Leicestershire Partnership NHS Trust

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, Infection Prevention & Control	
Version:	10	
Adopted by:	Quality Assurance Committee	
Date Adopted:	13th February 2024	
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Name of responsible Committee:	Infection Prevention and Control Committee	
Date issued for publication:	February 2024	
Review date:	September 2026	
Expiry date:	February 2027	
Target audience:	All LPT Staff	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	Outcome 8 – Infection Prevention and Control	

Contents

Appendices

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.
8	August 2022	Addition Optiflo S Protocol
9	December 2022	Final review and update for sign off with, Blocked catheter-Haematuria Flowcharts, Instillagel Protocol, and EOL addendum added
10	November 2023	Final review and update for sign off with, Blocked catheter-Haematuria Flowcharts, Instillagel Protocol, Justification For Catheterisation, Reviewed TWOC Pathways, updated Continence Formulary, Reviewed Blocked Bypassing Pathway and EOL addendum added

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. If you require a copy of this document in another format please contact

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

ANP	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.
ANTT	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.
AUR	Acute Urinary Retention
Bladder Maintenance Solution	Bladder Maintenance solution is used to prevent blockages and maintain draining of urine via the catheter
Body Fluid splashes	Blood / blood-stained 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.
CAUTI	Catheter Acquired Urinary Tract Infection – an infection associated with an indwelling catheter
CSU	A catheter specimen of urine (CSU) is collected for bacteriological examination, if a patients symptoms suggest the presence of an infection
HAI	A health care acquired infection also known as a nosocomial infection, is an infection that is acquired when receiving healthcare
Intermittent self-catheterisation	Intermittent Self-Catheterisation (ISC) is the insertion and removal of a catheter several times a day to empty the bladder.
LCAT	Leicester Clinical procedure Assessment Tool used to assess competency for a clinical task
Mid-Stream Specimen of Urine **MSU**	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
Mucocutaneous exposure	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.
Personal protective Equipment (PPE)	Gloves, aprons, gowns, masks and eye protection.

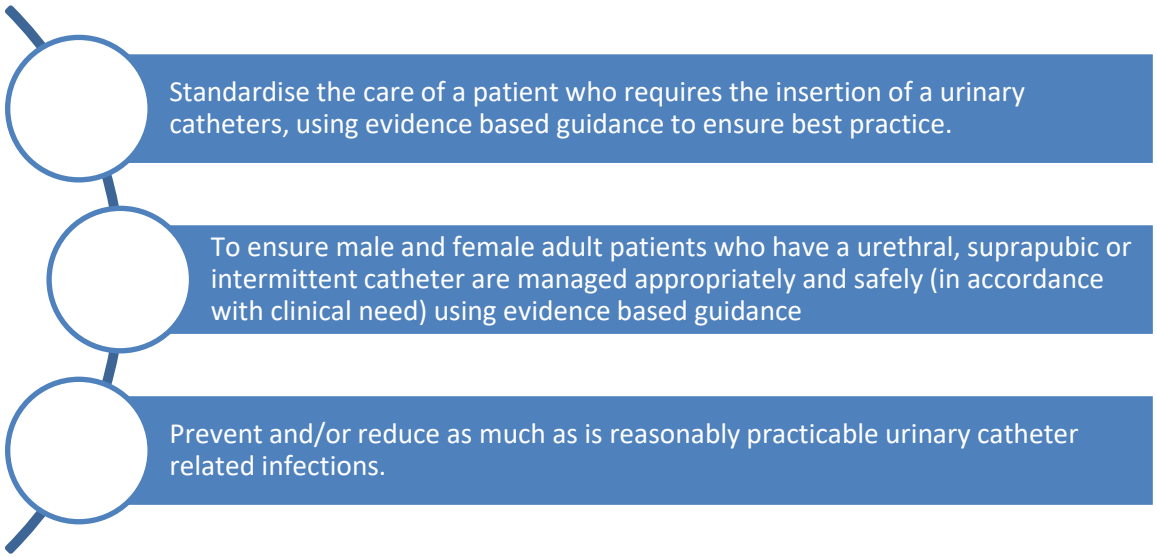
TWOC	Trial without Catheter

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 catheterisation 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 and Inpatients who are in acute urinary retention (AUR pathway). (*Appendix 7a and 7b*)
- The use of the catheter passport and the patient leaflet on managing their catheter

Chronic urinary retention is the gradual (over months or years) development of the inability to empty the bladder completely, characterised by a residual volume greater than one litre or associated with the presence of a distended or palpable bladder (NICE 2023). 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. For EOL patients who are in their last weeks of life and their Respect Form specifies no hospital admission please speak to the on call Urology Registrar to agree how the patient can be managed within the

Community /Inpatient setting.

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 is important to minimise the use and duration of urinary catheterisation in all patients, but especially those at higher risk for CAUTI-related morbidity and mortality such as: women, the elderly and individuals with impaired immunity (RCN 2021).

Urinary tract infection is the most common healthcare acquired infection accounting for 19% of all such infection, with between 43% and 56% of urinary tract infections associated with an indwelling urethral catheter HPA (2012).

The insertion of a urinary catheter carries considerable risk and therefore important consideration is needed to determine clinical justification for a patient to be Catheterised (Appendix 8a and 8b)

Indwelling urinary catheters should only be used when no suitable alternative available and must be left in for as short a time as possible. The care plan needs to stipulate why the catheter is in situ and if short/long term. Please ensure that TWOC (*Appendix 15a and 15b*) date is planned as soon as clinically indicated.

Intermittent catheterisation is the preferred alternative to indwelling catheterisation providing this is clinically relevant to the patient (*Appendix 12 and 13*).

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 2021). 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)
- Paraphimosis
- Urethral Erosion

If a patient has frank haematuria the indwelling catheter should not be removed; please refer to the Blocked – Haematuria Pathway (*Appendix 16a and 16b*). Refer to the Haematuria Ladder if not frank haematuria in relation to advice to patient/carer (*Appendix 20a and 20b)*

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 (2021).

Consequently, a positive urine dipstick test for leucocytes and nitrites is meaningless in a catheterised patient, therefore should not be performed. Antibiotics must not be prescribed purely based on 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 6 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 17*).

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 link:

https://www.areaprescribingcommitteeleicesterleicestershirerutland.nhs.uk/wp-content/uploads/2015/06/catheter-uti-guidance.pdf

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.

ANTT should be used when changing a leg bag as the closed drainage system has

been broken increasing the risk of infection.

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 2021), (*Appendix 8a and 8b*).

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. If patient declines to be catheterised, please consider mental capacity assessment, that patient is aware of the potential complications of not being catheterised and discuss further with family/GP/ANP/Ward Doctor.

ANTT must be documented as part of the catheterisation process on the Stop Think … Catheter Template within the patient's electronic record.

For patients who are receiving end of life care the Clinician can make the decision as to whether catheterisation is appropriate or not. (*Appendix 8a and 8b*) Any decisions and the rational 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 2021).

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 2015). Within the community setting all healthcare staff must record every catheter intervention clearly, accurately and correctly on the Stop Think ….. Catheter Template within the patients electronic record.

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).

Standard catheters are for urethral and suprapubic use in male and female patients. Female length catheters must only be used urethrally in female patients. All storerooms should stock standard length catheters only. Inflating a short female catheter in the male urethra can cause severe pain and lead to serious complications such as haematuria, penile swelling, urinary retention and renal failure. NPSA (2009)

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
Pure Silicone / 100% Silicone	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

For further information see LLR Continence Prescribing Formulary (See policy and guideline section on Staff Net):

https://www.areaprescribingcommitteeleicesterleicestershirerutland.nhs.uk/wp-content/uploads/2018/08/LLR-Continence-Formulary.pdf

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 5ml and 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 2021). 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 using ANTT.

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 again using ANTT.

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 using ANTT.

Catheter valves are only suitable for people with mental awareness, good manual dexterity, 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 2021)

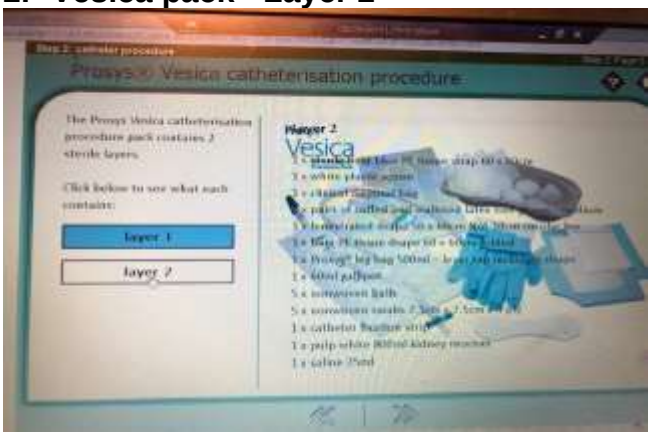
Patients in acute urinary retention are catheterised with a short-term catheter. Acute urinary retention is associated with abdominal pain and the inability to void urine. All community staff should follow the pathway for the community management of acute urinary retention in adults *(see Appendix 7a).* All inpatient staff should follow the pathway for the inpatient management of acute urinary retention in adults (see Appendix 7b).

Patients who have a residual of over a litre should be admitted to the acute hospital with the exemption of End Of Life (*See Addendum to Appendix 7a and 7b*).

