



# Urinary Catheter Care Policy



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## Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
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## 1 INTRODUCTION

Doncaster and Bassetlaw Teaching Hospital (DBTH) has a responsibility to ensure the safety of a patient requiring a urinary catheter. High quality catheter care should be accessible to all individuals presenting with a condition requiring catheterisation, regardless of age, disability, gender, race, sexual orientation, religion/belief or any other factors which may result in unfair treatment or inequalities in health or employment (DOH 2006b). Catheters are inserted for many reasons and have an essential role to play in patient care, but their use can result in serious complications. Catheterisation is an invasive procedure that should only be carried out following an assessment of need and after considering alternative methods of management. (NICE 2019) The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible (NICE 2019). The decision to catheterise, selection of equipment, maintenance of a closed drainage system and agreed plan of care are all part of patient management.

This policy will provide information to help staff to manage the procedure safely and competently. It is essential that nurses are competent both in providing health education and catheter care, when providing care for a patient who has a urinary catheter (Bond & Harris, 2005). The nursing management of individuals requiring a urethral catheter system includes obtaining consent, appropriate selection of equipment, aseptic non-touch technique (ANTT) for catheter insertion, appropriate drainage systems and its maintenance, continuing care and removal of the catheter (Pomfret, 2006; Bond & Harris 2005).

Urinary catheters are inserted into patients in a number of clinical areas within the Trust by medical and nursing staff from various specialities. This policy aims to aid all health care professionals in applying best practice within the setting of Doncaster and Bassetlaw NHS Trust, and will focus on minimising the risk of urinary tract infections in all patients with urinary catheters.

## 2 PURPOSE

This policy aims to aid all professionals in applying best practice for urinary catheter insertion, ongoing care and catheter removal within the setting of Doncaster and Bassetlaw NHS Trust. It has been written using national guidelines for good practice. Both indwelling and intermittent urinary catheters are included in the scope of this policy.

## 3 DUTIES AND RESPONSIBILITIES

<b>Chief Executive</b>	The Chief Executive has ultimate responsibility for ensuring that effective systems and processes are in place to minimise the risk of infection to patients, staff and visitors.
<b>Trust Board</b>	The Trust Board has a responsibility to ensure that the risk of infection to patients, staff and visitors is minimised to its lowest potential and therefore supports the full implementation of this policy.

<b>Director of Nursing and Director of Infection Prevention and Control (DIPC)</b>	Delegated responsibility for ensuring that effective systems and processes are in place to minimise the risk of infection to patients, staff and visitors.
<b>Medical Director/Director of Infection Prevention and Control</b>	The Medical Director has a shared responsibility with the Director of Nursing for ensuring effective Clinical Governance within the organisation.
<b>Infection Prevention and Control Team</b>	Infection Prevention and Control Team Provide expert and current advice, support and guidance on all aspects of infection prevention and control. Deliver mandatory education and training to all trust employees and users in accordance with epic 3 (2014) guidance.
<b>Matron</b>	Matrons have a responsibility for the reduction of healthcare associated infection. Responsibility to maintain high standards of infection prevention and control via clinical presence/expertise.
<b>Ward/Department Manager</b>	Must ensure that:- Appropriate personal protective equipment is available and that staff understand & comply with the PPE policy. All staff attend corporate/nursing induction and annual mandatory training updates thereafter. Local induction programmes and annual performance review incorporates relevant infection prevention and control for their area of practice, this includes ensuring a respirator mask fit test is undertaken if appropriate to their role.
<b>All staff</b>	All Trust staff has a responsibility to adhere to Trust policy and ensure that appropriate measures are taken to reduce risks associated with infection. All Trust staff has a responsibility to ensure they receive annual training in Infection Prevention and Control
<b>Urology Department</b>	Co-ordinates with clinical skills team to write (and deliver where appropriate) educational study days for the theory of catheterisation, and practical sessions. During office hours medical and nursing staff are available for referral and consultation for patients with urological conditions complex catheter problems.
<b>Supplies Department</b>	Supplies Department are required to top up ward and department stocks of catheter and drainage products to ensure there is a continual supply.

### Legal Implications of Catheter Selection and Storage

Catheterisation is affected by the Consumer Protection Act (1987). If a patient suffers damage, as result of a defect in a product, the producer (or if the **producer** is outside of the European Community the original EEC **Importer**) is held liable for that damage. If neither

producer nor importer can be identified, **the supplier of the product is held liable**. This relates to the NHS as a supplier, a producer and a keeper of products.

In relation to the act, it is vital that nursing staff, as suppliers:-

- Always comply with the manufacturer's guidelines regarding storage, by only using catheters that have been stored in boxes they are supplied in. Catheters should not be folded up, and should not have elastic bands tied round them. They should not be removed from their boxes and stored in racks.
- Within the hospital setting, it is the ward/departmental manager's responsibility to ensure that, if they have been designated to store/supply female length catheters, they are kept in separate areas.
- Areas other than urology that request a female length catheter are issued with one catheter.
- Documentary evidence on the catheter care sheet.
- The supplies department will not purchase short-term female catheters.
- Stock levels should reflect usage rates and new stock should be placed behind current stock to ensure stock rotation.
- Indwelling catheters should not be used beyond their expiry date.
- All coated catheters should only be left in situ for the period of time recommended by the supplying company.
- In 1988 a safety information bulletin was released from the department of health indicating that latex catheters may predispose some patients to form urethral strictures. Most indwelling catheters are latex coated. It is therefore important that nurses are aware of the manufacturer's recommendations for duration of use.
- Patients with known Latex allergy should always be catheterised with a 100% silicone catheter.
- Indwelling catheter shafts should never be clamped and nursing staff should never cut the inflation channel.
- Comply with the Organisation's Policy on Documentation so those faulty catheters can be traced back to source.
- Nurses need to be aware of their responsibilities and take the necessary precautions to protect themselves and patients.

## 4 PATIENT SELECTION AND CONSENT

Catheterisation is an invasive procedure that can cause embarrassment, physical and psychological discomfort and impact on the patients' self-image. To ensure the patient is fully prepared for catheterisation it is the responsibility of the health care professional to inform the patient of the reasons and necessity for the procedure:

- Prior to catheter insertion a full assessment of each patient must be performed. Consider the reason for urethral catheterisation, and determine whether there are any contra-indications to it.
- Explore the alternatives to catheterisation and ensure that the need for urinary catheterisation in each patient outweighs possible complications. (Essential steps DOH, 2006; EPIC National guidelines 2014).

- Explain any possible complications that could occur and provide enough information to enable the patients and carer to make an informed decision and consent to the procedure.
- Ensure that verbal consent and agreement is reached and the relevant information is recorded in the medical/ nursing notes.
- Consent should be seen as a process, not a single event. Patients can change their minds and withdraw their consent at any time (DOH, 2009).
- A holistic assessment on each patient requiring catheterisation must be performed including assessment of manual dexterity and determine which method of catheterisation is most suitable for person.
- Where possible staff will involve the patient/relatives/carers in the decision making process around their care needs.

