

# Urinary Catheter Policy for Community Health Services, Inpatient Facilities and Primary Care

The document describes the processes and procedures for insertion and management of urinary catheters for staff in Community Health Services, Inpatient Facilities.

Key Words:	Urinary Catheter,	
Version:	8	
Adopted by:	Quality Assurance Committee	
Date Adopted:	20 August 2019	
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Name of responsible Committee:	Infection Prevention and Control Committee	
Date issued for publication:	August 2019	
Review date:	May 2023	
Expiry date:	29 <sup>th</sup> February 2024	
Target audience:	All LPT Staff	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	Outcome 8 – Infection Prevention and Control	

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### Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1		Guideline reviewed
2	Mar-Aug 2013	Reviewed in line with NICE (2012) and Safety Thermometer requirements. Changed to policy and associated format
3	July 2016	Policy reviewed
4	August 2016	Amendments from IPC & UHL
5	October 2016	Addition of UHL CAUTI Care Bundle & Contents Amendments from CHS Continence Leads
6	April 2017	Review in line with becoming LPT Policy Only
7	February 2019	Review in line with RCN (2019) Guidelines. Included Intermittent Catheterisation.

**For further information contact:** Clinical/Operational Lead Continence

### Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of their service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender),

gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT are responsible, including policy development and review.

### **Due Regard**

This policy provides LPT staff with clear information and procedures to ensure that patients, clients and carers receive timely, effective and appropriate care that reduces or eliminates the risk of healthcare acquired infections. LPT want those accessing healthcare to feel confident that the care they receive will do them no harm.

There will be continuous monitoring of the operation of this policy and the associated procedures to ensure that they are not discriminating against any particular equality group and that there is equality of access to the protection that the procedures offer. This will be demonstrated by effective monitoring of relevant service user equality data.

All LPT policies are available in alternative formats on request both for staff and service users.

### **Definitions that apply to this Policy**

<b>ANP</b>	Advanced Nurse Practitioner, A Nurse Practitioner is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which they are credentialed to practice.
<b>ANTT</b>	Aseptic Non Touch Technique – During any invasive clinical procedure the aim of an aseptic technique is to protect the patient from infection. In ANTT this is achieved by ensuring asepsis of key-parts and key sites are maintained by protecting them from contamination from the healthcare worker or environment.
<b>AUR</b>	Acute Urinary Retention
<b>Bladder Maintenance Solution</b>	Bladder Maintenance solution is used to prevent blockages and maintain draining of urine via the catheter
<b>Body Fluid splashes</b>	Blood / blood stained body fluids or body fluids which have the potential for carrying blood borne viruses which could have the potential for transmitting infection by being splashed into the eyes, nose or mouth.
<b>CAUTI</b>	Catheter Acquired Urinary Tract Infection – an infection associated with an indwelling catheter
<b>CSU</b>	A catheter specimen of urine (CSU) is collected for bacteriological examination, if a patients symptoms suggest the presence of an infection

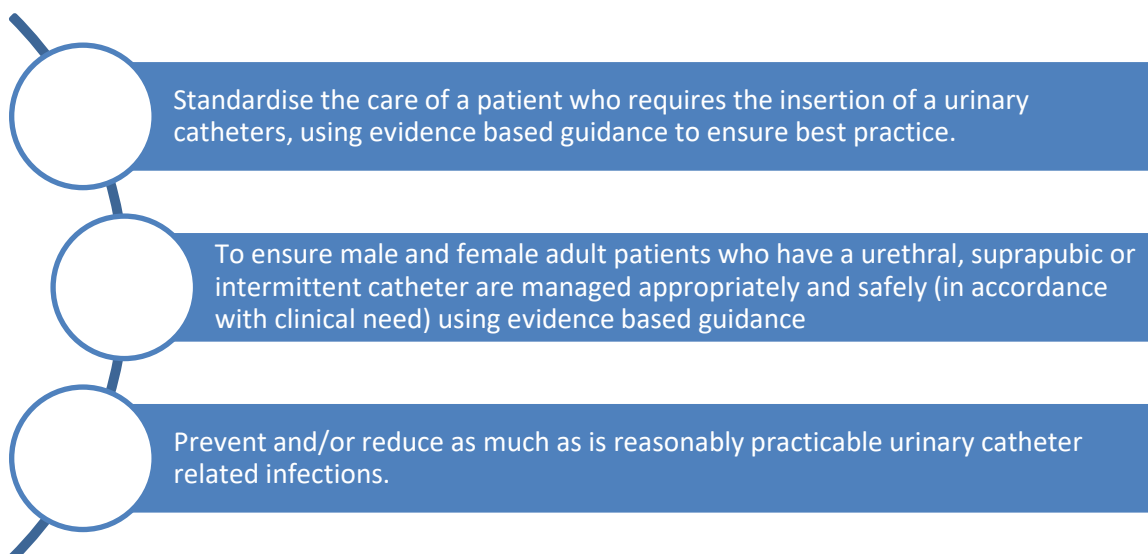
<b>HAI</b>	A health care acquired infection also known as a nosocomial infection, is an infection that is acquired when receiving healthcare
<b>Intermittent self-catheterisation</b>	Intermittent Self-Catheterisation (IC) is the insertion and removal of a catheter several times a day to empty the bladder.
<b>LCAT</b>	Leicester Clinical procedure Assessment Tool used to assess competency for a clinical task
<b>Mid-Stream Specimen of Urine MSU</b>	In order to obtain a specimen that is free of contamination, the peri-urethral area is cleansed and the patient is required to discard the initial flow of urine before collecting the specimen in a sterile container
<b>Mucocutaneous exposure</b>	Where the eye(s), the inside of the nose or mouth, or an area of non-intact skin of the healthcare worker are contaminated by blood or other body fluid.
<b>Personal protective Equipment (PPE)</b>	Gloves, aprons, gowns, masks and eye protection.
<b>TWOC</b>	Trial without Catheter

## 1.0 Purpose of the Policy

This policy sets out the procedural requirements for all staff employed within LPT who have undertaken the requisite training as required as part of their role to carry out the insertion, care and removal of a urethral, suprapubic or intermittent urinary catheter in male and female adult patients

The policy outline has been written by LPT which reflects the Organisations systems however the process for insertion, care and removal of a urethral/suprapubic catheter in the adult population remains the same and is transferable across other care providers.

The aim of this policy is to:



## 2.0 Summary of the policy

This document provides trust-wide guidance for:

- The insertion, management and removal of an indwelling urethral or suprapubic catheter.
- Selection of the most appropriate catheter for the patient
- Guidance on the use of intermittent catheterisation
- Management of adult patients in the community who are in urinary retention (AUR pathway).
- The use of the catheter passport and the patient leaflet on managing their catheter

Chronic urinary retention needs to be managed by a urology specialist; usually within a hospital environment. Further advice must be sought from a urology registrar in all of these cases.

### **3.0 Introduction**

Urinary catheterisation is defined as an intervention to enable emptying of the bladder by insertion of a catheter. Indwelling urinary catheterisation is categorised as either: short-term (in situ less than 28 days), or long-term (in situ greater than 28 days). The presence of a urinary catheter and the duration of its insertion are contributory factors to the development of catheter associated urinary tract infections (CAUTI).

It has been estimated that the risk of acquiring an infection increased by 5% each day the catheter remains in situ. An average of 25% of hospitalised patients are catheterised at some stage during their admission, therefore it is critical that practices and procedures are in place to minimise the risk of infection. (Saint and Chenoweth 2003)

The insertion of a urinary catheter carries considerable risk. Indwelling urinary catheters should only be used when no suitable alternative is available and must be left in for as short a time as possible.

Intermittent catheterisation is the preferred alternative to indwelling catheterisation providing this is clinically relevant to the patient (Appendix 11 and 12).

### **4.0 Procedural requirements for the insertion, care and removal of a urethral catheter in male and female adult patients**

Complications of catheterisation can affect a patient's quality of life and should not be underestimated (RCN 2019). Complications include:

- Urethral trauma resulting in infection (and possible septicaemia)
- Traumatic removal of catheter with the balloon inflated
- Urinary tract infection
- By-passing of urine around the catheter
- Stricture formation
- Encrustation and bladder calculi
- Urethral perforation
- Pain/bleeding
- Catheter blockage



- Trauma to the prostate (Due to inflated balloon positioned incorrectly)
- Para phimosis
- Urethral Erosion

#### **4.1 Catheter Acquired Urinary Tract Infection (CAUTI) and Antimicrobial Guidance**

When a urinary catheter is inserted into the bladder the probability of bacteria entering the bladder and colonising it is about 3-10% for each day the catheter remains in situ therefore, after one month almost all patients would be expected to have bacteria in the urine (bacteriuria), Royal College of Nursing 2019.

As a consequence, a positive urine dipstick test for leucocytes and nitrites is meaningless in a catheterised patient, antibiotics must not be prescribed purely on the basis of a positive dipstick test. Cloudy and offensive urine is not necessarily indicative of a Urinary Tract Infection (UTI). Advice should be given on fluid intake 1.5 – 2 litres per 24 hours providing patient is not on restricted fluid intake.

Catheterised patients should only be considered for antibiotic treatment if they develop symptoms of suspected UTI such as suprapubic pain, loin pain, fever, rigors or acute confusion without other obvious source. Refer to Appendix 5 to determine when to obtain and send a catheter specimen of urine. A catheter specimen of urine should be taken using the needle free port on the leg bag or urinary catheter bag (appendix 15).

