Policy for Urinary Catheterisation (Ongoing Care and Management)

County Durham and Darlington
NHS Foundation Trust

CDDFT Policy

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1 Introduction
This policy sets out the principles of urinary catheterisation, care and on-going management to minimise risk of catheter associated urinary tract infection (CAUTI) for patients requiring urinary catheterisation.

2 Purpose
This policy applies to all staff within County Durham & Darlington NHS Foundation Trust who have responsibility for catheterising patients and for their on-going care and management.

3 Duties (Roles and Responsibilities)
Departmental/Community Managers
Managers are required to ensure that their staff have access to and are aware of this policy. They must ensure the policy is implemented within their area and that staff attend appropriate training where required.

All Staff
Staff are professionally accountable for compliance with this policy, identifying training needs and attending appropriate training.

4 Training Requirements
It is necessary for anyone (staff, patients, carers, relatives) involved in catheterisation and management of the drainage system to have received appropriate training. Trust staff training is outlined in the Trust’s Lifelong Learning Directory.

5 Responsibilities and Training Competencies
Any healthcare professional who has received appropriate training may undertake a catheterisation procedure providing they can demonstrate appropriate knowledge and skill, work within the limits of their competence and within legal and professional boundaries (NMC 2008). Staff must be aware of:

- Issues of informed consent and a knowledge of the Mental Capacity Act
- Anatomy and physiology (male and female) of the urinary tract
- Indications for catheterisation
- Contraindications and precautions
- Types of catheterisation i.e., urethral, supra-pubic, intermittent
- Infection prevention control practice and legislation to minimise risk of catheter-associated infection
- Equipment and devices available
- Aseptic technique
- Catheterisation procedure & technique
- Care and ongoing management of a catheterised patient based on available evidence/practice
- Managing catheter blockage
- Limits of competence and cognition of when to seek experienced help

6 Advice and Guidance
Infection Control advice is available from the Trust intranet site: http://intranet/Directorates/CorporateDirectorates/NursingDirector/infectionControl/Pages/default.aspx

7 Policy Monitoring and Review
This policy will be reviewed every three years unless an earlier review is required due to change in practice or legislation.
Compliance with this policy will be monitored annually by the Infection Control Team (ICT) using the Infection Prevention Society (IPS) audit tool. Additionally healthcare teams will conduct Saving Lives High Impact Interventions or Essential Steps audits (DH 2007) to be reported appropriately (i.e. monthly or three monthly) as key performance indicators (KPI) on the Trust dashboard or the current means of measurement.

8 Urinary Catheterisation
Urinary catheterisation involves the insertion of a hollow tube (invasive device) into the bladder for the purpose of draining urine, clots/debris removal or drug instillation. This procedure is often unpleasant for patients and carries risk, therefore it must only be carried out after all other non-invasive management options have been explored; assessment of need must be made and consideration given to benefits versus risks for the patient.

An aseptic technique must be employed for the catheterisation procedure and also for any manipulation of the device, urine sampling, drainage bag emptying/changes required.

Catheter insertion and the on-going care and management must only be carried by trained healthcare professionals as defined within their scope of practice, taking account of legal and professional issues (RCN 2008). With appropriate instruction, healthcare professionals, the patient/family and/or home caregiver may be able to care for and manage the catheter however patient assessment, responsibility and accountability lies with the registered nurse or doctor.

9 Decision to catheterise
The decision to catheterise may be made by a registered nurse or medical practitioner following assessment of individual need and with the informed consent of the patient and/or their carer/advocate.

10 Consent
Consent may be written or verbal according to local protocol but must be documented in the patient’s record by the health professional obtaining consent (refer to Trust Consent Policy available at: http://intranet/Directorytes/CorporateDirectorates/NursingDirector/nursing/Consent/Forms/AllItems.aspx).

11 Indications for urinary catheterisation
There are many reasons why a patient may require catheterisation; this must be clearly documented in the patient’s record.

11.1 Indications for urinary catheterisation in acute care (hospital):
- Bladder emptying e.g. before/after certain investigations, abdominal, pelvic or rectal surgery, before/after childbirth
- Measuring residual urine
- Bladder irrigation
- Bypass an obstruction
- Introduction of cytotoxic drugs e.g. treatment of papillary bladder carcinomas
- Accurate measurement of urine output; e.g. patient critically ill/shock, undergoing bone marrow transplantation, receiving high-dose chemotherapy
- Avoid complications during the insertion of radioactive material (e.g. caesium into the cervix/womb, brachytherapy for the prostate)
- Facilitate bladder function tests
- Intermittent self catheterisation required
- Tissue viability and skin integrity
- Neurological disease or injury; incomplete/difficult bladder emptying
• Outlet obstruction; patient unfit for surgical repair
• Terminal illness; aids symptom management, catheterisation relieves pain, frequency of micturition, maintains dignity
• Management of acute/chronic urinary retention (with medical agreement)
• Intra-vesical drug instillation/bladder irrigation
• Caution regarding patients with spinal cord injury at or above the level of the 6th thoracic vertebrae at risk of autonomic dysreflexia (see Section 39)
• Chronic intractable urinary incontinence; unmanageable by other means (Never first line management for urinary incontinence; all other options must be have been considered and rejected)

11.2 **Key indications for urinary catheterisation in community care:**
• Chronic intractable urinary incontinence; unmanageable by other means
• Intermittent self catheterisation
• Tissue viability and skin integrity
• Neurological disease or injury; incomplete/difficult bladder emptying
• Outlet obstruction; patient unfit for surgical repair
• Terminal illness; aids symptom management, catheterisation relieves pain, frequency of micturition, maintains dignity
• Management of acute/chronic urinary retention (with medical agreement)
• Caution regarding patients with spinal cord injury at or above the level of the 6th thoracic vertebrae at risk of autonomic dysreflexia (see Section 39)

NB The need for any catheter should be reviewed at regular and agreed intervals throughout the period of catheterisation with consideration given to the continuing requirement for the device; ‘Is this device still necessary for this patient?’

12 **Contra-indications to urinary catheterisation:**
• Mental health or cognitive status of the patient may give cause for concern regarding the patients’ ability to give informed consent or present safety issues
• Patient’s ability to manage the catheter independently
• Carers availability to manage the catheter on behalf of the patient
• Undiagnosed haematuria
• History of injury or pelvic trauma
• Acute retention of urine (unless permission given by the doctor)
• Known difficulty in catheterising the patient
• Failure to catheterise at first attempt
• Urethral meatus cannot be visualised

13 **Special considerations:**
Although general principles of catheterisation and infection prevention control apply to all patient groups; some patients have particular needs, e.g. patients with prosthetic implants or those with spinal injuries. Staff working with these patients must familiarise themselves with local policy and patient needs.

14 **Infection risk**
A urinary catheter is an invasive medical device; insertion must be determined by clinical need and the device must be removed at the earliest opportunity to prevent complications and associated infection risk for the patient.

Method and duration of the catheterisation, on-going care and management and patient susceptibility are all significant infection risk factors for a catheterised patient.
Prior to any catheterisation, good personal hygiene and cleanliness is required to help reduce infection risk; if possible the patient should shower or bath prior to the procedure. Preceding urethral catheterisation, the genital area must be washed and dried (The foreskin must be retracted to permit thorough cleaning of the glans in male patients with a foreskin). Before changing a suprapubic catheter, ensure the abdominal area has been washed and dried.

15 Bacteriuria
As a general rule, a patient with an indwelling urinary catheter should not be given prophylactic antibiotics. Evidence informs that 20-30% of catheterised patients will develop bacteriuria (i.e. bacteria will be cultured from a urinary catheter sample); up to 90% of these patients will be asymptomatic (ie not have an infection). Treating bacteriuria with antibiotics must be carefully considered, as misuse is likely to produce malignant bacterial flora and antibiotic resistance; as a consequence the bowel and bladder may become reservoirs for antibiotic resistant organisms. To avoid these complications, antibiotics should be reserved for treating catheterised patients (both short and long term) with acute episodes of clinical infection.

