

Dear Sir/Madam

Thank you for your Freedom of Information request concerning Intermittent Self-Catheterisation.

The Trust can provide the following information:

What formularies and/or guidelines exist for Homerton University Hospital NHS Foundation Trust with regards to the following:

- Intermittent Self-Catheterisation
- Collecting Device

The Trust has a catheterization policy and follow guidelines by RCN (catheter care) and BAUN (British Association of Urology Nurses) Clean Intermittent Catheterisation: The patient journey.

See attach policy

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk, in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

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Yours sincerely

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Incorporating hospital and community health services, teaching and research

Urinary catheterisation policy

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1. Summary

This policy describes the infection control procedures required to reduce the risk of infections associated with the insertion and maintenance of different types of indwelling urinary catheters. These guidelines are based upon 4 areas highlighted by the evidence-based guidelines for preventing healthcare-associated infections (EPIC 1 and 2) projects [1, 2]:

1. Assessing the need for catheterisation.
2. Selection of catheter type
3. Aseptic catheter Insertion
4. Catheter maintenance

This policy will ensure a consistently high standard of practice across the Trust but it is the responsibility of the individuals involved with catheterisation to follow the procedures outlined in this policy in order to prevent unnecessary risk to the patient.

2. Introduction

Background: Urinary catheterisation can be defined as ‘the insertion of a special tube into the bladder, using aseptic technique, for the purpose of evacuating or instilling fluids’ [3]. Urinary catheterisation is one of the commonest interventions in an acute hospital setting [4, 5]. Nearly 12-25% of adult inpatients have an indwelling urethral catheter inserted at some point during their hospital stay [4, 5, 6]. However, urinary catheterisation is not without clinical risks. Indwelling urethral catheters are associated with a large number of healthcare-associated infections. Urinary tract infections are the second largest single group of healthcare-associated infections (HCAI’s) in the UK, accounting for 20% of all hospital acquired infections.[7] In 1999 this cost to the NHS was more than £124 million [8].The catheter-associated bacteraemia is seen in 1-4% of cases with urinary tract infection (UTI).In 13-30% of patients catheter-associated bacteraemia can be fatal [6] . The decision to catheterise therefore should not be taken lightly and should be avoided as far as possible [9]. Catheter related problems/complications can occur immediately after insertion (acute) or later (Chronic). Knowing how to manage these problems would help to prevent catheterisation associated morbidity and mortality. Lastly it is important to note that catheterisation is a skilled procedure and both doctors and nurses should undergo appropriate training [10].

3. Scope

This policy applies to all those working in the Trust who deal with the urinary catheter in whatever capacity. A failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate. This may include formal action in line with the Trust’s disciplinary or capability procedures for Trust employees; and other action in relation to other workers, which may result in the termination of an assignment, placement, secondment or honorary arrangement.

4. Roles & Responsibilities

It is expected that all staff involved in catheterisation should ensure that they have been educated in the principles of assessing patients need for catheterisation, choice of suitable catheter, aseptic technique, catheterisation procedure and ongoing catheter management. They should be supervised in practice by a competent practitioner before being allowed to catheterise independently and they should not practice outside their sphere of competence [11].

5. Catheterisation policy

5.1 Assessing the need for catheterisation

Urinary catheterisation should be used only when there is a clear clinical indication but not for the sake of convenience. Caution should be exercised in patients who have a history of:

- urethral stricture
- urethral injury
- 'false passage'
- recent surgery on the prostate, bladder neck or urethra
- suspected UTI

or those with artificial prosthesis or in the confused patient (see section 5.3 obtaining consent for catheterisation) [12].

Indications for catheterisation:

- Acute or chronic retention of urine
- Pre and post-operative bladder drainage
- Instillation of treatment agents into the bladder, e.g. chemotherapeutic agents or bladder irrigation
- Bladder drainage as a result of obstruction, for example as a result of enlarged prostate, urethral abnormality or trauma, blood clots
- To measure residual urine
- Urodynamic or radiological investigation
- Measurement of urinary output in critically ill patients
- Management of urinary incontinence as a last resort when all other methods have failed
- In some circumstances to obtain a sterile specimen of urine

Discussion with the patient and their carers as to why a catheter is needed and to decide which type of catheterisation is appropriate are vital to obtain maximum co-operation and consent. The patient should also be provided with adequate information both verbally and by giving a patient information leaflet relating to the need, insertion, maintenance and removal of the catheter (leaflets available from urology department)

5.1a Use of bladder scanners

If a patient, male or female, is to be catheterised for acute urinary retention then a non-invasive bladder volume scan is desirable but not mandatory as relief of patient's anguish and distress takes priority. Bladder scanning helps to assess bladder volume

and the degree of urinary retention. The quantity of urine drained from the bladder must be documented in the patient's medical notes.

