Guidelines and Standard Operating Procedures

The Management of Urinary Catheterisation (Adults)

February 2021

Document Profile

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Version control / changes made

Date	Version	Summary of changes made	Author
Dec 2020	2	Addition of catheter passport, RED pathway, competencies, care plans and Bee safe poster and glossary of terms Evidence updated throughout guideline, Catheter record updated. Updated HCS Catheter bundle, AUR guidelines and management of blocked catheters added	Fiona Le Ber
September 2022	2.1	2 - Clinical Staff: Amended to encompass revised scope of practice for pre-registration student nurses, as per the Nursing and Midwifery Council "Future Nurse: Standard of proficiency for registered nurses" (2018).	Mo de Gruchy

CONTENTS

1. INTRODUCTION

1. Rationale

Urinary catheterisation is an intervention performed by health care workers to enable emptying of the bladder, to facilitate instillation of a solution or medication or to dilate a urethral stricture by insertion of a catheter.

This guideline and standard operating procedures aim to provide a standardised set of measures for urethral, supra-pubic and intermittent catheterisation that can be followed by all healthcare workers giving care in a community setting.

2. Scope

This guideline and standard operating procedures cover the care of adult patients who are receiving urinary catheter intervention and are relevant to all community healthcare personnel who have direct contact with and make decisions concerning the catheter care of adult patients.

It applies to all clinical and nursing staff employed by Family Nursing & Home Care (FNHC) who are involved with the management or care of urinary catheters.

This guideline provides guidance for:

- The insertion, management and removal of an indwelling urethral or suprapubic catheter.
- Selection of the most appropriate catheter for the patient
- Guidance on the use of intermittent catheterisation
- Management of adult patients in the community who are in urinary retention (AUR pathway 2020). (Appendix 5)
- The use of the catheter record (Appendix 6) and catheter passport/ Risk assessment tool (Appendix 7)

3.0 Role and Responsibilities

The Chief Executive (CEO)

The CEO has overall responsibility for effective management of risk within the organisation. As accountable officer, the CEO is responsible for the effectiveness of the organisation's systems of internal controls.

Operational Leads

Operational leads have responsibility for ensuring that the required structures and resources are in place to enable effective care for patients requiring urinary catheterisation.

Team Leaders

Team leaders have responsibility to ensure that their staff:

- know when it is appropriate to carry out urinary catheterisation
- know how to seek advice/guidance
- are trained and have the competencies needed to undertake all elements of catheter management for which they are required to undertake (Appendix 13)

- have awareness and access to this document

Clinical Nurse Specialist

The Clinical Nurse Specialists (CNS) with specific knowledge of the procedures are responsible for providing training and advice.

Clinical Staff

Clinical staff have responsibility for:

- ensuring they only carry out catheter management procedures for which they have received training and have been deemed competent unless it is being carried out as part of that training or competency assessment, in which case they must be accompanied by a competent colleague.
- completing correct documentation on insertion of catheter.
- following the FNHC standard operating procedures (SOPs) for male, female, supra-pubic and intermittent catheterisation that have been developed with reference to NICE (2020) guidance and the Royal Marsden (2017) (Appendix 4)
- Student Nurses who have undergone theory and have had the opportunity to practice in a simulated environment can partake in catheter management procedures, including insertion and removal of catheters for all genders, under the direct and constant supervision of a competently trained registered practitioner (NMC 2018).
- If delegating any aspect of urinary catheter management to un-registered staff, must ensure they have been trained and deemed competent to do so.

All health care professionals have a responsibility to adopt best practice when caring for patients with a urinary catheter.

2. GUIDELINE

All Health Care Professionals who carry out catheter insertion must:

- be trained in catheter insertion, including suprapubic catheter replacement and catheter maintenance (NICE 2020).
- obtain verbal informed consent by ensuring the patient understands the procedure and gives consent for the procedure to be carried out
- carry out the procedure under aseptic technique (or if trained, Aseptic Non Touch Technique (ANTT) (Appendix 8) should be followed)

This document should be read in conjunction with the Consent Policy, Hand Hygiene and the use of Personal Protective Equipment Policy and Procedures. Staff will also act in accordance with relevant legislation and professional codes, including, amongst others, The Mental Capacity Act (MCA) 2005 and Nursing and Midwifery Council (NMC) Code (2018)

2.1 The risks of urinary catheterisation

Using any form of catheter has associated risks and with the continued risk of urine infections and associated life-threatening complications, such as sepsis, it is of great importance that risk assessment becomes an essential part of clinical decisions and catheter care in all care settings. Catheterisation should be only be undertaken after

considering alternative methods of management and the person's clinical need for catheterisation should be reviewed regularly, with the urinary catheter removed as soon as possible (NICE, 2020, RCN 2019).

In the UK, about 4% of people receiving home care, and around 9% of patients in nursing homes (but possibly up to 40% in some places), are living with long-term catheters.(Shepherd 2017)

2.2 Catheter-Associated UTI (CAUTI)

A Catheter-Associated Urinary Tract Infection (CAUTI) is a symptomatic infection of the bladder or kidneys in a person with a urinary catheter. The longer a catheter is in place, the more likely bacteria will be found in the urine; after 1 month nearly all people have bacteriuria. Antibiotic treatment is not routinely needed for asymptomatic bacteriuria in people with a catheter (NICE 2019)

The presence of a urinary catheter places patients at increased risk of a CAUTI. People with symptomatic CAUTI should be closely monitored to ensure the infection is treated appropriately, due to the risk of sepsis if the infection is not resolved. Antibiotics should only be prescribed if the patient is systemically unwell and an infection is suspected following clinical assessment. Catheters should be changed as soon as possible when a bacterial infection has been confirmed or is suspected. The clinical evidence is limited, but expert opinion recommends this should be immediately (if the patient is stable and comfortable) or within 48 to 72 hours of starting antibiotic treatment (RCN 2019)

2.3 Preventing catheter-associated urinary tract infections

Routine antibiotic prophylaxis to prevent catheter-associated UTIs in people with a short-term or a long-term (indwelling or intermittent) catheter is not recommended. (NICE 2019)

Indwelling urinary catheters should be used only after alternative methods of management have been considered.

The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible.

2.4 Catheter insertion, changes and care

Following assessment, select the best approach to catheterisation that takes account of:

- clinical need
- anticipated duration of catheterisation
- patient preference and risk of infection

All possible measures must be taken to eliminate the need for catheterisation, including consideration of viable alternatives, before a decision is made to introduce a new catheter into a patient.

Before an existing catheter is renewed, the continued need for a catheter must be assessed and a plan for removal developed. This can be established using the FNHC

RED Catheter Removal Criteria (Appendix 9)

- **R**etention of Urine
- **E**nd of Life Care
- **D**amaged skin (open sacral or perineal wound in an incontinent patient)

All information regarding reason for insertion, plan for removal and checks should be recorded on the Adult Indwelling Urinary Catheter Record.

Select the type and gauge of an indwelling urinary catheter based on an assessment of the patient's individual characteristics, including:

- age
- any allergy or sensitivity to catheter materials
- gender
- history of symptomatic urinary tract infection
- patient preference and comfort
- previous catheter history
- reason for catheterisation NICE 2020

2.5 Indications for Urinary catheterisation

Catheterisation is undertaken for one or more of the following reasons:

- Acute urinary retention (AUR).
- Chronic urinary retention, only if symptomatic and/or with renal compromise.
- Monitoring renal function hourly during critical illness.
- Monitoring/recording/draining residual urine volumes (wherever possible, use of a bladder scanner is the preferred option to measure residual urine volumes).
- During and post-surgery, for a variety of reasons.
- Allowing bladder irrigation/lavage.
- Allowing instillation of medications, for example, chemotherapy.
- Bypassing an obstruction/voiding difficulties.
- Enabling bladder function tests, for example, urodynamic assessment.
- Obtaining a sterile urine specimen in a female
- Non-healing sacral, buttock, or perineal pressure ulcers/injuries (stage III or IV) in incontinent patients. (RCN 2019, WOCN 2016)

2.6 Contra-indications for urethral catheterisation

- Less than 6 weeks post radical prostate surgery
- Patients with known complications / difficulty in catheterising
- No consent from patient

- Oedematous or ill-defined genitalia, refer back to GP
- Unexplained bleeding
- History of bladder tumour (unless agreed by urology)
- History of infection
- Urethral trauma
- False passages
- Risk of damage to internal and external sphincters
- Urethral surgery
- Gender reassignment surgery
- Priapism (WOCN 2016)

2.7 Complications of urethral catheterisation

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

- Urethral trauma resulting in infection (and possible septicaemia)
- Traumatic removal of catheter with the balloon inflated
- Urinary tract infection
- By-passing of urine around the catheter
- Stricture formation
- Encrustation and bladder calculi
- Urethral perforation
- Pain/bleeding
- Catheter blockage
- Trauma to the prostate (Due to inflated balloon positioned incorrectly)
- Paraphimosis
- Urethral Erosion (RCN 2019)

2.8 Supra-pubic catheters

Supra pubic catheters have the advantage of reduced risk of urethral trauma, less catheter related pain and sexual benefits.

Conversion to supra-pubic catheterisation from urethral catheterisation is not always successful for female patients, as there is a considerable risk of coincidental urethral leakage (WOCN 2016) Patients should be warned of this risk.

Catheters used must be licensed for supra-pubic use; Hydrogel coated or 100% silicone catheters are recommended. Licensed supra pubic catheters are only in the standard size and with supra pubic catheters- length of catheter cannot be down to individual choice.

2.9. Indications for suprapubic catheter

There is little evidence-based research on the use of suprapubic catheters compared to a urethral catheter. However there is:

- less risk of urethral trauma, necrosis, or catheter-induced urethritis and urethral strictures.
- greater comfort, particularly for patients who are in wheelchairs, as the catheter is not positioned between the legs and less risk of the catheter becoming kinked causing bypassing.
- less effort for patients who live alone and need to manage long-term urinary incontinence or retention and are unable to self-catheterise or lack a caregiver
- easier access to the cystostomy site for cleaning and catheter changes.
- reduced risk of catheter contamination with micro-organisms that are commonly found in the bowel, therefore reducing the number of urinary tract infections.
- greater freedom to be, or remain, sexually active
- micturition is still possible if urethra not surgically closed or obstructed.
- voiding trials (TWOC) may be easier (RCN 2019)

2.10 Complications of a Supra-Pubic Catheter are:

- bowel perforation during insertion
- tip of the catheter can lodge in the urethra or bladder wall causing bleeding
- urethral leakage
- increased incidence of stone formation
- hyper-granulation tissue may form and cause stricture at the cystostomy site
- altered body image (WOCN 2016)

2.11 Contraindications of supra-pubic catheterisation include:

- unexplained haematuria
- previous lower abdominal surgery
- history of bladder tumour
- blood clotting disorders
- ascites
- suspicion of ovarian cyst
- very obese patients
- pregnancy

The need for SPC must be clearly established on clinical grounds, it is hazardous to attempt insertion under local anaesthetic into an empty or a poorly filling bladder in these cases the patient will need to undergo a general anaesthetic.

The first change of a supra-pubic catheter is usually 10-12 weeks post insertion and the patient will be required to return to the urology department at Health & Community Services.

2.12 Supra-pubic catheter removal.

When removing a Supra-pubic catheter, a “ridge” can form on the catheter’s balloon resulting in a “cuffing” effect. Do not withdraw water out of the balloon, but attach a syringe and allow the water to flow out by gravity .Cuffing and/or encrustation can make suprapubic catheter removal difficult, causing pain and trauma. This has often been associated with all-silicone catheters, by leaving the catheter in situ for five minutes after deflating the balloon, allows the catheter to regain its original shape. Then, on removal, rotate the catheter slowly. Consider clamping the catheter, prior to removal, to ensure there is a sufficient volume of urine in the bladder to drain with the insertion of the new catheter, and avoid a prolonged wait to confirm the placement .Have the patient take deep breaths and relax the abdominal muscles during removal and reinsertion of the catheter (RCN ,WOCN 2016).