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 walleted latex free gloves – medium
   - 1 x 10ml luer slip syringe
   - 3 x non-woven swabs 7.5cm x 7.5cm x 4ply

2. **Vesica pack - Layer 2**



3. Anaesthetic lubricating gel – as prescribed & authorised for each patient – unless the patient is in acute retention, then staff may use the protocol for Instillagel (*Appendix 19).*
4. A catheter as prescribed & authorised for the patient, male or female as appropriate, size should be recorded on the care plan.
5. Water to inflate the balloon – this should be in the catheter pack, but please check prior to commencing the procedure.
6. Bags & fixation devices are included in the 2nd 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 9)*

4.10.2 Female catheterisation *(See Appendix 10)*

4.10.3 Supra-pubic catheterisation (*Appendix 11*)

For some patients an indwelling catheter inserted supra-publically 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 20 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.

Sterile lubricating gel should be used at time of catheter changes.

The choice of drainage system, fixation appliance used should be manageable for patients and carers and regularly re-assessed.

4.10.4 Intermittent Catheterisation *(Appendix 12 and 13)*

Intermittent self-catheterisation is considered the Gold Standard for urine drainage (NICE 2015, cited in RCN 2021). 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 2021).

Advice should be given, including supporting literature, to patients and carers on frequency of catheterisation, clean technique and the size of catheters to be used.

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) have been demonstrated and observed as part of a supervised practice by a competent experienced healthcare practitioner.

4.11 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 2021). 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 a 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 14).*

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 18*).

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.

Catheters should not be cut open to determine if blockage is due to sediment or encrustation. Roll the removed catheter between a gloved thumb and finger; sediment feels like toothpaste and encrustation is gritty.

4.12 Trial without Catheter (TWOC)

Refer to the Clinical Justification Pathway to determine if the catheter can be removed (*Appendix 8a and 8b*) If there is no clinical reason for the patient to remain catheterised please refer to LPT's TWOC pathway *(See appendix 15a and 15b*).

5.0 Duties within the Organisations

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

Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

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.

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.

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.

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.

This training is role specific. Staff for whom this is 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 catheter maintenance solution.

- Nursing Associates (registered) and Assistant Practitioners can perform planned routine re-catheterisation / catheter care, TWOC pathway (Appendix 15a and 15b) 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 unless the patient is on EOL pathway.

- Student Nurses can perform catheterisation under close supervision by their Qualified Nurse Supervisor.

6.0 Training Needs

There is a need for training identified within this policy.

The uLearn course directory 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	Completion of the urinary catheter study day Compliant with LCAT assessment or evidence from another Organisation Incident reporting	Team managers Lead Nurse Urinary Tract infection (UTI) working group	Quarterly

Ref	Minimum Requirements	Evidence for self-assess	Process for Monitoring	Responsible Ind/Group	Frequency of Monitoring
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 .. Catheter Template . 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
CQC Fundamental Standards 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	• STOP! Think forms will be used for all urinary catheterisations • A patient leaflet will be given to all patients who require a urinary catheter • A personalised plan of care will be developed for all patients who require continence support and/or a urinary catheter
NICE Guidance Infection: prevention and control of healthcare- associated infections in primary and community care Quality Standard 90: Urinary Tract Infections in Adults	Audit programme Nice guideline baseline assessment tool

9.0 Reference and Bibliography

This policy was drafted with reference to the following:

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

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Appendix 1

Training Needs Analysis

Training topic:	Procedural requirements for the insertion, and removal of a urethral catheter in male and female adult patients.
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) X Role specific ☐ Personal development
Directorate to which the training is applicable:	X Mental Health X Community Health Services Enabling Services X Families Young People Children / Learning Disability Services Hosted Services
Staff groups who require the training:	All clinical staff who have a responsibility for the insertion, care or removal of a urethral catheter in male and female adult patients.
Regularity of Update requirement:	Attendance of the urinary catheter training and LCAT assessment to identify competence.
Who is responsible for delivery of this training?	Continence Service.
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	X ULearn ☐ Other (please specify)

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

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

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Chris Rippin	Continence Lead
Sue Swanson	Clinical Trainer CHS
Amanda Hemsley	Lead Infection Prevention and Control Nurse
Michelle Law	ICSPC Matron
Emma Jackson	Senior Nurse Complex Care

Circulated to the following individuals for comment

Name	Designation
Continence team	Leicestershire Partnership Trust
Laura Brown	Infection Prevention and Control Nurse
Anne Scott	Executive Director of Nursing, Allied Health Professionals and Quality
Tracy Yole	Lead Nurse CHS – Community
Sarah Latham	Head of Nursing CHS
Zayad Saumtally	Head of Nursing FYPC /LD – Community
Michelle Churchyard	Head of Nursing DMH/MHSOP
Viveen Ashman	Deputy Head of Nursing Community
Tejas Khatau	Lead Pharmacist for FYPC
Joanne Charles	Lead Pharmacist CHS

Appendix 4

DATA PRIVACY IMPACT ASSESSMENT SCREENING

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.
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.

Name of Document:	**Management of a Urinary Catheter Policy**	
Completed by:	**Chris Rippin**	
Job title	**Clinical Operational Lead Continence Service**	**Date 25.10.23**

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**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	
Date of approval	

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

Appendix 5

Due Regard Screening Template

Section 1	
Name of activity/proposal	Procedural requirements for the insertion, care and removal of a urethral catheter in male and female adult patients
Date Screening commenced	November 2022
Directorate / Service carrying out the assessment	Quality and Innovation
Name and role of person undertaking this Due Regard (Equality Analysis)	Chris Rippin
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: To standardise the care of urinary catheters, using evidence based guidelines to ensure best practice is used across LPT	
OBJECTIVES: 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.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
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

Section 3			
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.			
Yes		No ✓	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	✓

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
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.			
Signed by reviewer/assessor	Chris Rippin	**Date**	25.10.23
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 6

NHS
Leicestershire Partnership
NHS Trust

When To Obtain and Send a Catheter Specimen of Urine

If an infection is suspected in a patient with a long term catheter **DO NOT** perform a urine dipstick test except for those on the AUR Pathway.

Is the patient systemically unwell; fever (or hypothermia), rigors, new onset delirium, pain over the kidney when percussed. Without these features, UTI is unlikely.

Yes → Suspected Sepsis – commence sepsis pathway

No

Do not send a Catheter Specimen of Urine. Cloudy bags and offensive urine are not indicative of a UTI

Change the catheter if it has been in place for more than 7 days.

Send Catheter Specimen of Urine using needle free port to obtain sample.

For patients with mild symptoms, normal immunity and normal renal function consider waiting for Culture and Sensitivity results to guide treatment.

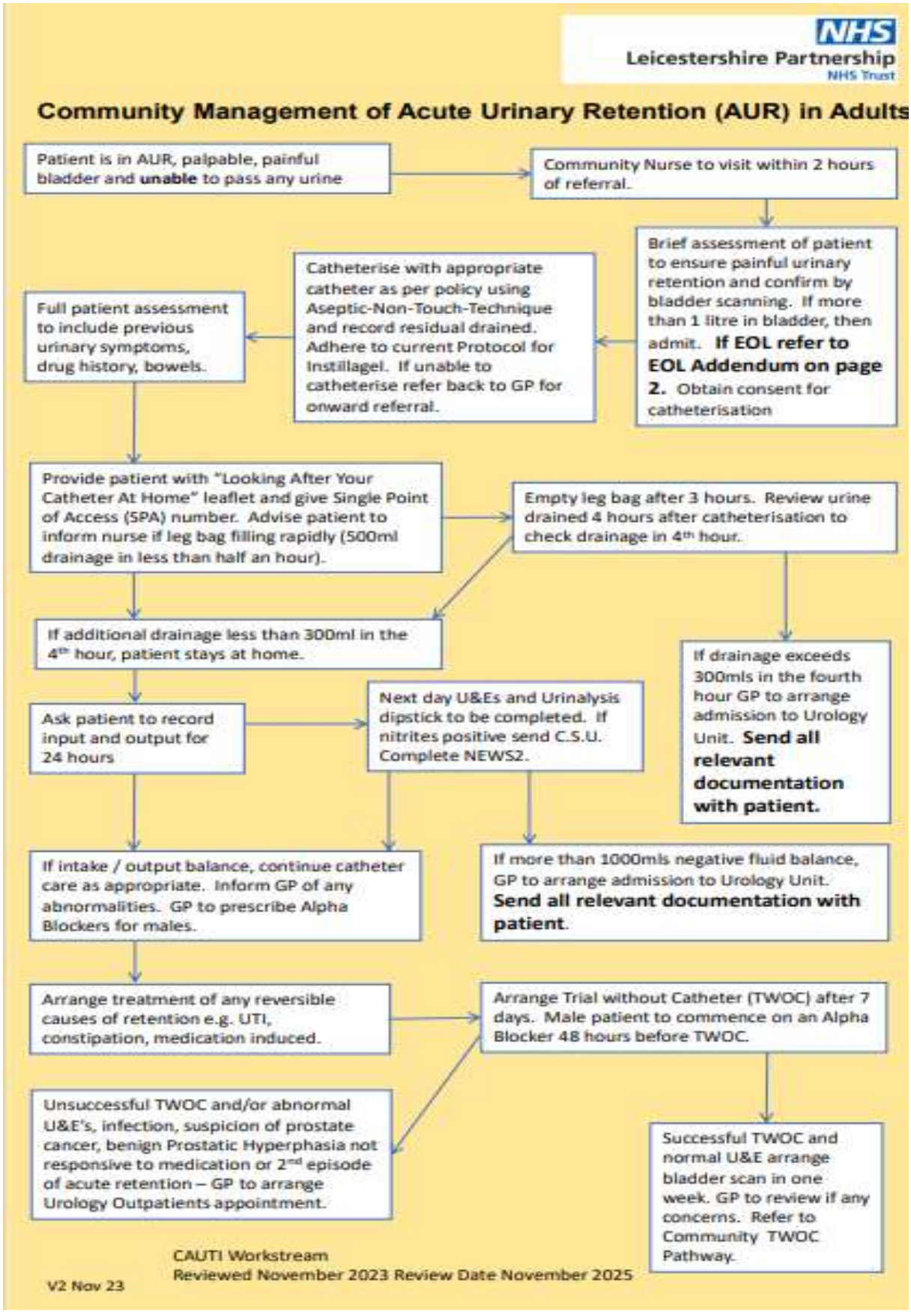
For patients who are unwell and treatment cannot wait Culture and Sensitivity refer to Antimicrobial Guidelines for the Management of Catheterised Patients in the Community (December 2016) in relation to commencing antibiotic therapy.