In chronic retention a decision to catheterise should not be based upon residual volume alone, even if the amount is considerable. In such cases patients' symptoms and severity profile along with their renal function and cognitive status need to be considered prior to considering catheterisation. Appropriately trained staff should conduct non-invasive bladder volume scanning, using the BVI3000 Non-invasive Bladder Volume Instrument. Training can be provided by the urology specialist nurse on the safe use of this equipment. Scanning devices are available for short-term loan 24hrs per day 7 days per week from Thomas Audley ward and Graham ward and there are also scanners on Priestley, RNRU, Surgical Centre, main out-patients and accident and emergency departments.

NB. A bladder scanner should not be used for post-partum women up to 7 days post delivery due to the possibility of the uterus being misinterpreted as a full bladder

Once a catheter has been inserted the following documentation must be recorded in the patient's notes:

- Indication (s) for catheterisation and who decided
- Date and time of catheterisation
- Catheter type, make, length and size
- Amount of water instilled in the balloon
- Batch number, manufacturer
- Problems encountered during procedure
- Date to review need for catheter or date of catheter change
- Volume of urine drained after catheterisation
- Follow up instructions: Intake/Output charting; Urea, electrolytes, creatinine estimations, Irrigation where required
- A fluid balance chart should be commenced on any patient who has a urinary catheter

Review of whether there is a continuing need for the catheter should be carried out on a daily basis by the patient's medical team as the presence of a urinary catheter and the duration of its insertion are contributory factors in the development of UTI. The risk of acquiring a catheter-associated infection (CAUTI) increases by 5-8% per day [13]. Bacteriuria is virtually inevitable as bacteria can gain access to the bladder [14, 15] extraluminally (during catheterisation procedure), intraluminally (by migration within the catheter lumen from the drainage bag or catheter-drainage tube junction) and extraluminally (via the mucus film adherent to the external catheter surface). Removal of the catheter should be done as soon as it is no longer needed but if it is needed for a longer period of time then a catheter that is designed for long-term use should be selected. The reason for extended catheter use should be documented in the patients' medical notes.

Limitation to Practice: Advice from urology team should be sought in the following instances.

- 1 History of difficult catheterisation or a previous 'false passage' created by catheterisation
2. If the patient has oedematous or ill-defined genitalia
3. Failure to insert catheter after 3 attempts at catheterising

5.2 Selection of catheter type and size

Choosing the right catheter for the patient is important to avoid unnecessary complications and to assist in patient compliance. There are several types of catheter available which come in various lengths and diameters (Ch or F). Smaller gauge catheters minimise urethral trauma, mucosal irritation and residual urine volumes compared to larger diameter ones which are likely to predispose to UTI. This would generally be 12Ch Foley Catheter with a 10ml balloon.

Larger balloon catheters are used for irrigation (see section 5.2.2 on three way catheters) e.g. for patients following transurethral resection of prostate (TURP) or transurethral resection of bladder tumour (TURBT)).

Currently at the Homerton teflon coated latex catheters are used for short term (≤ 28 days) and hydrogel coated latex or 100% silicone catheters for long-term use (≤ 12 weeks). Silicone catheters have larger lumens and therefore are useful for patients who have frequent blockages and for those who have latex allergy. If other types of catheter need to be used specialist advice should be sought first from the urology team. Female length catheters (short length) have been removed from the wards and departments following recommendation from the National Patient Safety Agency as erroneous insertion of these into male patients has caused serious injury and in some cases death due to sepsis.

5.2.1 Supra pubic catheterisation (SPC)

Supra-pubic catheterisation is an invasive surgical procedure to which the patient must consent verbally. It is undertaken where a total blockage of the urethra or prostatic urethra has occurred or where urethral catheterisation is contra-indicated. Supra-pubic catheterisation is performed under local or general anaesthetic by passing a trocar through the abdominal wall, the bladder wall and into the bladder. Any patient needing SPC should have the procedure done with ultrasound guidance and preferably by an experienced member of the urology team.

It is not suitable for patients who have a history of bladder cancer, lower abdominal surgery or scarring, or who are obese.