If the patient is to have a long term catheter inserted consider:

- The patient's ability to manage the catheter independently.
- Carer availability in order to manage/undertake catheter care for the patient.
- Tissue viability and preserving skin integrity

### **PATIENTS LACKING CAPACITY**

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the person's Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

## **5 ASSESSING THE NEED FOR URINARY CATHETERISATION – RISK ASSESSMENT**

Avoid catheterising patients where possible (DOH 2007a). The nurse must ensure, in consultation with the doctor, the patient and/or carer that the decision to catheterise is made for the right clinical reasons and not for the convenience of the carers.

Adams et al (2003) developed the HOUDINI nurse led approach, which considers acceptable rationales for patients being catheterised. This was updated by NHS improvement plan in 2011.



**Clinical indications for Catheterisation**

- **Haematuria**
  - Clot retention and gross haematuria (if irrigation required)
- **Obstructed**
  - Mechanical urology
- **Urologic Surgery**
  - Gynaecology/Perianal surgery/prolonged surgery
- **Decubitus Ulcers**
  - To assist healing of a perineal/sacral wounds for incontinent patients
- **Input/Output monitoring**
  - Accurate hourly or
  - acute kidney injury when urine production is of concern
- **Not for Resus / End of life care/ comfort**
  - Nursing at the end of life
- **Immobility due to physical restraints**
  - Immobilisation due to unstable fracture/spinal injury or neurological deficit where all other methods of toileting are contraindicated

If the patient requires an ultrasound scan of the bladder to determine residual urine, the bladder scan must be performed by a Health care professional who is competent to use the bladder scan device.

**5.1 Latex Allergy**

The practitioner must be aware of all known allergies that the patient may have including latex, lidocaine or chlorhexidine.

All patients with a latex sensitivity must be catheterised with a 100% all silicone catheter.

**5.2 Haematuria (during catheterisation)**

The practitioner performing the catheterisation must be aware of any risks of haematuria, including current anticoagulant medication, recent catheter related trauma, recent urinary tract surgery, cancer of the bladder or prostate, urethral/meatal bleeding or blood clots in urine.

### 5.3 Autonomic Dysreflexia

Autonomic Dysreflexia is a condition unique to spinal cord injuries most commonly affecting those with injuries at or above T6 (Harris 2001). If a pain stimulus is detected below the injury, the patients' blood pressure rises and can be life threatening.

The signs and symptoms of Autonomic Dysreflexia are:

- Raised blood pressure
- Bradycardia
- Pounding headache
- Flushing
- Sweating
- Blotching above the level of the injury
- Pallor
- Cold
- Goosebumps below the level of the injury

The most common cause of Autonomic Dysreflexia is bladder or bowel distention. This can be due to:

- blocked catheter
- urinary tract infection
- overfilled collection bag.
- Loaded colon

If a patient has a urinary catheter, check the following regularly:

- Is the drainage bag full?
- Is there a kink in the tubing?
- Is the drainage bag at a higher level than the bladder?
- Is the catheter drainage turned off?

Management of Autonomic dysreflexia:

- Remove the precipitating cause.
  - If the patient is catheterised and the catheter is not draining after 2-3 minutes, the catheter must be changed immediately.
  - If the patient does not have a urinary catheter, and urinary retention is suspected then perform a catheterisation and empty the patients bladder)
- Remove/loosen clothing.
- Monitor vital signs.
- If hypertension persists, give prescribed emergency medication.
  - The majority of spinal injured patients have been taught and been made aware of this complication while in a spinal unit and carry an emergency bag.

#### 5.4 Patients that may be at an increased risk of complications during catheterisation

- Patients with diagnosed CAUTI
  - DBTH policy for urinary tract infections state that 'catheter should be changed 24-48 hours after diagnosis if able.
- Patient's known to suffer from urethral strictures.
  - After one failed attempt by a suitable medic, advice should be sought from a senior member of the Urology team.
- Patients that are known to be difficult to catheterise.
  - After one failed attempt by a suitable medic, advice should be sought from a senior member of the Urology team.
- Patients that are known to have false passages in the urethra.
  - After one failed attempt by a suitable medic, advice should be sought from a senior member of the Urology team.
- Patients in chronic retention that may bleed following decompression of the bladder.
  - To minimise the risk of hypovolaemic shock / haemorrhage due to sudden decompression of a high pressure bladder, the patient should receive a bladder scan to confirm post void residual volume and a renal function check before proceeding.
  - If urea, electrolyte and creatinine values are abnormal then the patient should be catheterised under a controlled environment (ie secondary care) to ensure patient safety and admitted for monitoring. These patients must not be considered for TWOC unless requested by the urology team.
- Patients that have undergone prostate surgery within 3 months must not have their catheters changed by medical or nursing staff, unless they have had the relevant urological training/experience.
  - Advice should be sought from a senior member of the Urology team.
- Patients that have undergone a radical prostatectomy within 3 months must not have their catheter changed without the consent of the relevant consultant.
- Patients with artificial urinary sphincter must not be catheterised.
  - Discuss management with urology.

#### 5.5 Potential causes of increased risk of complications linked to CAUTI

- Patients aged over 65 years
- History of diabetes
- Suprapubic catheter (may indicate complex urinary tract problems)
- Currently taking steroids
- Single functioning kidney
- Currently taking antibiotics for UTI
- History of UTI while catheterised.
- Known MRSA – high risk of bacteraemia

## 5.6 Patients at increased risk of serious complications from CAUTI

- Patients with artificial heart valve
- History of UTI while catheterised
- Patients who are immunosuppressed
- Patients who have had organ transplant

Prophylactic antibiotics are not indicated in the majority of patients having a catheter change (HSE 2011).

However, if necessary, consult a senior member of the urology team or microbiology regarding the use of an appropriate prophylactic antibiotic to cover the procedure on an individual basis.

## 6 METHODS OF URINARY CATHETERISATION AND REASONS FOR USE

Following an assessment for the best approach to catheterisation, management should take account of the clinical need and anticipated duration-life of the catheter (Pomfret, 2007). Patient preference and potential risk of infection should also be considered.

Intermittent catheterisation should be used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient i.e. appropriate manual dexterity/cognitive function (Winder, 2008).

### 6.1 Intermittent catheterisation (ISC)

Intermittent catheterisation should be considered first, as there is a reduced risk of CAUTI than with an indwelling catheter. Indications for use of ISC are:

- Relief and management of acute or chronic retention of urine.
- Incomplete bladder emptying.
- To empty the contents of the bladder before or during childbirth.
- Estimation of residual urine -in the absence of bladder scanner.
- For bladder management in neurological disease, i.e. paralysis, spinal cord injury, multiple sclerosis, stroke etc.
- Management of urethral stricture. (See **Appendix 1** for Procedure of Intermittent Catheterisation).

### 6.2 Urethral catheterisation

Indications for use of urethral catheterisation are:

- To empty the contents of the bladder before or after abdominal, pelvic or rectal surgery.

