter changes and care.

Date of initial catheterisation ______________________________

Reason for catheterisation __________________________________

Additional comments _________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Recommended catheter is:

Manufacturer ______________________________

Type ______________________________________ Male/Female

Calibre (Ch) Size ______________________________ Balloon Size ____________

Catheter change due ______________________________

Please do not hesitate to contact our ward/department on ______________________ with any queries.

Yours sincerely

Discharge Nurse (Please print name).
Appendix 9 - Clinical Incident reporting for In-Appropriate Discharge for Catheterised Patients

Complete an Organisation Incident Report Form ensuring that the following information is included on the form:

- The name of the ward and hospital where the patient was either discharged or transferred from (section F).
- The reason why the discharge was inappropriate (Section F).
- The impact on the patient (section D & E).
- Indicate in section F whether they have contacted the ward and any other action taken (continue on a separate sheet of paper if necessary)
- Ensure the incident form is countersigned in line with your agreed local incident reporting processes.
- Send to the Risk Management Support Team, Personnel & Support Services Building, Llanfrechfa Grange Hospital.
Appendix 10 - Management of Catheterised Patients on Discharge and in the Community Pathway

Management of cathetised patient

- Patient to be discharged home
  - Refer to district nurse for discharge
  - Notify patient of discharge and emergency telephone number
  - Advice to patient about emergency catheter procedure
  - Patient discharged
    - Note: Nurse to arrange equipment
  - District nurse assessment
  - Remember to patient about emergency catheter procedure
  - Contact details for out of hours emergency catheter procedure
  - District nurse to check catheter suitability before visiting patient

- Patient to be discharged to nursing home
  - Refer to district nurse for discharge
  - Notify patient of discharge and emergency telephone number
  - Advice to patient about emergency catheter procedure
  - Patient discharged
    - Note: Nurse to arrange equipment
  - District nurse assessment
  - Remember to patient about emergency catheter procedure
  - Contact details for out of hours emergency catheter procedure
  - District nurse to check catheter suitability before visiting patient

IMPORTANT NOTE:

Locally reviewed 19 Apr 2010 Due for review: 17 Sep 2011 Printed on: 09 Jul 2010 © Map of Medicine Ltd

Status: Issue 2 rev 1
Approved by: Clinical Standards & Policy Group
Issue date: 08 August 2011
Review date: 08 August 2013
Expiry date: 08 August 2014

Page 33 of 37
Management of catheterised patient

1 Management of catheterised patient
Quick info:
Scope:
- This page applies to adults and children and all Gwent Health Community areas where patients are nursed or cared for including patients' own homes, community hospital environments including ward areas, intermediate care and day care facilities.
- It is designed to include all Trust employees including qualified nurses and competent health and social care workers.
- It is recommended that this also be adopted in independent care homes within the boundary of Gwent Health Community in order to promote consistently applied evidence based care.

2 Arrange discharge of catheterised patients to community
Quick info:
On discharge, ward staff should issue patient with:
- A copy of the catheter pathway paperwork, recording the catheter details and considering the reasons for requiring a catheter (please refer to Trust policy and discharge pack on Continence Service Intranet web page).
- Catheter date change (the date the district nurse needs to know when the catheter needs changing).
- Copies of the flowchart Management of catheterised patient on discharge and in the community (please refer to the form in the Urinary catheterisation policy - Appendix 10).
Pathway documents are passed to district nurse and/or matron of home, along with a Starter Pack (including spare drainage bags) and a Discharge letter to the district nurse.
In the case of problematic catheterisation, please inform the district nurses who need to consider referral to urology nurses for advice. District nurses are only to refer patients to secondary care when they encounter a problematic catheterisation resulting in a failed attempt at unblocking or recatheterisation.

4 Patient to be discharged to nursing home
Quick info:
Patients need to be referred to district nurses if and when Nursing home staff are unable to re-catheterise, as skills may not always be immediately available.

5 Refer to district nurse before discharge
Quick info:
Refer to district nurse on 01495 745555.
Details need to be directed to the correct district nurse and/or specific GP practice for each local health board area.

6 Central district nurse telephone system
Quick info:
The call handler will connect to the district nurse or voicemail – leave ward’s contact details and patient’s name for the district nurse to call back.