2.13 Clean Intermittent Self Catheterisation (CISC)

Intermittent catheterisation is considered the Gold Standard for urine drainage (NICE, 2015). It can be used as treatment for voiding problems due to disturbances or injuries to the nervous system, non-neurogenic bladder dysfunction or intravesical obstruction with incomplete bladder emptying. **2.14 Contraindications for CISC** Contraindications for CISC include

- priapism
- suspected urethral tumours or injury urethral
- false passage, stricture and some diseases of the penis (such as injury, tumours or infection)
- prostatic bladder neck or urethral surgery
- female genital mutilation
- stent or artificial prosthesis (RCN 2019)
- When considering CISC as an option, the following points should be considered:
- symptom severity profile
- renal function
- risk assessment
- psychological and physical ability to perform intermittent catheterisation
- practicality of undertaking CISC several times a day
- longevity of treatment
- ability to consent

- compliance and motivation

Do not initiate intermittent catheterisation based solely on the residual urine status. (RCN 2019)

2.15 Catheter selection

Catheter gauge/ charriere

Choose the smallest size of catheter necessary to maintain adequate urine drainage. If the urine to be drained is likely to be clear, a 12ch catheter should be considered.

Urological patients may require larger gauge catheters however, these should only be used on specialist advice.

Larger charriere sizes (16 – 22 gauge) may be used for supra-pubic catheterisation as this helps to avoid blockage.

Short length catheters

Shorter catheters (20-26cm) are for ambulatory females only, unless they are obese, bed or wheelchair bound. Changing an obese or bed/chair bound female from a short length to standard length catheter may resolve problems with by-passing or poor drainage.

The shorter length means a leg bag can be worn, which does not show beneath the skirt and also avoids kinking of the catheter or tubing.

A short catheter should NEVER be used in a male patient as this can cause severe trauma to the prostatic urethra (National Patent Safety Agency 2009a).

A female catheter warning notice (Appendix 10) and stickers (Appendix 11) should be displayed/ utilised if both male and female catheters are stored in the same home or a residential home.

Standard length catheters

Standard catheters (40-45cm) can be used for both male and females

Type of Catheter

The type of catheter to be used depends on the length of time it is to remain in situ. If it is known that the catheter will remain for longer than 4 weeks, a long term catheter should be inserted.

Short Term, up to 4 weeks (PTFE or uncoated Latex)

Long term, up to 12 weeks (100% Silicone or Hydrogel coated) (Royal Marsden 2017)

Catheter tip

Catheters are designed with different tips, which are selected according to the patient's needs. Catheter tips have several openings or fenestrations to facilitate drainage of urine, sediment, and blood clots. The standard or straight tip is most commonly used. An open tip is used for frequent blockages. The Coude or curved tip may be used for males who have difficult catheterisations due to prostatic enlargement. (WOCN 2016)
Balloon size

Nurses should follow manufacturer's recommendations. For the majority of patients 10ml balloons are satisfactory and are less likely to cause irritation of the bladder mucosa. Do not inflate the balloon to test for inflation (WOCN 2016)

30 ml balloons should NOT be used - these are for post-operative use only. The weight of water in larger balloons may lead to dragging/pulling of the catheter. The larger balloon may also cause bladder spasm and discomfort because it will rest against the delicate trigone of the bladder causing spasm, bypassing, pain, haematuria and possible erosion of the bladder wall. 30ml balloons were developed to prevent haemorrhage following prostatectomy, which is their intended use only.

NEVER insert more or less water into the balloon than specified by the manufacturer. Over inflation will NOT prevent a catheter being expelled. Under inflation, results in balloon distortion with the risk that the catheter may become dislodged from the bladder.

Balloons should be filled ONLY with sterile water. Tap water in the balloon may introduce bacteria to the bladder. Saline may cause crystal formation in the inflation channel.

2.16 Anti-microbial catheter inflation solution

Clinical evidence suggests that many catheter encrustations are caused by Proteus mirabilis. Using Triclosan in the catheter balloon inflation solution has been shown to improve the patency of the catheter and improve the patient experience. The use of antimicrobial catheter inflation solutions was licensed in the UK in 2016, although clinical evidence of its use in the wider European health care system has been documented for several decades. NICE issued a Medtech innovation briefing in 2017 on the use of Triclosan (NICE, 2017). It is a potential aid for the treatment of problematic catheters and can be considered by the Health care professional responsible for catheter management. (RCN 2019)

2.17 Cleaning Solutions

The skin cleaning solution recommended in the catheterisation procedure is normal saline 0.9% (Normasol).

2.18 Lubrication methods for catheter insertion

Lubricate 2 inches at the end and tip of the catheter with a water soluble lubricant, then instil the remaining lubricant into the urethra to dilate the urethra and mucosal recesses, minimize urethral trauma, and prevent sphincter spasms

Determine the need to use a lubricant containing lidocaine hydrochloride (2% often used), and if used, choose a single-use container. Instruct the patient that a stinging sensation may occur as the lidocaine gel is inserted. Cooling the gel to 4 °C (39.2 °F) before insertion may reduce the stinging. Allow 5 to 10 minutes for the anaesthetic to take effect. Caution is advised in using the lidocaine for patients with cardiovascular morbidity, hepatic insufficiency, or epilepsy. Lidocaine is contraindicated in patients with a known allergy to the product. Do not use lidocaine if there is urethral mucosal damage that could allow systemic absorption of the lidocaine.

The use of chlorhexidine for insertion of IUCs to prevent encrustations or CAUTI is not supported with sufficient evidence for its use, and there have been rare cases of anaphylaxis due to use of chlorhexidine gel (WOCN 2016)

2.19 Catheter securement

Indwelling catheters should be secured to avoid traction on the catheter, which causes irritation and trauma to the urethra (e.g. urethritis, necrosis, erosion, stricture), and/or the bladder trigone muscle resulting in pain, spasm, and incontinence (Moore & Franklin, 2016). Securement is needed to prevent inadvertent dislodgement of the catheter (WOCN, 2016).

2.20 Catheter Maintenance

Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve. Staff must ensure that the connection between the catheter and drainage bag is not broken except for good clinical reasons e.g. changing the bags in line with manufacturers' instruction (in most cases 5-7 days).

Patients should be fitted with a leg drainage bag or catheter valve in the day. A suitable link system must be used to facilitate overnight drainage to keep the original system intact. The drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux and should be changed when clinically indicated and following manufacturers' guidelines. Urinary bags must be positioned below the bladder and not come into contact with the floor

2.21 Infection Prevention & Control Issues

The urinary catheter and drainage system will become colonised by bacteria within 48 hours the longer a catheter remains in situ the greater the risk (RCN 2019) All patients with a long term catheter are bacteriuric, often with 2 or more organisms and this should be taken into account when deciding whether to send a sample for culture or sensitivity. Only send samples on catheterised patients if symptomatic. Urine samples should be taken from the dedicated needle free port using an aseptic technique.

Hands must be decontaminated according to local policy before and after manipulating catheters or drainage systems. Staff should put on an apron as well as a pair of clean, non-sterile gloves before manipulating a patient's catheter.

The meatus should be cleaned daily with mild soap and water.

Catheters should only be changed when clinically indicated or according to manufacturers' instructions.

2.22 Specimen collection

All catheterised patients will have an abnormal urinalysis (NICE, 2015]). Routine dipstick urinalysis testing on patients who regularly use intermittent self-catheterisation (ISC), or have an indwelling catheter, is therefore unnecessary and unreliable. Following a clinical assessment, if a patient has symptoms indicating a CAUTI, a Clean Specimen of Urine (CSU) should be taken to determine the cause of infection. Urine samples must be obtained using an aseptic technique from a catheter sampling port and only if: • fever or rigor

- new suprapubic tenderness
- new onset confusion/systemic features

- AND no other likely infection source

(H&SS Antimicrobial guidelines 2017, RCN 2019, HCS & FNHC Care Home & Community UTI Assessment Tool (> 65 years old))

2.23 Bladder irrigation, instillation and washouts

Bladder instillations or catheter washouts must not be used to prevent catheter associated infections (NICE, 2017).Regular use can lead to an increased risk if the sterile closed drainage system is repeatedly broken, which can lead to infection, sepsis and death.

When considering the use of washouts/ maintenance solutions, there must be evidence of an individualised assessment and the clinical indication for use must be recorded. Shepherd (2017) suggests there was not enough good research evidence to determine if catheter washouts were useful.

If required to remove a blockage then evidence suggests smaller volumes, instilled sequentially, are more effective than large volume single administrations. (RCN 2019) However, clinical evidence has proven that these are unsafe interventions, as their administration usually involves breaking the closed sterile drainage system, increasing the risk of infection. Additionally, the acidic solutions could damage the urothelial lining of the bladder, resulting in an inflammatory response. (Holroyd 2019)

2.24 Catheter Associated Problems

Catheter Blockage

Catheter blockages should be recorded to establish patterns of blockage causes as well as the average catheter lifespan

There are 3 main causes for catheter blockage:

- Mucosal occlusion – this occurs when the bladder mucosa blocks the eyes of the catheter. It is very important to identify this cause as the treatment is very different from encrustation. The best way to determine the cause of the blockage is to examine the catheter visually on removal, both internally and externally. If there is no visible evidence of encrustation and the catheter, when rolled between fingers, does not feel gritty, then it is safe to assume that mucosal occlusion has taken place.
- Hydrostatic suction results from the vacuum effect of urine in the drainage tubing. This sucks mucous into the eyes of the catheter and prevents drainage. This is most often found in drainage bags that are positioned more than 30 cm below the bladder and a slight temporary rising will often help, patient should be advised to wear leg bag on their thigh or use a catheter valve.
- Occlusion will also occur when the bladder mucosa closes around the catheter due to bladder spasm. This may be due to detrusor spasm or the catheter itself may irritate the bladder lining and trigger a spasm. Anti- cholinergic medication may help but patients should be made aware of the side effects in order to help with compliance. It should be discontinued if no positive effect is found. It is also possible that the spasm may occur as reaction to the catheter material and it may be worthwhile to try a different material for future catheterisation. It may be beneficial, where appropriate, to use a catheter valve for patients suffering from repeated mucosal occlusion. The presence of the urine may prevent the mucosa from entering the eyes of the catheter.

Bypassing

Leakage of urine around the catheter may be caused by a blocked catheter or bladder spasm. The sensitive trigone area of the bladder may be stimulated by the balloon, which in turn increases the spasm. A smaller catheter can overcome this problem as might ensuring that no more than 10 ml of water is used in the balloon.

N.B – A larger catheter or over inflated balloon will exacerbate the problem.

Purple Urinary Bag Syndrome

A blue to purple discoloration of the urine, catheter tubing, and collection bag may be seen in some patients. Women and chronically debilitated patients have higher rates of the syndrome and it has been associated with severe constipation. The clinical course is generally considered benign without serious consequences. There is no evidence that the discoloration itself is harmful. Most individuals are asymptomatic. Urine cultures and antibiotics are not considered necessary unless the patient is symptomatic. It often resolves after changing the catheter and collection bag (WOCN 2016).