Nurse taking sample has responsibility to ensure CSU result is followed up and appropriate medication has been prescribed. Document result in notes and systmone.

WeAreLPT
compassion respect integrity trust

Based on the Antimicrobial Guidelines for the Management of Catheterised Patients in the Community December 2016

Appendix 7a


NHS
Leicestershire Partnership
NHS Trust
Community Management of Acute Urinary Retention (AUR) in Adults
Patient is in AUR, palpable, painful bladder and unable to pass any urine
Community Nurse to visit within 2 hours of referral.
Brief assessment of patient to ensure painful urinary retention and confirm by bladder scanning. If more than 1 litre in bladder, then admit. If EOL refer to EOL Addendum on page 2. Obtain consent for catheterisation
Catheterise with appropriate catheter as per policy using Aseptic-Non-Touch-Technique and record residual drained. Adhere to current Protocol for Instillagel. If unable to catheterise refer back to GP for onward referral.
Full patient assessment to include previous urinary symptoms, drug history, bowels.
Provide patient with "Looking After Your Catheter At Home" leaflet and give Single Point of Access (SPA) number. Advise patient to inform nurse if leg bag filling rapidly (500ml drainage in less than half an hour).
Empty leg bag after 3 hours. Review urine drained 4 hours after catheterisation to check drainage in 4th hour.
If additional drainage less than 300ml in the 4th hour, patient stays at home.
If drainage exceeds 300mls in the fourth hour GP to arrange admission to Urology Unit. Send all relevant documentation with patient.
Ask patient to record input and output for 24 hours
Next day U&Es and Urinalysis dipstick to be completed. If nitrites positive send C.S.U. Complete NEWS2.
If intake / output balance, continue catheter care as appropriate. Inform GP of any abnormalities. GP to prescribe Alpha Blockers for males.
If more than 1000mls negative fluid balance, GP to arrange admission to Urology Unit. Send all relevant documentation with patient.
Arrange treatment of any reversible causes of retention e.g. UTI, constipation, medication induced.
Arrange Trial without Catheter (TWOC) after 7 days. Male patient to commence on an Alpha Blocker 48 hours before TWOC.
Unsuccessful TWOC and/or abnormal U&E's, infection, suspicion of prostate cancer, benign Prostatic Hyperphasia not responsive to medication or 2nd episode of acute retention – GP to arrange Urology Outpatients appointment.
Successful TWOC and normal U&E arrange bladder scan in one week. GP to review if any concerns. Refer to Community TWOC Pathway.
CAUTI Workstream
Reviewed November 2023 Review Date November 2025
V2 Nov 23

NHS
Leicestershire Partnership
NHS Trust

Addendum for EOL patients to be added to AUR policy.

Urinary catheterisation for end-of-life care in the community prevents delays in care, improves patient comfort and supports preferred place of care wishes.

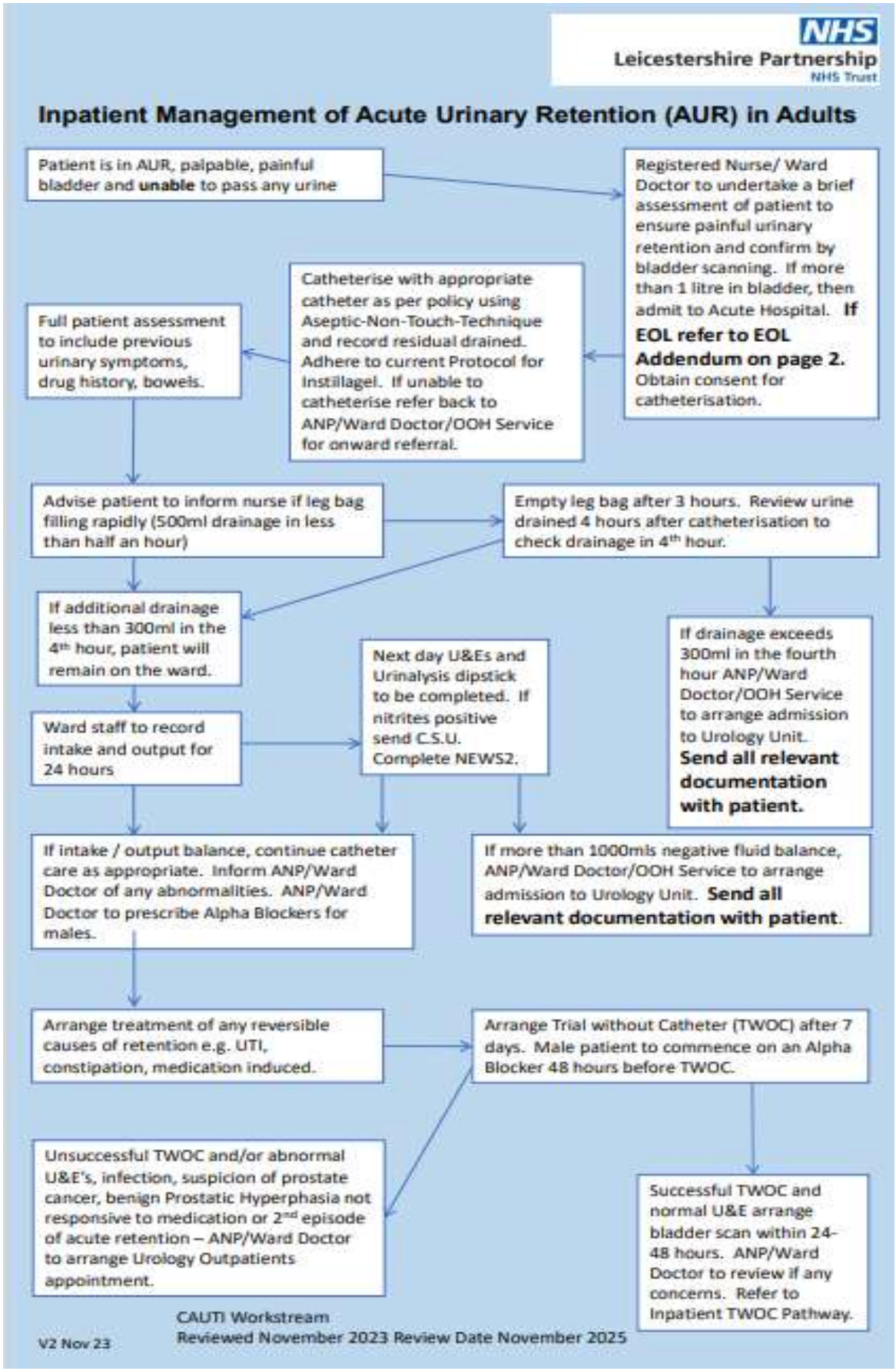
A full bladder or bowel in the terminal phase of life can cause patients to become agitated and restless. Common causes of urinary retention in the terminal phase are constipation and the use of medications such as glycopyrronium or morphine.

When a patient is at the end of their life please consider treating at home or in the community hospital and do not admit to emergency department if they wish to avoid this. This cohort of patients will usually have a ReSPECT form and advance care plan which will state whether they wish to be considered for acute admission. Often it will state that their wish is to avoid an acute admission.

If this is the case and they complain of symptoms related to urinary retention then catheterisation should be considered at home, draining the bladder slowly.

LOROS advice is to catheterise and empty 200mls at a time with a 15min break until bladder is empty. Patient should be encouraged to drink during the process, if possible, to support blood pressure.

