

Catheterisation Policy for Adults

**(To be read in conjunction with Aseptic Non Touch Technique Policy,
 Consent and Capacity to Consent to Treatment Policy)**

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1. INTRODUCTION

- 1.1 This policy has been developed by the Continence Service and Infection Prevention and Control Team using evidence based practice.
- 1.2 Expert advice with regard to catheterisation is available from the Continence Service (Bladder and Bowel).

2. PURPOSE & SCOPE

- 2.1 The purpose of this document is to provide the registered nurse and non - registered practitioners employed by Somerset Partnership NHS Foundation Trust practice guidelines for performing urethral and suprapubic catheterisation.

3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has a duty of care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents and delegate's responsibility as appropriate.
- 3.2 The **Executive Lead** is the Director of Nursing and Patient Safety with delegated responsibility to ensure this policy is reviewed at least once every three years or sooner if national or local procedures change.
- 3.3 Each **registered nurse** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of Practice of their professional body.
- 3.4 Each non registered practitioner is accountable for their actions and to work within their scope of practice.
- 3.5 **All staff** working with patients where catheter care is an issue should be familiar with the procedures detailed in this document and other related policies.
- 3.6 **Line Managers** are responsible for ensuring all staff are conversant with this policy and related policies.
- 3.7 **Continence Service** – will be available to provide telephone support and formal training as per service specification.

4. EXPLANATIONS OF TERMS USED

- 4.1 **Non Registered Practitioner** refers to an Assistant Practitioner who has a minimum QCF level 5 diploma
- 4.2 **Urethral Catheterisation** – This is an invasive procedure whereby a Foley catheter (a flexible hollow tube) is passed up the urethra and into the bladder to assist with drainage of urine, instil medication, or as part of medical treatment. This is a clinically aseptic procedure and should only be

performed by a competent professional who has had appropriate training and education.

- 4.3 **Suprapubic Catheterisation** – This is an invasive procedure whereby a Foley catheter (a flexible hollow tube) is passed through an insertion site in the abdominal wall and into the bladder to assist with drainage of urine. This is a clinically aseptic procedure and should only be performed by a competent professional who has had appropriate training and education.
- 4.4 **Intermittent Self Catheterisation (ISC)** – This is an invasive procedure whereby an intermittent catheter is passed up the urethra and into the bladder to assist with the drainage of urine. Once the urine has stopped draining the intermittent catheter is removed. This is a clean technique and should be undertaken by the individual on themselves. Intermittent Self Catheterisation is preferable to indwelling catheterisation and this should always be considered first.
- 4.5 **Trial Without Catheter (TWOC)** – this is where the catheter is removed from the patient. The patient is then monitored with regard to fluid intake and volume of urine passed. Dependent on ability to void will dictate outcome.
- 4.6 **Catheter Specimen of Urine (CSU)** - A catheter specimen of urine is a sterile specimen taken from a patient/client who has an indwelling urinary catheter in situ. Catheter associated urinary tract infection (CAUTI) is the most common nosocomial infection in hospitals (Pratt et al, 2007).
- 4.7 **Catheter Associated Urinary Tract Infection** - CAUTI must meet at least two of the following criteria (McGreer et al, 2000)
Patient/client has a urethral catheter in situ or had an indwelling urethral catheter removed within three days before the onset of the UTI plus two or more of the following with no other recognised cause:
- Fever [$>38^{\circ}\text{C}$ skin temperature] or chills.
 - New flank or suprapubic pain or tenderness
 - New or increased burning pain on urination, frequency or urgency [option is only available if catheter has been removed in the last 3 days]
 - Change in character of urine
 - Worsening in mental or functional status

5. CATHETERISATION PRE-REQUISITS

- 5.1 Registered nurses and non- registered practitioners must be trained and proficient in the assessment of need for, and performing, catheterisation. They should have completed the Trust Competency Assessment to perform the procedure and then be responsible for maintaining their own competency. Formal training is available via the Trust training department. New staff must be able to provide documentary evidence of catheterisation training and competency.
- 5.2 Non-registered practitioners can undertake routine re-catheterisations following an assessment, care planning and delegation by the registered

nurse. The registered nurse remains accountable for the care plan and review dates.

- 5.3 The registered nurse is accountable for their decisions to delegate tasks and duties to other people. To achieve this, the registered nurse must only delegate tasks and duties that are within the other person's scope of competence (NMC 2015) therefore before delegating catheterisation to a non-registered practitioner the registered nurse must ensure that the non-registered practitioner has undertaken catheterisation training and has been assessed as competent in this clinical task.

The non-registered practitioner must be given the opportunity to discuss, reflect and review the work and to be supported and developed so that they can fully meet the requirements of their role to deliver a high quality service.

- 5.4 All catheterisation requires the completion of the Catheterisation Assessment Form (Appendix F) by a registered nurse prior to undertaking the procedure. Any high risks identified must be discussed with a Doctor for authorisation.

- 5.5 Registered nurses who have undertaken a course in catheterisation and completed a competency assessment can undertake **first catheterisation** but only following a nursing assessment of the patient. A clear rationale for catheterisation must be recorded in the patient notes, including physical assessment (e.g., bladder palpation or bladder scan results) and planned removal date if appropriate.

- 5.6 Registered nurses who have undertaken a course in catheterisation and completed a competency assessment can undertake first catheterisation for **acute retention** by following the acute retention pathway (appendix H.)

- 5.7 Routine re-catheterisations, change of a blocked catheter or trial without catheter do not normally require medical authorisation.

- 5.8 Privacy, dignity and cultural differences of the individual should be integral to all aspects of catheterisation and catheter care.

Consideration should be given to the following:

- individuals with communication difficulties
- religious issues
- patient/client information in relevant format i.e. large print, specific language
- the effect on sexuality of being catheterised
- gender choice of individual undertaking the procedure

5.9 **Consent to Treatment**

As outlined in the Nursing and Midwifery Council Code of Professional Conduct and Department of Health Reference Guide to Consent for Examination or Treatment, the patient/client must also give valid consent to the procedure (NMC 2015). Mental Capacity should be evaluated and appropriate actions taken.

There is a presumption of capacity but if the patient lacks capacity to make a decision for himself on a particular matter and at a particular time, because of impairment of, or disturbance in the functioning of the mind or brain, the Mental Capacity Act 2005 applies (although treatment for mental disorder under the Mental Health Act 1983 is excluded).