When antibiotic treatment is prescribed for an infection; ensure that the existing catheter is changed prior to commencing the antibiotics if the catheter has not been changed within the last 7 days. This is in line with the Anti-Microbial Guidelines for the Management of Catheterised Patients in the Community (See policy and guideline section of e-source).

#### **4.2 Aseptic Non-Touch Technique (ANTT)**

**ANTT** is a technique that maintains asepsis and is non-touch in nature.

Catheterisation is a skilled aseptic procedure which must only be performed by a competent person who has undergone specific formal training, education and assessment.

ANTT and sterile equipment are essential in the insertion and management of catheters as urinary tract infections are the second largest single group of HCAI's in the UK (NHS Institute for Innovation and Improvement 2010).

A sterile catheterisation pack must be used at all times.

When carrying out catheterisation in a patient's own home, the healthcare worker may not have access to the specific equipment required i.e. sterile trolley surface, therefore staff must identify an appropriate area where a suitable clean working surface can be used for example a bedside table, tray or chair. If this is not deemed possible then a risk assessment must be carried out and alternative options must be explored i.e. attending a clinic.

### 4.3 Documentation

All initial catheterisations must be authorised by a Medical Practitioner/ANP and documented in the patient record. An appropriate identification and risk assessment is crucial to inform the decision making process for catheterisation and should be clearly documented (RCN 2019).

The initial reason for catheterisation of the patient must be clearly documented in the patients care plan as should any known difficulties with inserting the catheter.

Written, verbal or implied consent must be obtained and documented.

**ANTT** must be documented as part of the catheterisation process

For patients who are receiving end of life care the Lead Practitioner can make the decision as to whether catheterisation is appropriate or not. Any decisions and the rationale to this must be clearly and concisely documented in the patient files/notes.

Whilst the following are not necessarily contra indications, further advice or instruction should be considered if the patient is known to have:-

- Previous urethral trauma
- Known history of urethral stricture
- Previous difficulty with catheterisation
- Radical prostatectomy or bladder reconstruction within last 8 weeks
- Urethral reconstruction surgery within last 8 weeks
- Undiagnosed haematuria
- A history of lower urinary tract cancers
- Congenital abnormalities (e.g. Hypospadias or Epispadias)
- Artificial Heart Valve
- A Heart Defect
- Patient is immune-suppressed

Potentially the risks of developing a serious infection and/or associated life threatening conditions such as Sepsis is increasing with emergence of a range of multi-resistant bacteria which cause CAUTI's (RCN 2019).

#### 4.3.1 Catheter Passport and Patient Education leaflet

Providing the patient with a urinary catheter passport supports consistency of catheter care. The document provides the patient and healthcare professional with the relevant catheter care information, inclusive of reason for catheterisation, catheter type, size, insertion information, catheter related equipment, planned catheter change and forward planning (e.g. TWOC date).

A catheter passport must be commenced at the first visit and a patient leaflet on managing a urinary catheter must be given to the patient and/or carer and explained and discussed by the attending nurse/practitioner. This must accompany the patient for any catheter change, catheter intervention or treatment either by community or acute trust services.



Patient's clinical need for catheterisation should be reviewed regularly identifying patients whose catheter can be removed as soon as possible (NICE 2019). Within the community setting all healthcare staff must record every catheter intervention clearly, accurately and correctly on the STOP! THINK Assessment Form found on Systmone (*Appendix 6*). This should be filed in the patient's community notes or on the electronic patient record within SystmOne.

Wherever possible, patients and carers should be independent in the on-going management of the catheter. Information and advice should be given on hygiene, fluid intake, prevention of constipation, and correct use of drainage systems (NICE 2015)

#### 4.4 Selection of catheter type

There is a range of catheters available however indwelling urethral catheters should only be used after alternative methods of management have been considered, (NICE 2012).

Each type of catheter is recommended for use up to a certain length of time and this will usually dictate the type of catheter used.

#### Foley Catheter Types (Guide Only)

Material	Recommended Use	Advantages	Disadvantages
<b>Latex with silicone coating</b>	Short term, usually 7-14 days	May help to reduce potential encrustation	Must not be used in people with latex allergy
<b>Latex with (Teflon) PTFE coating</b>	Short to medium term, up to 28 days (4 weeks)	Smoother on external surfaces for insertion	If left in situ too long Teflon coating may wear thin.  Must not be used in people with latex allergy
<b>Hydrogel or Hydromer coating</b>	Long term up to 12 weeks	More compatible with body tissue, less trauma	Must not be used in people with latex allergy
<b>Pure Silicone / 100% Silicone</b>	Long term up to 12 weeks	The only catheter which can be used for patient with latex allergies	'Cuffing' of balloon can occur on deflation. Can be more difficult to remove suprapubically

<b>Silicone Elastomer Coating</b>	Long term up to 12 weeks	May help to reduce potential for encrustation	Must not be used in people with latex allergy
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For further information see LLR Continence Prescribing Formulary (See policy and guideline section of e-source)

#### **4.5 Catheter Size (Ch.)**

The internal diameter of a catheter is measured in Charriere (Ch) – one Ch equals 1/3 mm, therefore 12 Ch equals 4 mm. The following sizes are recommended:

- 12ch, 14ch or 16ch for male
- 10ch, 12ch or 14ch for female

Remember to select the smallest gauge to meet the patient's needs, to reduce the risk of bladder spasms, catheter bypassing and trauma and enable the bladder to drain.

The size of a supra-pubic catheter is determined by the Urologist who will be inserting the catheter.

#### **4.6 Catheter Length**

Standard length (40cm) catheters must be used for males but can be used for females in some circumstances, (e.g. females in wheelchairs)

The shorter female length (23cm) catheters must only be used for female patients, it must never be used for a male patient as it may cause severe urethral trauma if the balloon is inflated in the male urethra.

Standard-Length catheters are to be used for supra-pubic catheterisation.

#### **4.7 Catheter Balloon Size**

Patients will routinely have a 10ml balloon prescribed. 10ml balloon reduces bladder neck pressure and irritation which helps to reduce further complications.

Catheters are single use therefore the balloon must not be deflated and re-inflated.

A urinary catheter with a 20-30 ml balloon should only be prescribed by urology and further advice should be sought for these patients from Urology.

Sterile water must always be used to fill the catheter balloon unless otherwise instructed by a specialist practitioner responsible for the patients care. (NICE 2012)

#### **4.8 Catheter Drainage**

A closed drainage system should be used to minimise the risk of urinary tract Infection (RCN 2019). The choice of drainage system should be appropriate to individual clinical need, whilst taking into account the potential risks

Leg bags must be changed every 7 days in line with manufacturer's guidelines.

Leg bags should be positioned below bladder level to promote drainage and secured to prevent trauma to the urethra (NICE 2012). The exception to this is the use of a belly bag. Belly Bags are a closed drainage system that is worn around the abdomen and can be considered for use with amputee patients. The bag is changed every 28 days.

Never replace a used bag once it has been disconnected from the catheter. A new bag must always be used to reduce infection

Single use night bags should be used and attached to the outlet of the leg bag.

Intermittent bladder drainage can be achieved by use of a catheter valve as these allow the bladder to expand to store urine and contract to empty. This helps to maintain the muscular effect, stimulate blood supply and continue normal bladder health.

Catheter valves can be used (NICE 2012) and should be opened 3-4 hourly to prevent over-distension of the bladder during the day. Overnight the catheter can be attached to a single-use night bag and the catheter valve opened to allow free drainage. They must not be used for chronic retention.

Catheter Valves should be changed weekly in accordance with manufacturer's guidelines.

Catheter valves are only suitable for people with mental awareness, good manual dexterity, are mobile, and have physical awareness to feel a full bladder, as well as having adequate bladder capacity. Catheter valves should be encouraged for patients with supra pubic catheters.

#### **4.9 Catheter Fixation Devices**

Catheters must be fixed to the patient's leg correctly to support the catheter to reduce unnecessary trauma to the bladder and urethra.

G strap or other fixation devices are recommended during the day alongside the leg straps provided with catheter bags.

These must be allocated on a single patient use basis and changed if they become visibly soiled.

To prevent erosion of the urethra and or pressure sores to the genital area catheter and catheter bag position must be alternated daily (from leg to leg).

#### **4.10 Equipment and Procedure**

Patients should be catheterised safely, in accordance with clinical need and have the catheter in place for the shortest time possible (RCN 2019)

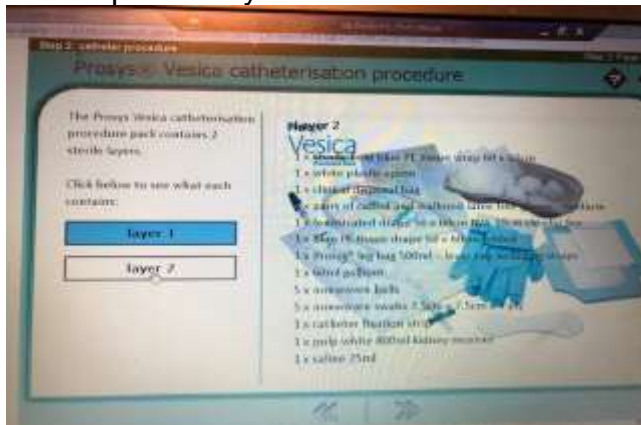
Patients in acute urinary retention are catheterised with a short-term catheter. Acute urinary retention is associated with abdominal pain and the inability to void urine. All community staff should follow the pathway for the community management of acute

urinary retention in adults (see Appendix 7)

Equipment required:

1. Vesica pack – Layer 1
  - 1 x sterile field blue PE tissue wrap 55 x 60cm
  - 1 x white plastic apron
  - 1 x white disposal bag
  - 1 x pair of cuffed and walled latex free gloves – medium
  - 1 x 10ml luer slip syringe
  - 3 x non-woven swabs 7.5cm x 7.5cm x 4ply

Vesica pack - Layer 2



2. Anaesthetic lubricating gel – as prescribed & authorised for each patient – unless the patient is in acute retention, then staff must use the PDG
3. A catheter as prescribed & authorised for the patient, male or female as appropriate, size should be recorded on the care plan.
4. Water to blow up the balloon – this should be in the catheter pack, but please check prior to commencing the procedure.
5. Bags & fixation devices are included in the 2<sup>nd</sup> layer of the Vesica pack, however if the patient has a preference for a different type, staff will need to access these separately.