Appendix 7b


NHS
Leicestershire Partnership
NHS Trust
Inpatient Management of Acute Urinary Retention (AUR) in Adults
Patient is in AUR, palpable, painful bladder and unable to pass any urine
Registered Nurse/ Ward Doctor to undertake a brief assessment of patient to ensure painful urinary retention and confirm by bladder scanning. If more than 1 litre in bladder, then admit to Acute Hospital. If EOL refer to EOL Addendum on page 2. Obtain consent for catheterisation.
Catheterise with appropriate catheter as per policy using Aseptic-Non-Touch-Technique and record residual drained. Adhere to current Protocol for Instillagel. If unable to catheterise refer back to ANP/Ward Doctor/OOH Service for onward referral.
Full patient assessment to include previous urinary symptoms, drug history, bowels.
Advise patient to inform nurse if leg bag filling rapidly (500ml drainage in less than half an hour)
Empty leg bag after 3 hours. Review urine drained 4 hours after catheterisation to check drainage in 4th hour.
If additional drainage less than 300ml in the 4th hour, patient will remain on the ward.
If drainage exceeds 300ml in the fourth hour ANP/Ward Doctor/OOH Service to arrange admission to Urology Unit. Send all relevant documentation with patient.
Next day U&Es and Urinalysis dipstick to be completed. If nitrites positive send C.S.U. Complete NEWS2.
Ward staff to record intake and output for 24 hours
If intake / output balance, continue catheter care as appropriate. Inform ANP/Ward Doctor of any abnormalities. ANP/Ward Doctor to prescribe Alpha Blockers for males.
If more than 1000mls negative fluid balance, ANP/Ward Doctor/OOH Service to arrange admission to Urology Unit. Send all relevant documentation with patient.
Arrange treatment of any reversible causes of retention e.g. UTI, constipation, medication induced.
Arrange Trial without Catheter (TWOC) after 7 days. Male patient to commence on an Alpha Blocker 48 hours before TWOC.
Unsuccessful TWOC and/or abnormal U&E's, infection, suspicion of prostate cancer, benign Prostatic Hyperphasia not responsive to medication or 2nd episode of acute retention – ANP/Ward Doctor to arrange Urology Outpatients appointment.
Successful TWOC and normal U&E arrange bladder scan within 24-48 hours. ANP/Ward Doctor to review if any concerns. Refer to Inpatient TWOC Pathway.
CAUTI Workstream
Reviewed November 2023 Review Date November 2025
V2 Nov 23

NHS
Leicestershire Partnership
NHS Trust

Addendum for EOL patients to be added to AUR policy.

Urinary catheterisation for end-of-life care in the community prevents delays in care, improves patient comfort and supports preferred place of care wishes.

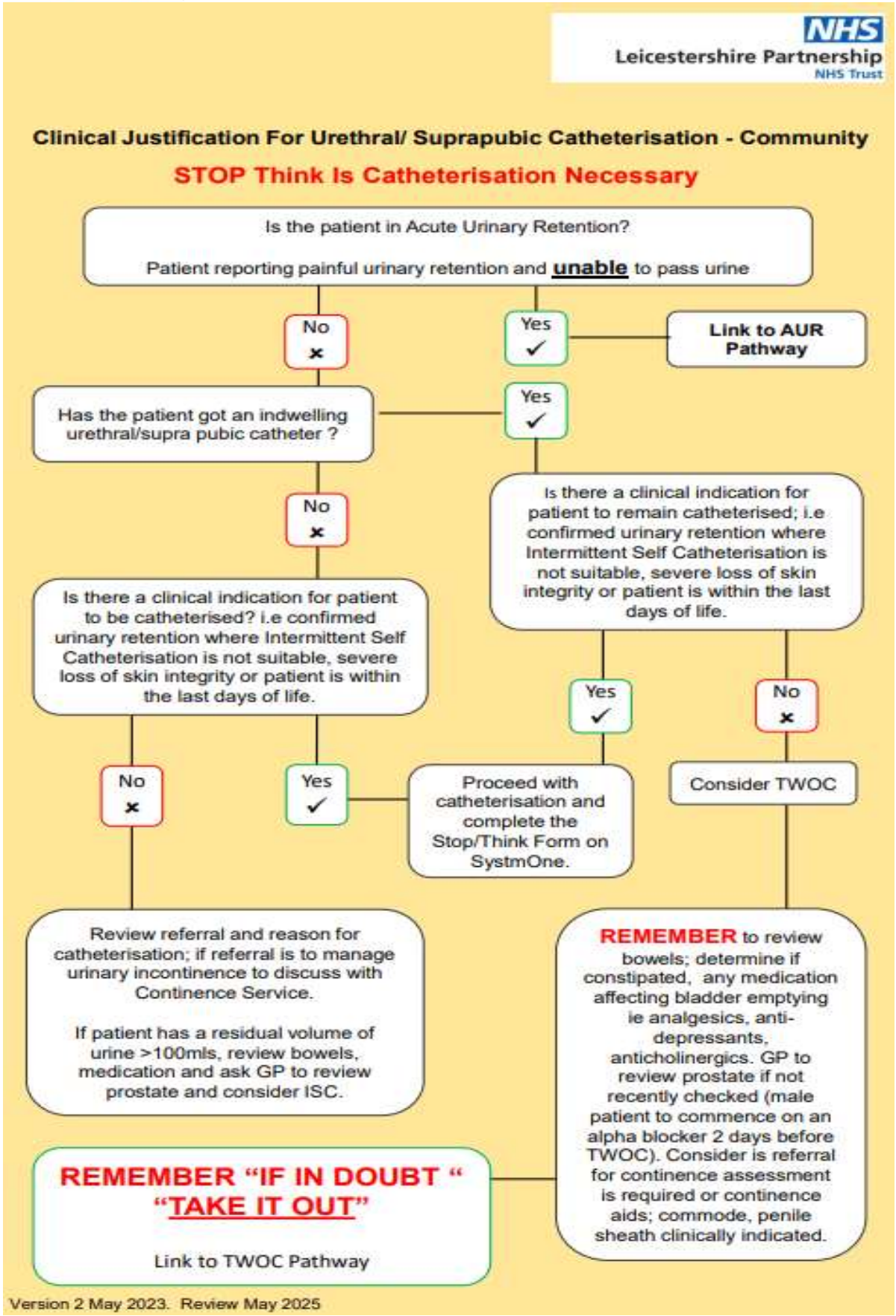
A full bladder or bowel in the terminal phase of life can cause patients to become agitated and restless. Common causes of urinary retention in the terminal phase are constipation and the use of medications such as glycopyrronium or morphine.

When a patient is at the end of their life please consider treating at home or in the community hospital and do not admit to emergency department if they wish to avoid this. This cohort of patients will usually have a ReSPECT form and advance care plan which will state whether they wish to be considered for acute admission. Often it will state that their wish is to avoid an acute admission.

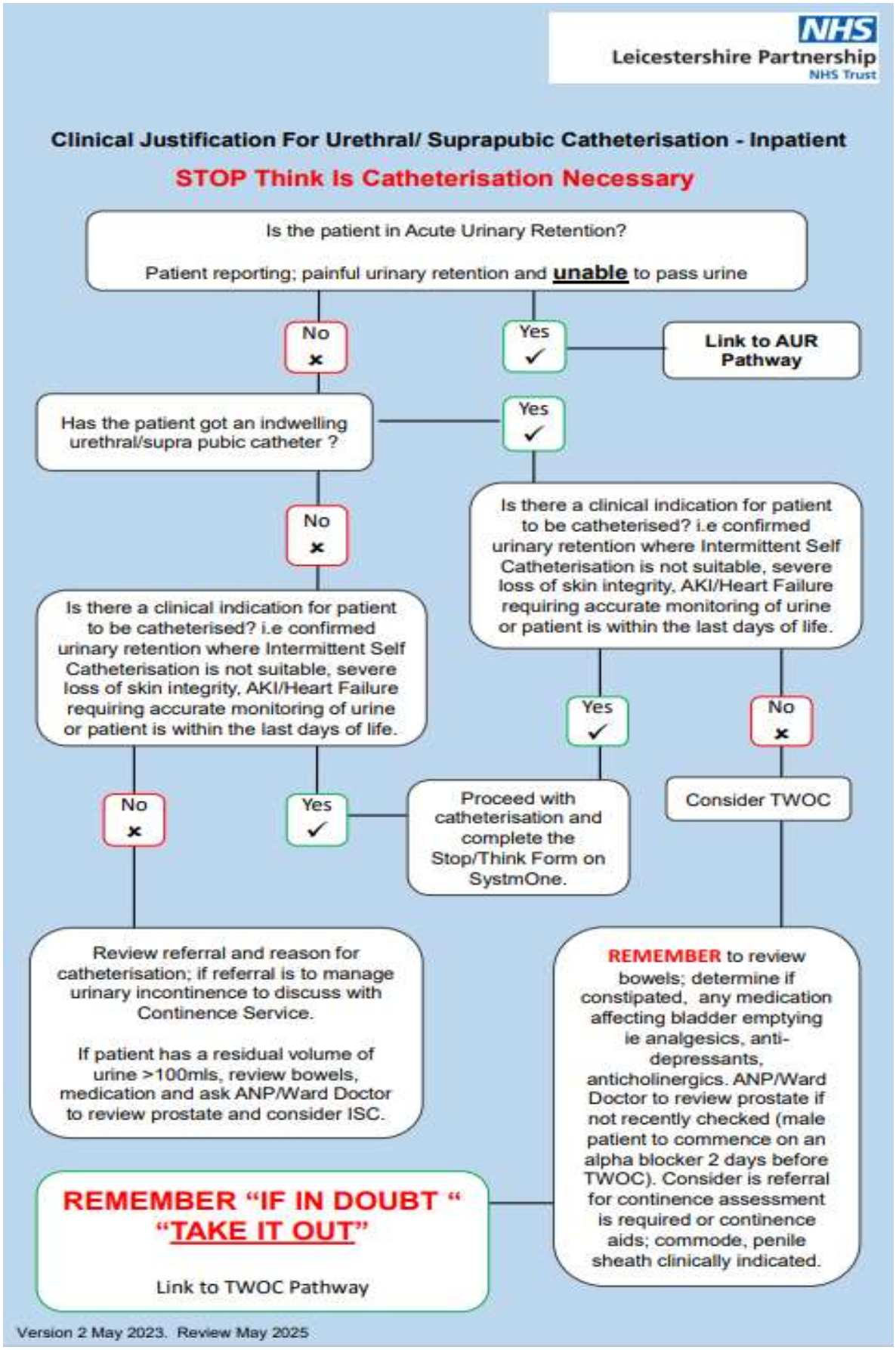
If this is the case and they complain of symptoms related to urinary retention then catheterisation should be considered at home, draining the bladder slowly.