For more information about the Mental Capacity Act 2005 and consent issues in relation to Part IV of the Mental Health Act 1983 refer to the Trust's Consent and Capacity to Consent to Treatment Policy.

6. CATHETERISATION RATIONALE

6.1 Catheterisation should only be considered for the following medical reasons (also see History Taking for Acute Urinary Retention, Appendix G):

- obstruction
- hypotonic bladder
- urological, gynaecological or abdominal surgery
- input/output fluid monitoring, for example as part of the surviving sepsis proforma
- pressure ulcer – open sacral or perineal wound in patient with incontinence
- end of life care

Catheters **should not** be used as a method of managing urinary incontinence (EPIC 2013).

7. CATHETERISATION ASSESSMENT AND CARE PLANNING

Pre-catheterisation Assessment

7.1 Reason for Catheterisation – select one of the above criteria.

If a first catheterisation, has a physical examination been undertaken and the Catheterisation Assessment Form (Appendix F) been completed? If re-catheterisation – is catheter still required?

If a first catheterisation for acute retention follow the acute retention pathway (appendix H)

7.2 **Key assessment criteria that must be considered before catheterisation and documented in patient notes:**

- reason for catheter
- is the patient/client febrile or unwell
- is the patient/client on treatment for a urinary tract infection
- patients/clients viewpoint/concerns/preferences
- latex allergy
- anaesthetic gel allergy
- MRSA/multi resistant gram negative organism status – increased risk of systemic infection
- urinary tract infection status – increased risk of systemic infection

- bowels:
 - constipation – increased risk of obstruction
 - diarrhoea – increased risk of catheter associated urinary tract infection (CAUTI) from contamination
 - cognitive ability – increased risk of pulling out catheter causing trauma
 - able to care for catheter – increased risk of CAUTI if inadequate hygiene or inability to understand care of catheter/bag/drainage system
- If evidence of any of the above – inform referrer prior to catheterisation.

8. ROUTE OF CATHETERISATION

8.1 Intermittent Self Catheterisation (ISC)

In the clinical decision making process to commence a patient/client on ISC the following should be considered:

- full investigations should be undertaken by the relevant Consultant to establish cause of urinary residual prior to ISC being initiated.
- bladder's ability to store urine between catheterisations
- renal function
- ISC has a reduced infection rate when compared to indwelling catheters (Patel et al, 2001)

Advantages

- decreased urinary infection rate compared to indwelling catheters
- increased promotion of self-care

Disadvantages

- physical ability to perform ISC
- cognitive ability to perform ISC

8.2 Suprapubic Catheterisation

In the clinical decision making process to recommend a suprapubic catheter there are the following contraindications:

- known bladder tumours
- small bladder capacity as this will result in urethral leakage
- other devices on abdomen i.e. stoma
- large abdomen/skin folds where placement and management of the catheter may be difficult.

Advantages

- no risk of urethral trauma
- greater comfort especially for those chair bound
- able to remain sexually active
- reduced incidence of urinary tract infection when compared with urethral catheterisation

Disadvantages

- surgical procedure
- altered body image (Addison and Mould 2000)

- bladder stone formation more common (Shah and Shah 1998)
- infection of site
- urethral leakage

8.3 Urethral Catheterisation

In the clinical decision making process to use a urethral catheter the following should be considered:

Disadvantages

- urethral trauma especially in long term catheterisation resulting in bypassing of urine and possible expulsion of catheter (Pomfret, 2000)
- increased risk of infection compared to other forms of catheterisation
- discomfort especially in those chair bound
- intercourse affected

Advantages

- no surgical procedure required

8.4 Catheter Selection

Retaining (Foley) catheters are used for indwelling catheterisation. Foley catheters are available in different lengths:

- paediatric (30-31cm)
- female (20-26cm) – only use in mobile women
- standard (40-45cm) suitable for male or female patients.

WARNING

ALWAYS CHECK LENGTH OF CATHETER BEFORE INSERTION. NEVER ATTEMPT TO INSERT A FEMALE LENGTH CATHETER IN A MALE PATIENT

Ch size is a measure of the diameter of the catheter in millimetres divided by 3.

Select the smallest gauge catheter that will allow urinary outflow (EPIC 2013)

Select a catheter that minimises urethral trauma, irritation and patient discomfort and is appropriate for the anticipated duration of catheterisation (EPIC 2013).

Recommended catheter sizes

- paediatric size 6 – 10ch
- size 12 – 14ch for clear urine
- size 14 – 16ch for urine containing debris/particles
- size 16 – suprapubic catheters
- size 18 and above for hospital use following surgery

Use a 10ml retention balloon in adults (EPIC 2013).

Only use sterile water to inflate balloon.

Only inflate balloon once.

Types and duration of use of available catheters

(Catheter changes should be planned at intervals to reduce risk of an emergency catheter change)

- short term (maximum 28 days duration)
- long term (maximum 12 weeks duration)

Short term – up to seven days

- uncoated latex
- plastic/PVC

Short term – up to 28 days

- silver alloy hydrogel coated latex
- PTFE coated latex

Long term – maximum 12 weeks duration

- hydrogel coated latex
- hydrogel coated silicone
- silicone elastomer coated latex
- all silicone

Specialist Catheter

Silver alloy coated – refer to manufacturer's guidelines. Evidence suggests silver coated urethral catheters reduce the risk of bacteriuria but insufficient evidence to indicate whether they reduce CAUTI infection rates (EPIC 2013)

8.5 Lubricating Gel selection

Current national guidelines (Loveday et al, 2014; National Institute for Health and Care Excellence, 2012; Royal College of Nursing, 2012) all recommend the use of **an appropriate lubricating gel** for catheterisation as it will:

- Reduce the risk of urethral trauma on catheter insertion
- Reduce discomfort and friction, which, in turn, may reduce infection
- Reduce pain
- Dilate the urethra

It is the registered nurse's responsibility to identify before catheterisation whether there are any risks, cautions or contraindications that may be identified or exacerbated, and should prevent a certain gel from being used on a particular patient (Yates, 2015).

Information on the type of gel used during catheterisation and any adverse effects should be documented in the personalised care plan.