2.25 Prevention of complications

Nice (2017) advocates the following to minimise the risk of catheter blockage, encrustations and catheter related associated infections:

- develop a patient specific care regime
- consider approaches such as reviewing the frequency of planned catheter changes and increase fluid intake
- document catheter blockage
- each individual with a catheter should have a care plan designed to minimise the problems of blockage and encrustation
- the tendency for catheter blockage should be documented

2.26 Documentation

The following information should be documented in accordance with the Nursing and Midwifery Council Guidance for Record Keeping (NMC 2018)

Complete all sections of FNHC “Catheter Record” and Catheter Passport with the following information:

- reason for catheterisation
- informed consent
- name of the person inserting or changing the catheter
- date and time of catheterisation
- type of catheter – including manufacturer, material, batch number and expiry date size and length of catheter
- type of sterile anaesthetic/lubricating gel used , batch no and expiry date
- volume of sterile water used in the balloon

- name, size and type of drainage system used
- problems encountered at the time of the procedure, including difficulties specific to the individual
- if patient leaflet discussed and evidence of the care instructions given to the patient or carer
- planned date of review and next catheter change (RCN 2019)
- patient Information

Care given should be reviewed against a current care plan (appendix 17-18)

Patients and their carers should be given verbal and written information on how to care for their catheters. A 'Urinary catheter' H&SS patient information leaflet should be provided and is available in English, Portuguese and Polish and can be downloaded from:

https://soj/depts/HSS/Registered%20Documents/ID%20Urinary%20Catheter.pdf#search=catheter

2.27 Catheter Passport

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

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

2.28 Patients Discharged from Hospital

The hospital is responsible for the notification of a patient being discharged with a urinary catheter in situ to the district nurse and relevant GP.

Hospital staff are responsible for providing a HCS catheter bundle (written information on date catheter inserted, type of catheter, balloon size and date of expected next catheter change.) (Appendix 12-13). The hospital staff must ensure both pages are emailed to FNHC Adult Referrals Adult.Referrals@fnhc.org.je

Before leaving hospital, patients should have been shown how to look after their catheter and drainage system and be discharged with a spare leg bag and night drainage bag. If at assessment the community nurse finds this discharge procedure has not been fully followed, a datix should be completed and the FNHC Incident reporting procedure followed. The relevant hospital ward/department should be contacted for the relevant information/equipment.

2.29 Indications for urethral catheterisation at the end of life Catheterisation

at end of life should only be considered for:

- the management or prevention of wound damage (for example, sacral pressure ulcers, fungating wounds or soreness of the anus, perineum, vulva or penis)
- painful physical movements due to frequent changes of bed linen caused by incontinence
- pain or difficulty for female patients getting in and out of bed to use a commode
- urinary incontinence associated with obstruction
- urinary retention/distended bladder
- excessive oedema of the genitalia making micturition uncomfortable Catheterisation is an invasive procedure and it is important to explore alternatives. Consider which method of containment is best for the patient so they are able to maintain comfort, hygiene, dignity and wellbeing (especially if the patient is unable to give consent). The benefits of inserting a urinary catheter at the end of life must outweigh any possible complications, such as catheter encrustation (leading to frequent changes) or bladder spasm (leading to pain and discomfort and possible catheter expulsion). (RCN 2019).

2.30 Supplies

The Health Care Profession (HCP) must know how to order the correct catheter equipment. The ordering of catheter equipment is the responsibility of the patient/ carer once the original voucher has been written and sent to the supplier. In areas where a stock of catheter equipment is required, overstocking must be avoided, and stock should be rotated to prevent products expiring and leading to wastage (RCN, 2019). At home, patients should have enough catheters and equipment for 3 catheter changes and enough leg bags, catheter valves and overnight bags to last for 1 month

3. PROCEDURE

3.1 Assess the need for catheterisation

See Appendix 3 SOP 1.

- Only consider a urinary catheter as a last resort when catheter use is unavoidable.
- Ensure there is an appropriate indication for catheterisation
- Consider if intermittent self-catheterisation could be used as an alternative to an indwelling urinary catheter.
- If catheterising is due to a high residual, only catheterise if symptomatic and the residual is over 400ml.

3.2 Catheter insertion

- All Health Care Professionals who carry out Male, Female, Suprapubic and Intermittent catheter insertion must be trained and competent to carry out the procedure. Competencies can be found in the FNHC Adult District Nurse Professional Portfolio and Skills Passport (Appendix 2) for:
    - Male Urethral catheterisation

- Supra-pubic catheterisation
- Female Catheterisation

- FNHC staff must adhere to the Standard Operating Procedures (SOP) (Appendix 3) which are included in this guideline and based on the Royal Marsden Manual of Clinical and Cancer Nursing Procedures https://www.rmmonline.co.uk/

  SOP 2 unsuccessful re-catheterisation

  SOP 3 Procedure for Male catheterisation

  SOP 4 Procedure for Female catheterisation

  SOP 5 Procedure for Intermittent catheterisation

  SOP 6 Procedure for Supra-Pubic Catheterisation

Further guidance can be found on https://www.clinicalskills.net/ for:

- Male indwelling urethral catheterisation
- Female indwelling urethral catheterisation
- Intermittent self-catheterisation
- Changing a suprapubic catheter
- Administering a catheter maintenance solution
- Catheter care
- Emptying an indwelling urinary catheter bag
- Catheter specimen of urine
- Trial removal of a urinary catheter

4. CONSULTATION PROCESS

Identify who has been involved and when including service users and partner agencies

Name	Title	Date
Lucy Henderson	Urology & Continence Lead Nurse HCS	16.12.2020
Tracey Blackmore	Uro-oncology CNS HCS	No response
Rui Cassenje	Urology Clinical Practitioner HCS	No response
Ben Hughes	Consultant Urologist HCS	16.12.2020
Karkala Pai	Associate Specialist HCS	11.12.2020
Gilly Glendewar	CNS Tissue Viability FNHC	11.12.2020
Elspeth Snowie	Clinical Effectiveness Facilitator FNHC	14.12.2020
Sandra Lamb	Community Staff Nurse	21.12.2020
Tim Hill	Practice Development Sister	No response
Judy le Marquand	Practice Development Sister Jersey Hospice Care	No response
Adam Leversuch	Specialist pharmacist for antimicrobials and palliative care.	21.12.2020
Kirstie Ross	Associate Specialist HCS	11.12.2020
Michelle Margetts	Team Leader FNHC	No response
Angela Stewart	Team Leader FNHC	No response
Jessica Clarke	Team leader FNHC	No response
Joanna Champion	Team leader FNHC	No response
Louise Hamilton	Team leader RRR FNHC	No response
Liliana Opinca	Care Manager -Jersey Cheshire Home	No response
Jayne Durance	Emergency Department Sister	No response
Justine Bell	Education lead FNHC	No response
Tia Hall	Operational Lead Adult Services	11.12.2020

5. IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Roll out to staff via 7 minute briefings	Fiona Le Ber	6 weeks

6. MONITORING COMPLIANCE

Effectiveness in practice will be monitored through competencies and audit.

7. EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity
- ✓ Work as a team

This guideline should be read and implemented with the Organisational Values in mind at all times. See appendix 19 for the Equality Impact Assessment for this guideline.

8. GLOSSARY OF TERMS

Adenocarcinoma

A cancerous tumour developing from the glandular component of any organ (in urology, this usually applies to the prostate or kidney)

Alpha-blocker

A drug which relaxes the muscle of the bladder neck & prostate to improve symptoms of urinary obstruction; formerly used to relax the ureter and encourage the passage of stones although the drug is no longer routinely used for this

Antiandrogen

A drug that blocks the effects of the male hormone (testosterone), often used in the treatment of prostate cancer

Acute urinary retention (ARU)

A medical emergency characterised by the abrupt development of the inability to pass urine (over a period of hours)

Urinary retention is the inability to voluntarily urinate. It may be secondary to urethral blockage, drug treatment (such as use of antimuscarinic drugs, sympathomimetics, tricyclic antidepressants), conditions that reduce detrusor contractions or interfere with relaxation of the urethra, neurogenic causes, or it may occur postpartum or postoperatively.

Balanitis

Inflammation / infection of the tip of the penis

Benign prostatic hyperplasia (BPH)

Benign enlargement of the prostate gland, invariably seen with increasing age

Bladder cancer (TCC)

A tumour which develops in the internal lining of the bladder wall; usually a malignant transitional cell carcinoma (TCC)

Brachytherapy

A type of radiotherapy where radioactive seeds are implanted directly into an organ, usually the prostate gland

Catheter Associated Urinary Tract Infection (CAUTI)

A symptomatic infection of the bladder or kidneys in a person with a urinary catheter, it is the most prevalent healthcare associated infection (HAI)

The longer a catheter is in place, the more likely bacteria will be found in the urine; after 1 month nearly all people have bacteriuria

•Chordee

A deformity of the penis which results in a bending on erection

Cystoscopy

Inspection of the bladder using a telescope (either flexible or rigid) with an attached light source to illuminate the interior of the bladder

Detrusor muscle

The interlocking muscle fibres which form the bladder wall, allowing the bladder to contract and empty itself of urine

Dysuria

Painful passage of urine

Frenulum

The thin bridge of skin on the under-surface of the penis joining the head of the penis to the inside of the foreskin

Haematuria

Blood in the urine

Nocturia

Abnormal passage of urine at night

Overactive bladder (OAB)

A condition caused by involuntary bladder contractions during filling which cannot be suppressed

Overflow incontinence

Leakage of urine from a bladder which is permanently full. Also known as chronic retention with overflow

Paraphimosis

Retraction of a tight foreskin which becomes "stuck" due to an inability to return it to its original position covering the head of the penis

Phimosis

Tightness of the foreskin, either due to a scarring disease or as a result of a congenital abnormality

Prostate

A chestnut-sized organ lying at the bottom of the bladder which produces chemicals to nourish sperms and facilitate their transport to the female uterus

Prostatectomy

Removal of the prostate gland by telescopic or open surgery

Prostate-specific antigen (PSA)

A chemical released into the bloodstream by the prostate gland which may be raised in men with prostate cancer

Purple bag syndrome (PUBS)

Uncommon presentation in patients with indwelling foley catheters. It is most frequently caused by an underlying urinary tract infection The urine is actually a dark brown color, but interaction with the plastic bag and tubing turns them into a bright purple .The

discoloration of the bag denotes the presence of an infection, but by itself is generally a benign process

Stricture

Abnormal scarring or narrowing of a hollow tube

Transurethral resection (TUR)

Usually of the prostate gland (TURP) or of a tumour in the bladder (TURBT)

Trial without catheter (TWOC)

Removal of a catheter from the bladder to re-establish normal passage of urine

https://www.baus.org.uk/patients/glossary/

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10. APPENDIX

Appendix 1 Male Urethral Catheterisation Competency

Assessment Criteria Stage	Self-Assessment Date Signature	Formative Assessment Date Signature	Final Assessment Date Signature
Performance indicator	**Stage achieved**	**Stage achieved**	**Stage achieved**
1. Preparation			
Introduces self to the patient, explains and discuss the procedure with them, and gains their consent to proceed. Offers a chaperone.			
Ensures curtains / blinds and doors are closed			
Undertakes hand hygiene			
Prepares work surface, cleans box lid with Clinell wipe			
Assists the patient to get into the supine position with the legs extended on the bed.			
Removes patient's underwear/pyjama trousers.			
Places a towel over the patient's thighs and genital area.			
Ensures that a good light source is available.			
Washes hands using soap and water			
Puts on a disposable apron			
Opens the outer cover of the catheterisation pack and slides the pack on the box lid.			
Using an aseptic technique, opens sterile pack, pours 0.9% sodium chloride into gallipot and opens appropriately sized catheter and places it on sterile field.			
Removes cover from the patient's genital area and maintaining the patient's privacy positions a disposable procedure sheet under the patient's buttocks and thighs			

2. Removal of Catheter if in situ			
Applies non-sterile gloves prior to removal of catheter.			
Deflates balloon and gently removes catheter			
Examines tip of catheter for encrustation.			
Following removal of catheter and gloves, cleans hands with a bactericidal alcohol hand rub.			
3. Catheterisation Procedure			
If there is no catheter to remove - undertakes hand hygiene.			
Puts on sterile gloves			
Places sterile towels under the patient's buttocks.			
With one hand, wraps a sterile topical swab around the penis and uses this to retract the foreskin.			
If necessary and using the other hand, cleans the glans penis with 0.9% sodium chloride.			
Inserts the nozzle of the lubricating jelly into the urethra and squeezes the gel into the urethra before removing the nozzle and discarding the tube.			
Massages the gel along the urethra using the barrel of the syringe.			
Waits 5 minutes to give anaesthetic gel time to take effect			
Removes gloves, cleans hands with a bactericidal alcohol hand rub and applies new pair of sterile gloves.			
Applies sterile field around the penis			
With one hand, holds the penis firmly behind the glans raising it until it is almost totally extended and maintains this hold of the penis until the catheter is inserted and urine flowing.			