LOROS advice is to catheterise and empty 200mls at a time with a 15min break until bladder is empty. Patient should be encouraged to drink during the process, if possible, to support blood pressure.

Appendix 8a


NHS
Leicestershire Partnership
NHS Trust
Clinical Justification For Urethral/ Suprapubic Catheterisation - Community
STOP Think Is Catheterisation Necessary
Is the patient in Acute Urinary Retention?
Patient reporting painful urinary retention and unable to pass urine
No
Yes
Link to AUR Pathway
Has the patient got an indwelling urethral/supra pubic catheter ?
Yes
No
Is there a clinical indication for patient to remain catheterised; i.e confirmed urinary retention where Intermittent Self Catheterisation is not suitable, severe loss of skin integrity or patient is within the last days of life.
Is there a clinical indication for patient to be catheterised? i.e confirmed urinary retention where Intermittent Self Catheterisation is not suitable, severe loss of skin integrity or patient is within the last days of life.
Yes
No
No
Yes
Proceed with catheterisation and complete the Stop/Think Form on SystmOne.
Consider TWOC
Review referral and reason for catheterisation; if referral is to manage urinary incontinence to discuss with Continence Service.
If patient has a residual volume of urine >100mls, review bowels, medication and ask GP to review prostate and consider ISC.
REMEMBER to review bowels; determine if constipated, any medication affecting bladder emptying ie analgesics, anti-depressants, anticholinergics. GP to review prostate if not recently checked (male patient to commence on an alpha blocker 2 days before TWOC). Consider is referral for continence assessment is required or continence aids; commode, penile sheath clinically indicated.
REMEMBER "IF IN DOUBT "
"TAKE IT OUT"
Link to TWOC Pathway
Version 2 May 2023. Review May 2025

Appendix 8b


NHS
Leicestershire Partnership
NHS Trust
Clinical Justification For Urethral/ Suprapubic Catheterisation - Inpatient
STOP Think Is Catheterisation Necessary
Is the patient in Acute Urinary Retention?
Patient reporting; painful urinary retention and unable to pass urine
No
Yes
Link to AUR Pathway
Has the patient got an indwelling urethral/supra pubic catheter ?
Yes
No
Is there a clinical indication for patient to be catheterised? i.e confirmed urinary retention where Intermittent Self Catheterisation is not suitable, severe loss of skin integrity, AKI/Heart Failure requiring accurate monitoring of urine or patient is within the last days of life.
Is there a clinical indication for patient to be catheterised? i.e confirmed urinary retention where Intermittent Self Catheterisation is not suitable, severe loss of skin integrity, AKI/Heart Failure requiring accurate monitoring of urine or patient is within the last days of life.
Yes
No
No
Yes
Proceed with catheterisation and complete the Stop/Think Form on SystmOne.
Consider TWOC
Review referral and reason for catheterisation; if referral is to manage urinary incontinence to discuss with Continence Service.
If patient has a residual volume of urine >100mls, review bowels, medication and ask ANP/Ward Doctor to review prostate and consider ISC.
REMEMBER to review bowels; determine if constipated, any medication affecting bladder emptying ie analgesics, anti-depressants, anticholinergics. ANP/Ward Doctor to review prostate if not recently checked (male patient to commence on an alpha blocker 2 days before TWOC). Consider is referral for continence assessment is required or continence aids; commode, penile sheath clinically indicated.
REMEMBER "IF IN DOUBT "
"TAKE IT OUT"
Link to TWOC Pathway
Version 2 May 2023. Review May 2025

Appendix 9

Insertion/Changing Male Catheter

	Action	Rationale
1.	Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied. Check patient electronic notes and care plans. The patient should be given the choice regarding a chaperone. The Community policy can be found by following the link below. http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf	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 **removal pack**; 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.

	Action	Rationale
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 **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 anaesthetic container on sterile field and empty saline into gallipot. Wash/decontaminate hands and apply sterile gloves using ANTT.	To minimise the risk of infection
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	Hold the penis firmly with a sterile swab raising until almost totally extended. Squeeze the anaesthetic lubricating gel into the urethra, remove and discard the syringe.	To straighten the urethra Adequate lubrication helps to prevent urethral trauma. Using 11mls local anaesthetic gel minimises the discomfort experienced by the patient.

	Action	Rationale
20	Cover end of penis with sterile swab and wait 5 minutes. Wash/decontaminate hands and apply sterile gloves using ANTT.	To prevent leakage of lubricating gel and to allow the anaesthetic gel to take effect. To reduce the risk of infection
21	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. 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. When urine begins to flow, advance the catheter almost to its bifurcation (allow 75mls to drain to provide assurance catheter is in the bladder not the urethra or prostate). Gently inflate the balloon according to manufacturer's instructions having ensured that the catheter is draining freely beforehand. Withdraw the catheter slightly until resistance is felt on the bladder neck and attach it to the drainage system. 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. Advise patient to alternate daily. Ensure that the glans penis is clean and then reposition the foreskin.	This manoeuvre straightens the urethra and facilitates catheterisation. The male urethra is approximately 18-21 cm long. Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter. Advancing the catheter ensures that it is correctly positioned in the bladder. Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma. To ensure catheter is correctly positioned. To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Retraction and constriction of the foreskin behind the glans penis (paraphimosis) may occur if this is not done.

	Action	Rationale
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.	Record information in relevant documents; ensuring the catheter passport is completed this should include: • reasons for catheterisation • date and time of catheterisation • use of ABTT • catheter type, length and size • amount of water instilled into the balloon • batch number • manufacturer • batch number and expiry date of Instillagel; • any problems occurring during the procedure • review date to assess the need for continued catheterisation or date of change of catheter.	To maintain accurate information. Attach sticky labels from equipment to documentation.

Appendix 10

Insertion/Changing Female Catheter

	Action	Rationale
1	Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied. Check patient electronic notes and care plans. The patient should be given the choice regarding a chaperone. The Community policy can be found by following the link below: http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf	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 **removal pack**; 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.

	Action	Rationale
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 **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 anaesthetic container on sterile field and empty saline into gallipot. Wash/decontaminate hands and apply sterile gloves using ANTT.	To minimise the risk of infection
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

	Action	Rationale
19.	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.	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter.
	Squeeze the anaesthetic lubricating gel into the urethra, remove and discard the syringe. Wait 5 minutes to allow the gel to take effect.	Adequate lubrication helps to prevent urethral trauma. Using 6mls local anaesthetic gel minimises the discomfort experienced by the patient.
	Wash/decontaminate hands and apply sterile gloves using ANTT	To reduce the risk of infection
	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.	To maintain sterility. This manoeuvre facilitates ease of catheter insertion. The female urethra is approximately 5cm long.
	Gently inflate the balloon according to manufacturer's instructions having ensured that the catheter is draining freely beforehand. Allow 75mls to drain prior to inflating the balloon to provide assurance catheter balloon is in the bladder not the urethra.	Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma
	Withdraw the catheter slightly until resistance is felt on the bladder neck and attach it to the drainage system.	To ensure catheter is correctly positioned
	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.	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma.
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.

	Action	Rationale
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.	Record information in relevant documents; ensuring the catheter passport is completed, this should include: • reasons for catheterisation • date and time of catheterisation • use of ANTT • catheter type, length and size • amount of water instilled into the balloon • batch number • manufacturer • batch number and expiry date of Instillagel; • any problems occurring during the procedure • review date to assess the need for continued catheterisation or date of change of catheter.	To maintain accurate information. Attach sticky labels from equipment to documentation.

Appendix 11

Changing a Suprapubic Catheter

	Action	Rationale
1.	Explain and discuss the procedure with the patient and gain valid consent. Check patient electronic notes and care plans.	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 into 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

	Action	Rationale
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 gloves using ANTT. Dry thoroughly using single use disposable paper towels.	To minimise the risk of infection
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 at least 75mls of 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.

	Action	Rationale
21.	Record in the patients records: • the reason for the catheter change • type of catheter used. • ANTT process • (Charriere length, material, balloon size batch no, manufacturer) • cleansing solution used • Lubricant • any problems negotiated. • date for re-assessment • colour, amount and consistency of urine drained. • patient's condition following catheterisation	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.	Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied. Check patient electronic notes and care plans The patient should be given the choice regarding a chaperone. The Community policy can be found by following the link below: http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf Undertake bladder scan to determine residual volume and refer to Care Plan to determine if intermittent catheter needs to be passed.	To ensure that the patient understands the procedure and gives valid consent. Determine if clinical need to pass intermittent catheter.
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 **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. Wash/decontaminate hands and apply sterile gloves using ANTT.	To minimise the risk of infection

	Action	Rationale
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	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. 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. When urine begins to flow, advance the catheter a further 1-2cms. 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.	This manoeuvre straightens the urethra and facilitates catheterisation. The male urethra is approximately 18-21 cm long Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter. Advancing the catheter ensures that it is in the bladder. Ensure that the bladder is empty
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.

	Action	Rationale
18.	Dispose of equipment according to local policy.	To prevent environmental contamination.
19.	Record information in relevant documents; ensuring the catheter passport is completed this should include: • reasons for catheterisation • date and time of catheterisation • use of ANTT • catheter type, length and size • batch number • manufacturer • any problems occurring during the procedure	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 Fluid. Report any concerns to GP.