Advantages of SPC: It has several advantages over urethral catheterisation. The incidence of UTI is less than urethral catheterisation as there are fewer bacteria on abdominal skin as opposed to the perineal/ perianal areas, but patients can still develop bacteriuria and catheter encrustation [16, 17]. Integrity of the urethra is maintained and resumption of normal voiding after surgery is easier as the supra pubic catheter can be clamped to allow urethral voiding to occur. A catheter valve fitted to the end of the catheter is useful for this procedure.

Pain and catheter associated discomfort are reduced and patient satisfaction is increased as independence is increased and sexual intercourse can occur with less impediment [18, 19, 20, 21].

5.2.1a Staff responsible for undertaking SPC procedure

This procedure has inherent dangers i.e. perforation of the bowel and should only be undertaken by appropriately trained professionals. In this Trust that would normally be a urology registrar who has been assessed as competent by the urology consultant. In the Rapid Response Report (2009) the National Patient Safety Agency identified 3 incidents

of death and 7 causing severe harm from supra-pubic catheter placement between Sept 2005 and June 2009, 9 of which involved bowel perforation. The British Association of Urological Surgeons (BAUS) have produced guidelines which reinforces the importance of expertise both in the insertion technique and bladder ultrasound to ensure that the bladder is adequately filled (more than 300mls) and there are no bowel loops along the planned catheter track.

A new supra pubic seldinger catheterisation kit has recently been introduced to the Trust which enables safer catheterisation. The kits are kept in the A&E and urology departments.

If expertise is not available in insertion of the catheter or in performing ultrasound and the bladder is easily palpable then supra-pubic insertion of a needle up to 21 gauge can be used to temporarily relieve the patient's symptoms. Post-operatively, patients, carers and clinical staff must be aware of the risk of bowel injury and be able to recognise the signs and symptoms of such. Written instructions covering contact details and indications for seeking medical help should be given to patients or their carers after the procedure.

Full BAUS guidelines on suprapubic catheter practice can be accessed on their website www.baus.org.uk

5.2.1b Training lead (urology consultant)

The training lead (the urology consultant) is responsible for ensuring staff are trained and competent in the insertion of supra-pubic catheters. A training plan will be developed by the urology consultant. There should be access to ultrasound equipment to ensure the bladder is visualised and full enough before supra-pubic catheterisation takes place and that patients are monitored closely after the procedure and they are followed up by the urology team initially. An action plan outlined by the Rapid Response Report is expected to be completed by medical directors in acute and community hospitals.

5.2.2 Three-way catheters

3 way catheters have 3 channels: larger one for drainage from bladder, an irrigating channel to run clear fluids usually saline or glycine and a smaller channel connected to the balloon. They are used to manage haematuria and blood clots. At Homerton a size 22Ch simplastic (PVC) catheter (Teleflex Medical, UK) is most commonly used. It is transparent and the colour of the urine can easily be observed. This simplastic catheter is commonly used following endoscopic urological surgery but can be used when patients have severe haematuria. This catheter is made of a fairly rigid material and is therefore not suitable for long term use. This catheter should be inserted by an appropriately trained doctor or nurse after seeking a urology opinion especially in post TURP patients.

5.2.3 Intermittent self catheterisation (ISC)

This procedure is an alternative to long term catheterisation. It involves periodic insertion of a pre-lubricated sterile catheter (hydrophyllic-coated) to prevent the bladder becoming overdistended and to prevent incontinence [22]. The frequency of catheterisation varies between individuals but generally if the patient is unable to void without a catheter it will be between 3-6 times a day depending on the residual volume.

ISC offers considerable advantages to the patient including freedom from an uncomfortable urethral catheter, leg bags or bulky incontinence pads leading to a greater degree of freedom of movement, less UTIs and no problems with sexual intercourse and an overall improved quality of life. Urinary tract complications are minimised and normal bladder function is restored [23,24,25,26]. The decision to advise ISC is made by the urology team in conjunction with the patient and their carer. Patients' suitability for ISC is based on their ability to store urine between catheterisations without leakage, to comprehend the technique, to be able to position themselves, to have good manual dexterity to handle the catheter, and to be sufficiently committed and motivated to carry out the procedure. If the patient is not able to carry out the procedure they should have a willing carer or partner who will perform catheterisation for them.

Intermittent catheters (Nelaton) are available in standard, female and paediatric lengths and in sizes 6-24Ch. Size 12 Ch is the usual size for adult males and females, 6 or 8 Ch for children. The larger sizes are used for urethral dilatation following surgery for urethral stricture (optical urethrotomy or urethral dilatation by bougies). The procedure is usually taught by a urology nurse specialist/practitioner to be performed by the patient once or twice a week initially.