With the free hand, places the receiver containing the catheter between the patient's legs.			
Takes the catheter and insert it into the penis for 15–25 cm until urine flows.			
If resistance is felt at the external sphincter, increases the traction on the penis slightly, applies steady, gentle pressure on the catheter and asks the patient to cough gently.			
When urine begins to flow, advances the catheter almost to its bifurcation (where the catheter branches into two parts).			
Gently inflates the balloon according to the manufacturer's direction having ensured that the catheter is draining properly beforehand.			
Withdraws the catheter slightly and attaches it to the drainage system.			
Supports the catheter, by using a specially designed support such as the Simpla GStrap.			
Ensures that the catheter is supported in such a way that it will not become taut when patient is mobilising.			
Ensures that the catheter lumen is not occluded by the fixation device or tape.			
Ensures that the glans penis is clean and dry and then extends the foreskin.			
Ensures that the area is dry and removes and disposes of procedure sheet from under patient.			
Assists the patient to replace underwear and clothing and replaces bed cover			
Measures the amount of urine.			
If required, takes a urine specimen for laboratory examination, following advice in guideline.			
Disposes of equipment, including apron and gloves, in a plastic waste bag and seals the bag.			
Disposes of waste bag in a larger bin.			
Washes hands thoroughly with soap and water.			
Completes all documentation			

Competency Achieved

Date……

Assessors signature……

Nurse Signature……

Appendix 2 Supra Pubic Catheterisation Competency

Assessment Criteria Stage	Self-Assessment Date Signature	Formative Assessment Date Signature	Final Assessment Date Signature
Performance indicator Stage 1: Technical skills	**Stage achieved**	**Stage achieved**	**Stage achieved**
1. Preparation for the procedure			
Introduces self to the patient, explains and discuss the procedure with them, and gains their consent to proceed. Offers a chaperone.			
Ensures curtains / blinds and doors are closed			
Undertakes hand hygiene prior to preparing work surface/assisting patient			
Prepares work surface, cleans box lid/trolley with Clinell wipe			
Assists the patient to get into the supine position with the legs extended on the bed.			
Places a towel over the patient's thighs and abdomen.			
Ensures that a good light source is available.			
Washes hands using soap and water or bactericidal hand-rub			
Puts on a disposable apron			
Opens the outer cover of the catheterisation pack and slides the pack on the box lid/top shelf of trolley.			
Using an aseptic technique, opens sterile pack, pours 0.9% sodium chloride into gallipot and opens appropriately sized catheter and places it on sterile field.			
Removes towel/cover and maintaining the patient's privacy positions a disposable procedure sheet under the patient's buttocks and thighs			
2. Removal of catheter			
Applies non-sterile gloves prior to removal of catheter.			

Applies anaesthetic gel around the catheter entry site.			
Deflates balloon and with gauze tied around the catheter to mark the length, gently removes catheter.			
Holds the gauze tie in position and lays the removed catheter on the edge of the sterile field.			
Cleans around catheter site to remove any exudate.			
Examines tip of catheter for encrustation.			
Following removal of catheter and gloves, cleans hands with a bactericidal alcohol hand rub.			
3. Catheterisation			
Lubricates cystostomy site with a sterile gel which is licensed for supra-pubic use e.g. Instillagel.			
Undertakes hand hygiene			
Puts on sterile gloves			
Places the catheter, in the sterile receiver, on the patient's legs/thighs			
Inserts new catheter as quickly as possible after comparing the insertion length to the old catheter			
Checks that the urine is draining satisfactorily			
Inflates the balloon according to the manufacturer's directions			
Withdraws the catheter slightly			

Connects catheter to the drainage system			
3. Post Catheter insertion			
Supports the catheter, by using a specially designed support such as the Simpla GStrap			
Ensures that the catheter is supported in such a way that it will not become taut when patient is mobilising.			
Ensures that the catheter lumen is not occluded by the fixation device or tape.			
Ensures that the area is dry and removes and disposes of procedure sheet from under patient.			
Assists the patient to replace clothing and where applicable replaces bed cover			
Measures the amount of urine			
If required, takes a urine specimen for laboratory examination, following advice in guideline			
Disposes of equipment, including apron and gloves, in a plastic waste bag and seals the bag.			
Disposes of waste bag in a larger bin			
Washes hands thoroughly with soap and water			
Completes all documentation			

Competency Achieved

Date…….

Assessors signature…….

Nurse Signature……..

Appendix 3 Female Catheterisation Competency

Assessment Criteria Stage	Self-Assessment Date Signature	Formative Assessment Date Signature	Final Assessment Date Signature
Performance indicator	**Stage achieved**	**Stage achieved**	**Stage achieved**
1. Preparation			
Introduces self to the patient, explains and discuss the procedure with them, and gains their consent to proceed. Offers a chaperone.			
Ensures curtains / blinds and doors are closed			
Undertakes hand hygiene prior to preparing work surface/assisting patient			
Prepares work surface, cleans box lid with Clinell wipe			
Assists the patient to get into the supine position with the legs extended on the bed.			
Removes patient's underwear.			
Assists patient to get into the supine position with knees bent, hips flexed and feet resting about 60 cm apart.			
Places a towel over the patient's thighs and genital area.			
Ensures that a good light source is available.			
Washes hands using soap and water			
Puts on a disposable apron			
Opens the outer cover of the catheterisation pack and slides the pack on the box lid.			
Using an aseptic technique, opens sterile pack, pours 0.9% sodium chloride into gallipot and opens appropriately sized catheter and places it on sterile field.			
Removes cover from the patient’s genital area and maintaining the patient’s privacy positions a disposable procedure sheet under the patient’s buttocks and thighs			

2. Removal of Catheter if in situ			
Applies non-sterile gloves prior to removal of catheter.			
Deflates balloon and gently removes catheter			
Examines tip of catheter for encrustation.			
Following removal of catheter and gloves, cleans hands with a bactericidal alcohol hand rub.			
3. Catheterisation Procedure			
If there is no catheter to remove - undertakes hand hygiene.			
Puts on sterile gloves			
Places sterile towels under the patient's buttocks.			
Using gauze swabs, separates the labia minora so that the urethral meatus is seen.			
Cleans around the urethral orifice with 0.9% sodium chloride using single downward strokes.			
Places a small amount of the anaesthetic gel onto the tip of the catheter, then inserts the nozzle of the lubricating jelly into the urethra and squeezes the gel into the urethra before removing the nozzle and discarding the tube.			
Waits 5 minutes to give anaesthetic gel time to work			
Removes gloves, cleans hands with a bactericidal alcohol hand rub and applies new pair of sterile gloves.			
Places the catheter, in the sterile receiver, between the patient's legs			
Introduces the tip of the catheter into the urethral orifice in an upward and backward direction.			
Advances the catheter until 5–6 cm has been inserted.			
If there is no urine present, removes the catheter gently and starts procedure again.			
If urine is present, advances the catheter 6–8 cm			

Inflates the balloon according to the manufacturer's directions having ensured that the catheter is draining adequately			
Withdraws the catheter slightly			
Connects catheter to the drainage system			
4. Post procedure			
Supports the catheter, by using a specially designed support such as the Simpla GStrap.			
Ensures that the catheter is supported in such as way that it will not become taut when patient is mobilising.			
Ensures that the catheter lumen is not occluded by the fixation device or tape.			
Ensures that the area is dry and removes and disposes of procedure sheet from under patient.			
Assists the patient to replace underwear and clothing and replaces bed cover			
Measures the amount of urine.			
If required, takes a urine specimen for laboratory examination, following advice in guideline.			
Disposes of equipment, including apron and gloves, in a plastic waste bag and seals the bag.			
Disposes of waste bag in a larger bin.			
Washes hands thoroughly with soap and water.			
Completes all documentation			

Competency Achieved

Date…….

Assessors signature…….

Nurse Signature……..

Appendix 4 Standard Operating Procedures (SOP) for Catheterisation

SOP 1 Assessing the Need for Catheterisation

Purpose

To ensure that urinary catheterisation is only used as a last resort

Scope

All adult patients where there is an indication for urinary catheterisation.

Core Requirements

- Only consider a urinary catheter as a last resort when catheter use is unavoidable.
- Ensure there is an appropriate indication for catheterisation
- Consider if intermittent self-catheterisation could be used as an alternative to an indwelling urinary catheter.
- If catheterising is due to a high residual, only catheterise if symptomatic and the residual is over 400ml.

SOP 2 Unsuccessful re-catheterisation

Purpose

To provide a pathway for the safe management of patients following unsuccessful re-catheterisation

Scope

All adult patients where re-catheterisation has been unsuccessful following a maximum of two attempts

Core Requirements

- A maximum of two attempts at catheterising should be undertaken (RCN 2008) using the size of catheter that was initially in situ.
- Following this, contact your Team Leader or, where appropriate, the on call surgical team at the Jersey General Hospital (see appendix 12- *FNHC nursing management of patients with urinary catheter related problems pathway)*
- Advise the patient to attend the Emergency Department at Jersey General Hospital.
- The patient must be sent to the Emergency Department with a spare catheter and a Home to Hospital Catheter Liaison letter. (Appendix 13)

SOP 3 Procedure for Male Catheterisation

Purpose

To provide a safe, effective and standardised procedure for undertaking urinary catheterisation

Scope

All adult male patients where urethral catheterisation is indicated.

Core Requirements

Assemble all necessary equipment **Equipment**

required:

- Sterile catheterisation pack containing galipots, receiver, low linting swabs, disposable towels.
- Gloves x 3 pairs (2 sterile) (1 non-sterile)
- Sterile catheter that has been previously selected
- Sterile anaesthetic/ lubricating gel (6mls for female; 11mls for male and supra-pubic)
- Universal specimen container – if CSU required + syringe and sterile needle
- Bactericidal alcohol hand rub
- Disposable bed pad/procedure sheet
- 0.9% sodium Chloride for cleaning meatus
- Sterile water, and syringe if catheter not pre-filled (+ sterile syringe for deflating balloon)
- Disposable plastic apron Catheter retaining strap/sleeve Drainage bag/valve.
- Community Adult Client Held Records(CACHR) and appropriate documentation

Action	Rationale
Introduce yourself to the patient, explain and discuss the procedure with them, and gain their consent to proceed. Offer a chaperone.	To ensure that the patient feels at ease, understands the procedure and gives their valid consent
Ensure curtains / blinds and doors are closed	To ensure patient's privacy.