- To allow irrigation of the bladder.
- To bypass an obstruction.
- To relieve acute retention of urine.
- To relieve chronic retention of urine - if symptomatic or renal function is compromised (RCN 2008).
- Haemodynamic monitoring.
- To instil medication in to the bladder.
- To enable investigations to be performed e.g. urodynamic studies.
- For some cases at end of life care (RCN 2008).
- To relieve incontinence when no other means is practicable.
- To maintain skin integrity Patient has open wounds/pressure damage and healing is impaired by contamination of urine.
- Patient has a disability that makes moving or changing position painful.
- To empty the bladder before childbirth.

### 6.3 Suprapubic catheterisation

Indications for use of Supra-pubic catheterisation are:

- Trauma of the pelvis or urinary tract.
- Patient choice in patients who require long term catheterisation e.g. for sexual activity, dignity, comfort etc.
- Following pelvic, gynaecological or urological surgery.
- Urinary retention or voiding problems caused by prostatic obstruction, infection, urethral stricture or where urethral catheterisation is not possible (RCN 2008).

Contraindications to Suprapubic catheterisation include:

- Haematuria.
- Known history of bladder tumour.
- History of extensive open pelvic surgery.
- Prosthetic devices or material in the lower abdomen (RCN 2008).

## 7 SELECTION OF APPROPRIATE EQUIPMENT

### 7.1 Catheter Size

Charrier (CH) size	
Female 12/14Ch	Choose the smallest size possible which provides adequate drainage (NICE 2019)
Male 12/14/16Ch	
	Larger catheters can cause urethral irritation and bypassing around the catheter.

	<p>Larger sizes should only be used if clots or debris are present.</p> <p>If the catheter is being changed is due to blockage, consider increasing the catheter size. If patient is already using a 16Ch, use a 16Ch and refer to urology as an outpatient for further management.</p>
16-22Ch	<p>Larger charrier sizes (16 – 22Ch) should be used for supra pubic re-catheterisation as this helps to avoid blockage.</p> <p>Re-catheterise with the same size as previously used, unless troubleshooting.</p> <p>If unable to insert a 16-22Ch catheter, use a smaller size to try to preserve the cystostomy site and refer to urology for urgent review.</p>

## 7.2 Catheter Material

Catheter material	Advantage	Disadvantage	Duration of catheter
<b>PTFE - Teflon coated latex</b>	Smoother outer surface – reduces tissue damage and more resistant to encrustations than pure latex.	Unsuitable for people with latex allergies.	28 days
<b>Hydrogel coated latex</b>	More compatible with body tissue, less trauma. Low surface friction, improved patient comfort.	Unsuitable for people with latex allergies.	12 weeks
<b>All Silicone</b>	They have a slightly wider lumen than that of coated catheters; therefore should be considered if the patient is prone to blockage of their catheter. Suitable for patients with a latex allergy	Silicone allows diffusion of water: balloons may therefore occasionally deflate in situ, causing the catheter to fall out	12 weeks

## 7.3 Length of Catheter

Length	Suitable for:
Standard/Male	<p>Male/Female</p> <p>Used for male patients and also for female patients if obese confined to bed/chair or on initial catheterisation.</p>

Female	<p><b>Female only</b></p> <p>For ambulatory female patients, unless they are bariatric, bed or wheelchair bound, changing an obese or bed/chair bound female from a short length to standard length catheter may resolve problems with by passing or poor drainage.</p> <p>The shorter length means a leg bag can be worn, which does not show beneath the skirt/ and also avoids kinking of the catheter or tubing.</p> <p>A female catheter should <b>NEVER</b> be used in a male patient, as this can cause severe trauma to the prostatic urethra. National Patent Safety Agency (NPSA 2009).</p>
Paediatric	Children only

#### 7.4 Balloon Size

5ml	<p>Paediatric catheters.</p> <p>Adult Linc Medical size 12-14 indwelling catheters.</p>
10ml	Standard size for routine catheterisation.
30mls	<p>Should <b>NOT</b> be used - these are for urology post-operative use only.</p> <p>The weight of water in larger balloons may lead to dragging/pulling of the catheter. The larger balloon may also cause bladder spasm and discomfort because it will rest against the delicate trigone of the bladder causing spasm, bypassing, pain, haematuria, possible erosion of the bladder wall and damage to the bladder neck. (Getliffe, 1996).</p>
<b>Integrated Catheter Balloon</b>	The 'Unibal' integral balloon is an innovative design feature which acts to dramatically reduce cuffing upon catheter insertion and removal, following deflation. Discuss with urology if required.
<b>Balloon Inflation</b>	<p>Balloons should always be inflated with Sterile water <b>only</b>. The use of any other fluid will result in osmosis of the water in the balloon contents, resulting in crystal formation within the balloon. This will lead to problems with deflation of the balloon prior to removal.</p> <p>The correct volume of water must be used to inflate the balloon. If less than the recommended amount of water is used the balloon may inflate unevenly, thus not holding the catheter securely in place.</p>

	It is not best practise to deflate and re-inflate the balloon for trouble shooting.
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## 7.5 Catheter Tips

Catheter Tips	
Straight tip	A number of different catheter tips are available designed for specific use but the standard tip is straight, rounded and has two drainage eyes. Unless otherwise stated/indicated, use a standard tipped catheter.
Open tip	Suitable for both Urethral and Suprapubic use.  An open end catheter allows drainage of large amounts of debris (e.g., blood clots) May be more suitable for catheters that block regularly.
Coude/Tiemann	These catheters have a curved tip and are used to negotiate through the bladder neck or enlarged prostate.  Should not be used, unless specifically trained in their use.

## 7.6 Lubricating Gels for Urinary Catheterisation

<b>Urethral catheterisation male and female</b>	<p>Lubricants with anaesthetic should be used for both male and female urethral catheterisation, unless there is an allergy or sensitivity (NICE, 2019). This is to ensure urethral trauma and discomfort is minimised.</p> <p>Female 6 ml syringe. Male 11 ml syringe.</p> <p><b>N.B</b> Products containing local anaesthetics should also be used with caution in-patients with impaired cardiac conditions, hepatic insufficiency and in epileptics.</p> <p>It is important that after insertion that you wait the full 5 minutes, before inserting the catheter to allow the anaesthetic to take effect.</p>
<b>Suprapubic catheterisation</b>	A sterile non lidocaine based lubricant gel must be used for all suprapubic catheterisations to reduce the risk of bleeding from the cystostomy site.



## 7.7 Urinary Drainage Systems

All indwelling catheters should be connected to a sterile closed drainage system or catheter valve. Maintaining a sterile, continuously closed urinary drainage system is central to the prevention of CAUTI (Pratt *et al*, 2007). Selection of an appropriate system must take into account the reason for catheterisation, duration required, patient/carer preference and other infection prevention measures. Patients must be educated on their drainage system prior to discharge home.