In/out intermittent catheterisation

This can be used as a method of draining the bladder for post-operative retention as an alternative to an indwelling catheter. The nurse responsible for carrying out this procedure should have had appropriate training and supervision to ensure competency. This type of catheterisation encourages the bladder to return to normal function much more quickly than an indwelling catheter and also reduces the risk of infection.

5.3 Obtaining consent for catheterisation

The patient's consent must be obtained prior to insertion of an indwelling urinary catheter as it is an invasive procedure associated with potentially serious risks. Consent can be verbally given and must be documented in the patients' medical notes. Following the introduction of the Mental Capacity Act (2005) the five key principles of the act need to be taken into consideration when obtaining informed consent prior to catheterisation:

- Presumption of capacity – every adult has the right to make his/her own decisions and must be assumed to have capacity to do so unless it has been proved otherwise.
- Individuals should be supported to make their own decisions – A person must be given all practicable help before anyone treats them as not being able to make decisions for themselves.
- Unwise decisions – Just because an individual makes what seems to be an unwise decision, they should not be treated as lacking the capacity to make that decision.
- Best interests – An act done or decision made under the Act, for or on behalf of the patient who lacks capacity to make the decision for themselves must be done in their best interests and documented.
- Least restrictive option – Anything done for or on behalf of a person who lacks the capacity to make an informed decision but should be the least restrictive of their basic rights and freedoms.

Catheterisation is an invasive procedure with associated serious risks, therefore obtaining documented informed consent is vital prior to undertaking the procedure.

5.4 Catheter insertion using aseptic non-touch technique (ANTT)

When undertaking any invasive procedure it is important that all the necessary equipment is gathered before commencing.

All in one catheter packs (Foley trays) are available on the wards which makes this process easier as they have all the necessary equipment in the pack, however careful choice of the correct pack is essential to avoid wastage. Please note that the gel contained in the pack does NOT contain anaesthetic or antiseptic agents so Instillagel is available if needed.

The catheterisation procedure is detailed in **appendix 1**

The right choice of a closed, sterile drainage system should be based on an individual patient assessment and type of usage.

Please note: Only sterile water is used to inflate the catheter balloon

5.5 Maintenance of the urinary catheter system

The urinary drainage system must be kept closed to the external environment to remain sterile. In an open system the frequency of infection is as high as 97% (EPIC2 guidelines) Breaches of the closed system are likely to increase the risk of infection and should be avoided.

When manipulating the drainage system, a plastic apron must be worn, the hands should be decontaminated and clean non-sterile gloves should be worn. The hands must be decontaminated after the gloves have been removed. Catheters should be positioned to prevent backflow of urine. This means that the catheter drainage bag must be positioned below the bladder on a suitable stand with the drainage tap clear of the floor. If the patient is ambulant then a leg bag may be more appropriate with a night bag being attached onto the outlet tap of the leg bag when the patient is in bed. When the bag is emptied, use a clean container and avoid contact between the container and the drainage system. Hands must be decontaminated and gloves worn before emptying a urine drainage bag. Sterile swabs containing 70% alcohol and 0.5% Chlorhexidine should be used to decontaminate the outlet tap before and after emptying the bag.

The tap should be completely emptied to minimise the build up of organisms at the tap outlet. After emptying the drainage bag, gloves should be removed and hands decontaminated with soap and water before emptying any further urinary drainage bags or performing other duties (**see Elsevier Clinical Skills online at www.elsevierclinicalskills.co.uk**)

Catheters should only be replaced when there is a clinical need i.e. catheter blockage, leakage, UTI, or when specified by the catheter manufacturer. Urinary drainage bags should be changed every 5-7 days. The addition of antimicrobials and/or disinfectants to drainage bags does not reduce the incidence of bacteriuria and is not recommended.

The connection between the catheter and the drainage bag should not be broken without a good reason i.e. changing the drainage bag according to the manufacturers instructions. If a urine sample is required it should be taken from a sampling port using aseptic technique (**Refer to Elsevier Clinical Skills online at www.elsevierclinicalskills.co.uk**) Drainage bags used by the Homerton have needle free ports for safer urine collection.

Urine samples for bacteriological testing must not be taken from the drainage bag. Meatal hygiene with antiseptic solutions is not recommended because it does not reduce the frequency of bacteriuria compared with routine daily bathing. Bladder irrigation, instillation or washout with antiseptic agents does not reduce the frequency of catheter-associated infections. Many agents have toxic effects on the bladder mucosa and may

contribute to the development of resistant organisms. Bladder irrigation, instillation and washout are therefore not recommended for the prevention of infection.