Lidocaine gel with chlorhexidine is an anaesthetic gel for surface anaesthesia. It contains 2% lidocaine hydrochloride and chlorhexidine gluconate solution 0.25%. The gel anaesthetises, has antiseptic properties and dilates the urethra thus reducing the risk of trauma and infection.

Indications for Use:

This is a prescription-only drug. Lidocaine gel with chlorhexidine is clinically indicated for catheterisation, cystoscopy, exploratory and intra-operative investigation, exchange of fistula catheters (supra-pubic), protection against iatrogenic damage in the rectum and colon and for use during gynaecological investigation.

Wait for 5-10 minutes after applying gel before attempting catheterisation

Exclusion criteria:

Patients known to be allergic to lidocaine or other local anaesthetics, hydroxybenzoates or chlorhexidine
Patients with complete heart block
Patients with injury to the urethra or bladder mucosa.

Cautions for use:

patients with liver or renal impairment
patients with epilepsy
patients with respiratory impairment
patients with acute porphyria

Water-soluble lubricating gels have no anaesthetic or bactericidal properties, however they still:

- Provide lubrication on insertion of the catheter;
- Reduce friction;
- Can help with dilation

There have been no adverse reactions known in patients who have had multiple trauma to the urethra or in terms of multiple use. However it is still important to check whether the patient is allergic to any of the gel's ingredients.

9. CATHETER INSERTION

- 9.1 The registered nurse must complete a catheterisation assessment (Appendix F) before catheterisation and consider all key assessment criteria 7.2 of this policy. Including reason for catheter and plan for review and removal (EPIC 2013).
- 9.2 Patient/client consent must be obtained prior to catheterisation and clearly documented on patient notes.
- 9.3 Assess patient's needs prior to catheterisation in terms of:
- latex allergy
 - length of catheter
 - type of sterile drainage bag and sampling port or catheter valve

- comfort and dignity (EPIC 2013)

9.4 CONTACT REGISTERED NURSE/ GP/CONSULTANT/DOCTOR IN CHARGE OF CARE IMMEDIATELY DURING CATHETERISATION IF:

- persistent or sudden haematuria
- significant resistance to catheterisation/unable to pass catheter
- catheter balloon fails to deflate
- for community patients any report of blood following catheterisation should be investigated and a visit undertaken
- if no urine is passed post-catheterisation

9.5 After catheterisation patient/clients and carers should be given the following information:

- how to:
 - manage the catheter and drainage system
 - minimise the risk of urinary tract infection
 - obtain additional supplies suitable for individual needs (EPIC 2013)
- potential problems:
 - catheter blockage
 - urinary tract infection
 - bladder spasm
 - by-passing
- contact numbers if problem with catheter
- there should be a personalised care plan drawn up by the registered nurse with the patient/client along with appropriate goal setting
- give patient Indwelling Urinary Catheter and Drainage System fact sheet (available on the Trust Intranet – under ‘continence related patient leaflets’).

9.6 Always record the following information in the patient/client’s notes:

- reason for catheterisation/catheter change or ongoing reason for a catheter being required
- patient/client consent to procedure
- health status of the patient/client prior to catheterisation
- key assessment criteria discussed with medical practitioner prior to catheterisation
- difficulties with the insertion, resistance, if trauma caused/bleeding record and inform medical practitioner
- date and time of catheterisation
- type/make/gauge/length/material of catheter and balloon inflation volume – sticky label from catheter packaging
- drainage system
- record volume of urine drained, colour and smell. If necessary dipstick for signs of infection
- code/lot number sticky label from catheter packaging
- code/lot number of anaesthetic lubricating gel used
- date next catheter change due

- print name – signature
- if a re-catheterisation, also record length of time previous catheter had been in situ
- condition of catheter on removal; signs of encrustation; check catheter tip and balloon are intact.

9.7 If there is any change related to the patient/client's condition as a result of the catheterisation, the medical practitioner prescribing the procedure must be notified immediately.

9.8 The ongoing need for the catheter should be reviewed at each change, and justification required for long term catheterisation.

9.9 The urinary catheter care record is to be maintained on a daily basis in community hospitals (appendix E)

10. CATHETER DRAINAGE SYSTEMS

10.1 A catheter valve allows the intermittent drainage of the bladder. This is an alternative to a closed urine drainage system.

10.2 Patient/client can have a valve over a 24 hour period but for some patients/clients it may be more appropriate to use a valve during the day and add a night drainage bag overnight with the valve turned to open.

10.3 Catheter valves are available on prescription and should be changed every seven days.

10.4 When assessing a patient/client for possible use of a valve, the following should be addressed:

- cognitive function – confused patients/clients may forget to empty the valves or fiddle with it
- manual dexterity
- bladder sensation – with patients/clients with reduced sensation, fixed time emptying will be required
- mobility
- catheter valves should be considered when the patient/client is first catheterised as patients/clients who have been catheterised long term will have reduced bladder capacity and a valve will cause bypassing and discomfort.

10.5 Advantages of a catheter valve

- allows the bladder to fill and empty – maintaining normal bladder function – maintenance of bladder tone and capacity
- reduced urinary tract infections due to “flushing effect”
- discrete for patient/client – allows greater freedom with choice of clothes and activities, for example swimming.

10.6 Disadvantages of a catheter valve

- contraindicated in patients/clients with overactive bladder, ureteric reflux or renal impairment (Woodward 2013)
- unsuitable in patient/client with reduced bladder sensation or confusion
- must be released regularly to prevent over distension of bladder

10.7 Urine drainage bags

- to minimise the risk of infection a sterile closed urinary drainage system with sampling port should be used (EPIC 2013) where the catheter and collection device are continuous
- type of drainage system(drainage bag size, tubing length and type of tape) should be determined by the individual patient/client requirements
- do not break the connection between the catheter and the urinary drainage system unless clinically indicated (EPIC 2013).
- drainage bags should be changed when clinically indicated and in line with manufacturer's instructions
- ambulant patients/clients should be supplied with a leg bag and then have a link drainage system at night where the leg bag is not disconnected and the night bag is connected to the drainage tap of the leg bag
 - night bags – to try to prevent urinary tract infections only single use disposable night bags should be used.
 - correct support systems, to support both catheter tubing and catheter bag to reduce trauma to bladder neck, urethra and meatal opening.
 - In a community hospital setting, where sterile drainable night bags are being used for non-ambulant patients, ensure catheter tap is not resting on the floor.