A wide range of drainage bags/devices are available:

- Large night drainage bags (2 litre) - commonly used for immobile patients/overnight drainage
- Leg bags (350-750 ml) - Permit greater mobility & can be worn under clothes
- Urometer - designed to measure hourly urine output
- Belly bags - commonly used for patients who mobilise in a wheelchair
- Flip flow valves

## 7.8 Drainage Bags

- The leg bag and/or night drainage bag, attached directly to the catheter, must be sterile and form a closed system.
- The closed system should never be broken except for good clinical reason (Pratt *et al* 2007). For example, changing the catheter bag in accordance with manufacturer's instructions (normally every 5–7 days). Bags that are damaged, leaking or contain an accumulation of debris or have been disconnected should be changed immediately.
- Night drainage bags should be connected to a stand that prevents the bag from coming into contact with the floor (night bag stand or hanger).
- To facilitate urinary drainage and prevent reflux to minimise infection risk and upper urinary system damage, the drainage bag must be positioned below the level of the bladder (Belly-bags incorporate an integral valve to prevent reflux) (Evans 2001).
- All urinary catheters must be secured with a catheter fixation device or strap (G-strap) to the thigh or abdomen to minimise the risk of catheter tugging and urethral trauma which increases the risk of CAUTI.
- Leg drainage bags should also be attached using straps or sleeves as recommended by manufacturers.
  - Care must be taken when assessing for a leg/night bag or valve and the following should be taken into consideration:
  - If there is a history of venous or arterial supply problems to the legs, then leg straps must not be used. Alternatives to this would be to use a sleeve or valve. It is important that no one who has ischemia is supplied with straps as this can cause necrosis.
  - Manual dexterity – can they use the tap / slide safely on their own.
  - Cognitive function – is the patient/ carer able to comply with the instructions, can they carry out emptying safely, are they aware how often they need to empty the

bag, or is there a carer who could empty the bag for them? (See **Appendix 2** for Procedure for Changing a Leg Bag).

## 7.9 Emptying urinary drainage bags

Urinary drainage bags should be emptied when no more than 2/3 full to maintain free drainage, prevent reflux and maintain the dignity and comfort of the patient (NICE 2019).

- Healthcare staff emptying drainage bags should decontaminate their hands in accordance with Trust Hand Hygiene Policy and wear appropriate personal protective equipment (PPE).
- When emptying the drainage bag, a separate clean container should be used for each patient.
- When emptying the drainage bag, avoid contact between the drainage tap and the container (Pratt et al 2007). Dry the outlet tap with a disposable wipe following emptying.

## 7.10 Catheter valves.

Catheter valves can be used as an alternative to a leg bag presuming no contraindications. The valve is connected to the urinary catheter outlet to allow bladder filling and intermittent emptying.

To prevent bladder over-distension and urinary backflow, urine should be drained at regular intervals by opening the valve. Frequency of emptying will be determined by the patient, but should be at least every 3 to 4 hours. Following a longer period of catheterisation the bladder may need to be emptied sooner than this whilst the bladder is retrained. The interval between emptying should be gradually increased until the patient can hold for 3 to 4 hours. Do not use a spigot as an alternative to a catheter valve.

In order to maintain the benefits of having a valve, drainage bags are best avoided overnight. However, if using with a night bag, attach an overnight bag to the valve and once the night bag is connected, the valve should be in the open position to allow urine to drain

Contra-indications for valve use:

- Renal impairment
- Cognitive impairment and confusion
- Ureteric reflux
- Poor dexterity
- Reduced bladder capacity
- Detrusor over activity
- Reduced bladder sensation

Valves should be changed according to manufacturer's instructions (usually every 5 to 7 days). The valve should be disposed of into clinical waste:

- Healthcare staff emptying drainage bags should decontaminate their hands in accordance with Trust Hand Hygiene Policy and wear appropriate personal protective equipment (PPE).
- When emptying the valve, a separate clean container should be used for each patient.
- When emptying the valve, avoid contact between the tap and the container (Pratt et al 2007). Dry the outlet tap with a disposable wipe following emptying.

### 7.11 Catheter securing devices

Best practice indicates a catheter securing device should be used to anchor the urethral catheter to the patient's leg. This is to prevent urethral and bladder neck trauma, unsecured catheters can also lead to catheter movement, inflammation, and pain (NHSI, 2020). It is preferable to use a strap system rather than a fixation dressing as this is kinder on the skin.

Pink (2013) asserts that unstable catheters can lead to irritation of the detrusor, resulting in bladder spasm in patients with over active bladders. This can lead to 'dislodgement' and in some cases actual expulsion.

As well as ensuring the urethral catheter itself is fixed to the leg any leg bag should also be attached to the patient's calf or thigh using leg bag straps or catheter sleeves.

Catheter securing devices, leg bag securing straps and catheter sleeves should be used to help reduce the risk of urethral erosion. Urethral erosions are usually found in patients with long-term catheters, this may be caused by not securing the catheter appropriately. Alternating sites daily when securing the position of the catheter may help reduce the risk of erosion. Take extra care when securing devices to fragile skin to avoid skin damage and take caution with patients having cognitive impairment.

### 7.12 Catheter hygiene

Routine hygiene is advised as part of daily personal care which helps to decrease the risk of CAUTI. Self-care should be encouraged, but carried out by a health care professional if the patient is unable. All hospitalised patients must be advised to use prontoside foam daily

For patients with urethral catheters:

- Using soap and water, wash around the meatus, starting at the entry point of the catheter, being sure to wash in strokes away from the entry point.
- Rinse well
- Ensure foreskin is replaced (in men) after cleaning.

For patients with suprapubic catheters:

- the site should be cleaned daily with soap and water
- rinse well
- Excessive cleaning is not required and may increase the risk of infection (EAU 2012)

- Dressings are best avoided (EAU 2012)
- Ensure the site is observed for signs of infection and over granulation.

There is no evidence that routine application of antimicrobial preparations around the meatus or around the suprapubic site will prevent infections (EAU 2012).

### **7.13 Catheter maintenance: Indications for the use of catheter maintenance solutions**

Eliminate simple mechanical obstruction first:

- Bladder Spasm
- Constipation
- Kinked Tubing
- Restrictive Clothing
- Drainage Bag Full
- Urinary tract infection

Systematic review of the evidence has failed to demonstrate any beneficial effect of bladder instillation, irrigation or washout with a variety of antiseptic or antimicrobial agents in preventing CAUTI (Pratt et al 2007). Therefore routine catheter washouts using antiseptic solutions should not be undertaken.

Catheter maintenance solution should only be used when all other options have been considered. For catheters that regularly block due to encrustation, try to establish the life of the catheter. This will establish a clear pattern. Once the pattern has been established and a clear treatment plan has been written, the use of the appropriate catheter maintenance solution and planned catheter changes can be adopted.

Best practice in the treatment of encrustation is to use two solutions consecutively. Current research supports the use of two sequential instillations of a small volume are more effective at dissolving encrustation (Getliffe, et al 2000). B-Braun Uro-Tainer Twin, has two chambers of 30mls solution, each chamber is instilled for 5 minutes and therefore you are only breaking the closed drainage system the once. Alternative solutions would therefore mean that you would have to break the closed drainage system twice to instil two solutions. By limiting the amount of times that the closed drainage system is broken, reduces the risk of introducing infection.