#### 4.10.1 Male catheterisation (See Appendix 8)

#### 4.10.2 Female catheterisation (See Appendix 9)

#### 4.10.3 Supra-pubic catheterisation (Appendix 10)

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.

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.

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.

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.

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.

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

Lubricating gel (i.e. instigel) should be used at time of catheter changes.

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

The choice of appliance should be regularly re-assessed.

#### **4.10.4 Intermittent Catheterisation** (*Appendix 11 and 12*)

Intermittent self-catheterisation is considered the Gold Standard for urine drainage (NICE 2015, cited in RCN 2019). It 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.

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.

It is acceptable for the patient to use a clean technique (EUAN 2013, cited RCN 2019)

Advice should be given, including supporting literature, to patients and carers on frequency of catheterisation, size of catheters to be used and on the completion of documentation post insertion i.e. volume of urine obtained.

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.

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 with a requirement that genital and hand hygiene (prior to insertion and removal) have been demonstrated and observed as part of a supervised practice by a competent experienced healthcare practitioner.

## 4.12 Catheter Maintenance Solutions

Bladder irrigation, instillation and washouts do not prevent catheter-associated infection. Regular use can lead to an increased risk if the sterile closed drainage system is repeatedly broken which can lead to serious infections and Sepsis (RCN 2019). Catheter maintenance solutions should only be used as part of a management plan for prevention of catheter blockage based on clinical need.

These are sterile prefilled prescription only products, they should only be used when all other options have been considered. Evidence suggests smaller volumes, instilled sequentially, are more effective than large volume single administrations.

The solution should only be used following a patient assessment by a Registered Health Care Professional who will then arrange an authorisation and prescription.

For problems and complications associated with urethral catheters such as blockage or bypassing review fluid intake, bowels and frequency of change and follow the Registered Nurse Pathway for Blocked or Bypassing Catheter (*Appendix 11*).

For unplanned catheter blockage/bypassing staff need to refer to the Protocol for the Administration of Catheter Patency Solution, OPTIFLO® S For Blocked and Bypassing Catheters; to be administered by Band 5 and above. (See Appendix ??).

The following products are used for maintenance

- OPTIFLO® G (Suby G - 3.23% citric acid)  
Used for encrustation
- OPTIFLO® R (Solution R - 6% citric acid)  
Used for encrustation (double strength of G)
- OPTIFLO® S (0.9% saline)  
Used for blood and debris **not** encrustation.



In exceptional circumstances it may be necessary to carry out a manual bladder wash out. Please contact your Urology/Continence Lead Nurse for further advice.

## 4.13 Trial without Catheter (TWOC)

If after discussion with an identified specialist practitioner i.e. GP/ANP it is agreed that there is no clinical reason for the patient to remain catheterised please refer to LPT's TWOC pathway (*See appendix 14*)

## 5.0 Duties within the Organisations

5.1 **The Trust Board** has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.



- 5.2 **Trust Board Sub-committees** have the responsibility for ratifying policies and protocols.
- 5.3 **Hospital Matron, Community Service Managers and Heads of Services** - it is their role and responsibility to ensure that the policy for the management of urinary catheters is adhered to and that there is a clear process for dissemination.
- 5.4 **Line Managers**- It is their role and responsibility to identify and support the appropriate staff to attend the necessary training and complete the LCAT assessment of competence in practice within the community setting. Ensure all staff are aware of their responsibilities regarding urethral catheterisation and ongoing care.
- 5.5 Maintaining a record of staff that are competent in the insertion, care of and removal of a urethral catheter ensuring that numbers of staff trained meet service need.
- 5.6 **Healthcare Staff whose role includes urinary catheterisation** - it is their role and responsibility to have undertaken the appropriate education and training which must be identified at their appraisal.
- 5.7 This training is role specific. Staff for whom this is a an essential clinical skill must attend the one day catheterisation training, followed by a period of supervised practice performing a range of catheterisation procedures. Staff will be assessed as competent using the LCAT Tool prior to carrying out this practice or alternatively have evidenced competence if this clinical practice has been part of their role, previous to being employed by LPT.
- Healthcare Support Workers, who undertake training & have been supervised and assessed, can change legs bags & insert a planned / delegated solution
  - Nursing Associates (registered) and Assistant Practitioners can perform planned routine re-catherisation / catheter care following training, supervised practice & assessment
  - Registered Nurses can assess, plan & deliver all care, and can initiate catheterisation at the end of life if required.
  - Initial catheterisation requires authorisation from a Medical Practitioner / ANP

## 6.0 Training Needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

The course directory e-source link will identify who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access training.

A record of the event will be recorded on Ulearn. The governance group in each directorate are responsible for monitoring the training.

## 7.0 Monitoring Compliance and Effectiveness

Where monitoring identifies any shortfall in compliance with policy and requirements for assessments; the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance

Ref	Minimum Requirements	Evidence for self-assess	Process for Monitoring	Responsible Ind/Group	Frequency of Monitoring
4.2	Catheterisation is a skilled aseptic procedure which must only be performed by a competent person who has undergone specific formal training and education	4.2	Attendance at the trust urinary catheterisation and bladder scanning training/PDR  Completion of the urinary catheter e-learning module Compliant with LCAT assessment or evidence from another Organisation  Incident reporting	Team managers  Lead Nurse  Urinary Tract infection (UTI) working group	Quarterly
4.3 - 4.9	All patients who are catheterised must have the most appropriate catheter for their clinical need	4.3 – 4.9	Evidence of documentation using care plan  Audit  Catheter passport Catheter leaflet	Registered practitioners undertaking the task Team managers  UTI working group	Annual
4.10	Patients will be catheterised safely, in accordance with clinical need and have the catheter in place for the shortest time possible	4.10	Evidence of the STOP! Think form.  Management plan in place for patients with urinary catheter  Audit	Registered practitioners undertaking the task  Team managers  Patient Safety Group	Quarterly   Annual

## 8.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
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<p><b>CQC Fundamental Standards</b>  Reg 9 Person Centred Care,  Reg 10 Dignity and Respect  Reg 11 Need for consent  Reg 12 Safe Care and Treatment  Reg 17 Good Governance</p>	<ul style="list-style-type: none"> <li>• STOP! Think forms will be used for all urinary catheterisations</li> <li>• A patient leaflet will be given to all patients who require a urinary catheter</li> <li>• A personalised plan of care will be developed for all patients who require continence support and/or a urinary catheter</li> </ul>
<p><b>NICE Guidance</b>  Infection: prevention and control of healthcare- associated infections in primary and community care</p> <p>Quality Standard 90: Urinary Tract Infections in Adults</p>	<p>Audit programme</p> <p>Nice guideline baseline assessment tool</p>

## 9.0 Reference and Bibliography

This policy was drafted with reference to the following:

Department of Health (2009) Reference guide to consent to the procedure. London.

Department of Health (2012) updated 2015 The Health and Social Care Act – Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. London. Department of Health

Leicestershire Partnership Trust 2015, Overarching Infection Prevention and Control policy and associated documents.

National Audit Office (2004) cited in NHS Institute for Innovation and Improvement (2010) High Impact Actions for Nursing and Midwifery. The Essential Collection. Coventry.

NICE National Institute of Clinical Excellence (2015) Urinary Tract Infections in Adults. NICE quality standard 90. [guidance.nice.org.uk/qs90](http://guidance.nice.org.uk/qs90)

NICE National Institute of Clinical Excellence (2012) Infection Control: Preventing healthcare associated infection in primary and community care.

NICE National Institute of Clinical Excellence (2003) Infection Control No 2. Care of patients with long term catheters.

NMC (2018) Nursing and Midwifery Council. Code of Professional Conduct. NMC London.

NPSA (National Patient Safety Agency), Female urinary catheters causing trauma to adult males. 30<sup>th</sup> April 2009. NPSA/2009/RRR02

RCN (2019) Catheter Care; RCN Guidance for Health Care Professionals. RCN. London.

Saint S, Chenoweth CE.; Biofilms and catheter-associated urinary tract infections. Infectious Diseases Clinical North America 2003 Jun;17 (2): 411-32

SARI (2011) Guidelines for the Prevention of Catheter-associated Urinary Tract Infection, Published on behalf of SARI by HSE Health Protection Surveillance Centre 2011.