11. CATHETER MAINTENANCE

11.1 There is no indication for prophylactic use of catheter maintenance solutions; they must not be used when a catheter is blocked. “Do not use bladder maintenance solutions to prevent catheter associated urinary tract infection” (EPIC 2013).

IF A CATHETER IS BLOCKED IT SHOULD BE CHANGED.

11.1.1 Catheter maintenance solutions are prescription only.

11.1.2 Because the solution is instilled into the bladder, patient/client consent must be given and patients should be made aware of any possible side effects.

11.1.3 Cut the tip of the removed catheter to show evidence that the catheter is blocked by encrustation prior to using a maintenance solution, also cutting lengthwise if it is suspected that the lumen may be blocked by 'silt' as flexible cystoscopy may be indicated to check for bladder stones especially in supra-pubic catheters.

11.1.4 Advice on type of maintenance solution to be used, maintenance regime and planned length of treatment should be provided by the Continence Nurse Specialist prior to the maintenance regime starting.

- 11.1.5 Solution should be warmed prior to use and aseptic techniques applied when administering a maintenance solution.
- 11.1.6 Maintenance solutions should not be used long term and consideration should be given to whether it is cost effective to use a maintenance solution or should the catheter be changed more frequently. Continued use should be reviewed weekly.

12. OBTAINING A SPECIMEN OF URINE FROM A CATHETER

- 12.1 In the presence of a catheter, antibiotics will not eradicate bacteria therefore bacteria should only be treated if the patient/client is symptomatically unwell (Campbell, 2008).
- 12.2 A catheter specimen of urine (CSU) should be taken if there is a change in the urine smell and/or colour and one of the following:
- the patient/client is reporting flank or suprapubic pain
 - the patient/client is pyrexial
 - the patient/client has nausea or vomiting
 - the patient/client has become confused (new onset)
 - the patient/client has rigors
 - the patient/client has had a fall (SIGN 2006)
- 12.3 A urine sample from a patient/client with an indwelling urinary catheter must be obtained from the needle free sampling port, using an aseptic non touch technique (DH 2003,) as per policy.
- 12.4 Specimens should not be collected from the tap or from the main collecting chamber of the catheter bag because of colonisation and multiplication of bacteria. Use the sampling port and an aseptic technique to obtain a catheter sample of urine (EPIC 2013).

13. TRIAL WITHOUT CATHETER (TWOC) – PLANNED EVENT

- 13.1 Assess and record the reasons for catheterisation every day/or at every visit. Remove the catheter when no longer clinically indicated (EPIC 2013).
- 13.1.1 The longer a catheter is in situ the higher the incidence of a symptomatic catheter associated urinary tract infection, 80% of urinary tract infections occurring in hospital can be traced to indwelling urinary catheters. (Kelsi et al: 2003).
- 13.2 **Before Catheter Removal**
- **Catheters** should be removed when no longer clinically indicated.
 - **Constipation** – ensure the patient/client is passing regular stools and ideally had their bowels open less than 24 hours prior to catheter removal.
 - **Catheter valve** – if the catheter has been in situ for more than 2 weeks, using a catheter valve for 1-2 days prior to catheter removal

may help as a catheter valve improves bladder tone and bladder capacity (Addison and Rigby 1998).

Please contact the Continence Nurse Specialist to discuss if a catheter valve would be appropriate.

- **Inform patient/client** – explain reason for catheter removal, the procedure and expectations post removal with regard to drinking and measuring urine passed and possible complications.
- The patient/client should be made aware that they may experience discomfort the first time they pass urine, and that the urine may be blood stained as a result of trauma following catheter removal.

13.3 **Time of catheter removal**

13.3.1 Kelleher (2002) undertook a study where catheters were removed at midnight. The patient/client's bladder then filled overnight whilst the patient/client was sleeping, the patient/client then woke and voided normally in the morning. Other practitioners suggest early morning e.g. 6 am - this ensures the patient/client receives full support and monitoring during the day (Gilbert 2006). Removal time dependent on where the catheter is being removed:

- in a hospital setting – 6.00am
- in the individual's home – as early as possible

13.4 **Fluid intake/monitoring urine passed**

13.4.1 Fluid intake and urine output must be recorded as accurately as possible. The output should be approximately equal to intake and voided volumes should be greater than 100mls. Patients/clients may take responsibility for recording their own fluid intake, measuring their own urine output and documenting this. (Addison 2001)

13.4.2 Fluid intake should be a glass/ cup (180mls) every 45 minutes to an hour (Thiruchelvam 2005); approximately 1.5 – 2 litres a day so that enough urine is produced to challenge their bladder.

13.5 **Possible Complications**

13.5.1 The patient/client or staff caring for the patient/client should understand the importance of immediately reporting discomfort or passing blood, especially if this is associated with difficulties in passing urine and a community visit should be made. (Addison 2001)

In the community a follow up visit should be planned for 2pm if needed.

13.5.2 If the patient/client experiences pain/ difficulty in passing urine/ only passing small volumes of urine under 100mls, a bladder scan should be undertaken to assess residual volume in bladder. If no scanner available then an intermittent catheter should be passed and the volume of urine drained

recorded. The healthcare practitioner must be competent to use the scanning equipment and be able to interpret the results. (Addison 2001)

13.5.3 If a significant urinary residual is detected then the patient/client will need to be re-catheterised; Addison (2007) defines a significant residual urine as follows:

- under 100ml residual insignificant
- between 100mls and 500mls could be significant
- over 500mls is very significant.

13.5.4 The decision to re-catheterise a patient/client should include the following factors (medical advice should be sought where indications to re-catheterise are unclear):

- Volume of urine patient/client is able to pass
- Residual urine measurement
- patient/client symptoms, discomfort, urinary urgency and urinary frequency

13.5.5 The patient/client may experience urinary urgency and frequency without a significant urinary residual this can be either as a result of reduction in bladder capacity whilst the catheter has been on free drainage or a urinary tract infection. The patient/client should be taught bladder training and provided with a patient information fact sheet.

13.6 **Successful trial without catheter**

13.6.1 The patient/client is able to pass urine comfortably without discomfort and no significant urinary residual detected.