Action	Rationale
Prepare work surface, clean box lid with clinell wipe	Lid of box acts as a clean working surface.
Assist the patient to get into the supine position with the legs extended on the bed.	To ensure the appropriate area is easily accessible.
Remove underpants or pyjama trousers and use a towel to cover the patient's thighs and genital area.	To maintain patient's dignity and comfort
Wash hands using bactericidal soap and water .	To reduce risk of infection (Fraise and Bradley).
Put on a disposable plastic apron.	To reduce risk of cross infection from micro-organisms on uniform (Fraise and Bradley).
Open the outer cover of the catheterization pack and slide the pack onto the box lid.	To prepare equipment
Using an aseptic technique, open the sterile/catheter pack. Pour 0.9% sodium chloride into galipot. Open an appropriately sized catheter onto the sterile field.	To reduce the risk of introducing infection into the bladder (NICE,).
Remove cover from the patient's genital area, maintaining the patient's privacy, and position a disposable procedure sheet under the patient's buttocks and thighs.	To ensure urine does not leak onto bedclothes
Clean hands with a bactericidal alcohol hand rub.	Hands may have become contaminated by handling the outer packs
Put on sterile gloves.	To reduce risk of cross infection
On the sterile field, place the catheter into the sterile receiver with drainage bag attached.	To ensure a closed system, minimizing the infection risk
Place a sterile towel across the patient's thighs.	To create a sterile field.
With one hand, wrap a sterile topical swab around the penis. Use this to retract the foreskin, if necessary, and with the other hand clean the glans penis with 0.9% sodium chloride or sterile water.	To reduce the risk of introducing infection to the urinary tract during catheterisation.

Confirm patient's allergy status first. If no allergies to products exist, then insert the nozzle of the local anaesthetic or lubricating gel into the urethra. Squeeze the gel into the urethra and withdraw the nozzle, being sure not to touch the penis with your dominant hand. Wait 2 to 5 minutes (as per manufacturer's instructions)..	Adequate lubrication helps to prevent urethral trauma. Use of a local anaesthetic minimizes the discomfort experienced by the patient .To allow the anaesthetic gel to take effect
Squeeze the penis and wait approximately 5 minutes.	To prevent anaesthetic gel from escaping. To allow the anaesthetic gel to take effect.
With one hand hold the penis firmly behind the glans raising it until it is almost totally extended. Maintain this hold of the penis until the catheter is inserted and urine flowing.	This manoeuvre straightens the penile urethra and facilitates catheterization Maintaining a grasp of the penis prevents contamination and retraction of the penis.
With the free hand, place the receiver containing the catheter between the patient's legs. Take the catheter and insert it into the penis for 15–25 cm until urine flows.	The male urethra is approximately 18 cm long
If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to cough gently.	Some resistance may be due to spasm of the external sphincter. Coughing gently helps to relax the external sphincter.
When urine begins to flow, advance the catheter almost to its bifurcation (where the catheter branches into two parts)..	Advancing the catheter ensures that it is correctly positioned in the bladder.
Gently inflate the balloon according to the manufacturer's direction having ensured that the catheter is draining properly beforehand.	Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma
Withdraw the catheter slightly and attach it to the drainage system.	To ensure that the balloon is inflated and the catheter is secure.
Support the catheter, by using a specially designed support, for example Simpla Gstrap. Ensure that the catheter does not become taut when patient is mobilizing or when the penis becomes erect. Ensure that the catheter lumen is not occluded by the fixation device or tape	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken in using adhesive tapes as they may interact with the catheter material

Ensure that the glans penis is clean and dry and then extend the foreskin.	Retraction and constriction of the foreskin behind the glans penis (paraphimosis) may occur if this is not done
Assist the patient to replace underwear and pyjamas and replace bed cover. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed
If required, take a urine specimen for laboratory examination follow advice in guideline	
Dispose of equipment including apron and gloves in an plastic waste bag and seal the bag Dispose of clinical waste bag in a larger bin	To prevent environmental contamination
Wash hands thoroughly with bactericidal soap and water.	To reduce risk of infection
Complete all documentation	To provide a point of reference or comparison in the event of later queries

SOP 4 Procedure for Female Catheterisation

Purpose

To provide a safe, effective and standardised procedure for undertaking urinary catheterisation

Scope

All adult female patients where urethral catheterisation is indicated.

Core Requirements

Assemble all necessary equipment **Equipment required:**

- Sterile catheterisation pack containing galipots, receiver, low linting swabs, disposable towels.
- Gloves x 3 pairs (2 sterile) (1 non-sterile)
- Sterile catheter that has been previously selected
- Sterile anaesthetic/ lubricating gel (6mls for female; 11mls for male and supra-pubic)
- Universal specimen container – if CSU required + syringe and sterile needle
- Bactericidal alcohol hand rub
- Disposable bed pad/procedure sheet
- 0.9% sodium Chloride for cleaning meatus
- Sterile water, and syringe if catheter not pre-filled (+ sterile syringe for deflating balloon)
- Disposable plastic apron Catheter retaining strap/sleeve
- Drainage bag/valve.

Action	Rationale
Introduce yourself to the patient, explain and discuss the procedure with them, and gain their consent to proceed. Offer a chaperone.	To ensure that the patient feels at ease, understands the procedure and gives their valid consent
Ensure curtains / blinds and doors are closed	To ensure patient's privacy.
Prepare work surface, clean box lid with Clinell wipe	Lid of box acts as a clean working surface.
Assist the patient to get into the supine position with the legs extended on the bed.	To ensure the appropriate area is easily accessible.

Action	Rationale
Remove patient's underwear. Assist patient to get into the supine position with knees bent, hips flexed and feet resting about 60 cm apart.	To enable genital area to be seen
Place a towel over the patient's thighs and genital area.	To maintain the patient's dignity and comfort
Ensure that a good light source is available.	To enable genital area to be seen clearly.
Wash hands using l soap and water or alcohol-based handrub. Apply personal protective equipment.	To reduce risk of cross infection
Open the outer cover of the catheterization pack and slide the pack on the top of clean box lid	To prepare equipment
Using an aseptic technique, open sterile pack. Then open appropriately sized catheter. On the sterile field, place the catheter into the sterile receiver	To reduce risk of introducing infection into the urinary tract.
Remove towel, maintaining the patient's privacy, and position a disposable pad under the patient's buttocks.	To ensure urine does not leak onto bedclothes.
Clean hands with a bactericidal alcohol handrub.	Hands may have become contaminated by handling of outer packs, and so on
Put on sterile gloves.	To reduce risk of cross infection (NICE).
Place sterile towels under the patient's buttocks.	To create a sterile field.
Using gauze swabs, separate the labia minora so that the urethral meatus is seen. One hand should be used to maintain labial separation until catheter is inserted and urine flowing.	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter.
Clean around the urethral orifice with swabs soaked with 0.9% sodium chloride using single downward strokes, being careful not to touch the surrounding skin	To clean the urethra orifice and thereby reduce the risk of CAUTI

Place a small amount of the lubricating jelly/anaesthetic gel onto the tip of the catheter. Apply anaesthetic lubrication to the meatus and then insert the nozzle of the syringe into the urethra and instil gel into the urethra, being careful not to touch the surrounding skin	Adequate lubrication helps to prevent urethral trauma. Use of a local anaesthetic minimizes the patient's discomfort
Place the catheter, in the sterile receiver, between the patient's legs attach the drainage bag.	To ensure a closed system, minimizing infection risk
Using your dominant hand, introduce the tip of the catheter into the urethral orifice in an upward and backward direction. If the meatus is difficult to identify, this may be due to vaginal atrophy Advance the catheter until urine is draining and up to the bifurcation (where the catheter branches into two parts).)	The direction of insertion and the length of catheter inserted should relate to the anatomical structure of the area.
If there is no urine present, check that the catheter has not accidentally been inserted into the vagina. If the urethral meatus is clearly visible, consider removing the catheter and reattempting the procedure with a second sterile catheter.	This prevents repeated misplacement of the catheter
Inflate the balloon according to the manufacturer's directions having ensured that the catheter is draining adequately.	Inadvertent inflation of the balloon within the urethra is painful and causes urethral trauma
Withdraw the catheter slightly so that the balloon is sitting at the bladder neck	To ensure that the balloon is inflated and the catheter is secure.
Support the catheter, by using a specially designed support, for example Simpla Gstrap. Ensure that the catheter does not become taut when patient is mobilizing. Ensure that the catheter lumen is not occluded by the fixation device or tape.	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken when applying securing devices to ensure these do not interfere with the drainage of the catheter by being applied too tightly. Leg straps must not impair circulation

Assist the patient to replace her underwear and clothing, feeding the catheter down the leg. Replace the bedcovers and ensure that the area is dry.	So that the catheter it is not occluded by clothing or tight underwear and is aided to drain by gravity. If the area is left wet or moist, secondary infection and skin irritation may occur
Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance if clinically indicated. It is not necessary to measure the amount of urine if the patient is having a routine catheter change
If required, take a urine specimen for laboratory examination, following advice in guideline.	
Dispose of equipment including apron and gloves in a plastic waste bag and seal the bag. Dispose of waste bag in a larger bin.	To prevent environmental contamination. To reduce the risk of infection
Wash hands thoroughly with soap and water.	To reduce risk of infection
Record information in relevant documents; this should include: reasons for catheterization date and time of catheterization catheter type, length and size amount of water instilled into the balloon batch number and manufacturer any problems negotiated during the procedure a review date to assess the need for continued catheterisation or date of change of catheter	To provide a point of reference or comparison in the event of later queries

SOP 5 Procedure for Intermittent Catheterisation

Purpose

To provide a safe, effective and standardised procedure for undertaking intermittent catheterisation

Scope

All adult patients where intermittent catheterisation is indicated.

Core Requirements

Assemble all necessary equipment

Equipment required:

•Personal protective equipment

•Appropriately sized intermittent catheter

•Lubricating gel if using a non-coated catheter

Optional equipment:

•Suitable container (clean jug or receiver) if required

•Mirror if required

Action	Rationale
Introduce yourself to the patient, explain and discuss the procedure with them, and gain their consent to proceed. Offer a chaperone.	To ensure that the patient understands the procedure and gives his valid consent
Ensure curtains / blinds and doors are closed	To ensure patient's privacy.
Prepare work surface, clean box lid with Clinell wipe	Lid of box acts as a clean working surface.
Assist the patient to get into the supine position with the legs extended on the bed.	To ensure the appropriate area is easily accessible.
Remove patient's underwear. Assist patient to get into the supine position with knees bent, hips flexed and feet resting about 60 cm apart.	To enable genital area to be seen
Place a towel over the patient's thighs and genital area.	To maintain the patient's dignity and comfort (NMC).
Ensure that a good light source is available.	To enable genital area to be seen clearly.
Wash hands using soap and water or bactericidal alcohol hand rub.	To reduce risk of cross infection (Fraise and Bradley).