16 Catheter associated urinary tract infection (CAUTI)
In healthcare, catheter associated urinary tract infection (CAUTI) is a major cause for concern. Urinary tract infections (UTI’s) are the second most common healthcare associated infection (HCAI), accounting for 17.2% of all HCAI’s. These infections contribute to increased mortality and other associated healthcare costs (Health Protection Unit (HPU) 2011).

Diagnosis of a UTI is presumptive and based upon medical diagnosis with the presence of one or more symptoms e.g. fever >37.8 degrees centigrade (C), rigors, nausea, vomiting, diarrhoea, tachycardia, loin tenderness in the absence of other causes.

Simply finding bacteria in a Catheter specimen of urine (CSU) does not imply that there is an infection that needs antimicrobial treatment. Please note the laboratory does not report CSU results but antibiotic sensitivities will be available on request.

17 Considerations prior to catheterisation
17.1 Catheter material
Prior to catheter selection, staff must be aware of any patient allergy or intolerance to materials such as latex (possibility of allergic reaction to coated catheters) (see National Patient Safety Agency (NPSA) Patient Safety Information 08 – ‘Protecting people with allergy associated with Latex’ (2005) and Trust’s Latex Policy).

100% silicone catheters must be used when there is latex allergy. Note: not all silicone catheters are licensed for supra-pubic use. However, Argyle catheters are indicated for supra-pub use.

17.2 Catheter selection (see Appendix 1)
There is a wide variety of urinary catheters available; selection should also be based upon patient comfort/tolerance and a low rate of infection and rejection. Appropriate selection will maximise patient comfort and minimise infection risk. Initial assessment should involve patient and/or carers to determine a suitable choice of catheter and drainage system. Re-assessment of initial choice must also be mutually agreed.

To ensure consistent practice across the Trust, catheter equipment has been standardised.

For general use, hydrogel catheters are normally used.
The length of time a catheter is expected to remain in situ (short, medium or long-term use) is one of the main factors influencing catheter choice:

**Short term (1–7 days) and intermittent catheters**: e.g. Polyvinyl chloride (PVC), latex

**Short to medium term (up to 28 days)**: Teflon coated catheters

**Medium term catheter** – these can be used for a maximum of 4 weeks before they require changing; (Teleflex) PTFE Aqua-Flate Catheter recommended.

**Medium to long term (6 weeks–12 weeks)**: e.g. Hydrogel and silicone coated

**Long term catheter (for up to 12 weeks)**; made from materials that better resist the build-up of encrustation; Kendall Argyle (Tyco Healthcare) Silicone Catheter recommended

Silver coated catheters are not used routinely but may be considered if patients are at high risk or prone to developing infections (discuss with Specialist Continence Nurses).

Research is ongoing into other types of catheter materials, particularly examining materials resistant to formation of biofilms (bacterial colonies that develop and adhere to the catheter surface and drainage bag) to reduce risk of catheter associated urinary tract infections (CAUTI) (Pratt *et al*, 2007)

### 17.3 Catheter size

Urinary catheters are measured in Charriere (Ch); this refers to the diameter measurement of the catheter in millimetres (mm).

Choose the smallest suitable size to maintain adequate urinary drainage. If urinary drainage is likely to be clear, a size 12/14 Ch catheter is normally recommended for urethral catheterisation of men and women & size 16 for supra-pubic catheterisation.

Larger gauge catheters may be necessary if debris or clots are present in the urine.

### 17.4 Catheter balloon

To keep the device in position in the bladder, the inflatable catheter balloon must be filled with the correct amount of sterile water (as indicated on the urinary catheter & packaging).

Adults 5–10 millilitres (ml) balloon is normally recommended but may vary depending upon circumstances (e.g. large 30 ml balloons used post-prostatic surgery).

Using the correct amount of water to fill the balloon avoids distortion of the catheter tip which can cause bladder irritation and trauma. Under-inflation of the balloon may result in the catheter drainage eyes becoming blocked or the catheter dislodging. Over-inflation may burst the balloon leaving fragments inside the bladder.

Never deflate/re-inflate the catheter balloon unless removing the catheter.

### 17.5 Length of catheter

In hospitals, standard length catheters are recommended for short and medium-term use for both males and females. Since 2009, only specialist wards stock female length catheters (National Patient Safety Alert (NPSA) 2009).

In the community, female patients with long-term urinary catheters may benefit from shorter (female) length catheters, however these are not recommended for women who are wheelchair bound or those with obese thighs.
17.6 **Catheter tip**

Normal urinary catheters have a round tip but other tip types are available for patients with specific urological conditions. Further information is available from the Specialist Continence Nurses.

18 **Closed drainage system**

Maintaining a sterile, continuously closed urinary drainage system is central to the prevention of CAUTI (Pratt *et al.*, 2007). Selection of an appropriate system must take into account the reason for catheterisation, duration required, patient/carer preference and other infection prevention measures.

19 **Drainage bags**

The drainage bag should be kept below the level of the bladder to assist drainage and prevent reflux (optimum level is not more than 30cm below bladder level (Evans 2001)).

A wide range of drainage bags/devices are available; e.g.:

- Large bags (2 litre) commonly used for immobile patients/overnight drainage
- Leg bags (350-750 millilitre (ml)) Permit greater mobility & can be worn under
- Body/belly bags clothes

A variety of supports are designed for use with these bags including:

- Sporran
- Waist belts
- Leg holsters
- Knickers/pants
- Leg straps

Most leg bags allow for larger 1–2 litre bags to be connected via the outlet tap, to increase drainage capacity e.g. overnight.

Measuring devices are also available for monitoring urinary output accurately.

The leg bag and/or drainage bag, attached directly to the catheter, must be sterile. These are normally replaced every 5–7 days, when the catheter is changed or in line with manufacturer's instructions. However they may be changed earlier if damaged, leaking or when there is an accumulation of sediment (DH 2001). Record the date the drainage bag is changed, in patient record. Once a drainage bag has been disconnected from the catheter, it must be discarded and replaced with a new sterile bag.

To facilitate urinary drainage and prevent reflux to minimise infection risk and upper urinary system damage, the drainage bag must be positioned below the level of the bladder and emptied regularly to prevent overfilling and urinary back-flow. (Belly-bags incorporate an integral valve to prevent reflux).

When moving a patient, it may be necessary to clamp the drainage system to prevent reflux, if normal drainage cannot be maintained. Once the patient is positioned release the clamp to resume drainage.

The drainage bag should be suspended on a suitable stand or hung, off the floor, to reduce infection risk.
20  **Anaesthetic lubricating gel**
There is lacking research regarding the efficacy of anaesthetic lubricating gels, therefore current practice is based on available evidence and known anatomy and physiology of the urethra.

Trauma risk is reduced due to the lubricating effect of these gels. To ensure full anaesthetic effect, 6–11 ml must be instilled for more than 4 minutes prior to catheterisation.

Prior to male urethral catheterisation, the gel must be instilled directly into the urethra and down the length of the penis, with the exception of conforming gels (e.g. Instillagel).

Prior to female urethral catheterisation, the gel must be instilled into the urethra (not just applied to the tip of the urinary catheter) to provide the necessary anaesthetic effect prior to insertion.

Prior to supra-pubic catheterisation, apply the anaesthetic lubricating gel to provide the necessary anaesthetic/lubricating effect prior to insertion.