When considering catheter maintenance solutions for blocked catheters, there must be clear evidence to suggest that the patient may benefit from:

- one off use to relieve blocked catheter
- planned use of catheter maintenance solution to extend the life of the urinary catheter
- The use of catheter maintenance solution prior to removal of a urinary catheter to dissolve crystal formation to prevent trauma.

Therefore it is essential that the catheter history is clearly documented.

## 7.14 Catheter maintenance solutions

- Catheter maintenance may be indicated to manage catheter obstruction. (See **Appendix 3** for procedure).
- During office hours on call urology and urology nursing staff are available for advice for patients with urological conditions and complex catheter problems.

Catheter Maintenance solutions that can be used in DBTH are as follows:

- **Suby G Citric Acid 3.23% (also known as Suby G):**
  - Recommended if the patient is identified as a 'blocker'.
  - Maximum dose is twice daily.
  - If irritation is experienced then treatment should be stopped.
- **Solution R Citric Acid 6%:**
  - Recommended prior to catheter change and for persistent 'blockers'.
  - Solution R can be effective in clearing a catheter which is completely blocked with encrustation.
  - Prior to catheter removal it will help to dissolve crystals formed in and around the catheter tip making removal less traumatic to delicate urethral tissue.
  - A combination of Suby G and Solution R is also an option for persistent 'blockers'.
  - If irritation is experienced then treatment should be stopped.
- **Sodium Chloride NaCl 0.9%:**
  - Recommended to flush out debris and mucus.
  - It has a purely mechanical action.

### Precautions/ Risk Factors

- Known history of haematuria.
- Known cancer of urinary tract.
- Where fistula is present.
- Recent radiotherapy to lower urinary tract.
- Urinary tract infection.
- Clients with spinal injuries. Observe for signs of autonomic dysreflexia (Addison & Rew 1999).

Continuous bladder irrigation is often required following certain urological surgeries or for some patients with haematuria with clots and is only to be used under instruction of a urologist.

### 7.15 Disposal of waste

The disposal of clinical waste from catheter care procedures should adhere to the Trust waste disposal policy.

## 8 CATHETER INSERTION

### 8.1 Catheter insertion.

The procedure for catheter insertion is detailed in the following clinical skills packages available via ESR or via the HIVE training and education page

- Male catheterisation: EPGG/20/17
- Female catheterisation: EPGG/20/16
- Changing suprapubic catheters: EPGG/20/18

### 8.2 Collection of urine samples

A urinalysis is not recommended and should not be carried out for those with a urethral catheter, suprapubic catheter or using intermittent catheters.

A Catheter specimen of urine (CSU) should only be sent for culture and sensitivities if:

- the patient is systemically unwell
- patient has a high temperature
- following lack of response to treatment
- as part of a septic screen
- has symptoms of a urinary tract infection (UTI).

The CSU must be collected before antibiotics are administered.

It is essential to maintain the closed urinary drainage system when collecting the sample. Use the needle-free sample port. Do not sample directly from the urinary catheter or drainage bag.

Use an aseptic technique to obtain the sample. (See **Appendix 4** for CSU procedure).

### 8.3 Documentation of catheter insertion

Catheter insertion details should be clearly documented in the patients' records and catheter care sheet. The following information should be recorded in accordance with The Code (NMC 2018).

- Patient consent.
- Reason for catheterisation and volume of urine drained.
- Type of catheter, batch number and expiry date.
- Catheter material, length and size.
- Make and type of lubricating gel used, batch number and expiry date.
- Drainage system and method of drainage.
- Securing device being used and attachment site.
- Date and time of insertion and by whom.
- Date of planned change/reassessment and expected duration.
- Ensure evidence that patient information and guidance has been given.
- Interventions specific to identified problems including rationale.
- Reviews/care given.

## 9 CARE OF PATIENTS ADMITTED TO THE TRUST WITH AN IN-DWELLING URINARY CATHETER

When a patient is admitted into hospital with a urinary catheter in situ from the community, the nurse must ensure that they obtain a copy of the patient's catheter care plan from the patient (catheter passport). If the patient is unable to provide the information, hospital staff should contact the patients' district nursing team via single point of access to obtain the following information:

1. Reason for the catheter.
2. Date of last catheterisation.
3. Proposed date of next catheter change.
4. Any problems experienced during catheterisation.
5. Any prescribed catheter maintenance solutions.

This information should be documented on the urinary catheter record document. Points 1-3 are audited by the infection control team.

At this point, CSU should only be obtained for culture and sensitivity if the patient is either

- unwell with unknown cause
- suspected CAUTI.

## 10 REMOVAL OF URINARY CATHETERS

Urinary catheters should be removed as soon as the catheter is no longer indicated using a clean, non-touch technique. Results of the TWOC should be documented in the patients' records and on the discharge summary. If unsuccessful, results should be documented within the patient's catheter passport and the catheter IPOC.

All indwelling catheters must have the balloon deflated prior to removal and the catheter must be removed slowly to minimise trauma. When deflating the balloon, allow the syringe

to naturally pull back as this prevents the catheter balloon collapsing in either a crease or a ridge formation (Robinson 2003).

### 10.1 Indications for trial without catheters (TWOC)

Unnecessary continuation of indwelling catheterisation heightens the risk of catheter-associated urinary tract infection (UTI) or sepsis.

Timely removal of an indwelling catheter is essential to prevent unnecessary infections.

Trial without catheter (TWOC) is used to assess patients' bladder function and establish their ability to effectively and successfully empty their bladder unaided.

Pre TWOC considerations:

- Check Urea & Electrolytes (U&E's) for most recent results.
  - If no recent U&E results available arrange a blood test for U&E's.
    - If U&E results were deranged pre catheterisation or remain deranged seek advice from Urology prior to TWOC.
- Check CSU results if appropriate.
  - Arrange antibiotics with medical team if CSU results recommend antibiotic treatment and delay TWOC for 24-48 hours.
- Treat any constipation prior to TWOC
- For male patients with benign prostatic enlargement an Alpha blocker e.g. Tamsulosin 400mcg nocte, should be considered and if appropriate 48 hours before the TWOC.
- Discuss TWOC process and obtain verbal consent from the patient.

### 10.2 Timing of TWOC

There is currently no evidence to support removing catheter at any particular time i.e. midnight removal or early morning removal. Factors which should be considered include:

- Availability of appropriate healthcare professionals to assess success or failure of TWOC.
- Ensuring that appropriate healthcare professionals will be available if the patient is unable to void urine.
- Patient preference.
- Patients with nocturnal polyuria (passing more urine during the night than during the day) may not pass urine within eight hours of catheter removal, if catheter removed early morning.



### 10.3 Problematic catheter removal

- Ensure the patient is relaxed and bladder/ urinary sphincter is not in spasm, allow the patient time to relax for a few minutes.
- If balloon cuff formation suspected
  - Re-inflate catheter balloon with 2-3 mls of water and deflate again (EAUN 2005). If catheter still cannot be removed seek more experienced help.
- If unable to deflate the catheter balloon (This is a rare complication):
  - Never cut the catheter or try to burst the balloon by over-inflating it with water. If the balloon fails to deflate follow the following steps (EAUN 2005).
    - Place a syringe in the inflation valve and leave for 20-40 minutes, the balloon may deflate during this time.
    - If channel obstruction is suspected due to crystal formation, squeeze the visible catheter tubing to try to displace the crystals.
    - If you are still unable to deflate the catheter balloon, urology assistance should be sought. An ultrasound scan may be needed to ensure that the catheter balloon is deflated and if necessary the balloon can be deflated suprapubically by a trained radiology healthcare professional.