Action	Rationale
Put on a disposable apron.	To reduce risk of cross infection from microorganisms on uniform
Open catheter packaging or container. If using an uncoated catheter, a water soluble lubricating gel may be applied to the surface of the catheter.	To prepare catheter and to ease insertion
Hold the catheter with the dominant hand, being careful not to touch the part of the catheter entering the body, and gently insert it into the opening of the urethra. Advance the catheter into the bladder.	
Drain the urine into the toilet or suitable container. When the urine stops flowing, slowly remove the catheter, halting if more urine starts to flow.	To ensure that the bladder is completely emptied.
Assist the patient to replace underwear and pyjamas and replace bed cover. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed
If required, take a urine specimen for laboratory examination, following advice in guideline.	
Dispose of equipment including apron and gloves in a plastic waste bag and seal the bag. Dispose of waste bag in a larger bin.	To prevent environmental contamination.
Wash hands thoroughly with soap and water.	To reduce risk of infection (Fraise and Bradley
Complete all documentation	To provide a point of reference or comparison in the event of later queries

SOP 6 Procedure for Supra-Pubic Catheterisation

Purpose

To provide a safe, effective and standardised procedure for undertaking suprapubic catheterisation

Scope

All adult patients where supra-pubic catheterisation is indicated

Core Requirements

Assemble all necessary equipment

Equipment required:

- Sterile catheterisation pack containing galipots, receiver, low linting swabs, disposable towels.
- Gloves x 3 pairs (2 sterile) (1 non-sterile)
- Sterile catheter that has been previously selected
- Sterile anaesthetic/ lubricating gel (6mls for female; 11mls for male and suprapubic)
- Universal specimen container – if CSU required + syringe and sterile needle
- Bactericidal alcohol hand rub
- Disposable bed pad/procedure sheet
- 0.9% sodium Chloride for cleaning meatus
- Sterile water, and syringe if catheter not pre-filled (+ sterile syringe for deflating balloon)
- Disposable plastic apron Catheter retaining strap/sleeve
- Drainage bag/valve.

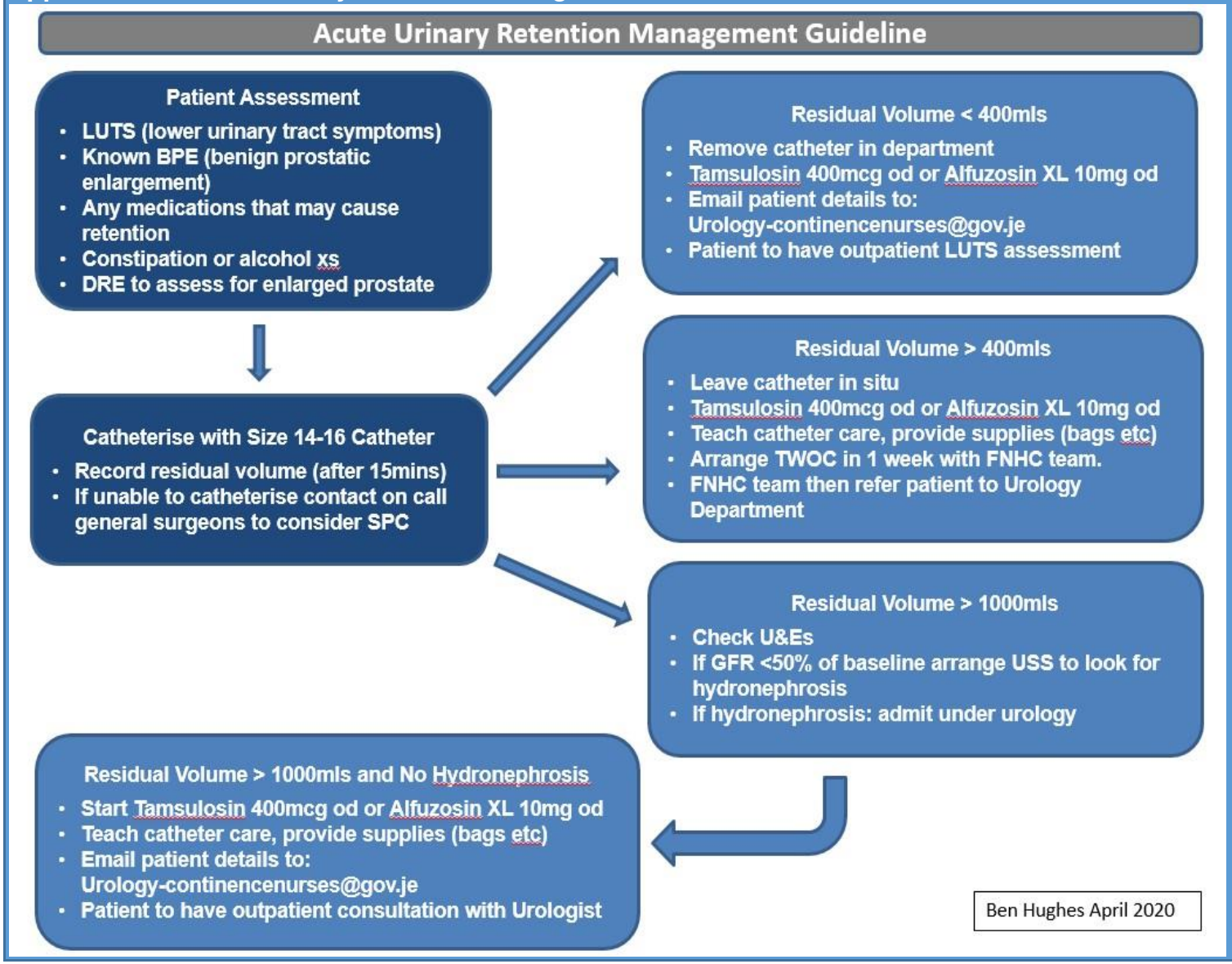
Action	Rationale
Introduce yourself to the patient, explain and discuss the procedure with them, and gain their consent to proceed. Offer a chaperone.	To ensure that the patient feels at ease, understands the procedure and gives their valid consent
Ensure curtains / blinds and doors are closed	To ensure patient's privacy.
Prepare work surface, clean box lid with Clinell wipe	Lid of box acts as a clean working surface.
Assist the patient to get into the supine position with the legs extended on the bed.	To ensure the appropriate area is easily accessible.

Action	Rationale
Place a towel over the patient's thighs and abdomen.	To maintain the patient's dignity and comfort
Ensure that a good light source is available.	To enable area to be seen clearly.
Wash hands using soap and water or bactericidal alcohol handrub.	To reduce risk of cross infection
Put on a disposable apron.	To reduce risk of cross infection from microorganisms on uniform
Open the outer cover of the catheterization pack and slide the pack on the top shelf of the trolley.	To prepare equipment
Using an aseptic technique, open sterile pack. Then open appropriately sized catheter and place on sterile field.	To reduce risk of introducing infection into the urinary tract.
Remove towel, maintaining the patient's privacy, and position a disposable pad under the patient's buttocks.	To ensure urine does not leak onto bedclothes.
Clean hands with a bactericidal alcohol handrub.	Hands may have become contaminated by handling of outer packs, and so on
Put on sterile gloves.	To reduce risk of cross infection
Place sterile towels over the patient's abdomen.	To create a sterile field.
Apply anaesthetic gel around catheter Tie a piece of gauze around the existing catheter close to the abdominal wall and then deflate the balloon of the catheter	To allow removal of catheter and maintain comfort of patient.
Place fingers as close to the skin as possible and remove existing catheter, holding the gauze in position. Lay removed catheter on edge of sterile field.	To ensure the correct length is reinserted.
Clean around catheter site to remove any exudate	To minimise risk of introducing infection during catheter insertion.
Lubricate cystostomy site with a sterile gel which is licensed for supra- pubic use e.g. instillagel	To cleanse the tract and maintain patency.
Remove gloves, decontaminate hands	To reduce cross infection
Put on sterile gloves	To eliminate risk of contamination to new catheter.
Insert new catheter as quickly as possible after comparing the insertion length to the old catheter	To keep tract open. Use the gauze, wrapped around the new catheter to match the old assists this process.

Check that the urine is draining satisfactorily.	
Inflate balloon according to manufacturer's instructions.	To retain urinary catheter in the bladder.
Withdraw the catheter slightly and connect it to the drainage system.	To ensure that the balloon is inflated and the catheter is secure.
Support the catheter, by using a specially designed support, for example Simpla Gstrap. Ensure that the catheter does not become taut when patient is mobilizing. Ensure that the catheter lumen is not occluded by the fixation device or tape.	To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. Care must be taken in using adhesive tapes as they may interact with the catheter material
Assist the patient to replace clothing. Ensure that the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur
Measure the amount of urine.	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance. It is not necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed
If required, take a urine specimen for laboratory examination, following advice in guideline.	
Dispose of equipment including apron and gloves in a plastic waste bag and seal the bag. Dispose of waste bag in a larger bin.	Prevent environmental contamination.
Wash hands thoroughly with soap and water.	To reduce risk of infection

All Standard Operating procedures based on guidance from https://www.rmmonline.co.uk/

Appendix 5 – Acute Urinary Retention Management Guideline



Family Nursing & Home Care

Appendix 6 COMMUNITY CATHETER RECORD

Name .....

D.O.B .....

Date / Time			
Informed consent obtained			
Reason for Change			
Catheter details			
ype of catheter – including manufacturer, material batch number and expiry date			
size and length of catheter			
volume of sterile water used in the balloon lot / expiry date			
antimicrobial catheter balloon inflation solution if used Lot/Expiry date			

Meatal Cleansing Solution Lot/ Exp			
Sterile anaesthetic/lubricating gel used Lot/ Expiry Date			
name, size and type of drainage system used			
Problems encountered at the time of the procedure, including difficulties specific to the individual			
Planned date of next review and catheter change / removal.			
Ongoing care instructions given to the patient or carer			
Catheter passport completed /			
Catheter Assessment tool Score			
Name of the person inserting or changing the catheter			

Appendix 7 – Urinary Catheter Passport

Complications and problem solving

Catheters that are not draining or are draining slowly

-Check that the catheter or tubing is not kinked
-Check that the drainage bag is below the level of the bladder
-Check that there is no tension on the catheter
-Check that the urine bag is not over full
-Check to make sure that the patient is not constipated
-Check for signs of infection and treat if appropriate
-The urothelium may get sucked into eyelets of the catheter preventing the flow of urine. raise the level of the drainage bag above the level of the bladder briefly. This may release the vacuum and allow the urine to drain freely again.
-If the blocking pattern has been established, plan a date for the next change of catheter at an earlier interval.

Encrustation

-If severe, check for bladder calculi / refer to urology

Bypassing

Explore the possibility of bladder irritation. Signs of this would be bypassing of urine preceded by an urge to void. If this is the case consider:
-Increasing fluid intake.
-Checking for infection
-Catheter support
-Replacing the catheter with a smaller size (urethral catheter)
-Discussing the possibility of anticholinergic/ ant muscarinic medication with GP

Haematuria

-Small amounts of blood can be caused by trauma, check that the catheter is properly secured and that leg bag is being emptied at half full.
-Large amounts of blood –patient should attend ED

Catheter expelled

-Review the need for indwelling catheter and consider appropriate alternative , for example intermittent catheterisation, uro-sheath, body worn pads.
-Consider bladder spasm

The balloon does not deflate when the catheter is being changed

-Try a different syringe, leave in place for a while
-Check for constipation and, if present, relieve.
-"Milk" the catheter along its length
-Try inflating up to an extra 1mL of sterile water into balloon
-Never attempt to burst the balloon and never cut the end of the catheter

Difficulty in removing existing supra pubic catheter

-If the catheter is difficult to remove, consider re-inflating the balloon with 1-2mls of sterile water and attempt to remove the catheter slowly.
-Apply lubricant, maintain traction, gently rotate catheter while asking the patient to bear down.
-Allow the bladder to fill then attempt removal
-To avoid recurrence consider an alternative catheter material, for example hydrogel coated
-If unable to remove the catheter, contact surgical registrar on call via hospital switchboard as per policy.

The use of catheter washouts may increase the production of debris and are not

Government of JERSEY

Family Nursing & Home Care

Urinary Catheter Passport

Name:.....

D.O.B:.....

URN No: .....

Please keep this passport with you and share it with other professionals

Purpose of the catheter passport

This passport is for you and/or anyone else involved in the care of your catheter. The information in it will ensure healthcare professionals have the right information about your catheter.