Continuous bladder irrigation with irrigating saline 0.9% may be needed following urological surgery to prevent catheter blockage with clots **(see Elsevier Clinical Skills online at www.elsevierclinicalskills.co.uk for management of continuous bladder irrigation and also appendix 2 for irrigation chart) An irrigation care plan is also available as part of 'Priorities of Care'. Catheter maintenance solutions can be used to prevent or treat catheter blockages caused by encrustation in long term catheterisation i.e. Solution G (Citric acid 3.23%) or Solution R (Citric acid 6%). In persistent blockage the catheter should be changed to an all-silicone catheter and may have to be changed more frequently [27]. **(Refer to Elsevier Clinical Skills online at www.elsevierclinicalskills.co.uk)****

5.6 Use of antibiotics

Long term antibiotic prophylaxis is ineffective and should not be used. Treatment of asymptomatic bacteriuria is also not indicated in catheterised patients [28]. Patients should be treated with antibiotics only if there is clinical evidence of infection i.e. the patient is febrile, has a raised white cell count and has proven bacteriuria [28]. If treatment of a urinary tract infection is required the catheter must be changed and if possible removed. Removal of a urinary catheter is often sufficient to eliminate bacteriuria without the need for antibiotic treatment.

The use of prophylaxis in catheter manipulation/change of catheter is not indicated under most circumstances but is indicated in patients routinely if they are neutropaenic or have a prosthesis in situ. Gentamycin 80mgs IV or IM is given STAT just before the manipulation. **(For further information on the management of catheter-related UTI please refer to the Trust's current antibiotic policy via the intranet)**

5.7 Catheter valves

These offer a useful alternative to using a drainage bag. The valve, which resembles the tap on a drainage bag, is attached to the catheter and can be supported with a leg bag strap or catheter stabilising device. It allows the bladder to fill naturally before the valve is released to drain the bladder which mimics normal bladder function. This is useful as it helps the bladder to flush out impurities reducing possible UTI's and it maintains normal bladder capacity. The catheter valve can be used prior to a patient having trial without catheter to encourage a return to normal bladder function. Catheter valves should only be used for patients who understand how they are used, have good manual dexterity to operate the valve, and have normal bladder sensation. They are not suitable for patients with poor bladder capacity, overactive bladder, ureteric reflux or renal impairment [26].

5.8 Troubleshooting (problem management): This is summarised in the table below:

Problem	Cause	Suggested action
1. Urinary tract infection introduced during catheterisation	Inadequate ANNT and /or urethral cleansing. Contamination of catheter tip	Manage and treat immediate symptoms, inform medical staff. Obtain a CSU and send for culture. Treat UTI
2. Urinary tract infection introduced via the drainage system	Inappropriate handling of equipment. Breaking the closed system	As above
3. Urethral/prostatic trauma	Incorrect size or positioning of catheter. Poor insertion technique.	Check catheter drainage system and re-position as necessary. Re-catheterise patient with correct

		size catheter Remove catheter if it is not draining urine and seek medical advice
4. Inability to tolerate indwelling catheter	Creation of false passage during catheter insertion	
	Urethral and/or bladder mucosal irritation	Use catheter support device to prevent catheter pulling Consider changing catheter to 100% silicone if latex allergy is suspected Consider prescription of anticholinergic medication
	Impacting on patient's self-image	Reassure patient and discuss the need for and function of the catheter Consider alternative options i.e. intermittent catheterisation, urinary sheath
5. Inadequate drainage of urine	Kinked drainage tubing	Ensure free flow of urine
	Blocked tubing with blood clots, debris	If a 3 way catheter is in situ, irrigation should be commenced and/or a bladder washout should be performed. A 2 way catheter should be flushed with sterile saline
	Incorrect placement of catheter i.e. in bladder neck	Remove and re-site the catheter
6. Leakage of urine around the catheter (by-passing)	Bladder irritation	Ensure the catheter/drainage system is well supported. Discuss use of anticholinergic medication
	Irritation from catheter balloon	Ensure balloon size is 10mls for standard drainage
	Incorrect size of catheter	Replace with the correct size usually smaller size is needed
7. Balloon cannot be deflated	Valve channel is blocked with encrustations	Instill Solution R or Suby G for up to 20 mins and attempt removal again
	Valve is faulty	Refer patient to urologist for possible ultrasound-guided deflation of the balloon. Inform manufacturer of the batch number to record the fault in the catheter

(Adapted from EAUN male catheterisation guidelines, 2005 [12])

5.9 Removal of a urinary catheter (trial without catheter)

If the patient is to have a trial without catheter this should be done under controlled conditions so that the patient can be observed for signs of urinary retention and a bladder scan performed to confirm residual volume. This can be done whilst an in-patient or in a designated clinic (Catheter clinic) or by suitably trained community staff. If the patient is an in-patient the catheter should be removed at midnight or early morning

so that the patient is likely to sleep and thereby fill the bladder making a return to normal voiding more likely. The patient should have opened their bowels prior to a trial without catheter being performed to ensure the full rectum does not obstruct the bladder.