Appendix 13

Intermittent Catheterisation for a Female Patient

	Action	Rationale
1	Explain and discuss the procedure with the patient and gain valid consent verbal, written or implied. Check patient electronic notes and care plans The patient should be given the choice regarding a chaperone. The Community policy can be found by following the link below: http://www.leicspart.nhs.uk/Library/ChaperonePolicyJuly2015.pdf Undertake bladder scan to determine residual volume and refer to Care Plan to determine if intermittent catheter needs to be passed,	To ensure that the patient understands the procedure and gives valid consent. Determine if clinical need to pass intermittent catheter.
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

	Action	Rationale
9.	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. Empty saline into 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.	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. Wash/decontaminate hands and apply sterile gloves using ANTT 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 gently lift the parted labia upwards towards the pubic bone. Insert the catheter until urine flows. When urine begins to flow, advance the catheter a further 1-2cms. 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.	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter. To reduce the risk of infection To maintain sterility. This manoeuvre facilitates ease of catheter insertion. The female urethra is approximately 5cm long. Advancing the intermittent catheter ensures that it is in the bladder To ensure that the bladder is empty

	Action	Rationale
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: • reasons for catheterisation • date and time of catheterisation • use of ANTT • catheter type, length and size • batch number • manufacturer • any problems occurring during the procedure	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.

Appendix 14

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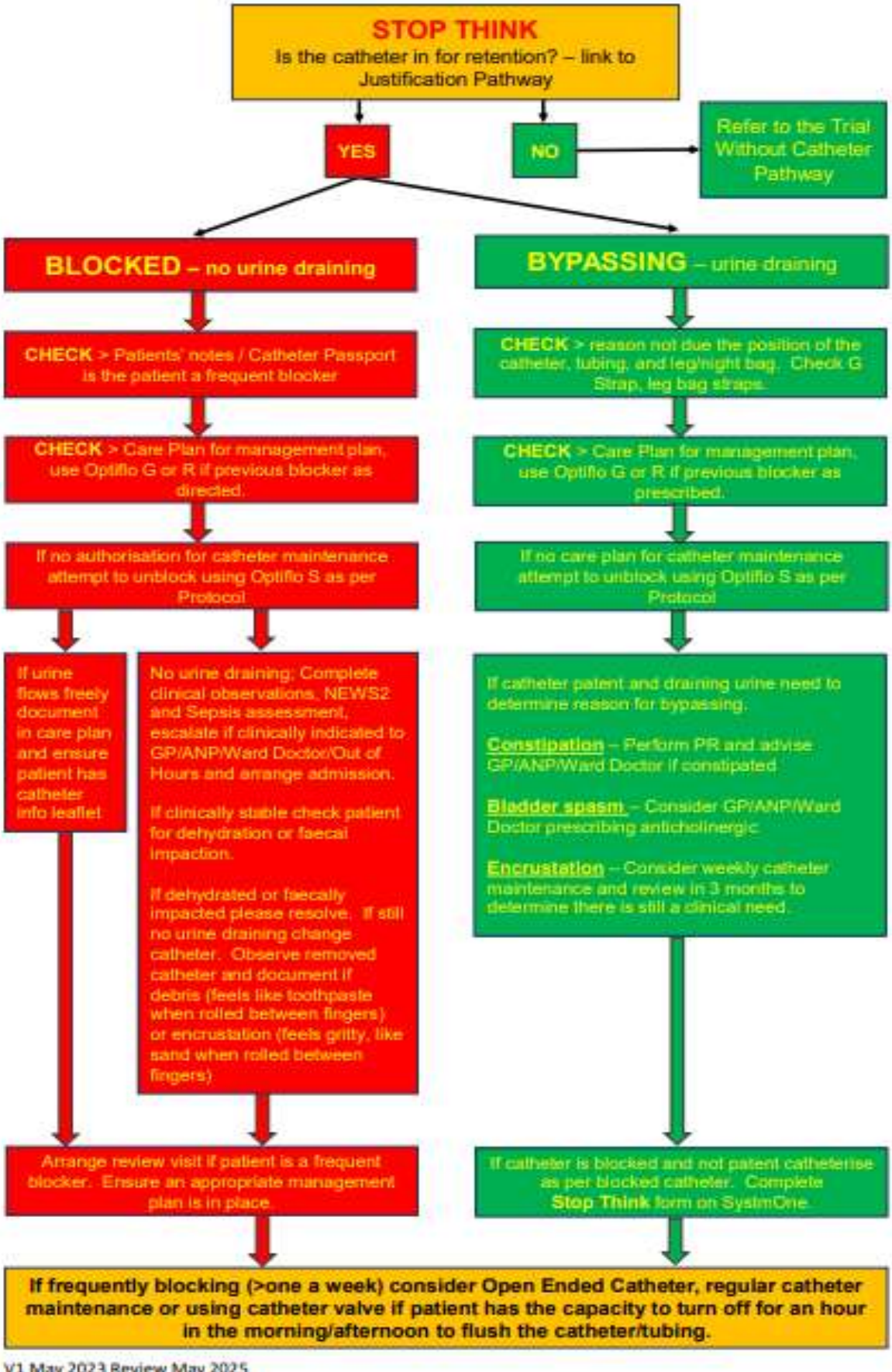
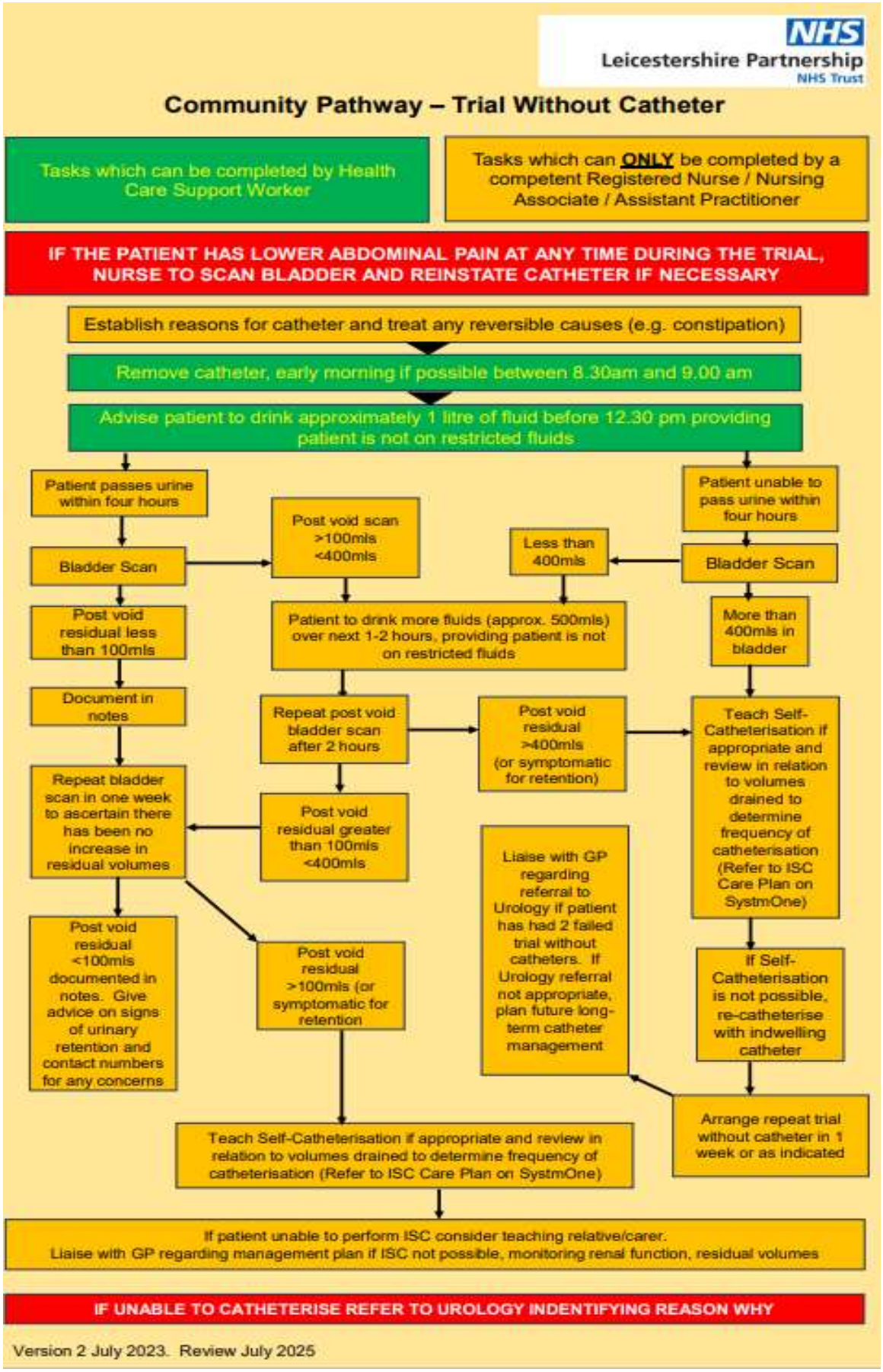
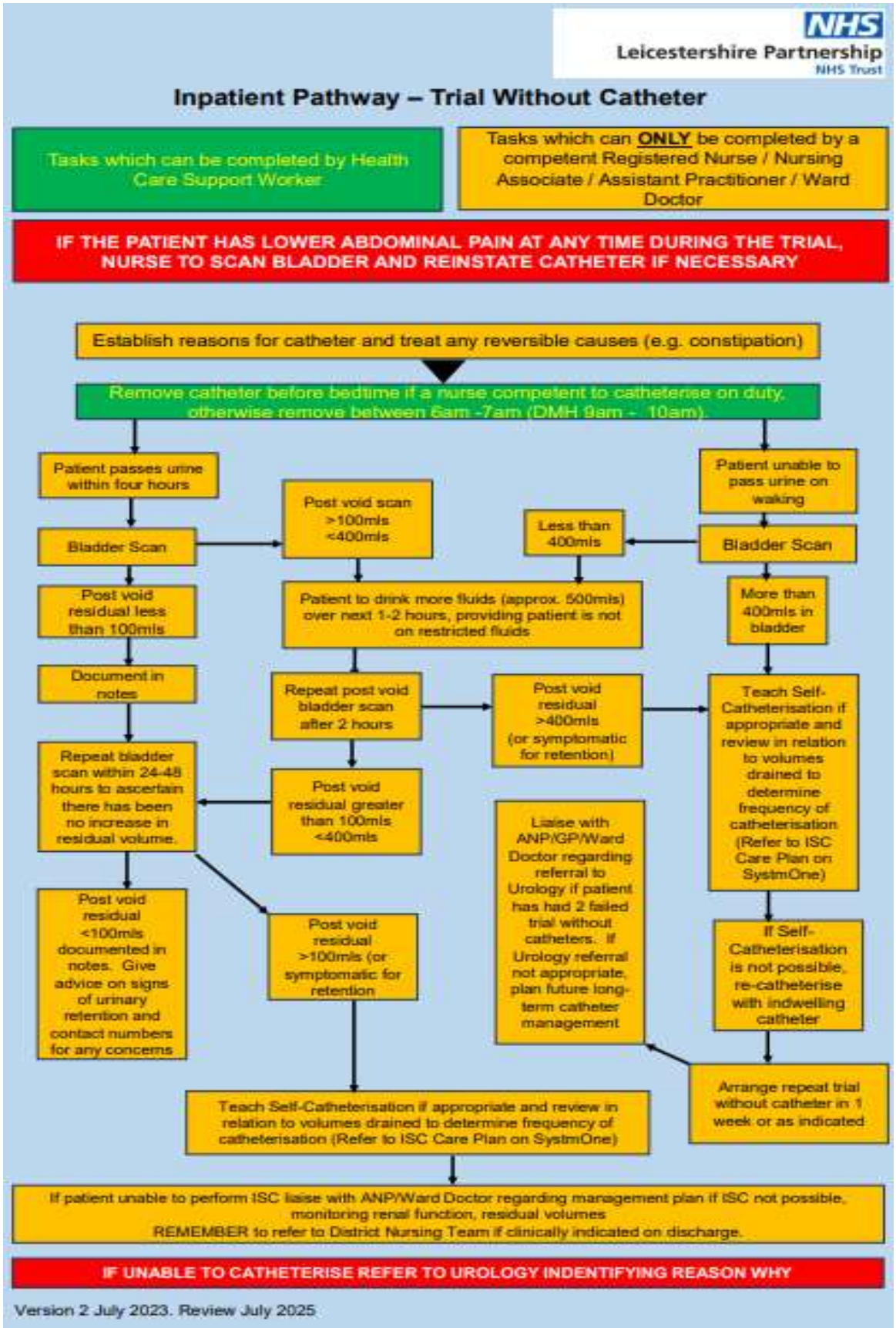
Registered Nurse Pathway for Blocked or Bypassing Catheter