Good management of your catheter could improve your quality of life. Catheters significantly increase the risk of urinary tract infections (UTIs) and these can seriously affect your general health and wellbeing. Catheters are only inserted if there is a medical need. They must not be inserted at the request of a patient/family member alone.

My Catheter is changed by

District Nurse

Team : .....

8am-5pm: District Nurse administrator

443603

5pm -11pm: Twilight District Nurses

442000

GP

Name .....

Practice .....

Telephone .....

Urology Department

Urology Consultant .....

Urology Nurse .....

.....

.....

Please tick

Reason for catheterisation

Retention of Urine
End of Life Care
Damaged skin (open sacral or perineal wound in an incontinent patient)
(O) - other please specify

.....

If no to any of the above discuss with community CNS / GP and plan TWOC

Catheter information

Type of catheter – including manu-facturer, material .....

Size and length of catheter ..... ch /fr .....

Volume of sterile water used in the balloon ..... mls

Antimicrobial catheter balloon inflation solution .....

Date of passport issue .....

Place of catheter changes .....

Known allergies .....

To be completed by District Nurse

Catheter Record p 2

Date / Time			
Informed consent			
Reason for Change			
Catheter details			
type of catheter – including manufacturer, material batch number and expiry date			
size and length of catheter			
volume of sterile water used in the balloon lot / expiry date			
antimicrobial catheter balloon inflation solution if used Lot/Expiry date			
Meatal Cleansing Solution			
Sterile anaesthetic/ lubricating gel used Lot/ Expiry Date			
name, size and type of drainage system used			

Please tick

Reason for catheterisation

Retention of Urine
End of Life Care
Decubitus ulcer - to assist the healing of a perianal/sacral wound in an incontinent patient
(**O**) - other please specify
……

If no to any of the above discuss with community CNS / GP and plan TWOC

Catheter information

Type of catheter – including manufacturer, material ……

Size and length of catheter ……ch./fr……

Volume of sterile water used in the balloon ……mls

Antimicrobial catheter balloon inflation solution ……

Date of passport issue ……

Place of catheter changes ……

Known allergies ……

Page 4

Urinary Catheter Risk Assessment Tool

PATIENT	Male (1)		Female (2)	
	Independent (1)		Lives at home has carer (2)	
	Lives at home with full care (3)		Residential/ nursing home (5)	
	MRSA (30)		Infection in other part of the body (20)	
HEALTH	Heart defects/ Artificial heart valve (10)		Renal Insufficiency (10)	
	Diabetic (10)		Immuno suppressed (10)	
	Chronic wounds (10)		Taking warfarin/ Aspirin (5)	
	Taking steroids (5)		Long term condition (5)	
	Latex allergy/ sensitivity (5)			
	Immobile (5)		Walks short distances (3)	
SELF CARE	Catheterised in hospital (5)		Recent hospital admission (5)	
	Poor dexterity (3)		Poor sensation (3)	
	Visual problems (3)			
	Poor hand hygiene (5)		Poor personal hygiene (5)	
	Poor fluid intake (5)		Swallowing difficulties (3)	

To be completed by District nurse

Catheter Record p 2

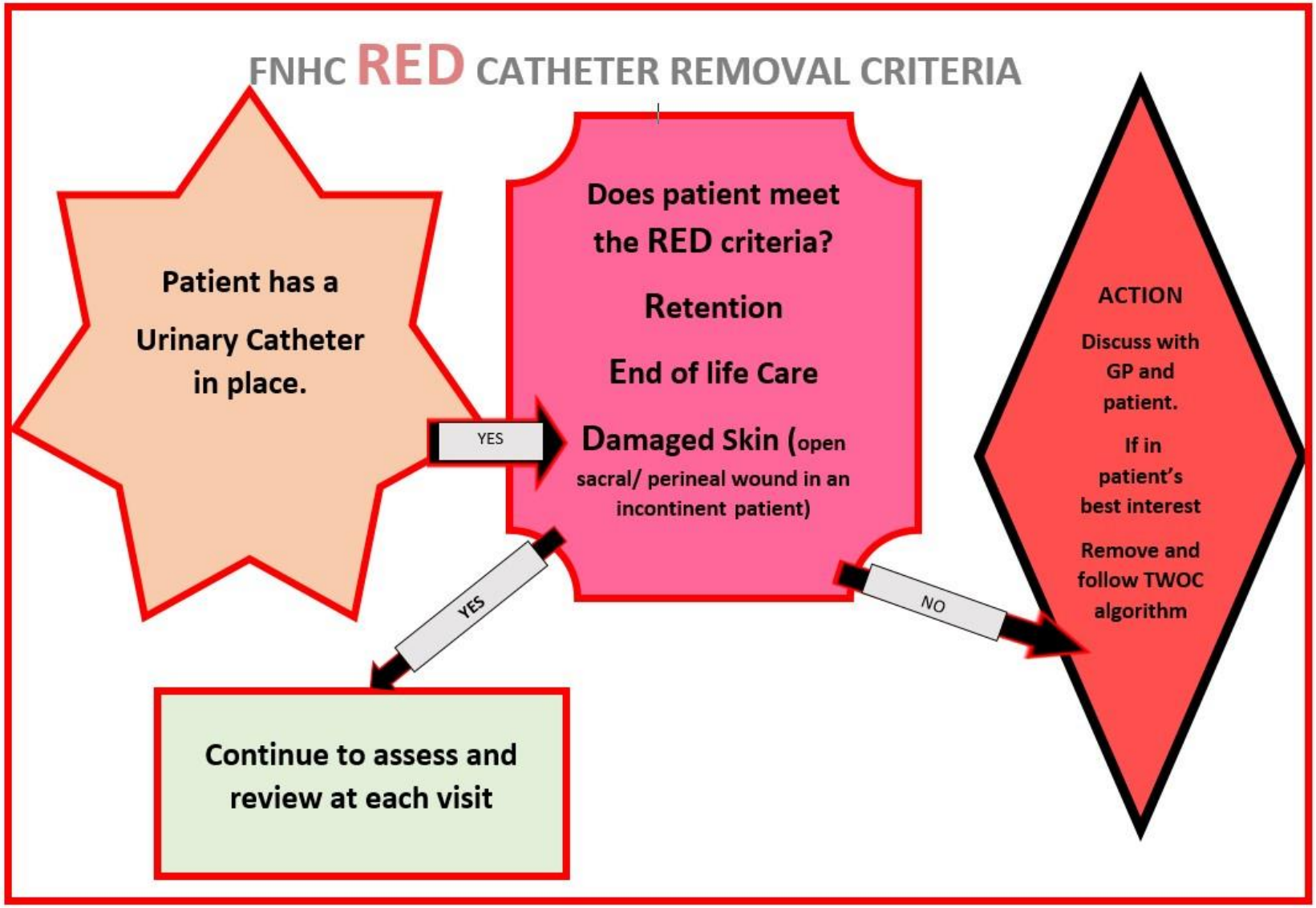
Page 7

Problems encountered at the time of the procedure, including difficulties specific to the individual			
Planned date of next review and catheter change / removal.			
Ongoing care instructions given to the patient or carer			
Catheter passport			
Catheter Assessment tool Score			
Name of the person inserting or changing the catheter			

Problems experienced: Please circle	**None** **Pain** **Blockage** **Bypassing** **Infection** **Meatal Tear** **Haematuria**	**None** **Pain** **Blockage** **Bypassing** **Infection** **Meatal Tear** **Haematuria**	**None** **Pain** **Blockage** **Bypassing** **Infection** **Meatal Tear** **Haematuria**

Appendix 8 ANTT Indwelling catheterisation principles

Appendix 9 FNHC RED Catheter Removal Criteria



Appendix 10 – Female Catheter Warning NoticeAppendix

MAKE SURE YOU SELECT THE CORRECT SIZE CATHETER

Shorter catheters **(20-26cm)** are for females only.

Standard catheters **(40-45cm)** can be used for males and females.

Female only catheters can cause severe trauma and haemorrhage if used in males.

For further information, go to **www.npsa.nhs.uk/rrr**

NHS
National Patient Safety Agency
National Reporting and Learning Service

Appendix 11 – Female Catheter warning labels

FEMALE	urinary catheter

For **Female** use only

WARNING	Use in males can cause severe **trauma and haemorrhage**

FEMALE	urinary catheter

For **Female** use only

WARNING	Use in males can cause severe **trauma and haemorrhage**

FEMALE	urinary catheter

For **Female** use only

WARNING	Use in males can cause severe **trauma and haemorrhage**

FEMALE	urinary catheter

For **Female** use only

WARNING	Use in males can cause severe **trauma and haemorrhage**

Appendix 12 Catheter Care Bundle 1/1

Please Complete or Affix Addressograph

Surname:

Forename:

Address:

Date of Birth:

URN No:

Catheter Care Bundle 1/1

Government of JERSEY

Ward / Area: _____

Date & Time: _____

Name/ Designation: _____

Signature: _____

Catheter inserted by:

URINARY CATHETERISATION CARE BUNDLE - ADULTS

Stop, Think & Avoid if Possible...Is catheterisation really needed?

Catheter already in place? **Yes** ☐ **No** ☐ **If Yes proceed to Part 2**

Insertion Criteria
1. Short term catheterisation (< 4 weeks)
2. Long term catheterisation (> 4 weeks)

Catheter Type:-
Suprapubic ☐
Urethral ☐

Part 1 - Catheterisation	**Tick box or specify why?**	**Signature**
Possible alternative management of patient has been considered and documented - catheter use is unavoidable		
Has intermittent or self catheterisation been considered?		
Any Allergies? Yes ☐ No ☐	Specify:-	
Appropriate Indications are (Tick one of the following)		
• Acute urinary retention		
• Urinary retention with large residual volume (>400 ml)		
• Surgical procedure >2 hours / Gynae / Caes Section		
• Epidural / Spinal		
• Strict monitoring of urine output required		
• Bladder irrigation required		
• Other - Please specify.....		
• Verbal consent given? Yes ☐ No ☐	Specify:-	
Asceptic technique performed (ANTT) on insertion		

Estimated date of catheter removal / change	
Enter amount of urine drained (ml)	
Positive urinalysis result	• • • •
Optilube used	Female - 6 ml ☐ Male - 11 ml ☐
Specimen sent for MC&S	Yes ☐ No ☐
Attach drainage system	Flip Flow ☐ Leg Bag ☐ 2 Ltr Bag ☐ Hourly Bag ☐

Catheter details / label:-

Catheterisation Problems:-	**Yes**	**No**	**Comments:-**	**Signature**
• Post catheterisation bleeding				
• Pain				
• No drainage after 20 mins				
• Inability to pass the catheter				
• Other (please specify)				

Part 2 - Daily review / Care Record (for first seven days) Please complete daily

Date													
Is catheter still needed?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Catheter care provided?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Maintain closed system?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Overnight link system?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Catheter bag position - 1. Below level of bladder	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
2. Consultant instructions														
Date for draining system change?														
Signature														

If catheter remains insitu for > 7 days continue daily review on continuation sheet

Appendix 13 Catheter Care Bundle 1/2

Please Complete or Affix Addressograph

Surname:

Forename:

Address:

Date of Birth:

URN No:

Catheter Care Bundle 2/2

Government of JERSEY

Ward / Area:

Date & Time:

Name/ Designation:

Signature:

URINARY CATHETERISATION CARE BUNDLE - ADULTS - DISCHARGE

Part 3 - Patient Information	Yes	No	Date and comments	Signature
Urinary Catheter Patient leaflet given?				
Verbal care information provided?				