After removal of the catheter a record should be kept of the patient's intake and output on a suitable chart or in the patient's records. If there is no urine output after 6 hours a scan should be performed to ascertain volume in the bladder and if >400mls the patient should be re-catheterised and referral to urology made. If the volume is <400mls then further filling of the bladder should be encouraged and the bladder re-scanned within 2 hours.

Removal of a supra pubic catheter employs the same principles but pressure should be applied to the supra pubic wound until leakage of urine ceases and then a sterile dry dressing can be applied. The wound usually takes a few days to heal.

If the balloon cannot be deflated advice should be sought from an experienced practitioner as the patient may need to be referred to the ultrasound department for ultrasound guided deflation of the balloon by a urologist.

(See appendix 3 for guidance on removing a catheter)

5.10 Discharging patients home with a urinary catheter

All patients who are to be discharged with a catheter in situ must have the following in place:

- District nurse referral - this should detail the reason the patient is catheterised, the date of insertion, type and size of catheter, when the catheter needs changing, follow up arrangements.
- A discharge summary that states the presence of an indwelling catheter and arrangements for its removal or ongoing care
- The nurse who is discharging the patient should use a check list (**see appendix 4**) to ensure that the patient and/ or his/her carer knows essential information about the catheter before he/she leaves
- Catheter to home pack (supplied by Coloplast Ltd on a top up system). The pack contains a leg bag, a night bag, a pair of straps to secure leg bag, patient information on how to care for their catheter and also information on how to order more supplies via **Charter Healthcare on 0800 374654**. Staff can order supplies for the patient if they are not able to do this for themselves.

6. Training and awareness

Staff will be made aware of this policy via the Trust's intranet under the policies and the education sections. Male/female catheterisation study days are held twice a year and are arranged via the education department. Staff can request their manager to book them onto them.

FY1 training in catheterisation is done as part of their skills training programme and also is included in teaching on management of acute retention given by the urology team.

7. Review

This policy will be reviewed in 3 years time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

8. Monitoring/Audit

Measurable Policy Objective	Monitoring/Audit	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, inc responsibility for reviewing action plans
DoH High Impact Intervention for catheter insertion and ongoing catheter care	ICT sends monthly figures to ward managers, consultants, executive directors, lead nurses and senior nurses	monthly	Ward/unit manager or sister	Division performance meetings/lead nurses responsible for action plans. Quarterly reports to ICC and included in DIPC reports to the Board
Standard procedures used for catheterisation and ongoing care of patients with urinary catheters	Incident reporting via Trust incident reporting system	As required	Clinical staff	Incident Review Group

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APPENDIX ONE

Procedure for urethral catheterisation using the all-in-one Foley tray

- Explain the procedure to the patient and gain his or her consent
- Assist the patient into an appropriate supine position
- Wash hands
- Open the outer packaging of the Foley tray and slide it onto the top of a clean trolley
- Open the paper cover to reveal the contents
- Put on the disposable plastic apron
- Attach the rubbish bag to the trolley
- Place the waterproof surface blanket under the patients buttocks and thighs
- Clean hands with alcohol hand gel
- Put on sterile gloves (single or double glove in line with local policy)
- Open the 0.9% sodium chloride solution and empty into the well of the plastic tray
- Place the sterile paper over the patient's thighs to create a sterile field
- In men, wrap a gauze swab around the penis and retract the foreskin if necessary. Clean with swabs soaked in 0.9% sodium chloride solution using single strokes away from the meatus
- In women, use a gauze swab to separate the labia minora to visualize the urethral meatus. Clean with swabs soaked in 0.9% sodium chloride solution using single downward strokes away from the meatus
- If using a double glove technique remove the outer set of gloves. If not, change your gloves
- In men, grasp the penis behind the glans and extend towards the abdomen. Maintain this extension throughout the procedure
- Insert the nozzle of the urethral lubricant into the urethra and squeeze to empty the syringe. In men, massage the gel along the urethra
- Place the pre-connected catheter system on the sterile field covering the patient's thighs
- Holding the catheter through the packaging gently insert the catheter using a slow steady pressure
- If urine is draining advance the catheter almost to its bifurcation
- Inflate the catheter balloon using the syringe of sterile water observing the patient for discomfort
- Withdraw the catheter gently
- Clean away any excess lubricant. In men, reduce or reposition the foreskin
- Remove the sterile field
- In preparation for stabilizing the catheter fully extend the leg and position the catheter straight on the front of the thigh. Then back the catheter up approximately 3 cms to create some slack. This amount of slack is important as it allows movement of the swivel clamp while it is not enough to cause the catheter to kink
- Open the Foley catheter stabilization device and clean the thigh using both skin preparation swabs. Allow to dry for around ten to fifteen seconds
- Press the Foley catheter into the stabilization device ensuring that the bifurcation of the catheter sits neatly around the central post. This will stop the catheter from pulling. Close the lid by pressing from the side of the lid (this prevents the catheter from being pinched)