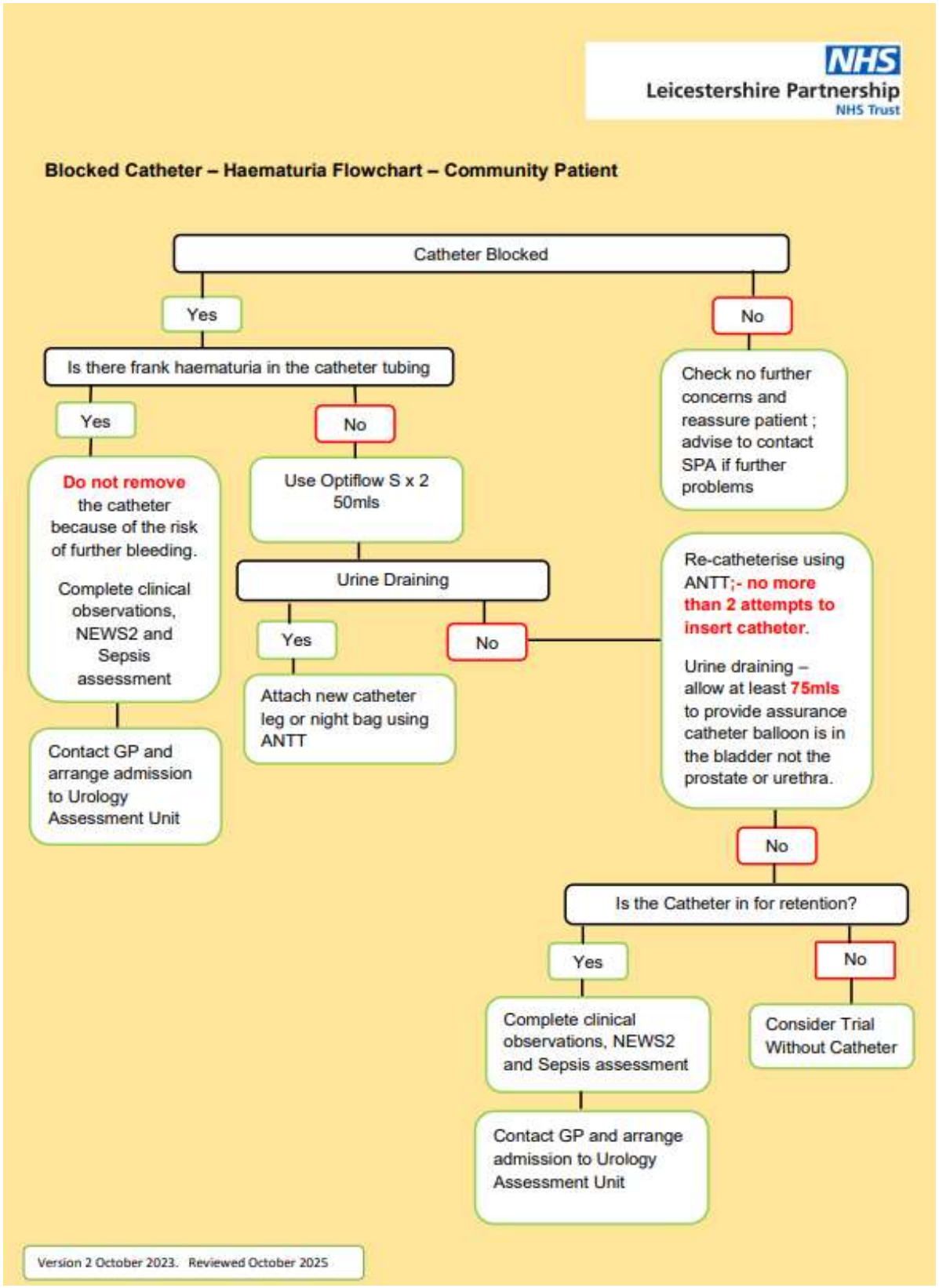
Appendix 15a



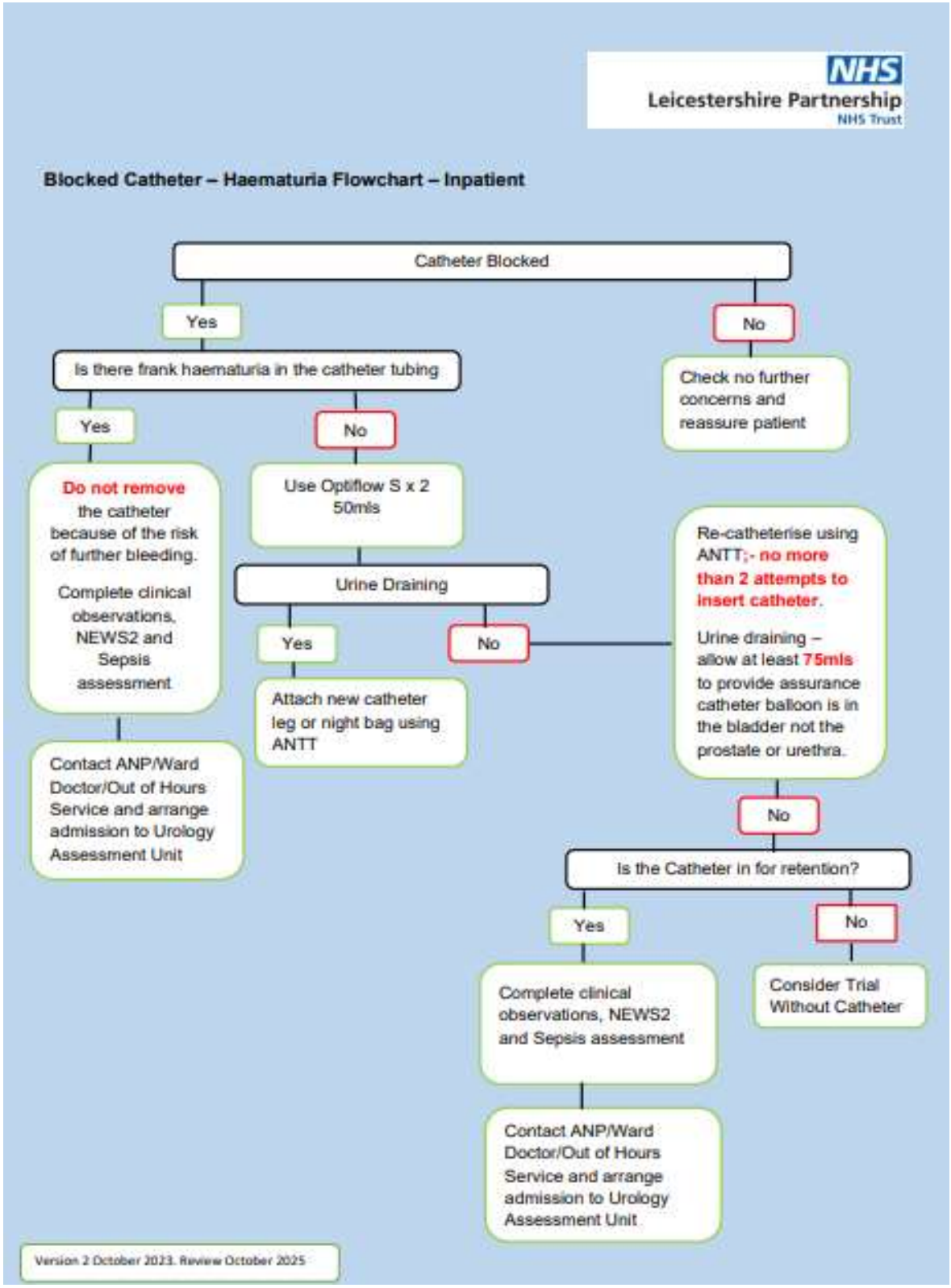
Appendix 15b



Appendix 16a



Appendix 16b



Appendix 17

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 18

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; **Do not force solution in to the bladder** 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.

Clinical Condition	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.
Exclusions	• Spinal patient showing signs of Autonomic Dysreflexia with a non-draining blocked catheter. The catheter should be changed in this instance. • Known allergy to the preparation or any of its ingredients. • Patients aged under 18 years. • Patient has had surgery to bladder in the last week. • Significant haematuria
Cautions / Need for further advice	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 was not prescribed any laxative. 2. Drainage Bag above the level of the bladder with the exclusion of the belly bag 3. Drainage Bag more than two thirds full. 4. Twisted or kinked drainage tubing. 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.
Side effects	Adverse reactions to Optiflo® S are unlikely. May cause some patients to experience slight irritation.
Further advice	All patients with a catheter in situ should be given a copy of : • LPT Patient Information Leaflet. "Looking after your urinary catheter at home": information for patients and carers leaflet. • LPT Urinary Catheter Passport
Record keeping	Ensure treatment and outcome is documented in the written notes or on SystmOne, including assessment of patient need in relation to the intervention, dose given, time given and any further advice or follow up given.

Appendix 19
Protocol for the Administration of Lidocaine 2% with Chlorhexidine Gluconate 0.25% Sterile Gel (Instillagel®)

Preparation	Route/Method of administration	Frequency
Lidocaine 2% with Chlorhexidine Gluconate 0.25% Sterile Gel (Instillagel®) **Two sizes** 6ml (recommended for female patients) 11ml (recommended for male patients)	Topical to urethra	Single dose only

Clinical Condition	Local anaesthesia and disinfection prior to catheterisation of adults in acute urinary retention. Acute urinary retention is associated with abdominal pain and the acute inability to void urine. Referral by a medical practitioner or ANP with assessment and treatment to follow in line with the Urinary Catheter Policy for Community Health Services, Inpatient Facilities and Primary Care [1]
Exclusions	• Patients aged under 18 years. • Pregnancy • Known allergy to the active ingredients (lidocaine, chlorhexidine, methylhydroxybenzoate, propylhydroxybenzoate and any other ingredients listed in the manufacturers information. • Patient who has severe injury to the urethra or has damaged or bleeding mucous membranes (= risk of absorption of the lidocaine hydrochloride). • Patient with complete heart block or receiving treatment with an antiarrhythmic drug.
Cautions / seek further advice	• Patient with hepatic impairment • Patient with epilepsy
Side effects	There is a risk of anaphylactic reaction due to chlorhexidine allergy (MHRA 2012). Undesirable effects of the local anaesthetic, lidocaine is possible where there is severe injury to the mucosa and absorption may occur (see exclusions). Examples are anaphylaxis, bradycardia and a fall in blood pressure or convulsions.
Advice to patient/carer	Advise the patient that the anaesthetic takes up to 5 minutes to become fully effective. It may take up to 2 hours for sensation to fully return. The patient may feel some stinging at the time of the administration and there may be slight soreness when the local anaesthetic wears off. The ability to drive or operate machinery may be slightly impaired after the use of this product. If affected, patients should be advised not to drive or use machinery.
Record Keeping	Ensure treatment and outcome is documented in the written notes or on SystmOne, including assessment of the patient need in relation to the intervention , time given, dose given and batch number/expiry date and any further advice or follow up given.

1. Urinary Catheter Policy for Community Health Services, Inpatient Facilities and Primary Care (2023).

Appendix 20a

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Haematuria Ladder Community Patients