Part 4 - Referral to Family Nursing and Home Care (FNHC)	Yes	No	Comments	Signature
Referral to Family Nursing for catheter care (all patients)				
Referral to Family Nursing for future changes of catheter				
Voucher written to obtain further supplies at New Era H/C to include a spare catheter and relevant drainage system				

Part 5 - Urology Clinical Nurse Specialist Referral	Yes	No	Comments	Signature
Patients requiring 1st change of suprapubic catheter				
Anticipated difficult change of catheter				

Additional Information required for FNHC:- ** If this information is not completed the referral will be rejected**

Confirmed date of discharge;

Date Trial Without Catheter (TWOC) required;

Is the person experiencing any symptoms- cough, high temperature, muscle aches? Yes ☐ No ☐

Is the person self- isolating? Yes ☐ No ☐

Risk Alerts i.e. Infection control / lone worker ;

Relevant medical history & current medication;

Any changes made to medication? ;

GSF code at time of referral ;

Blue (year plus prognosis) ☐ Amber (weeks prognosis) ☐

Green (months prognosis) ☐ Red (days prognosis) ☐

Relevant Social Circumstances -

Lives alone? Yes ☐ No ☐

Domiciliary care package in place? Yes ☐ No ☐ If yes, care provider -

NOK name, relationship & contact number;

Patient Contact Details
Home phone number
Mobile phone number

Date referral faxed to FNHC / CNS (Staff) -	Signature / Designation -

FNHC email - adult.referrals@fnhc.org.je / urology CNS email - Urology-ContinenceNurses@gov.je

Date referral received (FNHC / CNS) -	Signature / Designation -

Appendix 14 - Home to Hospital Liaison

Family Nursing & Home Care

Name: .....

D.O.B: .....

Reason for Catheterisation	
	tick as appropriate
Retention of Urine	☐
End of Life Care	☐
Damaged skin (open sacral or perineal wound in an incontinent patient)	☐
Other (please specify)	

Description of Catheter			
Urethral:	☐	Suprapubic	☐
Size and Length:			
Mls in balloon:			
Catheter Valve:	☐	Leg Bag Details:	

Date catheter last changed	

Today's reason for change	
	tick as appropriate
Routine	☐
Catheter blocked	☐
Other (please specify)	

Problems Arising	
	tick as appropriate
Inability to pass catheter	☐
Pain	☐
Bleeding	☐
Other (please specify)	

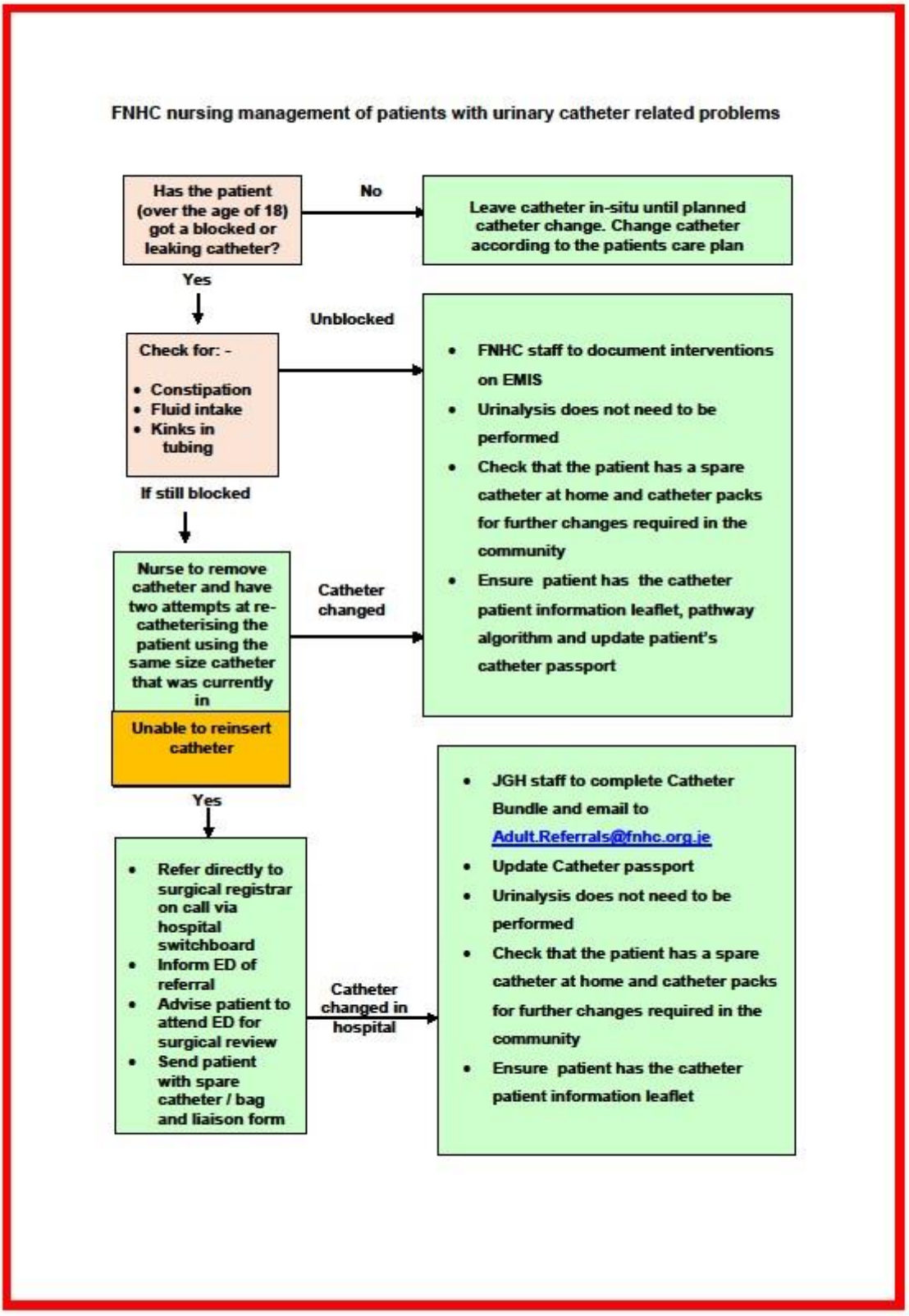
Action Taken

Signature: ..... **Print Name:** .....**Date/time:** .....

Patient's Name: ..... **URN:** .....

Feedback following surgical review:	
Date/Time	

Appendix 15 – FNHC Nursing Management of patients with urinary catheter related problems



Appendix 16 Catheter Awareness BEE Safe

Family Nursing & Home Care

Catheter Awareness BEE Safe

B Blocked, bypassing or pulled out catheters are not to be attended to FNHC SHCAs

E Ensure catheter is the correct size and type for the patient with a 5 or 10 ml balloon, 12/14ch for routine urethral catheterisation, 16ch -18ch if possible for suprapubic catheters although 20ch is acceptable.

The wrong size catheter can cause bladder spasms, expulsion, pain and physical damage.

30ml balloons are only prescribed and fitted by the Urology Department.

E Ensure you record all the information from the catheter fitted in the patient's catheter passport and EMIS catheter record

S **Sepsis** - To reduce the risk of sepsis: **do not flush** a blocked catheter, **do not deflate** and **reflate** the balloon, **do not re use** products (for example, catheter bags and valves when the circuit has been broken).

A Always ensure there is a clinical rationale for the catheterisation and this is recorded in the patients' notes. Follow **RED** criteria.

F Follow FNHC policy at all times, this is based on national guidance and instruction, to protect your patients and you. The policy can be found on the Family Nursing & Home Care website.

E Every time you catheterise a patient: remember this is an invasive procedure with risk to the patient if there are complications.

Protect Your Patient | Protect Yourself | Stay Safe

Appendix 17 Catheter Changes Care Plan

Name: .....
D.O.B: .....
HSS No: .....

Or Affix Patient Label

Problem/Issue
Mr / Mrs .....has a urinary catheter insitu and require catheter changes
tick as appropriate
Retention ☐
End of Life care ☐
Damaged Skin (open sacral/ perineal wound in an incontinent patient) ☐
Other (please specify) .....
Urethral Catheter ☐ Supra Pubic catheter ☐ Size .....ch Balloon.....mls
Goals
To prevent complications, maintain dignity and comfort. To deliver evidence based care as per FN&HC catheter guideline
Negotiated plan of care
1. Explain and discuss the procedure with the patient **2.** Utilise standard Infection Control Procedures **3.** Obtain consent, ensuring this is documented. **4.** Check for ALLERGIES, latex & Lidocaine (anaesthetic gel) **5.** Document problems experienced since last catheter change : a. Pain b. Blockage c. Bypassing d. Infection e. Meatal Tear f. Haematuria **6.** Ascertain if any problems have been experienced with previous catheterisations.

7. Remove and replace catheter as per FNHC urinary catheter policy and Standard Operating Procedure using an Aseptic Non Touch Technique (ANTT).
8. Document problems experienced during this catheter change.
9. Document Interventions specific to identified problems including rationale

10. Inform patient of next catheter change and document in catheter passport
11. Discuss catheter care and maintenance with patient/ carer
12. Ensure patient/ carer has FNHC contact details and HSS catheter information leaflet and catheter passport

Appendix 18 Catheter Care - Care Plan

Name: .....
D.O.B: .....
HSS No: .....

Or Affix Patient Label

Problem/Issue
……..has a urinary catheter in situ and requires assistance with catheter care.
Goals
To prevent complications, maintain dignity and comfort. To deliver evidence based care as per FN&HC catheter guideline and Standard Operating Procedure
Negotiated plan of care
• Explain and discuss all care with the patient • Follow standard infection prevention and control procedures at all times • Obtain consent for care • Encourage patient to maintain a good fluid intake 1.5-2L per day • Encourage patient to avoid constipation • Carry out catheter toilet daily – wash meatus with mild soap and water - washing along catheter downwards away from body x 4. • Support men to clean under foreskin daily with mild soap and water. • Observing for any meatal tears • Change leg bag / catheter valve weekly (specify day …….) - Ensure client is able to empty catheter valve 3-4 hourly • Ensure catheter is secured effectively using a G-strap change leg weekly • Ensure the leg bag is securely attached ○ Aquasleeve □ Velcro straps □ • Apply night drainage bag to leg bag / catheter valve at bed time record that urine is draining into night bag • Remove, empty and rinse out night bag every morning or dispose of single use night bag. • Replace night drainage bag weekly (specify day ……) □ Empty leg bag as required when no more than ½ full • Ensure that the tubing isn't kinked • Observe for signs of urinary infection

- Ensure client is able to access supplies as needed.

- Report any concerns to the Nurse
- Advise patient/carer about ongoing catheter care and maintenance
- Ensure patient/ carer has FNHC contact details and HSS catheter information leaflet
- Report to District Nurse if :
- Supplies need to be prescribed
- Catheter is blocked or bypassing
- Damage evident
- Inform DN immediately if client has been commenced on antibiotics for UTI as catheter may need to be changed.

Appendix 19 Equality Impact Screening Tool

Stage 1 - Screening				
Title of Procedural Document: Guidelines and Standard Operating Procedures The Management of Urinary Catheterisation (Adults)				
Date of Assessment	December 2020	Responsible Department	Specialist Nurses/Adults Services	
Name of person completing assessment	Fiona Le Ber		Job Title	CNS Continence and Stoma

Does the policy/function affect one group less or more favourably than another on the basis of :		
	Yes/No	**Comments**
Age	no	
Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	no	
Ethnic Origin (including hard to reach groups)	no	
Gender reassignment	no	
Pregnancy or Maternity	no	
Race	no	
Sex	no	
Religion and Belief	no	
Sexual Orientation	no	

If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions (what needs to be done to minimise / remove the impact)**	**Responsible Officer**

Monitoring of Actions