7 Give discharge details to district nurse
Quick info:
The district nurse will telephone the ward and take all the relevant details, including:
- List of details (please refer to the Catheter discharge letter and Care assessment form in Urinary catheterisation policy - Appendix 5).

Management of catheterised patient

Surgery > Urology > Management of catheterised patient

The district nurse must obtain the discharge date and record the referral details.

8 Notify patient of discharge and emergency telephone number

Quick info:
- ward staff should inform the patient that the District nursing team will contact them
- staff will also give the patient the Emergency Contact number – 01495 745615
- ward staff need to remind the patient that first contact should be with the district nurse or emergency number, not GPs or Ambulance service

9 Advice to patient about emergency catheter process

Quick info:
- ward staff are to advise patients that in the case of emergency catheter problems, the call handler will direct them to the correct district nurse or Out of Hours nurse
- ward staff need to explain to the patient that when they use the emergency number they will be asked for GP details.
- this will be reiterated by district nurses
Note for GPs and ambulance staff:
- please do not refer blocked catheters or emergency catheter changes to secondary care - please refer to district nurse or Out of Hours/Rapid response service
District nurses are only to refer patients to secondary care when they encounter a problematic catheterisation resulting in a failed attempt at unblocking or recatheterisation.

10 Patient discharged home

Quick info:
The nurse (both on the ward and district) is to arrange catheter prescription and/or register patient with a catheter equipment home delivery service.
Please refer to the list of home delivery services telephone numbers in Appendix 11 of the Urinary catheterisation policy

11 District nurse assessment

Quick info:
The district nurse will contact the patient within 24 hours of discharge to:
- check that the patient has the right catheter
- make assessment based on need
- plan the catheter review and catheter change date and ongoing needs
- if applicable, patient to arrange own prescription via GP

12 Reminder to patient about emergency catheter process

Quick info:
District nurses should:
- remind patients that in the case of emergency catheter problems the call handler will direct them to the correct district nurse or Out of Hours nurse
- explain to the patient when they use the emergency number they will be asked for GP details
District nurses are only to refer patients to secondary care when they encounter a problematic catheterisation resulting in a failed attempt at unblocking or recatheterisation

Locally reviewed: 14-Aug-2008  Due for review: 01-Oct-2008   Printed on 03-Oct-2008  © Medico-Medic

Page 3 of 5
Management of catheterised patient

Surgery > Urology > Management of catheterised patient

13. District nurse to check catheter availability before visiting patient

Quick info:
In the case of emergency and no catheter is available for patients at home, district nurses must access buffer stock or collect a catheter from their local community hospital.

14. Monitoring of patient

Quick info:
Regular monitoring and review by district nurses to check the catheter material and consider catheter removal or alternative methods of management.

District nurses are only to refer patients to secondary care when they encounter a problematic catheterisation resulting in a failed attempt at unblocking or recatheterisation.

Review should be recorded on the care plan:
- short-term (plastic) catheter will need changing after maximum of 7 days
- medium-term (polytetrafluoroethylene coated PYTFE) catheter will need changing after maximum of 21 days
- long-term (hydrogel coated biocath) catheter will need changing after maximum of 12 weeks
- review clinical need for ongoing catheterisation on 20 day or 12 week cycle
- if still needed consider intermittent self-catheterisation (ISC) or continue with appropriate indwelling catheter
- if not needed, cease treatment
Appendix 11 - Catheter Companies Home Delivery and Prescription Services

The following home delivery services can be used prior to and on discharge to obtain products and equipment so that the catheters are available at the patients home. This will enable district nurses to have the equipment for both planned and emergency catheter changes. Using a delivery service involves the nurses contacting the company to register the patients to give the demographic details. GP information will be requested in order for the home delivery/ dispensing service to request the prescription from the patients GP. Alternatively the equipment can be supplied by local chemists any decision must be made with the patient respecting patient choice and preference.

Bard
Prescription Express
85/87 Kempston Street
Liverpool
L3 8HE
Tel. 0800-0855424

COLOPLAST
Charter Healthcare
Unit 1, The Links
Bakewell Road
Arton Southgate
Peterborough
PE2 6BJ
Tel. 0800-132787

Great Bear healthcare Ltd
Cardiff Business Park
Cardiff
CF14 5NF
Tel. 0800-0556270

ASTRA TECH SELECT
Home delivery service
Free post SWC 1804
Stonehouse GL103BF
Tel . Free phone 0800 783 7027