The Royal Marsden Hospital (2011) Manual of Clinical Nursing procedures, Eighth Edition. Blackwell Science. Cambridge

## Appendix 1

### Training Needs Analysis

<b>Training topic:</b>	Procedural requirements for the insertion, and removal of a urethral catheter in male and female adult patients
<b>Type of training:</b> (see study leave policy)	<input type="checkbox"/> Mandatory (must be on mandatory training register) <input checked="" type="checkbox"/> Role specific <input type="checkbox"/> Personal development
<b>Division(s) to which the training is applicable:</b>	<input checked="" type="checkbox"/> Adult Mental Health & Learning Disability Services <input checked="" type="checkbox"/> Community Health Services <input type="checkbox"/> Enabling Services <input checked="" type="checkbox"/> Families Young People Children <input type="checkbox"/> Hosted Services
<b>Staff groups who require the training:</b>	All clinical staff who have a responsibility for the insertion, care or removal of a urethral catheter in male and female adult patients
<b>Regularity of Update requirement:</b>	Attendance of the urinary catheter and bladder scanning training and LCAT assessment to identify competence
<b>Who is responsible for delivery of this training?</b>	Continence team, Clinical Educators
<b>Have resources been identified?</b>	Yes
<b>Has a training plan been agreed?</b>	Yes

<b>Where will completion of this training be recorded?</b>	✓ Ulearn ✓ Other (please specify)
<b>How is this training going to be monitored?</b>	Monitoring will take place through a number of processes: <ul style="list-style-type: none"> <li>• Urinary Tract Infection Work stream</li> <li>• Line Managers</li> <li>• Patient Safety Groups</li> </ul>

## Appendix 2

### The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

<b>Shape its services around the needs and preferences of individual patients, their families and their carers</b>	✓
<b>Respond to different needs of different sectors of the population</b>	✓
<b>Work continuously to improve quality services and to minimise errors</b>	✓
<b>Support and value its staff</b>	✓
<b>Work together with others to ensure a seamless service for patients</b>	✓
<b>Help keep people healthy and work to reduce health inequalities</b>	✓
<b>Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance</b>	✓

## Appendix 3

### Stakeholders and Consultation

#### Key individuals involved in developing the document

Name	Designation
Chris Rippin	Continenence Lead
Jo Earle-Marshall	Operational Team Lead – Tissue Viability and Continenence CHS
Amanda Hemsley	Lead Infection Prevention and Control Nurse
Lesley Tooley	Clinical Education Lead
Ros Gretton	Continenence Lead

#### Circulated to the following individuals for comment

Name	Designation
Continenence team	Leicestershire Partnership Trust
Mel Hutchings	Infection Prevention and Control Nurse
Antonia Garfoot	Senior Infection Prevention and Control Nurse
Andy Knock	Infection Prevention and Control Nurse
Emma Wallis	Associate Director of Nursing and Education
Anne Scott	Chief Nurse - Interim
Tracy Yole	Lead Nurse CHS - Community
Claire Armitage	Lead Nurse AMHS/LD - Community
Rebecca O'Brien	Lead Nurse FYPC
Laura Belshaw	Lead Nurse MHSOP

Sarah Latham	Lead Nurse CHS Inpatient
Kam Palin	Occupational Health Nurse
Helen Walton	Property Manager, Estates and Facilities
Tejas Khatau	Lead Pharmacist for FYPC
Jane Martin	Matron, LD and Rehabilitation
Bernadette Keavney	Head of Trust Health and Safety, Compliance
Pauline Blake	Learning and Development Lead
Katie Willetts	Senior Nurse, FYPC

## DATA PRIVACY IMPACT ASSESSMENT SCREENING

<p>Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.</p> <p>The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.</p>		
Name of Document:	Management of a Urinary Catheter Policy	
Completed by:	Amanda Hemsley	
Job title	Lead Infection Prevention and Control Nurse	Date 10 June 2019
Screening Questions	Yes / No	Explanatory Note
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	no	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	no	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	no	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	no	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	no	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	no	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	no	
8. Will the process require you to contact individuals in ways which they may find intrusive?	no	
<p>If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via <a href="mailto:Lpt-dataprivacy@leicspart.secure.nhs.uk">Lpt-dataprivacy@leicspart.secure.nhs.uk</a>  In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.</p>		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust



## Due Regard Screening Template

<b>Section 1</b>			
<b>Name of activity/proposal</b>	Procedural requirements for the insertion, care and removal of a urethral catheter in male and female adult patients		
<b>Date Screening commenced</b>	April 2019		
<b>Directorate / Service carrying out the assessment</b>	Quality and Innovation		
<b>Name and role of person undertaking this Due Regard (Equality Analysis)</b>	Amanda Hemsley		
<b>Give an overview of the aims, objectives and purpose of the proposal:</b>			
<b>AIMS:</b> To standardise the care of urinary catheters, using evidence based guidelines to ensure best practice is used across LPT			
<b>OBJECTIVES:</b> To ensure male and female adult patients who have a urethral catheter are catheterised safely, appropriately and in accordance with clinical need. To prevent and/or reduce the potential risk of urinary tract infections including those related to urinary catheters.			
<b>Section 2</b>			
<b>Protected Characteristic</b>	<b>If the proposal/s have a positive or negative impact please give brief details</b>		
Age	N/a		
Disability	N/a		
Gender reassignment	N/a		
Marriage & Civil Partnership	N/a		
Pregnancy & Maternity	N/a		
Race	N/a		
Religion and Belief	N/a		
Sex	N/a		
Sexual Orientation	N/a		
Other equality groups?	N/a		
<b>Section 3</b>			
<b>Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.</b>			
Yes		No ✓	
High risk: Complete a full EIA starting click <a href="#">here</a> to proceed to Part B		Low risk: Go to Section 4.	✓
<b>Section 4</b>			
<b>If this proposal is low risk please give evidence or justification for how you reached this decision:</b>			
This policy has been reviewed in line with current guidance and practice. No major changes have been undertaken to its content. The policy will be reviewed through the Infection Prevention and Control Committee and then recommended to the Quality Assurance Committee for adoption.			
<b>Signed by reviewer/assessor</b>	Amanda Hemsley	<b>Date</b>	15 May 2019
<i>Sign off that this proposal is low risk and does not require a full Equality Analysis</i>			
<b>Head of Service Signed</b>	Emma Wallis	<b>Date</b>	

## Urinary Catheter Assessment & Monitoring Form

# Stop! Think ! Is Catheterisation Necessary?

Patient Name:	
NHS No:	D.O.B:

Ward/Unit/District Nursing Team .....

Is the catheter in for Urinary Retention    Yes                          No   

If No have you considered another option            Pads  Intermittent Self Catheterisation   
    Penile Sheath

Informed consent obtained            Yes             No

If No was Mental Capacity assessed                      Yes                No   

If no capacity was mental capacity assessment completed    Yes        No   

If no why .....

Procedure fully explained and understood by patient    Yes        No   

Patient Catheter Information Booklet given                      Yes                No   

Catheter Type            Short Term (up to 28 days)        Long Term (5-12 weeks)   

Urethral     Supra-Pubic                          Date Change Due .....

Routine change                Blocked Catheter   

Is patient pyrexial    Yes        No                          Urinalysis done    Yes                No   

CSU Sent            Yes                No   

Date Sent .....

**Allergies**

None                          Latex      
 Lidocaine                          Medication   

Others   

.....  
 Please Specify

Aseptic Technique    Yes                No   

Sterile Saline for Meatal Cleansing    Yes                No      
 If No specify cleansing agent used.....

Sterile Lubricant used            Yes                No   

Lot Number .....            Expiry Date .....

Sterile closed drainage system used            Leg Bag     2L Drainage Bag             Catheter Valve   
 Method of securing to leg    Leg Straps    Yes     No             G Strap used    Yes                No   

Catheter Label Information Attach Label From Catheter Package

Catheter secured safely to leg            Yes                No   

**Post Insertion**

Difficulty with catheter insertion?    Yes                No   

Did any bleeding occur?            Yes                No   

Volume of urine drained .....

Colour of Urine .....

If no urine drained state action taken .....

Print Nurse's Name .....                      Signature .....

Job Title .....                      Date and Time .....

Version 1                                      Number 2                                      Date: 13/05/2013



## Urinary Catheter Assessment & Monitoring Form

### Stop! Think ! Is Catheterisation Necessary?

Patient Name: \_\_\_\_\_

NHS No: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Ward/Unit/District Nursing Team .....

Is the catheter in for Urinary Retention Yes  No If No have you considered another option Pads  Intermittent Self Catheterisation   
Penile Sheath Informed consent obtained Yes  No If No was Mental Capacity assessed Yes  No If no capacity was mental capacity assessment completed Yes  No 

If no why .....

Procedure fully explained and understood by patient Yes  No Patient Catheter Information Booklet given Yes  No Catheter Type Short Term (up to 28 days)  Long Term (5-12 weeks) Urethral  Supra-Pubic  Date Change Due .....Routine change  Blocked Catheter Is patient pyrexial Yes  No  Urinalysis done Yes  No CSU Sent Yes  No 

Date Sent .....

**Allergies**None  Latex Lidocaine  Medication Others .....  
Please SpecifyAseptic Technique Yes  No Sterile Saline for Meatal Cleansing Yes  No 

If No specify cleansing agent used.....

Sterile Lubricant used Yes  No 

Lot Number ..... Expiry Date .....

Sterile closed drainage system used Leg Bag  2L Drainage Bag  Catheter Valve Method of securing to leg Leg Straps Yes  No  G Strap used Yes  No 

Catheter Label Information

Attach Label From Catheter Package

Catheter secured safely to leg Yes  No **Post Insertion**Difficulty with catheter insertion? Yes  No Did any bleeding occur? Yes  No 

Volume of urine drained .....

Colour of Urine .....

If no urine drained state action taken .....

Print Nurse's Name .....

Job Title .....