Because of the risk of systemic absorption, anaesthetic lubricating gel must be used with caution in the elderly, those with cardiovascular disease or drug sensitivity (British National Formulary (BNF) 2012) available at: http://www.medicinescomplete.com/mc/bnf/current/6694.htm

21  **Intermittent urethral urinary catheterisation**
For patients whose bladder emptying is incomplete, intermittent self-catheterisation may be a preferred method of bladder management to indwelling catheterisation and should always be considered as a first option (rather than indwelling catheterisation), providing this is a safe and acceptable alternative for the patient/carer.

Intermittent catheterisation requires dexterity, ability and desire to manage the procedure. If the patient is unable to self catheterise, the procedure may be carried out by carers or healthcare workers after appropriate training, with the patient’s consent.

Patients and carers require advice and information: supporting literature, frequency of catheterisation, catheter size, and any documentation required e.g. measuring urinary volume.

Healthcare professionals should seek advice/guidance from Urologist/Specialist Nurses regarding the intermittent catheterisation procedure. Healthcare professionals/paid carers must adopt an aseptic procedure. Patients/unpaid carers should follow a clean procedure.

Patients with urethral strictures carrying out intermittent catheterisation, require information and advice from Urologist regarding frequency of catheterisation and catheter size.

22  **Indwelling urethral catheterisation procedures**
Adult male urethral catheterisation procedure (Appendix 2)
Adult female urethral catheterisation procedure (Appendix 3)

23  **Supra-pubic catheterisation**
Initial supra-pubic catheterisation involves inserting a trocar (a surgical instrument with a cutting point enclosed in a tube) through the lower abdominal wall into the bladder, above the pubic bone to make a tract, through which the catheter can be inserted. Some catheters have a fixing plate sutured to the abdomen to keep them in place. For long-term use, Foley catheters are normally used (Large charrière size hydrogel-coated or 100% silicone catheters are recommended (refer to manufacturer’s instructions).
The initial procedure must be performed by a urology staff grade doctor and first catheter change must be performed by experienced urology staff in an acute healthcare setting or by an experienced practitioner in the community, with ultrasound imaging (National Patient Safety Agency (NPSA) 2009). Local or general anaesthetic must be used.

24 Indications for suprapubic catheterisation:
- Limited mobility (e.g. wheelchair bound) where a urethral catheter may be uncomfortable or difficult to manage
- Urethral damage or at risk of trauma
- Long term catheterisation
- Post operative urological/gynaecological surgery
- Sexually active patients

25 Contra-indications for suprapubic catheterisation:
- Undiagnosed haematuria
- Carcinoma/tumour of the bladder
- Obesity
- Confusion
- Reduced bladder capacity
- Previous lower abdominal surgery
- Blood clotting disorders
- Ascites
- Ovarian cyst

26 Benefits of suprapublic catheterisation
- Maybe more easily managed than urethral catheter by wheelchair bound patients/carers
- No risk of urethritis or urethral damage
- Freedom from urethral catheter for those sexually active
- Reduced risk of bacterial contamination from perineum
- Suitable for patients with chronic urethral catheter problems, e.g. bypassing, expulsion of catheter

27 Initial suprapubic catheterisation and catheter changes
The initial suprapubic catheterisation procedure must always be performed by an experienced urology staff grade doctor usually under local or general anaesthetic. Sometimes the initial supra-pubic catheter is sutured to the skin surface; normally this can be changed to a Foley catheter at the initial change. Contact the local Urology Department for advice.

Following initial suprapubic catheterisation, the first catheter change should not occur before 4 weeks as a tract (allowing new catheter insertion) will not be established. If the supra-pubic catheter blocks during this time, leave the suprapubic catheter in situ and insert a urethral catheter.

The first change is normally performed at 6-8 weeks and may be carried out in a community setting by a competent registered nurse (ACA 2004). Further supra-pubic changes are normally at 6-12 week intervals depending on medical direction and the type of catheter used. If there are any doubts or previous difficulty has been encountered, medical help must be sought.
Supra-pubic catheters are usually standard male length to enable sufficient length to connect to a bag or valve without tension though female length may be considered depending on patient preference.

Compared with urethral catheterisation, larger sizes may be used as there is no risk of urethral damage; for most patients 14-18 ch. (usually 16) is suitable. The catheter balloon is normally inflated with 10mLs. sterile water.

28 Complications of suprapubic catheterisation:

_Urine leaking from urethra when suprapubic catheter in situ_

This may be caused by kinked tubing, bladder spasm or bladder neck incompetency. Check for kinked tubing. Consider use of an anti-cholinergic drug to manage bladder spasm. Surgical closure of the urethra maybe considered as a last resort.

_Closure of the catheter channel if the catheter is removed and not replaced before a tract has formed_

The catheter needs to be replaced within approximately 10 minutes otherwise the tract may close; if this occurs patient will need referral to Urology Department for replacement.

_Over-granulation of insertion site_

Over-granulation may be caused by excessive moisture or movement of the catheter around the insertion site. If this is not causing the patient a problem, no further action may be needed but where over-granulation is problematic consultation with the Tissue Viability Nurse Specialist is recommended.

_Skin excoriation_

Urine leakage around the catheter site may cause the skin to become sore; use of a barrier film e.g. Cavilon may provide effective skin protection. If skin is excoriated or there are any signs of infection (i.e. red or inflamed) it may be necessary to take a swab and send this for culture and sensitivity testing to exclude infection.

29 Replacing/Changing a suprapubic catheter (see Appendix 4 procedure)

Catheter changes should be planned according to the type of catheter selected and the patient’s previous history. Monitoring catheter change history may establish a pattern of recurrent problems and allow planned changes prior to problems developing e.g. encrustation leading to blockage.

30 Emptying urinary drainage bags

Urinary drainage bags should be emptied regularly to avoid reflux and accidental leakage from overfilling.

Patients/carers should use an aseptic technique:
- Wash and dry hands prior to emptying the drainage bag into a toilet/clean container (avoid contact with the drainage tap)
- Close the drainage tap, wipe tap clean and dry
- Wash and dry hands after bag emptying

Staff are required to use an aseptic technique:
- Explain procedure and obtain consent from patient/carer
- Don disposable plastic apron
- Wash and dry hands
- Don non-sterile disposable gloves
- Clean the outlet tap with a 70% isopropyl alcohol wipe
• Drain urine into a toilet/disposable or disinfected receptacle (a separate container must be used for each patient) avoiding contact with the drainage tap.

*For Community staff who need to disinfect receptacles, wash with hot water and detergent then disinfect with chlorine solution (1,000 parts per million of available chlorine) and dry*

• Close the drainage tap & clean tap with a detergent wipe
• Carefully remove gloves and apron
• Wash and dry hands

31 **Catheter hygiene**
In addition to daily washing/bathing/showering, meatal cleansing with soap and water twice each day (using a disposable washcloth) is required to keep the meatus free of encrustation/contamination (particularly after a bowel action).

32 **Catheter valves**
Catheter valves are single use disposable items which may provide an alternative drainage arrangement. Using a catheter valve will maintain bladder muscle tone and also can be used to retrain the bladder following a period of catheterisation. *Do not use a spigot as an alternative to a catheter valve.*

The decision to use a catheter valve should involve the patient/carer and multidisciplinary team appropriately e.g. General Practitioner, District Nurse, Urologist or Specialist Continence Nurse.

Patients/carers are required to be able to manipulate the valve to empty the bladder regularly to avoid leakage (especially supra-pubic catheters), overfilling and subsequent back flow of urine to the upper urinary tract.