13.7 **Failed trial without catheter**

13.7.1 Consideration should be given to the suitability of the patient/client to undertake intermittent self catheterisation. If appropriate should be discussed with the patient/client and continence nurse specialist or general practitioner to plan appropriate individual care.

14. **NEAR PATIENT DIPSTICK TESTING AND MANAGEMENT OF BACTERIAL URINARY TRACT INFECTION IN PATIENTS WITH CATHETERS**

Introduction

Historically clinicians have always tested catheter specimens of urine for indicators of infection (such as nitrites and leucocyte esterase) in the home, surgery and in the hospital surroundings. Patients/clients may then be given various courses of antibiotics, which in turn can promote antimicrobial resistance and the development of resistant strains of bacteria, such as multi resistant gram negative organisms or Meticillin-resistant *Staphylococcus aureus* (MRSA). (SIGN 2006)

This guideline advises on the identification of catheter-associated urinary tract infection, the testing criteria, and which antibiotic to treat the infection as appropriate.

14.1 **Near Patient/Client Dipstick Testing:**

14.1.1 Near patient/client dipstick testing should **NOT** routinely be used to diagnose urinary tract infections in patients/clients who are catheterised.

14.1.2 Urine dipstick testing is used generally for the assessment; management and treatment. Symptomatic UTI cannot be differentiated from asymptomatic bacteriuria on the basis of urine analysis with dipstick tests. Pyuria is common in catheterised patients and its level has no predictive value (Tambyah and Maki 2000)

14.1.3 Rapid reagent strip tests can detect a number of substances in the urine:

- a. Nitrites – detect a product of bacterial metabolism

This test is specific for the presence of bacteria but not very sensitive as not all bacteria produce nitrites. Testing of old urine specimens may result in false positives due to the proliferation of scanty perineal flora with time.

- b. Leucocyte Esterase – detects the presence of polymorphonuclear leucocytes involved in the inflammatory response.

This test is sensitive but not very specific e.g. leucocytes may have been picked up from elsewhere in the genitourinary tract due to an infection, inflammation from other causes e.g. stones.

14.1.4 Soon after catheterisation the bladder becomes colonised with bacteria resulting in positive nitrites and leucocytes. Rapid reagent strips are therefore of limited use in the assessment of these patients. Colonisation is not necessarily harmful and does not require investigation or treatment unless the patient/client is actually symptomatic.

14.2 **Urine Microscopy & Guidance from the Microbiologist**

14.2.1 The value of microscopy of urine samples from catheterised patients is limited in diagnosing symptomatic UTI as all patients/clients will have bacteriuria. It is **ESSENTIAL** that all relevant symptoms, antibiotic therapy and catheter history are given on the microbiology request form. This will inform the analysis of the laboratory results and ensure relevance for the individual patient.

14.2.2 Urinary catheterisation dramatically alters the normal microbiology of urine. **ALWAYS** clearly document the presence of a catheter, identifying the sample as a 'catheter specimen of urine' (CSU) on the microbiology request form.

14.2.3 There is no relationship between the level of pyuria and infection in patients/clients with indwelling catheters, since the presence of the catheter invariably induces pyuria without the presence of infection. (Sign 2006)

14.2.4 Public Health England South West – Bristol Laboratory advised that, since 2003, microscopy will no longer be performed routinely on the majority of urine samples.

- 14.2.5 Indwelling catheter urines will no longer be processed unless there is evidence on the request form that “the patient/client is systemically unwell or about to undergo urinary or orthopaedic surgery. If there are no relevant clinical details on the request form the specimen will not be processed. Please discuss if clinical concern”.
- 14.2.6 Unprocessed specimens will be held in the laboratory for 3 days.
- 14.2.7 CSU taken as part of an MRSA screen will be investigated for MRSA only.
- 14.2.8 Urines obtained through intermittent self catheterisation should be clearly stated on the request form as these specimens will be treated as an MSU.
- 14.2.9 Treatment of laboratory confirmed CAUTI’s will be undertaken by a Medical Practitioner who may source advice via the Taunton and Somerset NHS Foundation Trust Consultant Microbiologist Team.
- 14.2.10 When changing catheters in patient/clients with a long term indwelling urinary catheter:
- do not offer antibiotic prophylaxis routinely.
 - consider antibiotic prophylaxis for patients who have a history of symptomatic urinary tract infection after catheter change or experience trauma after catheterisation (NICE 2012).

15. CATHETERISATION PROCEDURE

- 15.1 The procedure for female catheterisation Royal Marsden Manual, Ninth Edition, Chapter 5, Procedure Guideline 5.8 Urinary Catheterisation: female
- 15.2 The procedure for male catheterisation Royal Marsden Manual, Ninth Edition, Chapter 5, Procedure Guideline 5.7 Urinary Catheterisation; male
- 15.3 The procedure for urinary catheter removal. Royal Marsden Manual, Ninth Edition, Chapter 5, Procedure Guideline 5.12. Urinary Catheter Removal
- 15.4 The procedure for supra-pubic re-catheterisation is set out in Appendix A.
- 15.5 The procedure for collecting a catheter specimen of urine is set out in Appendix B.

16. CATHETERISATION DOCUMENTATION

- 16.1 Urinary Catheter Care Record – Appendix E.
- 16.2 Paper documents to be scanned onto electronic patient record.

17. TRAINING REQUIREMENTS

- 17.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Staff Mandatory Training Matrix (training needs analysis) where mandatory training is indicated. Training will be provided for this

policy as part of the Trust catheterisation training day. All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

17.2 To complete specific competence in clinical practice appropriate to catheterisation – Appendices C and D.

17.3 To review competency on a yearly cycle.

18. EQUALITY IMPACT ASSESSMENT

18.1 All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity lead who will then actively respond to the enquiry.

19. MONITORING OF COMPLIANCE AND EFFECTIVENESS

19.1 Evaluation of training sessions – completion of Trust evaluation form.

19.2 Post-training practice - completion of competence form – Appendices C and D – once completed, a copy should be sent to the training department.

19.3 All Datix incidents relating to catheter issues are reviewed by the Tissue Viability team who monitor incidence within the Trust.

19.4 Monitoring arrangement for compliance and effectiveness

- overall monitoring will be by the Continence Service Best Practice Group.