Version 1

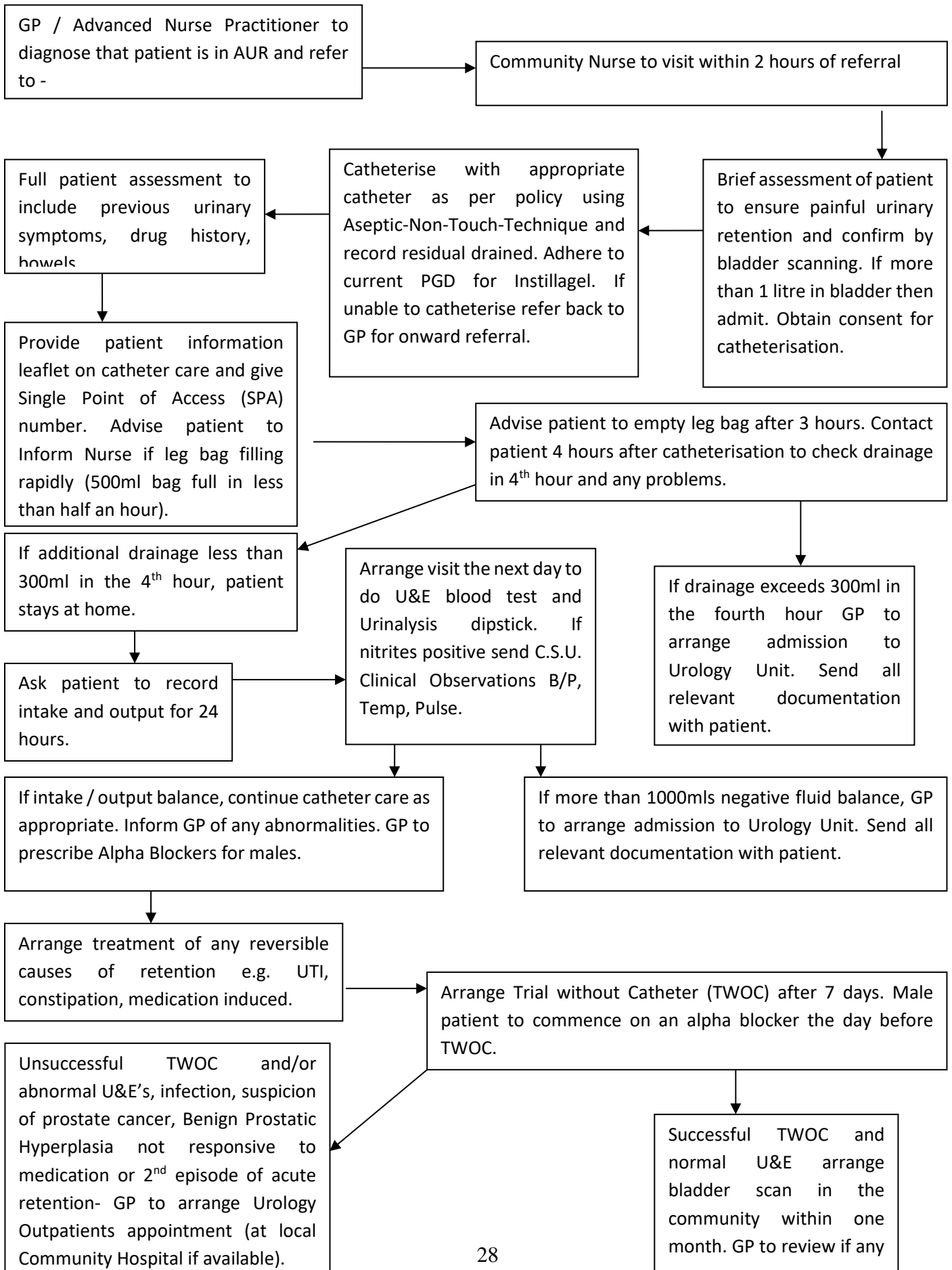
Signature .....

Date and Time .....

Number 2

Date: 13/05/2013

## COMMUNITY MANAGEMENT OF ACUTE URINARY RETENTION (AUR) IN ADULTS



## Insertion/Changing Male Catheter

	Action	Rationale
1.	<p>Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied.</p> <p>The patient should be given the choice regarding a chaperone.</p> <p>The Community policy can be found by following the link below</p> <p><a href="http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf">http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf</a></p>	To ensure that the patient understands the procedure and gives valid consent.
2.	Check the patient has no known allergies	To prevent anaphylaxis or skin irritation
3.	Ensure privacy and that there is appropriate protection on the bed, to prevent soiling.	To ensure patient's privacy and protect bed
4.	Assist the patient to get into the supine position with legs extended.	To ensure the appropriate area is easily accessible
5.	Do not expose the patient at this stage of the procedure.	To maintain patient's dignity and comfort.
6.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross infection from micro-organisms.
7.	Prepare clean surface by wiping with a detergent wipe, or suitable alternative placing all equipment required in easy reach.	To ensure a clean working surface
8.	Open the outer cover of the catheterisation pack and slide the pack onto a clean surface.	To prepare equipment
9.	If changing catheter open <b>removal pack</b> ; put on the disposable plastic apron and disposable gloves using ANTT.	To reduce risk of cross-infection from micro-organisms
10.	Remove cover that is maintaining the patient's privacy	To expose genitalia.
11.	To remove the catheter; deflate catheter balloon using 10ml syringe allowing the syringe to fill without applying any traction on the plunger (keep urine bag attached)	To prevent cuffing of the balloon  To reduce the risk of potential infection
12.	Gently withdraw the catheter	To avoid discomfort for the patient
13.	Dispose of catheter and used equipment including apron and gloves according to Trust Policy	To ensure safe disposal of waste
14.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce the risk of infection
15.	Open <b>catheter insertion</b> pack; spreading out the wrapping to form a sterile working area, put on apron and using waste bag as sterile glove position	To minimise the risk of infection

	<p>equipment ready for use on sterile field. Position the waste bag for easy use during procedure. Open package and place anaesthetic container on sterile field and empty saline in to gallipot.</p> <p>Wash/decontaminate hands and apply sterile gloves using ANTT.</p>	
16.	Place sterile field under patient	To protect the bed
17	Retract the foreskin, and clean the glans penis with 0.9% sodium chloride.	To reduce the risk of introducing infection to the urinary tract during catheterisation
18	Place sterile towel from catheter pack over the patients' genital area.	To reduce the risk of introducing infection into the bladder
19	<p>Hold the penis firmly with a sterile swab raising until almost totally extended.</p> <p>Squeeze the anaesthetic lubricating gel in to the urethra, remove and discard the syringe.</p>	<p>To straighten the urethra</p> <p>Adequate lubrication helps to prevent urethral trauma. Using 11mls local anaesthetic gel minimises the discomfort experienced by the patient.</p>
20	<p>Cover end of penis with sterile swab and wait 5 minutes</p> <p>Wash/decontaminate hands and apply sterile gloves using ANTT.</p>	<p>To prevent leakage of lubricating gel and to allow the anaesthetic gel to take effect</p> <p>To reduce the risk of infection</p>
21	<p>Place the receiver containing the sterile covered catheter between the patient's legs. Maintaining hold of the penis insert the catheter until urine flows maintaining hold of the penis until the procedure is finished</p> <p>If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to cough or strain gently as if passing urine.</p> <p>When urine begins to flow, advance the catheter almost to its bifurcation.</p> <p>Gently inflate the balloon according to manufacturer's instructions having ensured that the catheter is draining freely beforehand.</p> <p>Withdraw the catheter slightly until resistance is felt on the bladder neck and attach it to the drainage system.</p>	<p>This manoeuvre straightens the urethra and facilitates catheterisation. The male urethra is approximately 18-21 cm long</p> <p>Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter</p> <p>Advancing the catheter ensures that it is correctly positioned in the bladder</p> <p>Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma</p>

	<p>Support the catheter using an appropriate fixation device and ensure that the catheter will not become taut when patient is mobilising or when the penis becomes erect. Ensure that the catheter lumen is not occluded by the fixation device, and urine is able to run freely.</p> <p>Ensure that the glans penis is clean and then reposition the foreskin.</p>	<p>To ensure catheter is correctly positioned</p> <p>To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma.</p> <p>Retraction and constriction of the foreskin behind the glans penis (paraphimosis) may occur if this is not done.</p>
22.	Make the patient comfortable. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
23.	Observe the amount and colour of urine drained and document.	To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed.
24.	Take a urine specimen for laboratory examination, if clinically indicated	To ensure appropriate treatment and prevent routine prescribing of antibiotics
25.	Dispose of equipment according to local policy.	To prevent environmental contamination.
26.	<p>Record information in relevant documents; ensuring the catheter passport is completed this should include:</p> <ul style="list-style-type: none"> <li>• reasons for catheterisation</li> <li>• date and time of catheterisation</li> <li>• use of ABTT</li> <li>• catheter type, length and size</li> <li>• amount of water instilled into the balloon</li> <li>• batch number</li> <li>• manufacturer</li> <li>• batch number and expiry date of Instillagel;</li> <li>• any problems occurring during the procedure</li> <li>• review date to assess the need for continued catheterisation or date of change of catheter.</li> </ul>	To maintain accurate information. Attach sticky labels from equipment to documentation.