Contra-indications for valve use:
• Poor dexterity
• Cognitive impairment and confusion
• Reduced bladder capacity
• Detrusor over activity
• Ureteric reflux
• Renal impairment
• Reduced bladder sensation

The valve is connected to the urinary catheter outlet to allow bladder filling and intermittent emptying. To prevent bladder over-distension and urinary backflow, urine should be drained at regular intervals by opening the valve. Frequency of emptying will be determined by the patient but should be at least every 3 to 4 hours. Following a longer period of catheterisation the bladder may need to be emptied sooner than this whilst the bladder is retrained. The interval between emptying should be gradually increased until the patient can hold for 3 to 4 hours. In order to maintain the benefits of having a valve, drainage bags are best avoided overnight. Valves should be changed according to manufacturer’s instructions (usually every 5 to 7 days). The valve should be disposed of into clinical waste (hospitals/health-centres) or double bagged prior to disposal into patient’s household waste (community).

**Connecting/disconnecting the catheter valve/drainage urine**
Patients/carers should use an aseptic technique:
• Wash and dry hands
• Use an aseptic technique to open/connect/disconnect the valve or drainage bag
• Clean and dry area
• Wash and dry hands
Staff are required to use an aseptic technique:
- Explain procedure and obtain consent from patient/carer
- Don disposable plastic apron
- Wash and dry hands
- Don non-sterile disposable gloves
- Decontaminate the valve outlet with a 70% alcohol wipe; allow to dry
- Use an aseptic technique to open/connect/disconnect the valve or drainage bag
- Clean the urinary catheter outlet with a detergent wipe
- Remove gloves and apron
- Wash and dry hands

33 Record keeping
It is a legal requirement to maintain patient records; the record must include information regarding:
- Reason for catheterisation
- Date of catheterisation
- Anaesthetic gel & its expiry date
- Catheter type and batch number
- Signature of the person performing the catheterisation
- Anticipated date for catheter change
- Comments or problems encountered during or prior to the catheter change, e.g. encrustation, adverse reactions, bypassing and actions taken

The following documentation must be used as part of the record keeping:
- SystmOne Patient Record (Community)
- Catheterisation Pathway First Seven Days (Hospitals) (Appendix 5)
- Continuation Pathway (Hospitals) (Appendix 6)

34 Urine sampling
Urine samples must only be taken from catheters if there is a valid reason to do so, e.g. suspected infection. It is essential to maintain the closed urinary drainage system when collecting the sample. Use the needle-free sample port, do not sample directly from the urinary catheter or drainage bag.

Use an aseptic technique to obtain the sample:
- Explain procedure and obtain consent from patient/carer
- Don disposable plastic apron
- Wash and dry hands
- Don non-sterile disposable gloves
- Clean the sample port with a 70% isopropyl alcohol wipe; allow to dry thoroughly
- Connect sterile syringe to the sample port and withdraw urine sample
- Put urine sample into sterile universal container
- Clean sample port with a detergent wipe
- Carefully remove gloves and apron
- Wash and dry hands
- Label container with patients details, complete laboratory form, send sample to laboratory, record in patients record

35 Catheter maintenance solutions
There is limited clinical evidence regarding the use of catheter maintenance solutions and they should not be used routinely. They are available on prescription for treatment of specific conditions.
Catheter maintenance solutions should only be used following thorough assessment. Where assessment indicates a catheter maintenance solution may be beneficial, the prescribed solution must be appropriate for the condition being treated (see Appendix 7).

As these solutions may increase shedding of epithelial cells within the bladder they must be used with caution. Additional caution is advised if patients have a spinal injury due to the possibility of autonomic dysreflexia. The effect of the treatment should be systematically assessed and ongoing care planned accordingly.

In a first time blockage, where there is no apparent reason for the cause of the blockage, the catheter should be removed, examined, and urine tested to explore possible causes. The findings should be recorded and these may provide the rationale for using a prescribed catheter maintenance solution.

If the catheter blockage is secondary to formation of struvite crystals (formed in alkaline urine), regular urine pH testing should be undertaken, to monitor/predict future blockages and an individual maintenance programme can be planned.

See Procedure Guidelines Urinary Catheter Maintenance Solution Administration (Appendix 8).

### 36 Decision to remove a catheter

The decision to remove a catheter must be based upon assessment of the patient’s condition and in consultation with the patient and healthcare professionals responsible for their care. Following catheter removal the patient must be monitored and action taken if problems arise.

Catheter removal must be performed by an appropriately trained registered nurse, midwife or medical practitioner, though in certain circumstances, and with prior agreement, other healthcare workers/informal carers may perform this procedure. However, specific training must have been given by a registered nurse, midwife or medical practitioner prior to other healthcare workers/informal carers undertaking this procedure.

#### 36.1 Removing a catheter:

- Explain procedure and obtain consent from patient/carer
  
  *Patient may feel the need to void urine following catheter removal; have urinal, bedpan, toilet near by*
  
  - Have waste bag available; clinical waste (Hospitals/health-centres) or household waste (Community)
  - Don plastic apron
  - Position patient; preferably sitting or lying
  - Wash and dry hands
  - Don gloves
  - Take catheter specimen urine (CSU) if required (see section 34 Urine sampling) prior to catheter removal
  - Connect sterile syringe (correct size for volume of water to be withdrawn) securely into the catheter inflation valve; slowly withdraw water; dispose into clinical waste (Hospitals/Health-centres) or household waste (Community)
  - If the catheter balloon will not deflate seek medical help; do not attempt to burst it by over inflating, do not cut the catheter (see Appendix 9 Check list for problems with urinary catheter removal)
  - Remove the catheter slowly; dispose into clinical waste (Hospitals/Health-centres) or household waste (Community)
Check condition of the removed catheter, document any anomalies and report appropriately, document in patient’s record.

- Remove PPE; dispose into clinical waste (Hospitals/Health-centres) or household waste (Community)
- Wash and dry hands; dispose into clinical waste (Hospitals/Health-centres) or household waste (Community)

37 Urine Spillage
Staff:
- Don plastic apron
- Wash and dry hands; dispose paper towels into domestic/household waste
- Don non-sterile gloves
- Cover spillage with disposable paper to soak up urine (avoid splashing); dispose into clinical waste (Hospitals/health-centres) or household waste (Community)
- Wash affected area with water and detergent (do not use chlorine product) & dry thoroughly
- Remove and dispose of protective clothing into clinical waste (Hospitals/health-centres) or household waste (Community)
- Wash and dry hands

38 Waste Disposal
Waste from any nursing or care procedure must be appropriately disposed in accordance with the Trust’s waste policies available on intranet.

38.1 Acute hospitals & community health centres:
- Clinical waste (dark orange bag) e.g. plastic aprons, used gloves, items contaminated with blood/body fluids, urinary catheter and drainage equipment, incontinence pads, infected waste, paper hand towels from rooms where patients have infection
- Non-clinical (household) waste (clear bag) e.g. paper hand towels, all types of packaging, non-contaminated blue roll & other domestic type waste

38.2 Richardson, Weardale & Sedgefield community hospitals:
The same regulations apply as for acute & community health centres but in addition:
- Offensive (non-infectious) waste (yellow bag with black stripe (tiger bag) ) e.g. sanitary towels, incontinence pads, nappies, gloves, aprons etc. contaminated with non-infectious bodily fluids

38.3 Community (patient’s home):
- Clinical waste (orange bag) e.g. soiled infected dressings, wound drains. Contact local authority for collection as per community nursing waste procedures
- Household waste – it is acceptable in the domestic setting for small quantities of non-infectious waste e.g. aprons, gloves, incontinence pads, urinary drainage equipment (once the urine has been emptied into a toilet) to be double bagged (ordinary carrier bag) & placed in the householder’s bin with their permission

39 Autonomic dysreflexia
Autonomic dysreflexia (also known as autonomic hyper-reflexia) is one of the most serious life threatening conditions affecting patients with spinal cord injury at or above the level of the 6th thoracic vertebrae.