19.5 Responsibilities for conducting the monitoring

- local monitoring and reporting to be undertaken by Ward Sisters/Unit Manager/Team Leader.

19.6 Methodology to be used for monitoring

- complaints monitoring
- safeguarding alerts
- serious incidents requiring investigation and action plans.

19.7 Frequency of Monitoring

- 6 monthly as part of Best Practice Group reporting.

20. COUNTER FRAUD

20.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the

inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

21. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

21.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

21.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

21.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

22. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

22.1 References

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22.2 Related Documents

- Code of professional Conduct, May 2015, NMC, London
- Association for Continence Advice (ACA) Notes of Good Practice Care of Urinary Catheters and Drainage bags, January 2008
- Department of Health. Reference Guide to consent for examination or treatment, August 2009
- Department of health. Essence of Care, Patient Focused Benchmarking for Health Care Practitioners, October 2010
- National Institute for Clinical Excellence – CG2, Infection Control Clinical Guidelines, May 2010
- National Institute for Health and Care Excellence – CG139 –Prevention and control of health care – associated infections in primary and community care, March 2012
- NHS Quality Improvement Scotland, Urinary Catheterisation and Catheter Care, June 2004
- Royal College of Nursing, Catheter Care, March 2012
- High Impact Actions for Nursing and Midwifery, 2009
- NHS Safety Thermometer, 2011

22.3 Cross Reference to Other Procedural Documents

- Aseptic Techniques Policy
- Cleaning of Equipment and Decontamination Policy

- Consent and Capacity to Consent to Examination and/or Treatment Policy
- Hand Hygiene Policy
- Indwelling Devices Policy
- Infection Prevention and Control Policy
- Learning Development and Mandatory Training Policy
- Medical Devices policy
- MRSA Policy
- Professional Interpreting and Translation Services policy
- Record Keeping and Records Management Policy
- Risk management Policy and Procedure
- Staff Mandatory Training Matrix (Training Needs Analysis)
- Syringe Driver Policy
- Training Prospectus

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

23. APPENDICES

23.1 For the avoidances of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A	Procedure for Supra-pubic Re-catheterisation
Appendix B	Collecting a Catheter Specimen of Urine
Appendix C	Competencies for Male/Female Urethral Catheterisation
Appendix D	Competencies for Supra-pubic Catheterisation
Appendix E	Urinary Catheter Care Record
Appendix F	Catheter Assessment Form
Appendix G	History Taking for Acute Urinary Retention
Appendix H	Urgent Referral Pathway for Acute Urinary Retention

Procedure for Supra-Pubic Re-Catheterisation

- Equipment:
- Disposable plastic apron
- Sterile pack
- Sterile and non-sterile latex free gloves
- Lubricating gel as per personalised care plan
- Water for injection and syringe if not using a pre-filled catheter
- Catheter (material type and size already assessed)
- Catheter leg bag and catheter support straps

	Action	Rationale
1	Wash hands with soap and water or alcohol hand rub. Put on apron and non sterile gloves.	To reduce risk of cross infection
2	Assist patient/client into a patient into a comfortable supine position with legs extended, cover chest area and legs leaving supra pubic area exposed.	To facilitate insertion of catheter and maintain patient dignity
3	Prepare work surface. Open sterile pack, remove sterile gloves from outer wrapping and place on sterile field. Remove catheter from outer wrapping and drop into sterile field.	Aseptic procedure
4	Draw up 10mls sterile water (if required) and place nearby.	To inflate catheter balloon
5	If required, wash around catheter site with soap and water, then dry – the patient/client should be encouraged to do this themselves. Dispose of water.	To reduce risk of introducing infection
6	Attach 10ml syringe to indwelling catheter inflation valve. Drain balloon of water without aspirating forcibly.	To deflate catheter balloon
7	Remove catheter and bag and dispose – do not use force. If difficulties experienced removing catheter, contact a medical practitioner for advice. (Note length of catheter within the bladder and also the angle of the fistula track from which it is removed and use this information to guide the insertion of the new catheter).	To remove catheter safely with minimal discomfort/trauma and dispose of correctly.

	Action	Rationale
8	Lubricate cystostomy site with a sterile gel which is licensed for supra- pubic use. Remove gloves and wash hands.	Reduce discomfort, friction and pain
8	Put on sterile gloves, place sterile dressing towel across abdomen below insertion site.	Aseptic procedure
9	Remove top of catheter packaging and using dominant hand, gently insert catheter into supra pubic insertion site.	Ease of insertion
10	Advance catheter the length recorded from catheter withdrawal.	To ensure catheter balloon will inflate inside bladder.
11	Inflate the catheter balloon with the recommended volume of sterile water.	To keep catheter within the bladder.
12	Connect drainage system.	To collect urine
13	Remove gloves and wash hands.	Reduce risk of cross infection
14	Place leg bag on patient's leg and support correctly by use of straps or leg bag support.	Prevent catheter balloon distending bladder neck
15	Urine drainage should be observed after catheterisation. If no drainage after 30 minutes, seek medical advice.	To ensure catheter correctly positioned within the bladder.
16	The following details must be documented in the patient/client's notes: Reason for catheterisation Amount of urine drained Problems encountered Patient/client discomfort Date of insertion Catheter type, size length, balloon size, batch number and expiry date. Date next change planned	Comprehensive data for protection of nurse carrying out procedure and patient/client receiving the procedure.
17	Ensure the patient/client is given information on how to care for the catheter, potential problems, how to get further supplies. Give patient/client/carer the Trust catheterisation booklet.	Encourage patient/client self-care. Reduce/prevent complications.

Collecting a Catheter Specimen of Urine

To obtain a specimen of urine for testing from a patient/client with an indwelling catheter in place.