## Insertion/Changing Female Catheter

	Action	Rationale
1	<p>Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied.</p> <p>The patient should be given the choice regarding a chaperone.</p> <p>The Community policy can be found by following the link below</p> <p><a href="http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf">http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf</a></p>	To ensure that the patient understands the procedure and gives valid consent.
2	Check the patient has no known allergies	To prevent anaphylaxis or skin irritation
3	Ensure privacy and that there is appropriate protection on the bed, to prevent soiling.	To ensure patient's privacy and protect bed
4	Assist the patient to get into the supine position with legs extended.	To ensure the appropriate area is easily accessible
5.	Do not expose the patient at this stage of the procedure.	To maintain patient's dignity and comfort.
6.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross infection from micro-organisms.
7.	Prepare clean surface by wiping with a detergent wipe, or suitable alternative placing all equipment required in easy reach.	To ensure a clean working surface
8.	Open the outer cover of the catheterisation pack and slide the pack onto a clean surface.	To prepare equipment
9.	If changing catheter open <b>removal pack</b> ; put on the disposable plastic apron and disposable gloves using ANTT.	To reduce risk of cross-infection from micro-organisms
10.	Remove cover that is maintaining the patient's privacy	To expose genitalia.
11.	To remove the catheter; deflate catheter balloon using 10ml syringe allowing the syringe to fill without applying any traction on the plunger (keep urine bag attached)	<p>To prevent cuffing of the balloon</p> <p>To reduce the risk of potential infection</p>
12.	Gently withdraw the catheter	To avoid discomfort for the patient
13.	Dispose of catheter and used equipment including apron and gloves according to Trust Policy	To ensure safe disposal of waste
14.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce the risk of infection
15.	Open <b>catheter insertion</b> pack; spreading out the wrapping to form a sterile working area, put on apron and using	To minimise the risk of infection



	waste bag as sterile glove position equipment ready for use on sterile field. Position the waste bag for easy use during procedure. Open package and place anaesthetic container on sterile field and empty saline in to gallipot. Wash/decontaminate hands and apply sterile gloves using ANTT.	
16.	Place sterile field under patient	To protect the bed
17.	Using sterile swabs, separate the labia minora so that the urethral meatus is seen. Clean around the urethral orifice with 0.9% sodium chloride using single downward strokes	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter
18.	Place sterile towel from catheter pack across the patients' thighs.	To reduce the risk of introducing infection into the bladder
19.	<p>Using sterile swabs, separate the labia minora so that the urethral meatus is seen. One hand should be used to maintain labial separation until catheterisation is completed.</p> <p>Squeeze the anaesthetic lubricating gel in to the urethra, remove and discard the syringe. Wait 5 minutes to allow the gel to take effect.</p> <p>Wash/decontaminate hands and apply sterile gloves using ANTT</p> <p>Place the receiver containing the sterile covered catheter between the patient's legs. Introduce the tip of the catheter into the urethral orifice in an upward and backward direction. If there is any difficulty in visualising the urethral orifice due to vaginal atrophy and retraction of the urethral orifice GENTLY lift the parted labia upwards towards the pubic bone. Insert the catheter until urine flows.</p> <p>Gently inflate the balloon according to manufacturer's instructions having ensured that the catheter is draining freely beforehand.</p>	<p>This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter.</p> <p>Adequate lubrication helps to prevent urethral trauma. Using 6mls local anaesthetic gel minimises the discomfort experienced by the patient.</p> <p>To reduce the risk of infection</p> <p>To maintain sterility. This manoeuvre facilitates ease of catheter insertion. The female urethra is approximately 5cm long.</p> <p>Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma</p>

	<p>Withdraw the catheter slightly until resistance is felt on the bladder neck and attach it to the drainage system.</p> <p>Support the catheter using an appropriate fixation device. Ensure that the catheter does not become taut when patient is mobilising. Ensure that the catheter lumen is not occluded by the fixation device.</p>	<p>To ensure catheter is correctly positioned</p> <p>To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma.</p>
20.	Make the patient comfortable. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
21.	Observe the amount and colour of urine drained and document.	To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed.
22.	Take a urine specimen for laboratory examination, if clinically indicated	To ensure appropriate treatment and prevent routine prescribing of antibiotics
23.	Dispose of equipment according to local policy.	To prevent environmental contamination.
24.	<p>Record information in relevant documents; ensuring the catheter passport is completed, this should include:</p> <ul style="list-style-type: none"> <li>• reasons for catheterisation</li> <li>• date and time of catheterisation</li> <li>• use of ANTT</li> <li>• catheter type, length and size</li> <li>• amount of water instilled into the balloon</li> <li>• batch number</li> <li>• manufacturer</li> <li>• batch number and expiry date of Instillagel;</li> <li>• any problems occurring during the procedure</li> <li>• review date to assess the need for continued catheterisation or date of change of catheter.</li> </ul>	To maintain accurate information. Attach sticky labels from equipment to documentation.

## Changing a Suprapubic Catheter

	Action	Rationale
1.	Explain and discuss the procedure with the patient and gain valid consent	To ensure that the patient understands the procedure and gives valid consent.
2.	Check the patient has no known allergies	To prevent anaphylaxis or skin irritation
3.	There is less chance of the bladder going in to spasm if there is urine in the bladder. Use of a catheter valve prior to re- catheterisation to allow bladder to fill should be considered.	To reduce bladder spasm and trauma
4.	Ensure privacy and that there is appropriate protection on the bed.	To ensure patient's privacy and protect bed
5.	Assist the patient to get into the supine position.	To ensure the appropriate area is easily accessible
6.	Do not expose the patient at this stage of the procedure.	To maintain patient's dignity and comfort.
7.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross infection from micro organisms
8.	Prepare clean surface, placing all equipment required in easy reach. (dressing trolley to be used in inpatient areas)	To ensure a clean working surface
9.	Open the outer cover of the catheterisation pack and slide the pack onto a clean surface.	To prepare equipment
10.	Open removal pack; put on the disposable plastic apron and disposable gloves using an aseptic non touch technique, as per policy.	To reduce risk of cross-infection from micro-organisms
11.	To remove catheter deflate catheter balloon as manufacturer's instructions and gently remove the existing catheter.	To prevent cuffing of the balloon
12.	Use sterile gauze from removal pack to contain any leakage from stoma site.	To contain any urinary leakage.
13.	Discard removal pack and old catheter; remove gloves and apron then wash/decontaminate hands. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross-infection from micro-organisms
14.	Open catheter insertion pack; spreading out the wrapping to form a sterile working area, put on apron and using waste bag as sterile glove position equipment ready for use on sterile field. Position the waste bag for easy use during procedure. Open package and place sterile lubricating gel if required on sterile field and empty saline in to gallipot. Wash/decontaminate hands and apply sterile	To minimise the risk of infection

	gloves using ANTT. Dry thoroughly using single use disposable paper towels.	
15.	Clean thoroughly around existing catheter site using 0.9% Sodium Chloride. If required administer sterile lubricating gel.	To ensure stoma site is clean and reduce risk of infection.
16.	Remove gloves; wash/decontaminate hands and put on sterile gloves. Place sterile towel from catheter pack across the patients thighs	To reduce the risk of introducing infection into the bladder
17.	Gently insert the new catheter; some resistance may be felt, this will ease when the catheter enters the bladder.	Ensure safe catheter insertion.
18.	Insert the catheter until urine drains. Occasionally urine does not drain immediately: this is dependent upon the level of urine in the bladder. Asking the patient to move or cough often promotes urine drainage. Do not inflate the balloon until urine drains.	To ensure that the catheter is in the bladder and has not entered the urethra. To ensure that the catheter is correctly positioned.
19.	Once urine drainage has occurred half inflate the balloon leaving the syringe attached; gently withdraw the catheter until it is felt to be firm against the bladder wall then completely inflate the balloon to 10mls.	To prevent the catheter entering the urethra via the supra pubic route.
20.	Attach the catheter to a previously selected urine drainage system or valve. Clear away equipment and dispose of any urine drained as per clinical waste policy. Take off and dispose of gloves and apron. Wash hands. Dry thoroughly using single use disposable paper towels.	To maintain closed drainage system and reduce the risk of infection.
21.	Record in the patients records: <ul style="list-style-type: none"> <li>• the reason for the catheter change</li> <li>• type of catheter used</li> <li>• ANTT process</li> <li>• (Charriere length, material, balloon size batch no, manufacturer)</li> <li>• cleansing solution used</li> <li>• Lubricant</li> <li>• any problems negotiated</li> <li>• date for re-assessment</li> <li>• colour, amount and consistency of urine drained</li> <li>• patient's condition following catheterisation</li> </ul>	To ensure the correct care is provided. To avoid duplication of care. To ensure all equipment has been used as instructed by the manufactures as to avoid liability on the part of the nurse. To pass on care to other nurses as required.