This syndrome develops secondary to a noxious stimulus below the level of injury. As the spinal cord is damaged, signals cannot pass normally to the brain, therefore, the body produces exaggerated abnormal nerve signals which cause problems above and below the
level of the spinal injury. Below the injury, blood vessels go into spasm causing the blood pressure to rise. Above the level of injury, the body senses the high blood pressure and tries to relax the blood vessels (but can only influence the blood vessels above the level of injury) which causes flushing and blotchiness of skin and pounding headache.

**Symptoms** may be mild or severe; patients presenting with one or more of the following:
- Pounding headache
- Flushing and/or blotching above the level of cord damage
- Pallor below the level of injury
- Slowed heart rate
- Profuse sweating (above level of injury)
- Palpitations
- Goosebumps
- Blurred vision or seeing spots before your eyes
- Stuffy nose
- Feeling of doom and gloom, anxiety apprehension
- Elevated blood pressure (Hypertension which may be severe enough to lead to seizures, strokes or ultimately death (Under normal circumstances a tetraplegic patient may have low blood pressure (BP), e.g. 90/60; a rise of 20mm mercury (Hg) is therefore significant; if the BP rises to 120/80 this may become an emergency situation).

**Causes**
Bladder problems are the most common cause of autonomic dysreflexia; e.g.:
- Overfull bladder
- Kidney or bladder stones
- High pressure voiding
- Urinary tract infection
- Blocked catheter
- Defective drainage system (e.g. kinked tubing or leg bag too full).

**Treatment**
Identify the source of the noxious stimulus; remove the stimulus to resolve symptoms. Reduce the blood pressure by returning the patient to bed and place in a sitting position. (If bladder problems suspected, sit patient at 45 degrees; sitting at 90 degrees may cause increased pressure on the full bladder).

**Check bladder**
If patient is not catheterised and bladder appears full, catheterise immediately and leave on free drainage.

If patient is already catheterised, empty leg bag/drainage bag, check tubing is not kinked. If catheter appears blocked, change immediately; DO NOT ATTEMPT A BLADDER WASHOUT this will distend the bladder further with potentially fatal consequences.

**Check other causes**
If infection is suspected commence antibiotic therapy.

Check bowel and other potential causes; treat appropriately.
References


Department of Health (DH 2007) Saving Lives: A delivery programme to reduce Healthcare Associated infections, Department of Health
Available at: http://hcai.dh.gov.uk/whatdoido/high-impact-interventions/


Available at: www.nmc-uk.org/Nurses-and-midwives/Advice-by-topic/A/Advice/Consent


Available at: http://puricore.com/PDFs/Guidelines_for_Preventing_Healthcare.pdf

Available via Trust intranet; use popular links Nursing and Quality, Royal Marsden Clinical Procedures click on link, view procedures, click on link

Associated Documentation


CDDFT Hand Hygiene Policy.

CDDFT Latex Policy.

CDDFT Infection Control Guidelines

CDDFT Waste Policy

CDDFT Consent to Examination and Treatment Policy


NPSA (2009) Female Urinary Catheters Causing Trauma to Adult Males available at http://www.nrls.npsa.nhs.uk

### CATHETER SELECTION

<table>
<thead>
<tr>
<th>Catheter Material</th>
<th>Recommended Usage</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polyvinyl chloride (PVC)</td>
<td>Short-term only</td>
<td>Large internal diameter</td>
<td>Uncomfortable for long term use.</td>
</tr>
<tr>
<td>Polyvinyl chloride nonballoon</td>
<td>Maximum of 7 days</td>
<td>Allows good drainage</td>
<td>Rigid and inflexible</td>
</tr>
<tr>
<td></td>
<td>Intermittent catheterisation, can be reused</td>
<td>Postoperatively</td>
<td>Must be rinsed thoroughly after use for ICSC. Soap deposits can cause urethral irritation.</td>
</tr>
<tr>
<td>Teflon coated (PTFE) with latex core</td>
<td>Medium-term, up to 28 days</td>
<td>Smoother on external surfaces for insertion – reduces tissue damage.</td>
<td>If left in situ too long Teflon coating may wear thin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More resistant to encrustation</td>
<td>Unsuitable for patients allergic to latex</td>
</tr>
<tr>
<td>Silicone</td>
<td>Long-term, up to 12 weeks, follow manufacturer’s recommendations</td>
<td>Wide lumen for drainage. Suitable for patients with latex allergy.</td>
<td>‘Cuffing’ of balloon can occur on deflation can be more difficult to remove supra-pubically.</td>
</tr>
<tr>
<td>Hydrogel coated latex</td>
<td>Long-term use, up to 12 weeks</td>
<td>More compatible with body tissue, less trauma</td>
<td>Does contain latex – unsuitable for patients allergic to latex.</td>
</tr>
<tr>
<td>Silicone elastomer</td>
<td>Long term, up to 12 weeks, follow manufacturer’s recommendations</td>
<td>Wide lumen for drainage. Suitable for patients with latex allergy.</td>
<td>‘Cuffing’ of balloon can occur on deflation can be more difficult to remove supra-pubically</td>
</tr>
<tr>
<td>Hydrogel coated latex</td>
<td>Long-term use, up to 12 weeks</td>
<td>More compatible with body tissue, less trauma</td>
<td>Does contain latex – unsuitable for patients allergic to latex.</td>
</tr>
<tr>
<td>Silicone elastomer-coated latex (silicone bonding to outer and inner surfaces)</td>
<td>Long term use, up to 12 weeks</td>
<td>May help to reduce potential for encrustation</td>
<td>Unsuitable for patients allergic to latex</td>
</tr>
<tr>
<td>Hydrogel coated silicone</td>
<td>Long-term use, up to 12 weeks</td>
<td>Suitable for patients with latex allergy</td>
<td>Rigid; may be uncomfortable for patients</td>
</tr>
<tr>
<td>Silver coated silver alloy latex /hydrogel</td>
<td>Short-term use, use to 28 days</td>
<td>Suitable for patients more prone to (CAUTI) infection</td>
<td>Cost</td>
</tr>
</tbody>
</table>
ADULT MALE URETHRAL CATHETERISATION PROCEDURE

Environmental cleaning
Detergent wipes

Equipment decontamination
70% isopropyl alcohol wipes for aseptic technique trolley decontamination (Hospitals/health centres)
Detergent wipes for cleaning area identified for aseptic technique (Community)

Hand hygiene
Hand wash basin with running water
Liquid soap
Disposable paper towels
Hand sanitiser (at least 60% alcohol content)
Community hand hygiene pack required if patient facilities are limited

Personal protective equipment (PPE)
Single use disposable plastic aprons
Single use non-sterile disposable gloves

Catheterisation equipment
Sterile catheterisation pack containing kidney dish, plastic forceps, cotton wool balls, gauze swabs and sterile field.
Sterile gloves x2 pairs (correct size)
Urethral catheter (correct size (Ch. gauge), length, tip, balloon)
Sterile water (for catheter balloon inflation; 5–10 ml normally recommended)
Sterile anaesthetic lubricating gel – 6–11 ml for insertion into urethra prior to catheter insertion
Sterile universal specimen container (for catheter specimen of urine if required)
Sachet 0.9% sodium chloride (for cleaning urethral meatus)
70% isopropyl alcohol wipe (to clean saline sachet over tear mark)
Sterile leg bag/sterile drainage bag
Leg strap or sleeve
Drainage stand/holder
Clinical waste bag
Aseptic technique required
An aseptic technique must be used when catheterising, manipulating the closed drainage system and urine sampling
When undertaking the catheterisation procedure use your dominant hand (DH) as 'dirty hand' & non-dominant hand (NDH) as 'clean hand' to prevent contamination of sterile field/equipment

Removing PPE
Remove PPE carefully to prevent hands coming into contact with body fluids/touching contaminated surfaces