Light Pink 	Potentially due to trauma, medical condition (prostate/bladder cancer) or medication (blood thinning) which should resolve. Advise patient/carer to increase fluid intake providing he/she is not on any restricted fluids, checking that leg bag is positioned correctly and G-Strap in situ. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. Patient/Carer to Contact Single Point of Access 0300 300 7777 if urine becomes pinker/red in colour.
Medium Pink 	Potentially due to trauma, medical condition (prostate/bladder cancer) or medication (blood thinning) which should resolve. Advise patient/carer to increase fluid intake providing he/she is not on any restricted fluids, checking that leg bag is positioned correctly and G-Strap in situ. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. Patient/Carer to Contact Single Point of Access 0300 300 7777 if urine becomes pinker/red in colour.
Dark Old Haematuria 	Potentially due to previous trauma, medical condition (prostate/bladder cancer) or medication (blood thinning) so should resolve. Advise Patient/carer to change leg bag using Aseptic Non-Touch Technique, to increase fluid intake providing he/she is not on any restricted fluids, advice that leg bag is positioned correctly and G-Strap in situ. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. If catheter is blocked attempt to unblock using Optiflo S; Complete News2 if patient appears clinically unwell. Patient/Carer to Contact Single Point of Access 0300 300 7777 if urine becomes bright red in colour. **If CLINICALLY UNSTABLE FOLLOW NEWS2 PATHWAY.**
Bright Fresh Haematuria 	Potentially due to trauma, medical condition (prostate or bladder cancer) or medication (blood thinning). **DO NOT REMOVE THE CATHETER.** If blocked refer to the **Blocked Catheter – Haematuria Flowchart – Community** Completed NEWS2 and consider sepsis; to ascertain if admission is required; please consider Past Medical History i.e., bladder/prostate cancer. **If CLINICALLY UNSTABLE dial 9999.** **If catheter is not blocked and patient is passing bright fresh haematuria advise patient/carer to dial 9999.**

Reference – Pictures – For Improving Communication When Describing Gross haematuria. Urology Vol 148 Feb 2021 Pg 32-36

Haematuria Ladder – Community V1. November 2023 Review Date November 2025

Appendix 20b

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Haematuria Ladder – Inpatient

Light Pink 	Potentially due to trauma, medical condition (prostate/bladder cancer) or medication (blood thinning) which should resolve. Advise patient to increase fluid intake providing he/she is not on any restricted fluids; check leg bag is positioned correctly and G-Strap in situ. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. Commence Fluid Balance Chart, staff to monitor colour of urine over the next 4 hours and escalate if urine becomes more darker pink/red in colour.
Medium Pink 	Potentially due to trauma, medical condition (prostate/bladder cancer) or medication (blood thinning) which should resolve. Complete News2; encourage fluids check leg bag is positioned correctly and G-Strap in situ. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. Commence Fluid Balance Chart, staff to monitor colour of urine over the next 4 hours and escalate if urine becomes more darker pink/red in colour. **If CLINICALLY UNSTABLE INFORM ANP/Ward Doctor/dial 9999**
Dark Old Haematuria 	Potentially due to previous trauma, medical condition or medication so should resolve. Complete News2; encourage fluids. If catheter is blocked attempt to unblock using Optiflo S. Commence Fluid Balance Chart, change leg bag using ANTT, staff to monitor colour of urine over the next 4 hours and escalate if urine becomes more bright red in colour. Confirm patient has no symptoms of CAUTI i.e., fever malaise, supra pubic pain, or new/increased confusion. **If CLINICALLY UNSTABLE INFORM ANP/Ward Doctor/dial 9999**
Bright Fresh Haematuria 	Potentially due to trauma, medical condition (prostate/bladder cancer) or medication (blood thinning). **DO NOT REMOVE THE CATHETER.** If blocked refer to the **Blocked Catheter – Haematuria Flowchart – Inpatient** Completed NEWS2 and consider sepsis to ascertain if needs admission is required; please consider Past Medical History i.e., bladder/prostate cancer. **Inform ANP/Ward Doctor. If out of hours contact "out of hours service" for advice or 9999 if CLINICALLY UNSTABLE.**

Reference – Pictures – For Improving Communication When Describing Gross haematuria. Urology Vol 148 Feb 2021 Pg 32-36

Haematuria Ladder – Inpatient V1.November 2023 Review Date November 2025