## Appendix 12

### Intermittent Catheterisation for a Male Patient

	Action	Rationale
1.	<p>Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied.</p> <p>The patient should be given the choice regarding a chaperone.</p> <p>The Community policy can be found by following the link below  <a href="http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf">http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf</a></p> <p>Undertake bladder scan to determine residual volume and refer to Care Plan to determine if intermittent catheter needs to be passed.</p>	<p>To ensure that the patient understands the procedure and gives valid consent.</p> <p>Determine if clinical need to pass intermittent catheter.</p>
2.	Check the patient has no known allergies	To prevent anaphylaxis or skin irritation
3.	Ensure privacy and that there is appropriate protection on the bed, to prevent soiling.	To ensure patient's privacy and protect bed
4.	Assist the patient to get into the supine position with legs extended.	To ensure the appropriate area is easily accessible
5.	Do not expose the patient at this stage of the procedure.	To maintain patient's dignity and comfort.
6.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross infection from micro-organisms.
7.	Prepare clean surface by wiping with a detergent wipe, or suitable alternative placing all equipment required in easy reach.	To ensure a clean working surface
8.	Open the outer cover of the catheterisation pack and slide the pack onto a clean surface.	To prepare equipment
9.	Open <b>catheter insertion</b> pack; spreading out the wrapping to form a sterile working area, put on apron and using waste bag as sterile glove position equipment ready for use on sterile field. Position the waste bag for easy use during procedure. Wash/decontaminate hands and apply sterile gloves using ANTT.	To minimise the risk of infection
10.	Place sterile field under patient	To protect the bed
11	Retract the foreskin, and clean the glans penis with 0.9% sodium chloride.	To reduce the risk of introducing infection to the urinary tract during catheterisation
12	Place sterile towel from catheter pack over the patients' genital area.	To reduce the risk of introducing infection into the bladder

13	Hold the penis firmly with a sterile swab raising until almost totally extended.	To straighten the urethra
14	<p>Place the receiver containing the sterile covered catheter between the patient's legs. Maintaining hold of the penis insert the intermittent catheter until urine flows maintaining hold of the penis until the procedure is finished</p> <p>If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to cough or strain gently as if passing urine.</p> <p>When urine begins to flow, advance the catheter a further 1-2cms.</p> <p>When the urine has finished draining slowly withdraw the catheter; if urine starts to drain stop and allow the urine to drain; repeat this until the intermittent catheter has been removed.</p>	<p>This manoeuvre straightens the urethra and facilitates catheterisation. The male urethra is approximately 18-21 cm long</p> <p>Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter</p> <p>Advancing the catheter ensures that it is in the bladder</p> <p>Ensure that the bladder is empty</p>
15.	Make the patient comfortable. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
16.	Observe the amount and colour of urine drained and document.	To monitor renal function and fluid balance.
17.	Take a urine specimen for laboratory examination, if clinically indicated	To ensure appropriate treatment and prevent routine prescribing of antibiotics
18.	Dispose of equipment according to local policy.	To prevent environmental contamination.
19.	<p>Record information in relevant documents; ensuring the catheter passport is completed this should include:</p> <ul style="list-style-type: none"> <li>• reasons for catheterisation</li> <li>• date and time of catheterisation</li> <li>• use of ANTT</li> <li>• catheter type, length and size</li> <li>• batch number</li> <li>• manufacturer</li> <li>• any problems occurring during the procedure</li> </ul>	To maintain accurate information. Attach sticky labels from equipment to documentation.
20.	Refer to Care Plan to determine the frequency of passing Intermittent Catheter.	To ensure intermittent catheter is passed based on clinical need.
21.	Repeat bladder scan to determine residual volume.	To ensure that the bladder scanner is not picking up any other intra-abdominal

### Intermittent Catheterisation for a Female Patient

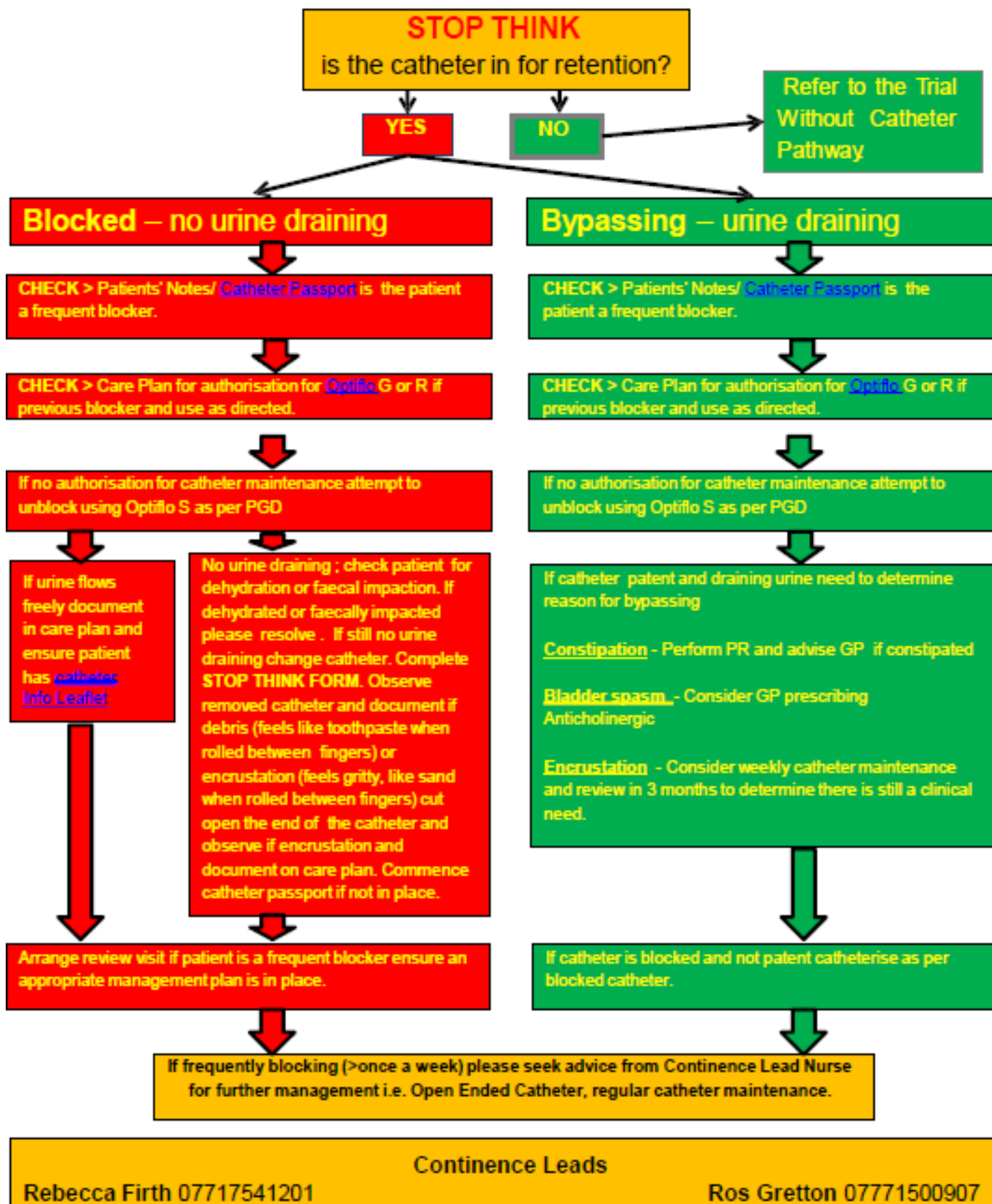
	Action	Rationale
1	<p>Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied.</p> <p>The patient should be given the choice regarding a chaperone.</p> <p>The Community policy can be found by following the link below  <a href="http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf">http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf</a></p> <p>Undertake bladder scan to determine residual volume and refer to Care Plan to determine if intermittent catheter needs to be passed,</p>	<p>To ensure that the patient understands the procedure and gives valid consent.</p> <p>Determine if clinical need to pass intermittent catheter.</p>
2	Check the patient has no known allergies	To prevent anaphylaxis or skin irritation
3	Ensure privacy and that there is appropriate protection on the bed, to prevent soiling.	To ensure patient's privacy and protect bed
4	Assist the patient to get into the supine position with legs extended.	To ensure the appropriate area is easily accessible
5.	Do not expose the patient at this stage of the procedure.	To maintain patient's dignity and comfort.
6.	Wash hands using liquid soap and water. Dry thoroughly using single use disposable paper towels.	To reduce risk of cross infection from micro-organisms.
7.	Prepare clean surface by wiping with a detergent wipe, or suitable alternative placing all equipment required in easy reach.	To ensure a clean working surface
8.	Open the outer cover of the catheterisation pack and slide the pack onto a clean surface.	To prepare equipment
9.	Open <b>catheter insertion</b> pack; spreading out the wrapping to form a sterile working area, put on apron and using waste bag as sterile glove position equipment ready for use on sterile field. Position the waste bag for easy use during procedure. Empty saline in to gallipot. Wash/decontaminate hands and apply sterile gloves using ANTT.	To minimise the risk of infection
10.	Place sterile field under patient	To protect the bed
11.	Using sterile swabs, separate the labia minora so that the urethral meatus is seen. Clean around the urethral orifice with 0.9% sodium chloride using single downward strokes	This manoeuvre provides better access to the

		urethral orifice and helps to prevent labial contamination of the catheter
12.	Place sterile towel from catheter pack across the patients' thighs.	To reduce the risk of introducing infection into the bladder
13.	<p>Using sterile swabs, separate the labia minora so that the urethral meatus is seen. One hand should be used to maintain labial separation until intermittent catheterisation is complete.</p> <p>Wash/decontaminate hands and apply sterile gloves using ANTT</p> <p>Place the receiver between the patient's legs. Introduce the intermittent catheter into the urethral orifice in an upward and backward direction. If there is any difficulty in visualising the urethral orifice due to vaginal atrophy and retraction of the urethral orifice <u>gently</u> lift the parted labia upwards towards the pubic bone. Insert the catheter until urine flows.</p> <p>When urine begins to flow, advance the catheter a further 1-2cms.</p> <p>When the urine has finished draining slowly withdraw the catheter; if urine starts to drain stop and allow the urine to drain; repeat this until the intermittent catheter has been removed.</p>	<p>This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter.</p> <p>To reduce the risk of infection</p> <p>To maintain sterility. This manoeuvre facilitates ease of catheter insertion. The female urethra is approximately 5cm long.</p> <p>Advancing the intermittent catheter ensures that it is in the bladder</p> <p>To ensure that the bladder is empty</p>
14.	Make the patient comfortable. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
15.	Observe the colour of urine drained. Measure and document amount drained.	To determine amount of urine drained. .
16.	Take a urine specimen for laboratory examination, if clinically indicated	To ensure appropriate treatment and prevent routine prescribing of antibiotics



17.	Dispose of equipment according to local policy.	To prevent environmental contamination.
18.	Record information in relevant documents; ensuring the catheter passport is completed, this should include: <ul style="list-style-type: none"> <li>• reasons for catheterisation</li> <li>• date and time of catheterisation</li> <li>• use of ANTT</li> <li>• catheter type, length and size</li> <li>• batch number</li> <li>• manufacturer</li> <li>• any problems occurring during the procedure</li> </ul>	To maintain accurate information. Attach sticky labels from equipment to documentation.
19.	Refer to Care Plan to determine frequency of passing intermittent catheter	To ensure intermittent catheter is passed based on clinical need.
20.	Repeat bladder scan to determine residual volume.	To ensure that the bladder scanner is not picking up any other intra-abdominal Fluid. Report any concerns to GP.