### 10.4 Documentation of catheter removal

- Date and time of catheter removal should be recorded in the urinary catheter care sheet with the reason for removal.
- Document if the balloon was fully deflated, noting if the catheter tip and balloon were intact and any encrustation or debris was visible on the catheter tip.
- Any adverse event during or following the procedure e.g. pain or urethral bleeding etc.
- Time of review of voiding pattern
- Signature and status of healthcare professional removing the catheter

### 10.5 TWOC procedure

**Prior to TWOC, assess if extra support would be needed for mobilising/toileting and ensure a plan is in place to prevent potential falls and reassess every 24 hours.**

Consider patient location in relation to toilets etc. Consider if a physiotherapy/mobility assessment is required if the patient has deconditioned/decreased mobility due to catheter use whilst in hospital. However, this assessment should not delay the TWOC.

TWOC must be terminated immediately in the event that:

- Bleeding is of concern
- Pain is of concern
- Urine has not been passed within 6 hours

## TWOC first 4 hours:

- The patient should be asked to pass urine into a measuring container or uroflowmetry machine if available.
- Bladder scan should be performed immediately after each void.
- If patient has voided twice (at least 150ml) within the first 4 hours and bladder scan is less than 150ml, the patient can be discharged home if TWOC is in a clinic setting.

## 4 hours after TWOC:

- Check patient has no discomfort since catheter was removed.
- Ensure patient has been drinking the recommended amounts
- Perform bladder scan if no urine passed
- If no concerns rescan in 2 hours
- If at any time the patient becomes uncomfortable and is unable to void consider teaching intermittent self-catheterisation (ISC) or consider an indwelling catheter if ISC is not appropriate

## 6 hours after TWOC:

- Check patient has no discomfort since catheter was removed,
- Ensure patient has been drinking the recommended amounts
- Perform bladder scan after each void,
  - Bladder scan less than 150ml and patient passes urine in good amounts (above 100mls)
    - TWOC is successful
    - Advise patient on signs of retention and when to seek medical advice.
  - Bladder scan between 100-300mls
    - If patient is asymptomatic of urinary retention eg. has no pain or discomfort and /or has had a poor fluid intake during the TWOC procedure, arrange a follow-up bladder scan the next day.
  - Bladder scan more than 300mls
    - Consider teaching intermittent ISC. (see appendix 1)
    - If ISC inappropriate, consider re-catheterisation with a urethral catheter.
    - Consider using a flip flow valve if appropriate
    - Document outcome within the catheter IPOC

## 10.6 Failure to void following TWOC

On Discharge:

- If unsuccessful TWOC ensure a catheter passport is completed and given to the patient. A referral to the Community Continence Service should be made for a follow up and a 2nd TWOC

## 11 DISCHARGE OF PATIENTS WITH A URINARY CATHETER

When a catheterised patient is discharged/transferred from hospital, the discharging nurse must ensure that a catheter discharge form/district nurse referral is completed and emailed through to the appropriate single point of access team (district nurses). This should state for follow-up care and consideration of trial without catheter if appropriate.

The district nurses will then visit the patient as soon as possible after receiving the referral to ensure that the patient has further equipment and to identify any problems or concerns that the patient may have following discharge.

### 11.1 Catheter passport

Ensure the patient has a completed copy of the catheter passport which is a patient held record for each catheter change and documents any problems during changes and any prescribed catheter maintenance.

WPR number: WPR46420

Available in urology if unavailable at the time of discharge.

### 11.2 Patient/carers education and support

- The aim of patient/carers education is to reduce the risk of complications and common problems of catheterisation. Patients/carers should be given written information to support information given verbally (patient education booklet available in discharge home pack).
- Patients and their carers should be educated about and trained in the correct technique of hand hygiene
- Attention should be paid to personal hygiene using soap and water, particularly around the urethral meatus, and the catheter tube there is no evidence to support the use of antiseptic solutions (Pratt et al 2007)
- Patients and their carers should also be advised that the maintenance of a closed drainage system is central in reducing the risk of catheter associated infection. It is therefore important to keep manipulation of the closed system to a minimum; this

includes unnecessary emptying, changing the draining bags or taking samples of urine.

- Patients and carers should be instructed in the correct use of the support devices for the drainage bags, and given advice to empty catheter leg bags when no more than three quarters full. This will help prevent trauma, discomfort and haematuria
- It must also be reiterated that all drainage bags are prescribed for individual patient use and are single use items of equipment. Once disconnected, the drainage bag must be discarded to reduce the risk of infection (DOH, 2006; Pratt et al 2007).
- Advice should be given to patient/carer on how to store and dispose of catheter equipment appropriately in the home.
- Avoidance/treatment of constipation
- Ensuring drainage equipment is secured below the height of the bladder avoiding kinks in tubing.
- Ensuring catheter bag is emptied frequently enough to avoid urine reflux (2/3 full).
- Unless medically contraindicated, a daily minimum of 1500mls of fluid intake should be encouraged.

### 11.3 Discharging with catheter equipment

Patients that are newly catheterised and are to be discharged with the catheter should be given the relevant equipment to take home which will be sufficient for 1 week. A catheter home pack is available on all wards which contain:

- 1 x night bag
- 1 x leg bag
- 2 x leg bag straps
- 1 x night bag hanger
- 1 x patient education booklet
- If unable to locate this item please contact the urology suite who can provide this.

The discharging nurse will also need to gather and provide:

- 1 x catheter of the same size and material for the next change, which must be in a catheter box (including 10ml water for the balloon)
- 1 x dressing pack
- 1 x tube of anaesthetic jelly
- 1 x sachet of normal Saline
- 2 x 10ml luer-slip syringes

## 12 TRAINING AND EDUCATION

The training requirements of all staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead or nominated person. Please refer to the mandatory and statutory training policy (CORP/EMP29) for details of the training needs analysis, as staff will require different levels of training.