Gloves:
• Use 1 gloved hand to grasp the outside of the opposite glove near the wrist
• Pull & peel the glove down over the hand (Glove will now be inside-out, with contaminated side on the inside)
• Hold removed glove in the opposite gloved hand, slide one or two fingers of the non-gloved hand under the wrist of the remaining glove
• Pull glove down over 1st glove from the inside

Aprons:
• Snap plastic at back of neck
• Fold bib down
• Snap waist ties
• Avoid contact with outer side of apron as you bring sides forward & carefully fold together

Waste disposal

Paper hand towels:
Domestic waste (Hospitals/Health-centres)
Patient’s household waste with patient’s permission (Community)

PPE & catheterisation equipment:
Clinical waste (Hospitals/Health-centres)
Patient’s household waste in double plastic bags with patient’s permission or dispose as per Trust waste policy (Community)
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Informed consent; explain/discuss catheterisation procedure with patient/carer &amp; gain consent</strong></td>
<td>Patient/carer understand procedure</td>
</tr>
<tr>
<td><strong>Check patient allergies/sensitivities</strong></td>
<td>Patient safety</td>
</tr>
<tr>
<td><strong>Personal hygiene/skin cleansing</strong></td>
<td>Minimises infection risk</td>
</tr>
<tr>
<td>- Request patient has shower/bath/wash</td>
<td></td>
</tr>
<tr>
<td>- If patient requires assistance to shower/bath or wash, clean hands &amp; don disposable plastic apron before patient contact. Assist patient to shower/bath/wash</td>
<td></td>
</tr>
<tr>
<td>- Following patient contact, remove plastic apron; dispose into waste</td>
<td></td>
</tr>
<tr>
<td>- Clean hands; sanitise or wash appropriately; dispose paper towels into waste</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental preparation</strong></td>
<td>PPE protects uniform/work wear</td>
</tr>
<tr>
<td>- Clean hands appropriately</td>
<td>Minimising activity allows dust to settle prior to aseptic technique reducing infection risk</td>
</tr>
<tr>
<td>- Don disposable plastic apron</td>
<td></td>
</tr>
<tr>
<td>- Prepare treatment room/patient area:</td>
<td></td>
</tr>
<tr>
<td>- Appropriately screen treatment room/patient area 10 minutes before procedure</td>
<td></td>
</tr>
<tr>
<td>- Minimise other activities (e.g. cleaning, family/pets)</td>
<td></td>
</tr>
<tr>
<td>- Switch off any fans</td>
<td></td>
</tr>
<tr>
<td>- Close windows</td>
<td></td>
</tr>
<tr>
<td>- Clean treatment room/bed space/patient environment with detergent wipes; allow to dry</td>
<td></td>
</tr>
<tr>
<td>- Decontaminate aseptic procedure trolley with 70% isopropyl alcohol wipes (Hospitals/health-centres) or clean specific work surface for aseptic procedure with detergent wipes (Community)</td>
<td></td>
</tr>
<tr>
<td>Depending upon the amount of environmental cleaning required pre-catheterisation procedure, it may be appropriate to remove disposable plastic apron; dispose into waste</td>
<td></td>
</tr>
<tr>
<td>- Clean hands</td>
<td></td>
</tr>
<tr>
<td><strong>Equipment &amp; patient preparation</strong></td>
<td>Protects uniform/work wear</td>
</tr>
<tr>
<td>- If apron previously removed following environmental decontamination, don disposable plastic apron</td>
<td>Minimise infection risk</td>
</tr>
<tr>
<td>- Check expiry dates &amp; packaging of sterile equipment/fluids is intact</td>
<td>If contaminated start again</td>
</tr>
<tr>
<td>- Put required equipment on bottom of aseptic procedure trolley (Hospitals/health-centre) or in prepared work area near patient (Community)</td>
<td>Prevents contamination of sterile field</td>
</tr>
<tr>
<td>- Wash &amp; dry hands; dispose paper towels into waste</td>
<td></td>
</tr>
<tr>
<td>- Open outer cover of catheterisation pack; slide inner pack onto top shelf of aseptic procedure trolley/work area without touching it</td>
<td></td>
</tr>
<tr>
<td>- Open sterile field; do not touch the upper surface of the sterile field</td>
<td></td>
</tr>
</tbody>
</table>
- Open the outer pack of the 1st pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field
- Open the outer packing of the other required sterile equipment and drop onto sterile field
- Clean the outer package of 0.9% sterile sodium chloride around the tear mark with 70% isopropyl alcohol wipe prior to opening; allow to dry thoroughly
- Tear the package where indicated, pour sterile saline into the sterile container in catheter pack
- Clean hands
- Put on non-sterile gloves
- Remove patient bed clothes/clothes (maintain dignity)
- Place disposable pad under patient’s buttocks/thighs
- Position patient; preferably supine, legs extended
- Wash and dry genital area; pay particular attention to thorough washing of glans and urethral meatus; ensuring foreskin (if present) is retracted prior to washing and drying. Leave foreskin back until catheterisation completed
- Remove gloves; dispose into waste
- Wash & dry hands; dispose paper towels into waste
- Put on 1st pair sterile gloves
- Arrange & prepare sterile equipment on sterile field
- Make a small tear along the perforation of the sterile plastic cover at the tip-end of the urinary catheter ready for later use (do not touch or expose the catheter)
- Put the urinary catheter (still inside sterile plastic cover) into the sterile receiver
- Place sterile towel across top of patient’s thighs; take care not to contaminate sterile gloves
- Pick up sterile gauze from sterile pack with NDH
- Pass gauze to DH
- Use NDH to hold penis wrapped with sterile gauze; take care not to contaminate glove
- Use DH to clean urethral meatus using 1 stroke then discard gauze into waste
- Instil anaesthetic lubricating gel
  - Use NDH to pick up sterile gel from sterile field

| Decontaminates outer packing & prevents contamination of sterile fluid |
| PPE prevents risk of contact with body fluid |
| Patient comfort, ease of procedure, bedding protected. |
| Creates a sterile work area to place the sterile receiver and catheter |
| Permits cleansing of urethral meatus |
Policy for Urinary Catheterisation (Ongoing Care and Management)

- Pass gel to DH
- Use NDH to hold penis wrapped with sterile gauze; take care not to contaminate glove
- Use DH to insert the nozzle of sterile gel into the urethra and squeeze gently to instil the gel
- When all gel instilled, use NDH to squeeze the end of penis gently to prevent gel from leaking out; hold for 4 minutes
- Remove gloves
- Wash & dry hands; dispose paper towels into waste

**Catheter insertion**
- Open the outer pack of the 2nd pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field. Don second pair of sterile gloves.
- Place the sterile receiver/catheter on sterile towel on top of patient’s thighs.
- In preparation for catheter insertion, use NDH to hold the penis behind the glans, raise & extend the penis
- Use DH to gradually feed the catheter out of the sterile plastic cover as you gently insert up the urethra & into the bladder (15–25 cm)

*Resistance may be felt at the external sphincter; increase the traction on the penis slightly & apply steady, gentle pressure on the catheter. Ask patient to cough or strain gently as if passing urine*
- When urine flows, continue to insert catheter to the bifurcation
- Gently inflate catheter balloon following manufacturer’s instructions
- Withdraw catheter slightly & attach leg bag and/or drainage system (use a non touch aseptic technique)
- Support catheter with support or tape
- Clean & dry penis; reposition foreskin if required (prevents paraphimosis)
- Ensure patient is dry & comfortable
- Measure & record urinary output

*Patients with urinary retention, record bladder capacity, record urine drained; not normally necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed*
- Dispose of used equipment into waste
- Remove gloves; dispose into waste
- Remove apron; dispose into waste
- Wash & dry hands; dispose paper towels into waste