### Registered Nurse Pathway for Blocked or Bypassing Catheter



### Care Pathway – Trial Without Catheter

Tasks which can be completed by AP/TAP

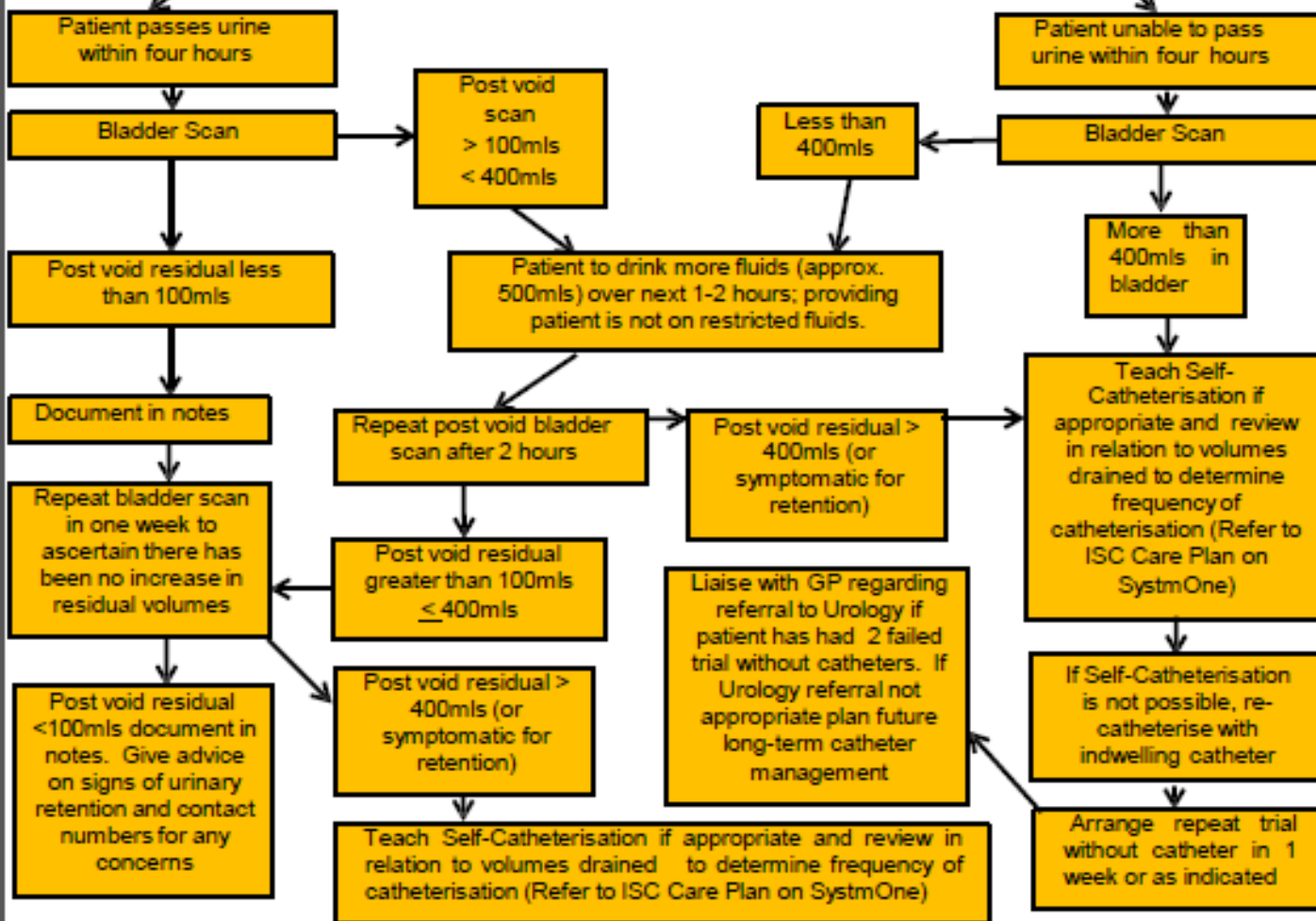
Tasks which can **ONLY** be completed by Registered Nurse

**IF THE PATIENT HAS LOWER ABDOMINAL PAIN AT ANY TIME DURING THE TRIAL, NURSE TO SCAN BLADDER AND REINSTATE CATHETER IF NECESSARY**

Establish reasons for catheter and treat any reversible causes (e.g. constipation)

Remove catheter, early morning if possible between 8.30 am and 9.00 am

Advise patient to drink approximately 1 litre of fluid before 12.30pm providing patient is not on restricted fluids



**IF UNABLE TO CATHETERISE REFER TO UROLOGY IDENTIFYING REASON WHY**

Continence Leads

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Ros Gretton 07771500907

## Diagnosing a catheter associated urinary tract infection (CAUTI) and collecting a specimen of urine from a urinary catheter

Diagnosis of a CAUTI must **always** involve assessing for clinical signs and symptoms. These may include:

- Fever
- Back Pain
- Acute haematuria
- Pelvic discomfort / pain
- Malaise / lethargy with no other cause
- New onset or worsening confusion
- Rigors, shivering, shaking

Dip Stick testing of urine must **NOT** be used to diagnose a CAUTI:

- When a urinary catheter is inserted into the bladder the chance of bacteria entering the bladder and colonising it is about 5% each day, therefore most patients would be expected to have bacteria in their urine.
- Patients with a urinary catheter are likely to have non visible haematuria due to the ongoing trauma of the catheter. (NICE 2012)



### When to take a catheter sample of Urine (CSU):

- A CSU should only be obtained when a diagnosis of CAUTI has been made.
- Obtain the CSU before the patient commences antibiotics.
- The CSU will guide the antimicrobial treatment.
- Obtaining a CSU when there is no clinical evidence of a CAUTI may lead to false positive results and unnecessary treatment with antibiotics.



### How to obtain a catheter sample of urine (CSU):

- Decontaminate hands and wear a new pair of clean, non-sterile gloves and single use apron prior to manipulating the catheter.
- Clean the sampling port on the drainage bag with an alcohol impregnated wipe and allow to dry.
- Obtain the specimen using Aseptic technique via the drainage bag needle free sampling port.
- The sample should normally be sent in a red-topped (boric acid containing) sterile contain and filled to the line.



## Appendix 17

### Protocol for the Administration of Catheter Patency Solution, OPTIFLO® S For Blocked and Bypassing Catheters; To Be Administered by Band 5 and above.

Preparation	Route	Frequency	Maximum Administration
Optiflo® S (0.9% sodium chloride)	Catheter irrigation; <b>Do not force solution in to the bladder</b> Follow manufacturer's instructions for use	Use 2 sequential doses of 50mls Optiflo® S	Can be repeated as clinically indicated until blockage resolved. Maximum of two treatments in 24 hours or three treatments in a seven day period.

<b>Clinical Condition</b>	Patients requiring mechanical flushing of a urethral or supra pubic catheter. Optiflo® S may only be used for clinical need and not for routine catheter care. Optiflo® S can be attempted in a patient with prostate cancer.
<b>Exclusions</b>	<ul style="list-style-type: none"> <li>• Spinal patient showing signs of Autonomic Dysreflexia with a non-draining blocked catheter. The catheter should be changed in this instance.</li> <li>• Known allergy to the preparation or any of its ingredients.</li> <li>• Patients aged under 18 years</li> <li>• Patient has had surgery to bladder in the last week</li> <li>• Significant haematuria</li> </ul>
<b>Cautions / Need for further advice</b>	<ol style="list-style-type: none"> <li>1. Prior to using Optiflo® S the following need to be reviewed: Constipation causing pressure on the urethra. Give dietary and fluid advice and general measures to prevent constipation. Check medication and refer to GP if patient not prescribed any laxative.</li> <li>2. Drainage Bag above the level of the bladder with the exclusion of the belly bag</li> <li>3. Drainage Bag more than two thirds full.</li> <li>4. Twisted or kinked drainage tubing.</li> </ol> <p>If more than two treatments are required in any 24 hour period/ or more than 3 treatments required in one week, refer to Community Nursing Team for re-assessment.</p>
<b>Side effects</b>	Adverse reactions to Optiflo® S are unlikely. May cause some patients to experience slight irritation.
<b>Further advice</b>	All patients with a catheter in situ should be given a copy of : <ul style="list-style-type: none"> <li>• LPT Patient Information Leaflet. "Looking after your urinary catheter at home": information for patients and carers leaflet.</li> <li>• LPT Urinary Catheter Passport</li> </ul>
<b>Record keeping</b>	Ensure treatment and outcome is documented in the written notes or on SystemOne, including assessment of patient need in relation to the intervention , dose given, time given and any further advice or follow up given