Equipment

- swab saturated with isopropyl alcohol 70%
- Sterile syringe (10mls).
- universal specimen container
- Disposable gloves

Procedure

	Action	Rationale
1	Explain and discuss the procedure with the patient/client	To ensure that the patient/client understands the procedure and gives informed consent
2	Screen the bed	To ensure the patient/client's privacy
3	Place bag in a horizontal position to allow urine to collect in the tubing	To obtain an adequate volume of urine
4	Wash hands using soap and water	To reduce the risk of infection
5	Put on a disposable plastic apron	To reduce the risk of cross infection from micro-organisms on uniform
6	Put on disposable gloves	To reduce risk of cross infection
7	Clean access point on the catheter bag with a swab saturated with 70% isopropyl alcohol	To reduce risk of cross infection
8	Insert syringe into port at 90 angle. Turn half a turn clockwise, slowly draw out sample. (If catheter valve used remember to change to open position)	Specimens collected from the catheter bag may give false result due to organisms proliferating there. To prevent needle stick injury.
9	Re-clean access point on the catheter bag with a swab saturated with 70% isopropyl alcohol	To reduce risk of cross infection

	Action	Rationale
10	Place specimen in sterile universal container.	To ensure that only organisms for investigation are preserved.
11	Ensure bag is comfortable for the patient and correctly supported	For patient comfort and dignity
12	Remove disposable gloves	To reduce risk of cross infection
13	Make patient/client comfortable	
14	Label the container correctly with the term CSU and dispatch it with the request	To ensure best possible conditions for lab testing
15	Record sample has been taken and reason	To prevent unnecessary samples

COMPETENCIES FOR MALE/ FEMALE URETHRAL CATHETERISATION

The competencies are to be used in conjunction with: -

- NMC (2008) The Code: standards for conduct; performance and ethics for nurses and midwives
- NICE Guideline 2 – infection Control Prevention of Healthcare Associated Infection in Primary and community Care
- Royal Marsden Manual of Nursing Procedures (seventh edition) 2008
- Somerset Partnership - Aseptic Technique Policy
- Somerset Partnership - Catheterisation in Adults Over the Age of 18 Policy

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners, to ensure safe practice in Male / Female Urethral Catheterisation.

The self-rating scale is to be used by the individual practitioner for self assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Key for Self-Assessment

- 1 = No knowledge / experience
- 2 = Some knowledge / experience
- 3 = Competent
- 4 = Competent with some experience
- 5 = Competent, experienced and able to teach others

Author	Catherine Weller
Date	May 2015
Review	April 2018

**ASSESSMENT OF COMPETENCE FOR MALE/FEMALE URETHRAL
CATHETERISATION**

I confirm that I have self-assessed as competent to practice Male/Female Urethral Catheterisation as below:

Practitioner Name:

Practitioner Qualification:

Practitioner Signature: Date:

I confirm that I have assessed the named practitioner above as competent to perform the above skill.

Name & Title:

Signature: **Date:**

Upon successful completion of your assessment of competency please send to your line manager and retain a copy for yourself.

KNOWLEDGE and SKILLS for Male/Female Urethral Catheterisation		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
1	Ensure the need for catheterisation is confirmed prior to procedure	1				
		2				
		3				
		4				
		5				
2	Demonstrate effective communication with the patient/client in gaining informed consent	1				
		2				
		3				
		4				
		5				
3	Demonstrate the ability to assess the individual patient/client's needs, including their fears about catheterisation and possible alternatives	1				
		2				
		3				
		4				
		5				
4	Demonstrate a good understanding of the male and female urinary system	1				
		2				
		3				
		4				
		5				
5	Discuss and highlight risk factors pertaining to male / female urethral catheterisation and measures to minimise these risks. Including correct antibiotic cover for MRSA patients	1				
		2				
		3				
		4				
		5				
6	Select appropriate catheter size and material and drainage system	1				
		2				
		3				
		4				
		5				

7	Perform catheterisation aseptically as per Trust Policy and Guidelines	1				
		2				
		3				
		4				
		5				
8	Demonstrate accurate record keeping of procedure	1				

COMPETENCIES FOR SUPRA-PUBIC RE-CATHETERISATION

The competencies are to be used in conjunction with: -

- NMC (2008) The Code: standards for conduct; performance and ethics for nurses and midwives
- NICE Guideline 2 – infection Control Prevention of Healthcare Associated Infection in Primary and Community Care
- Royal Marsden Manual of Nursing Procedures (seventh edition) 2008
- Somerset Partnership - Aseptic Technique Policy
- Somerset Partnership - Catheterisation in Adults Over the Age of 18 Policy

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners, to ensure safe practice in Supra-Pubic Catheterisation.

The self-rating scale is to be used by the individual practitioner for self-assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Key for Self-Assessment

- 1 = No knowledge / experience
- 2 = Some knowledge / experience
- 3 = Competent
- 4 = Competent with some experience
- 5 = Competent, experienced and able to teach others

Author	Catherine Weller
Date	May 2015
Review	April 2018

**ASSESSMENT OF COMPETENCE FOR SUPRA-PUBIC
RE-CATHETERISATION**



I confirm that I have self-assessed as competent to practice Supra-pubic Re-Catheterisation as below:

Practitioner Name:

Practitioner Qualification:

Practitioner Signature: Date:

I confirm that I have assessed the named practitioner above as competent to perform the above skill.

Name & Title:

Signature: **Date:**

Upon successful completion of your assessment of competency please send to your line manager and retain a copy for yourself.

KNOWLEDGE and SKILLS for Supra-pubic Re-Catheterisation		Self Assessment			Formal Assessment	
		Score	Tick	Date & Comments	Signature	Date & Comments
1	Ensure the need for re-catheterisation is confirmed prior to procedure	1				
		2				
		3				
		4				
		5				
2	Demonstrate effective communication with the patient/client in gaining informed consent	1				
		2				
		3				
		4				
		5				
3	Demonstrate the ability to assess the individual patient/client's needs, including their fears about catheterisation and possible alternatives	1				
		2				
		3				
		4				
		5				
4	Demonstrate a good understanding of the urinary system	1				
		2				
		3				
		4				
		5				
5	Discuss and highlight risk factors pertaining to supra-pubic catheterisation and measures to minimise these risks as recommended by the PCT Policies and Procedures	1				
		2				
		3				
		4				
		5				
6	Discuss situations where patient may need antibiotic cover	1				
		2				
		3				
		4				
		5				
7	Select appropriate catheter size and material and drainage system	1				
		2				
		3				
		4				
		5				

8	Perform-re-catheterisation aseptically as per PCT Policy and Guidelines	1				
		2				
		3				
		4				
		5				
9	Demonstrate accurate record keeping of procedure	1				
		2				
		3				
		4				
		5				

Indication for catheter?