**Provides lubrication to prevent trauma**
- Allows anaesthetic gel to take effect

**Catheter remains in sterile bag; tip can be exposed when required for catheterisation**
- Straightens urethra, prevents penile retraction, assists process
- Male urethra approx. 18 cm long
- Coughing/straining may help relax the external sphincter
- Ensures catheter correctly positioned in bladder
- Avoids accidental inflation of balloon in the urethra
- Catheter is secure
- Reduces risk of urethral & bladder neck trauma
- To enable monitoring renal function & fluid balance
### Post-catheterisation check catheter is:
- Draining
- Not stretched tight when patient is mobile or penis erect
- Lumen is not occluded by fixation device or tape
- Return patient to ward/department/draw back curtains/settle patient

### Catheter specimen of urine (CSU)
If CSU is required for laboratory examination:
- Don plastic apron
- Wash and dry hands; dispose paper towels into waste
- Don non sterile gloves
- Decontaminate urine sampling port with 70% isopropyl alcohol wipe
- Use aseptic technique to take urine sample from needle free sampling port
- Put urine sample into sterile container
- Clean sampling port with detergent wipe; dispose wipe into waste
- Remove PPE; dispose into waste
- Wash and dry hands; dispose paper towels into waste
- Label urine sample, complete laboratory form, send sample to laboratory, record in patients record

Use sterile equipment to take sample
Ensures sample not contaminated
Maintains closed drainage system
Needle-free system prevents needlestick injury.

### Environmental care
- Don non-sterile gloves & apron
- Clear equipment appropriately
- Clean aseptic procedure trolley or work surface identified for aseptic procedure with detergent wipes
- Dispose of any final waste appropriately

Prevents environmental contamination

### Record keeping
Record relevant information:
- Reasons for catheterisation, date & time
- Catheter type, length, size batch number, manufacturer, amount of water in the balloon
- Problems encountered during the procedure
- Review date to assess need for continued catheterisation or date to change catheter

Legal requirement & reference point
ADULT FEMALE URETHRAL CATHETERISATION PROCEDURE

Environmental cleaning
Detergent wipes

Equipment decontamination
70% isopropyl alcohol wipes for aseptic technique trolley decontamination (Hospitals/health centres)
Detergent wipes for cleaning area identified for aseptic technique (Community)

Hand hygiene
Hand wash basin with running water
Liquid soap
Disposable paper towels
Hand sanitiser (at least 60% alcohol content)
Community hand hygiene pack required if patient facilities are limited

Personal protective equipment (PPE)
Single use disposable plastic aprons
Single use non-sterile disposable gloves

Catheterisation equipment
Sterile catheterisation pack containing kidney dish, plastic forceps, cotton wool balls, gauze swabs and sterile field
Sterile gloves x2 pairs (correct size)
Urethral catheter (correct size (Ch. gauge), length, tip, balloon) Sterile water (for catheter balloon inflation; 5–10 mL normally recommended)
Sterile anaesthetic lubricating gel – 6–11 ml for insertion into urethra prior to catheter insertion
Sterile universal specimen container (for catheter specimen of urine if required)
Sachet 0.9% sodium chloride (for cleaning urethral meatus)
70% isopropyl alcohol wipe (to clean saline sachet over tear mark)
Sterile leg bag/sterile drain bag
Leg strap or sleeve
Drainage stand/holder
Clinical waste bag
Aseptic technique required
An aseptic technique must be used when catheterising, manipulating the closed drainage system and urine sampling

When undertaking the catheterisation procedure use your dominant hand (DH) as ‘dirty hand’ & non-dominant hand (NDH) as ‘clean hand’ to prevent contamination of sterile field/equipment

Removing PPE
Remove PPE carefully to prevent hands coming into contact with body fluids/touching contaminated surfaces

Gloves:
• Use 1 gloved hand to grasp the outside of the opposite glove near the wrist
• Pull & peel the glove down over the hand (Glove will now be inside-out, with contaminated side on the inside)
• Hold removed glove in the opposite gloved hand, slide one or two fingers of the non-gloved hand under the wrist of the remaining glove
• Pull glove down over 1st glove from the inside

Aprons:
• Snap plastic at back of neck
• Fold bib down
• Snap waist ties
• Avoid contact with outer side of apron as you bring sides forward & carefully fold together

Waste disposal

Paper hand towels:
Domestic waste (Hospitals/Health-centres)
Patient’s household waste with patient’s permission (Community)

PPE & catheterisation equipment:
Clinical waste (Hospitals/Health-centres)
Patient’s household waste in double plastic bags with patient’s permission or dispose as per Trust waste policy (Community)
## Procedure

| **Informed consent:** explain/diskuss catheterisation procedure with patient/carer & gain consent | **Rationale:** Patient/carer understand procedure |
| **Check patient allergies/sensitivities** | **Patient safety** |

### Personal hygiene/skin cleansing
- Request patient has shower/bath or wash
- If patient requires assistance to shower/bath or wash, clean hands & don disposable plastic apron before patient contact. Assist patient to shower/bath/wash
- Following patient contact, remove plastic apron; dispose into waste
- Clean hands; sanitise or wash appropriately; dispose paper towels into waste

### Environmental preparation
- Clean hands appropriately
- Don disposable plastic apron
- Prepare treatment room/patient area:
  - Appropriately screen treatment room/patient area 10 minutes before procedure
  - Minimise other activities (e.g. cleaning, family/pets)
  - Switch off any fans
  - Close windows
  - Clean treatment room/bed space/patient environment with detergent wipes; allow to dry
  - Decontaminate aseptic procedure trolley with 70% isopropyl alcohol wipes (Hospitals/health-centres) or clean specific work surface for aseptic procedure with detergent wipes (Community)

*Depending upon the amount of environmental cleaning required pre-catheterisation procedure, it may be appropriate to remove disposable plastic apron; dispose into waste*

### Equipment & patient preparation
- If apron previously removed following environmental decontamination, don disposable plastic apron
- Check expiry dates & packaging of sterile equipment/fluids is intact
- Put required equipment on bottom of aseptic procedure trolley (Hospitals/health-centre) or in prepared work area near patient (Community)
- Wash & dry hands; dispose paper towels into waste
- Open outer cover of catheterisation pack; slide inner pack onto top shelf of aseptic procedure trolley/work area without touching it

*Protects uniform/work wear*

*Minimise infection risk*

*If contaminated start again*
Policy for Urinary Catheterisation (Ongoing Care and Management)

- Open sterile field; do not touch the upper surface of the sterile field
- Open the outer pack of the 1st pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field
- Open the outer packing of the other required sterile equipment and drop onto sterile field
- Clean the outer package of 0.9% sterile sodium chloride around the tear mark with 70% isopropyl alcohol wipe prior to opening; allow to dry thoroughly
- Tear the package where indicated, pour sterile saline into the sterile container in catheter pack
- Clean hands
- Put on non-sterile gloves
- Remove patient bed clothes/clothes (maintain dignity)
- Position patient; preferably supine, knees bent, legs apart
- Place disposable pad under patient’s buttocks
- Wash and dry genital area (use top to bottom technique to avoid vulval contamination); pay particular attention to thorough washing and drying of urethral meatus
- Remove gloves; dispose into waste
- Wash & dry hands; dispose paper towels into waste
- Put on 1st pair sterile gloves
- Arrange & prepare sterile equipment on sterile field
- Make a small tear along the perforation of the sterile plastic cover at the tip-end of the urinary catheter ready for later use (do not touch or expose the catheter)
- Put the urinary catheter (still inside sterile plastic cover) into the sterile receiver
- Place sterile towel between patient’s legs; take care not to contaminate sterile gloves