For further support and advice please contact:

- Urology nurse practitioner 642537/643249 (within working hours)
- Clinical skills team

### 13 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Datix reporting	Urology governance	Monthly	Any Datix reports reviewed by Urology governance
Catheter care sheets	Urology nurse team	Bi-annually	10 patients catheter care sheets reviewed and reported to urology governance
The policy will be reviewed in the following circumstances	Urology team	Every 3 years routinely, unless: When new national or international guidance are received, When newly published evidence demonstrates need for change to current practice Action required from Root Cause Analysis Serious Investigation Report	

### 14 DEFINITIONS

Catheter Associated Arinary Tract Infection (CAUTI)

Catheter Specimen of Urine (CSU)

Department of Health (DOH)

Healthcare Associated Infection (HCAI)

Lower Urinary Tract (LUT)

National Institute for Clinical Excellence (NICE)

Personal Protective Equipment (PPE)

Primary Care Trust (PCT)

Royal College of Nursing (RCN)

Trial Without Catheter (TWOC)

Trust Wide Governance Committee (TWGC)  
 Urinary Tract infection (UTI)  
 Aseptic Non Touch Technique (ANTT)  
 Institute Of Healthcare Improvement (IHI)

**Best Interest decisions:**

Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

## 15 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See **Appendix 5**.

## 17 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy must be used in conjunction with:

PAT/IC 5 Hand Hygiene  
 PAT/IC 19 Standard Infection Control Precautions  
 PAT/PA 19 Mental Capacity Act 2005 Policy and Procedure, including Deprivation of Liberty Safeguards (DoLS)  
 PAT/PA 28 Privacy and Dignity Policy  
 PAT/PA 2 consent to examination or treatment policy  
 PAT/PS 7 Patient identification policy  
 PAT/IC 6 MRSA screening  
 CORP/EMP 4 – Fair Treatment for All Policy  
 CORP/EMP 27 – Equality Analysis Policy  
 CORP/HSFS 17(A) Waste Management

## 18 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:

<https://www.dbth.nhs.uk/about-us/our-publications/information-governance/>

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## APPENDIX 1 - PROCEDURE FOR INTERMITTENT CATHETRISATION (ISC)

### PROTOCOL FOR TUITION INTERMITTENT SELF CATHETERISATION

If procedure is performed by a member of the healthcare team, then it must be performed as an aseptic technique by a member of staff who has completed the catheterisation clinical skills package. The Healthcare member must wear personal protective clothing as appropriate and procedure must adhere to hospital policy for urethral catheterisation. If procedure is carried out by the patient or carer then it is a clean procedure.

### OBJECTIVES

The health care professional will:

- See those patients who condition would benefit from performing ISC.
- Make sure the patient is sufficiently dextrous and motivated to perform the procedure
- Ensure the patient is fully counselled and aware of the reason for performing the procedure and any possible alternatives to this treatment.
- Ensure the patient is aware of possible complications which can occur when performing ISC and that they are aware of the consequences of non-compliance/concordance.
- Ensure the patient is able to perform ISC using a clean technique and is fully aware of the treatment regime.
- Ensure the patient is aware of how to lubricate the catheters and any requisites for storage.
- Ensure the patient is offered a variety of catheters and delivery services.
- Arrange follow up the patient on a regular basis to ensure continued concordance with treatment.
- Identify any changes to patients condition and treat/investigate as appropriate

### PRIOR TO DISCHARGE FROM THE WARD/DEPARTMENT

The health care professional will:

- Ensure that the patient is competent performing ISC.
- Ensure that the patient has an adequate supply of catheters.
- Arrange home delivery service if necessary.
- Arrange follow up appointment.
- Give out information booklets and nurse contact numbers.
- Arrange community follow up if appropriate.
- Dictate a letter to patients GP with a copy to be sent to community continence team and patient.

**ISC PATHWAY**

- All patients will be seen by a health care professional and full explanation given re the reason for ISC, and possible other treatment options available.
- The HCP will assess patient dexterity and show and explain the catheters most suitable for the individual.
- The HCP will explain intermittent self-catheterisation using a patient information booklet designed for the specific catheter of choice and answer any queries or concerns they may have.
- The HCP will guide/observe the patient through performing the 1st catheterisation independently if possible, explaining anatomy and procedure throughout. The HCP will identify any aids which will be of benefit to the patient during the procedure.
- If the patient is required to repeat the procedure for competence reasons, they must remain on the ward/in the clinic until they have drunk sufficiently to repeat the ISC. (the patients may leave the clinic and return when they have a full bladder)
- The HCP will ensure the patient has a full understanding of the equipment and hygiene issues surrounding ISC, and the methods of receiving further supplies of equipment
- If the patient feels competent the HCP will arrange follow up by the appropriate team. This may be urology, gynaecology, or the continence or district nursing service as appropriate.

**Intermittent self-catheterisation Procedure guidelines for patients****Equipment**

- Mirror (for female patients).
- Appropriately sized catheters for male/female patients.
- Lubricating gel.
- Clean container (e.g. plastic envelope) for catheter.

**FEMALE INTERMITTENT SELF CATHETERISATION**Procedure

Action	Rationale
Wash hands using soap and water	To reduce the risk of cross infection
Take up a comfortable position, depending on mobility (e.g. sitting on the toilet, standing with one foot on toilet seat, lying in bed.	To facilitate insertion of intermittent catheter
Spread the labia and wash genitalia from front to back with soap and water, then dry	To reduce the risk of introducing infection
Open catheter packaging or container as per manufacturer's instructions.	To prepare catheter and to ease insertion

If using a coated catheter pre- soak as per manufacturer's instructions.	
Find the urethral opening above the vagina. A mirror can be used to help identify the urethral opening. Gently insert the catheter into the urethra, taking care not to touch the part of the catheter entering the body	To reduce the risk of introducing infection
Drain the urine into the toilet or suitable container. When the urine stops flowing slowly remove the catheter, halting if more urine starts to flow.	To ensure the bladder is completely emptied
Before removing the catheter from the urethra put a finger over the funnel end of the catheter and then remove the catheter from the urethra.	To trap urine in the catheter and prevent spillage on to clothing/bedding or the floor
Hold the catheter over the toilet or suitable container and remove finger from the funnel end to release the trapped urine.	To prevent spillage on to clothing/bedding or the floor
If using a coated catheter, dispose in a lidded orange clinical waste bin.	To prevent environmental contamination
Wash hands with soap and water.	To reduce the risk of infection

## MALE INTERMITTENT SELF CATHETERISATION

### Procedure

Action	Rationale
Wash hands using soap and water	To reduce the risk of cross infection
Take up a comfortable position, depending on mobility (e.g. sitting on the toilet, standing with one foot on toilet seat, lying in bed)	To facilitate insertion of intermittent catheter
Clean glans penis with soap and water. If the foreskin covers the penis it will need to be held back during the procedure	To reduce the risk of introducing infection
Open catheter packaging or container as per manufacturer's instructions. If using a coated catheter pre- soak as per manufacturer's instructions.	To prepare catheter and to ease insertion

Hold the penis in the non-dominant hand, upwards towards the stomach Standing in front of a mirror is useful for men with a large abdomen	To prevent trauma to the penoscrotal junction To enable a clear view of the penis
Hold the catheter with the dominant hand, being careful not to touch the part of the catheter entering the body, and gently insert it into the opening of the urethra. Advance the catheter into the bladder There will be a change of feeling as the catheter passes through the prostate gland and into the bladder. It may be a little sore on the first few occasions only. If there is any resistance, do not continue, withdraw the catheter and contact your urology/continence/district nurses.	To reduce the risk of introducing an infection The prostate gland surrounds the urethra (water pipe) just below the bladder and consists of much firmer tissue. The prostate can enlarge and cause an obstruction to the water pipe especially in older men.
Drain the urine into the toilet or suitable container. When the urine stops flowing slowly remove the catheter, halting if more urine starts to flow.	To ensure the bladder is completely emptied
Before removing the catheter from the urethra put a finger over the funnel end of the catheter and then remove the catheter from the urethra.	To trap urine in the catheter and prevent spillage on to clothing/bedding or the floor
Hold the catheter over the toilet or suitable container and remove finger from the funnel end to release the trapped urine.	To prevent spillage on to clothing/bedding or the floor
Dispose of the catheter in a lidded orange clinical waste bin.	To prevent environmental contamination
Wash hands with soap and water.	To reduce the risk of infection