<input type="checkbox"/> Accurate fluid balance (critically ill?)	<input type="checkbox"/> Urinary tract haemorrhage
<input type="checkbox"/> Urine retention	<input type="checkbox"/> Palliative
<input type="checkbox"/> Major Surgery incontinence	<input type="checkbox"/> Skin breakdown from
<input type="checkbox"/> Other (please specify):	

URINARY CATHETER CARE PLAN

Date of Insertion.....
 Estimated date for removal or change:

Please record actions each shift.
Please record in boxes below ✓ = yes x = no
Please record A/C for actions that are daily or weekly and have already been completed
Please initial after each review at bottom of the care plan

DATE																						
Action	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	E	L	N	
1 Hand hygiene Before and after each patient contact																						
2 Catheter hygiene Clean catheter site at least once a day as per policy CP1e																						
3 Drainage bag position Above floor but below bladder level to prevent reflux or contamination and assist drainage																						
4 Sampling (needle-free) aseptically via catheter port																						
5 Manipulation – Securing the catheter Catheter secured using a fixation device using aseptic technique and comfortable for patient. Leg straps must be removed at night																						
6 Manipulation – Catheter drainage bag emptying Empty at least twice daily Gloves and apron must be worn Clean container used every time Decontaminate port before emptying Avoid touching drainage tap Decontaminate hands after taking gloves and apron off																						
7 Manipulation – Changing drainage bag																						

CATHETERISATION ASSESSMENT FORM

Assessor

(name and tel. no):

Date: **Time:**

1 PERSONAL DETAILS (Block capitals)	
Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> NHS No.....	
Full name:	Telephone no:
Full address:	Date of birth:
.....	GP:
Post code:	GP Practice:
NHS No:	

2 MEDICAL HISTORY				
Relevant History:				
Medications:				
REASON FOR CATHETERISATION				
Retention: Acute <input type="checkbox"/>	Retention: Chronic <input type="checkbox"/>	Fluid input/output Monitoring <input type="checkbox"/>	Open sacral/perineal Wound <input type="checkbox"/>	End of Life Care <input type="checkbox"/>

3 ASSESSMENT	COMMENTS
How many drinks in 24 hours?.....	If fluid intake is low, advise 8-10 cups/mugs in 24 hrs. If caffeine is high, advise on decaffeinated drinks.
Type of drinks.....	
Voiding chart attached	

Patient Name:..... Date of Birth.....

NHS No:.....

Urinalysis performed:		If Leucocytes/Nitrates or symptoms of UTI present, take CSU and refer to doctor.
Glucose		
Keton		
S. Gravity		
Blood		
PH		
Protein		
Nitrite		
Leucocytes		

4 CATHETERISATION RISK FACTORS	COMMENTS
Haematuria	Report any bleeding pre-catheterisation to GP
Trauma following catheterisation	Report any bleeding post catheterisation to GP
Faecal incontinence	Increased risk of urinary tract infection
Urinary tract infection	Increased risk of systemic infection
Cognitive impairment	Increased risk of catheter being pulled out

5 ROUTE OF CATHETERISATION	COMMENTS
Client to undertake intermittent self-catheterisation	
Client to be catheterised urethrally	
Client to be catheterised with a suprapubic catheter	Refer to Urology Service

Comments:

.....

.....

.....

.....

Signature of nurse..... **Date**.....

The majority of patients presenting with retention will be unable to pass urine, have abdominal pain and have a palpable suprapubic mass (acute retention).

Some, who have chronic retention, may not have pain and a small number will be found to be in retention incidentally on scan.

The key to the history taking is to identify the underlying cause:

- Prostatic enlargement: Symptoms of bladder outflow obstruction: Hesitancy, poor stream, intermittent flow, incomplete emptying, terminal dribbling, nocturia.
- Infection: Preceding frequency, urgency, dysuria, visible haematuria
- Constipation: Usually on the background of obstructive lower urinary tract symptoms.
- Clot: Visible haematuria +/- clots usually precedes retention.
- Post operative: Epidural and spinal anaesthesia are particularly prone to inducing retention.
- Neurological disorder: Ask about lower limb weakness, paraesthesia, saddle anaesthesia, faecal incontinence.

Consider the following as possible causes:

- Spinal: back pain (disc prolapsed), spinal injury, surgery, metastases, abscesses.
 - Pelvic nerve injury: Pelvic trauma, damage during childbirth – instrumentation, prolonged second stage of labour.
 - Medical conditions: Diabetes – loss of autonomic nerves. MS can present as retention, always consider this important diagnosis particularly in women who present in retention. Shingles can cause retention so ask about painful rashes.
- Medication:
 - Anticholinergics for over active bladder (tolterodine, oxybutynin, solifenacin)
 - Other drugs with anticholinergic properties eg some antipsychotics, anticholinergic agents for respiratory conditions (eg tiotropium), antihistamines such as cetirizine, tricyclic antidepressants (eg amitriptyline)
 - opiates (inc tramadol)
 - Decongestants – as found in some over the counter allergy and cold preparations.

Catheter Problems

No urine drained check that the tubing is not kinked and if wearing a leg bag ensure it is fixed to the leg with an appropriate fix. Consider that the patient may have no urine output (profoundly shocked/unwell) or that the catheter is blocked with clots (haematuria), or that the catheter is not in the bladder. Liaise with GP for advice and if the catheter is not thought to be in the bladder deflate the balloon and remove.

Patient complains of pain when the balloon is inflated and no or little urine drained – the balloon may be in the prostatic urethra (can occur in men with enlarged prostates or

previous prostatic surgery). Liaise with GP for advice and remove the catheter if not in the correct place.

The urine is clear at first then haematuria develops. This can occur with decompression of a large bladder due to chronic retention. It usually settles with time and increased oral fluids. However liaise with GP for advice.

The patient produces more than 2 litres of urine in the first half hour, It is likely that the patient was in chronic retention. Monitor urine output, blood pressure, renal function and electrolytes (discuss blood tests with GP). Most patients can catch up with the diuresis by increasing oral fluids, but some may need intravenous fluids – discuss with GP.

- Routine Observation of Urine**
- Colour
 - Green
 - Pink/Red
 - Orange
 - Yellow
 - Brown
 - Odour
 - Fishy
 - Sweet
 - Debris
 - Cloudy
 - Sediment