- Position the stabilization device on the prepared area. To avoid applying too tightly peel away the paper backing one side at a time
- Position the catheter bag below the bladder either on a stand ensuring that the drainage port is not in contact with the floor or using leg straps
- Dispose of all equipment in the clinical waste bag in line with local procedure
- Measure the residual urine and document the procedure in the patient's records

(Based on Head 2006, Bard 2008, Dougherty and Lister 2008)

APPENDIX THREE

EQUIPMENT

- Non-sterile gloves
- Syringe for deflating the balloon
- Disposable incontinence pad to place under the patient

	ACTION	RATIONALE
1	Catheters should ideally be removed at midnight or early morning	So that any problems can be dealt with during the day when most staff are available
2	Explain the procedure to the patient Inform them of post procedure symptoms e.g. urgency, frequency, urge incontinence. Symptoms should resolve over the course of a few days and patient can be encouraged to do pelvic floor exercises to control symptoms Encourage patient to drink 1-2 litres of fluid if not restricted	So the patient knows what to expect and can plan their daily activities and toileting For adequate flushing of the bladder to dilute and expel debris and possibly infected urine
3	Wearing gloves and apron, take a catheter specimen of urine. Empty the drainage bag, measuring the amount and test with urinalysis strip	To assess if post catheterisation antibiotic therapy is required
4	Ensure patient is in a comfortable position lying on a disposable pad	For easier removal of the catheter
5	Having checked catheter balloon size, use the syringe to deflate the balloon. Do not cut the inflation channel	To ensure the balloon is fully deflated
6	Ask the patient to relax and take some deep breaths. Grasp the catheter firmly and remove slowly and gently discarding it into a disposal bag for clinical waste. Male patients should be warned of possible discomfort as the catheter passes through the prostate gland	To relax pelvic floor muscles
7	Make the patient comfortable and ensure the skin is dried. Maintain fluid balance chart for 24 hours post procedure	To ensure patient is passing adequate urine volume and fluid intake is adequate

APPENDIX FOUR



CATHETERISED PATIENT DISCHARGE CHECKLIST

HAVE YOU DISCUSSED WITH YOUR PATIENT? (TICK BOXES)

- Why the catheter has been fitted?
- Hand hygiene?
- How to connect the catheter with the drainage bag?
- What to do when the catheter needs changing?
- Advice on diet and fluids?
- What to do if there is a problem?
- How and when to change the leg and night bag?
- Securing and positioning the leg bag?
- Linking the leg and night bag together?
- Emptying the leg and night bag?
- How to dispose of leg and night bags?
- How to obtain further supplies and accessory items?

Signed:

Date:

Contact number of Charter Healthcare home delivery service: 0800 374 654

<h1 style="margin: 0;">Catheter Care Plan</h1>	<p>Name _____</p> <p>Hospital Number _____</p> <p>Ward _____</p> <p>Priority: Continance</p>
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- Records should be made **as soon as possible** after an event.
- Utilise free text below to **personalise** care plan for patient.
- The patient plan must be **referred to at each shift handover**.
- Evaluation of a problem is required **each shift**

<p>Problem: Patient has an indwelling catheter</p>

	Date/Signature
<p><input type="checkbox"/> Goal: To maintain continuous drainage of urine Goal: Minimise risk of introducing infection</p> <p>Core Requirements</p> <p>A1 Sterile equipment and aseptic, non-touch technique must be used for catheterisation</p> <p>A2 Documentation of catheterisation must be completed i.e. reason for catheterisation, catheter type, balloon size, batch No, expiry date, when catheter needs changing, residual urine volume.</p> <p>A3 Urine drainage bag should be placed below the level of the bladder on an appropriate stand with the tap clear of the floor</p> <p>A4 Meatal cleansing should be part of the patients daily hygiene routine using plain soap and water and disposable wipes</p> <p>Additional requirement for patient in relation to catheter care</p> <p>.....</p> <p>.....</p>	