## APPENDIX 2 - PROCEDURE FOR CHANGING A LEG BAG

### Equipment

- Sterile dressing pack containing galipots or an indented plastic tray, low-linting swabs or medical foam, gloves (sterile and non-sterile), sterile field and disposable bag
- New leg bag
- Receptacle for old leg bag
- Appropriate fixing to support leg bag

Action	Rationale
Explain and discuss the procedure with the patient Use suitable private area	To ensure the patient understands the procedure and gives informed consent.
Wash hands using liquid soap and dry thoroughly with paper towels.	To prevent cross-infection
Put on apron, open sterile dressing pack and apply sterile gloves.	To prevent cross-infection
Place sterile towel under connection between catheter and bag.	To maintain an aseptic technique.
Separate leg bag from catheter using a gauze swab and insert the new leg bag immediately without touching the end of the new leg bag.	To reduce risk of contamination and to minimise the length of time drainage system is broken.
Secure new leg bag with chosen method of support.	To prevent tension on the catheter by weight of urine.
Risk assesses the need to wear goggles. Empty urine in the night bag into sluice/toilet and discard night bag in appropriate waste stream.	To prevent cross-infection To prevent splash back
Remove and dispose of gloves and apron in the appropriate waste stream. Wash hands using liquid soap and dry thoroughly with paper towels.	To prevent cross-infection
Document the amount of urine drained and the date of the next change in the patients' records. Document the date of change on the Catheter bag.	Comprehensive data for protection of nurse carrying out procedure and patient receiving the procedure.

## APPENDIX 3 - PROCEDURE FOR CATHETER MAINTENANCE SOLUTION

### Equipment

- Sterile dressing pack containing galipots or an indented plastic tray, low-linting swabs or medical foam, gloves (sterile and non-sterile), sterile field and disposable bag
- New leg bag
- Receptacle for old leg bag
- Appropriate fixing to support leg bag

Action	Rationale
Explain and discuss the procedure with the patient Use suitable private area	To ensure the patient understands the procedure and gives informed consent.
Wash hands using liquid soap and dry thoroughly with paper towels.	To prevent cross-infection
Put on apron, open sterile dressing pack and apply sterile gloves.	To prevent cross-infection
Put pulp receptacle / jug under tap ensuring the tap does not come into contact with the jug. Open the tap and allow urine to drain until the bag is empty.	To prevent cross-infection and ensure complete emptying of the bag.
Close the tap and clean with gauze/tissue	To prevent leakage and prevent cross infection
Risk assesses the need to wear goggles. Dispose of urine in the sluice / toilet.	Assess risk of splash back. To prevent cross-infection.
Dispose of pulp receptacle using an appropriate waste stream.	To prevent cross-infection
Remove and dispose of gloves and apron in the appropriate waste stream. Wash hands using liquid soap and dry thoroughly with paper towels.	To prevent cross-infection
Document urine measurement in fluid balance chart	To maintain accurate fluid balance

## APPENDIX 4 - PROCEDURE FOR COLLECTING A CATHETER SPECIMEN OF URINE (CSU)

Action	Rationale
Confirm patients identity	To avoid error in patient identification
Explain and discuss the procedure with the patient	To ensure that the patient understands the procedure and gives their valid consent
Wash hands using liquid soap and water (Refer to Hand Hygiene Policy)	To reduce risk of cross infection
Put on a disposable plastic apron	To reduce risk of cross-infection from micro-organisms on uniform
Screen the bed or chair, or ensure appropriate measures in place	To ensure patient's privacy. To allow dust and airborne organisms to settle before the sterile field is exposed
If there is no urine visible in the catheter tubing then a clamp may be placed a few centimetres distal to the sampling port	To ensure sufficient sample has been collected for accurate sampling
Once there is sufficient urine visible in the drainage tube above the clamp, then wipe the sampling port with an alcohol swab and allow to dry	To decontaminate sampling port and prevent false-positive results
Insert a sterile syringe into the needle-free sampling port	To reduce the risk of sharps injuries
Aspirate the required amount of urine (approx. 10ml) and transfer specimen into sterile specimen pot	To avoid contamination and allow for accurate microbial processing
Wipe sampling port with an alcohol swab and allow to dry	To reduce contamination of access port and to reduce risk of cross contamination
Unclamp the drainage tubing	To allow drainage to continue
Dispose of all waste materials according to trust policy	To ensure correct clinical waste management and reduce risk of cross-infection
Wash hands using liquid soap and water (Refer to Hand Hygiene Policy)	To reduce risk of cross infection
Complete ICE request and label sample as per policy	To provide accurate information for laboratory analysis
Dispatch the specimen to the laboratory	To ensure the best possible conditions for microbial analysis and to prevent micro-organism proliferation.
Document procedure in patient records	To ensure timely and accurate records



## APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Catheter policy	Surgery and Cancer	Vivek Kumar	New	April 2022
<b>1) Who is responsible for this policy?</b> Name of Division/Directorate: Surgery				
<b>2) Describe the purpose of the service / function / policy / project/ strategy?</b> Who is it intended to benefit? What are the intended outcomes? To improve knowledge of staff and improve care of catheterised patients				
<b>3) Are there any associated objectives?</b> Legislation, targets national expectation, standards: to achieve national standards				
<b>4) What factors contribute or detract from achieving intended outcomes?</b> – n/a				
<b>5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?</b> Details: [see Equality Impact Assessment Guidance] - no				
<ul style="list-style-type: none"> <li>If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] –</li> </ul>				
<b>6) Is there any scope for new measures which would promote equality?</b> [any actions to be taken]				
<b>7) Are any of the following groups adversely affected by the policy?</b>				
<b>Protected Characteristics</b>	<b>Affected?</b>	<b>Impact</b>		
a) Age	x			
b) Disability	x			
c) Gender	x			
d) Gender Reassignment	x			
e) Marriage/Civil Partnership	x			
f) Maternity/Pregnancy	x			
g) Race	x			
h) Religion/Belief	x			
i) Sexual Orientation	x			
<b>8) Provide the Equality Rating of the service / function / policy / project / strategy – tick (✓) outcome box</b>				
<b>Outcome 1</b>	<b>Outcome 2</b>	<b>Outcome 3</b>	<b>Outcome 4</b>	
<i>*If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form – see CORP/EMP 27.</i>				
<b>Date for next review:</b> April 2025				
<b>Checked by:</b> J PLACE		<b>Date:</b> 6/4/22		