Prompts

1. Urine sampling should be performed using aseptic technique via the catheter port using a syringe
2. The connection between the catheter and drainage bag should only be broken for good clinical reasons and aseptic non-touch technique used
3. Urine bags should only be emptied when full. Disposable gloves and apron should be worn after hand decontamination when emptying the drainage bag and the tap dried and cleaned with an alcohol wipe after emptying urine
4. A catheter support device should be attached to the patient's leg to avoid the catheter pulling and causing urethral trauma
5. If the catheter blocks, a full assessment of the possible cause should be carried out and appropriately treated using catheter maintenance solutions if indicated in long term catheterisation
6. The catheter should only be changed when clinically indicated or according to the catheter manufacturer's instructions
7. The ongoing need for the catheter should be reviewed daily with the clinician responsible for the patient's care

Patient plan start date	Discontinued date
Initial patient care planned by:	
Print name	Staff title
Signed	

Review of care plan

Date	Time	Designation	Name	Signature

Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	Urinary catheterisation policy
Author:	Clare Smart
Role:	Urology specialist nurse
Directorate:	Surgical directorate
Date	26.11.10

Equalities Impact Assessment Question	Yes	No	Comment
1. How does the attached policy/service fit into the trusts overall aims?			Ensuring quality and safety in patient care
2. How will the policy/service be implemented?			Via the intranet
3. What outcomes are intended by implementing the policy/delivering the service?			Standardisation of catheter management and reduction in CAUTI's (catheter associated UTI's)
4. How will the above outcomes be measured?			By monitoring of catheter related incidents and by auditing catheter management in all departments
5. Who are they key stakeholders in respect of this policy/service and how have they been involved?			Urology consultants, urology nurses, Infection control dept, nursing and medical education depts. Who have been asked to comment on this policy
6. Does this policy/service impact on other policies or services and is that impact understood?	yes		Infection control policies
7. Does this policy/service impact on other agencies and is that impact understood?	yes		Community matrons and district nurse services
8. Is there any data on the policy or service that will help inform the EqIA?		No	

9. Are there are information gaps, and how will they be addressed/what additional information is required?	yes		Awaiting national guidelines from BAUS on the insertion of supra-pubic catheters
Equalities Impact Assessment Question	Yes	No	Comment
10. Does the policy or service development have an adverse impact on any particular group?		no	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		no	
12. Where an adverse impact has been identified can changes be made to minimise it?			Not applicable
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		no	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?		no	

EQUALITIES IMPACT ASSESSMENT FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Policy Submission Form

Policy Submission Form

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

1	Details of policy	
1.1	Title of Policy:	Urinary catheterisation policy
1.2	Lead Executive Director	Sheila Adam
1.3	Author/Title	Clare Smart
1.4	Lead Sub Committee	Patient Safety Committee
1.5	Reason for Policy	To ensure adherence to National Patient Safety Agency Alerts
1.6	Who does policy affect?	All patients with catheters
1.7	Are national guidelines/codes of practice incorporated?	Yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2	Information Collation	
2.1	Where was Policy information obtained from?	See references on policy and also Royal Marsden Manual of Clinical nursing procedures via intranet
3	Policy Management	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	
3.3	If NO explain why	
4	Consultation Process	
4.1	Was there internal/external consultation?	Yes
4.2	List groups/Persons involved	Vinod Nargund, Jhumur Pati, Junaid Masood, Vicki Longstaff, Community Matrons, Val Dimmock, Diane Goodenough

4.3	Have internal/external comments been duly considered?	Yes
4.4	Date approved by relevant Sub-committee	December 2014
4.5	Signature of Sub-committee chair	
5	Implementation	
5.1	How and to whom will the policy be distributed?	On the intranet
5.2	If there are implementation requirements such as training please detail?	
5.3	What is the cost of implementation and how will this be funded?	None
6	Monitoring	
6.1	List the key performance indicators e.g. core standards	Adherence to NPSA alerts. Monitoring of incidents involving catheters and high impact intervention monitoring for catheter insertion and ongoing catheter care in departments and wards.
6.2	How will this be monitored and/or audited?	As above
6.3	Frequency of monitoring/audit	

Date policy approved by Trust Policy Group:

..... 25/02/2014

Signature of Trust Board Group chair:

..... Sheila K. Adam
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