**Clean urethral meatus**

- Use NDH to pick up 2 pieces of dry sterile gauze-put these to 1 side on sterile field to use later to separate the labia
- Carefully place sterile gel from sterile field onto sterile towel between patient's legs
- Pick up remaining sterile gauze from sterile pack with NDH & wet this with 0.9% sterile sodium chloride, squeeze to remove excess
- Pass wet gauze to DH
- Pick up the 2 pieces of dry gauze in NDH; use to separate the labia & view urethral meatus (Leave this gauze in place for late use)
- Use DH to clean urethral meatus use a top to bottom downward stroke; discard this gauze into waste

**Instil the anaesthetic lubricating gel:**

- Use DH to pick up sterile gel from sterile towel

| Prevents contamination of sterile field | Decontaminates outer packing & prevents contamination of sterile fluid | PPE prevents risk of contact with body fluid | Patient comfort, ease of procedure, bedding protected. | Creates a sterile work area to place the sterile receiver and catheter | Permits cleansing of urethral meatus | Provides lubrication to prevent |
Policy for Urinary Catheterisation (Ongoing Care and Management)

- Use DH to insert the nozzle of sterile gel into the urethra; leave at least 4 minutes before inserting catheter
- Remove gloves
- Wash & dry hands; dispose paper towels into waste

**Catheter insertion**
- Open the outer pack of the 2nd pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field. Don second pair of sterile gloves.
- Place the sterile receiver/catheter on sterile towel between patient’s legs.
- Use NDH to separate the labia using gauze previously left in place to view urethral meatus
- Use DH to gradually feed the catheter (out of the sterile plastic cover) into the urethra as you gently insert up & backwards into bladder (5-6 cm)
- Resistance may be felt at the external sphincter; ask patient to cough or strain gently as if passing urine
- When urine flows, continue to insert catheter to the bifurcation
- Gently inflate catheter balloon following manufacturer's instructions
- Withdraw catheter slightly & attach leg bag and/or drainage system (use an aseptic technique)
- Support catheter with support or tape
- Clean & dry genital area; ensure patient is dry & comfortable
- Measure & record urinary output

**Patients with urinary retention, record bladder capacity, record urine drained**

*Not normally necessary to measure the amount of urine if the patient is having the urinary catheter routinely changed*

- Dispose of used equipment into waste
- Remove gloves; dispose into waste
- Remove apron; dispose into waste
- Wash & dry hands; dispose paper towels into waste

**Post-catheterisation check catheter is:**
- Draining
- Not stretched tight when patient is mobile
- Lumen is not occluded by fixation device or tape
- Return patient to ward/department/draw back curtains/settle patient

**Catheter specimen of urine (CSU)**
If CSU is required for laboratory examination:
- Don plastic apron

<table>
<thead>
<tr>
<th>Trauma</th>
<th>Allows anaesthetic gel to take effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter remains in sterile bag; tip can be exposed when required for catheterisation</td>
<td>Coughing/straining may help relax the external sphincter</td>
</tr>
<tr>
<td>Ensures catheter correctly positioned in bladder</td>
<td>Avoids accidental inflation of balloon in the urethra</td>
</tr>
<tr>
<td>Catheter is secure</td>
<td>Reduces risk of urethral &amp; bladder neck trauma</td>
</tr>
<tr>
<td>To enable monitoring renal function &amp; fluid balance</td>
<td>Use sterile equipment to take sample</td>
</tr>
</tbody>
</table>
### Policy for Urinary Catheterisation (Ongoing Care and Management)

- Wash and dry hands; dispose paper towels into waste
- Don non sterile gloves
- Decontaminate urine sampling port with 70% isopropyl alcohol wipe
- Use an aseptic technique to take urine sample from needle free sampling port
- Put urine sample into sterile container
- Clean sampling port with detergent wipe; dispose wipe into waste
- Remove PPE; dispose into waste
- Wash and dry hands; dispose paper towels into waste
- Label urine sample, complete laboratory form, send sample to laboratory, record in patients record

<table>
<thead>
<tr>
<th>Environmental care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don non-sterile gloves &amp; apron</td>
</tr>
<tr>
<td>Clear equipment appropriately</td>
</tr>
<tr>
<td>Clean aseptic procedure trolley or work surface identified for aseptic procedure with detergent wipes</td>
</tr>
<tr>
<td>Dispose of any final waste appropriately</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Record keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record relevant information:</td>
</tr>
<tr>
<td>Reasons for catheterisation, date &amp; time</td>
</tr>
<tr>
<td>Catheter type, length, size batch number, manufacturer, amount of water in the balloon</td>
</tr>
<tr>
<td>Problems encountered during the procedure</td>
</tr>
<tr>
<td>Review date to assess need for continued catheterisation or date to change catheter</td>
</tr>
</tbody>
</table>

- Ensures sample not contaminated
- Maintains closed drainage system
- Needle free system prevents needlestick injury.

- Prevents environmental contamination

- Legal requirement & reference point
REPLACING A SUPRAPUBIC CATHETER PROCEDURE

Environmental cleaning
Detergent wipes

Equipment decontamination
70% isopropyl alcohol wipes for aseptic technique trolley decontamination (Hospitals/health centres)
Detergent wipes for cleaning area identified for aseptic technique (Community)

Hand hygiene
Hand wash basin with running water
Liquid soap
Disposable paper towels
Hand sanitiser (at least 60% alcohol)
Community hand hygiene pack required if patient facilities are limited

Personal protective equipment (PPE)
Single use disposable plastic aprons
Single use non-sterile disposable gloves

Catheterisation equipment
Sterile catheterisation pack containing kidney dish, plastic forceps, cotton wool balls, gauze swans and sterile field
Sterile gloves x2 pairs (correct size)
Sterile syringe (appropriate size) to remove water from previous suprapubic catheter
Urethral catheter (correct size (Ch. gauge), length, tip, balloon)
Sterile water (for catheter balloon inflation; 5–10 ml normally recommended)
Sterile anaesthetic lubricating gel – 6–11 ml for use prior to catheter insertion
Sterile universal specimen container (for catheter specimen of urine if required)
Sachet 0.9% sodium chloride (for cleaning urethral meatus)
70% isopropyl alcohol wipe (to clean saline sachet over tear mark)
Sterile leg bag/sterile drainage bag
Leg strap or sleeve
Drainage stand/holder
Clinical waste bag
Aseptic technique required
An aseptic technique must be used when catheterising, manipulating the closed drainage system and urine sampling

When undertaking the catheterisation procedure use your dominant hand (DH) as ‘dirty hand’ & non-dominant hand (NDH) as ‘clean hand’ to prevent contamination of sterile field/equipment

Removing PPE
Remove PPE carefully to prevent hands coming into contact with body fluids/touching contaminated surfaces

Gloves:
- Use 1 gloved hand to grasp the outside of the opposite glove near the wrist
- Pull & peel the glove down over the hand (Glove will now be inside-out, with contaminated side on the inside)
- Hold removed glove in the opposite gloved hand, slide one or two fingers of the non-gloved hand under the wrist of the remaining glove
- Pull glove down over 1st glove from the inside

Aprons:
- Snap plastic at back of neck
- Fold bib down
- Snap waist ties
- Avoid contact with outer side of apron as you bring sides forward & carefully fold together

Waste disposal

Paper hand towels:
Domestic waste (Hospitals/Health-centres)
Patient’s household waste with patient’s permission (Community)

PPE & catheterisation equipment:
Clinical waste (Hospitals/Health-centres)
Patient’s household waste in double plastic bags with patient’s permission or dispose as per Trust waste policy (Community)
### Procedure

| Informed consent; explain/discuss catheterisation procedure with patient/carer & gain consent | Patient/carers understand procedure |
| Check patient allergies/sensitivities | Patient safety |

#### Rationale

- **Personal hygiene/skin cleansing**
  - Request patient has shower/bath or wash
  - If patient requires assistance to shower/bath or wash, clean hands & don disposable plastic apron before patient contact. Assist patient to shower/bath/wash
  - Following patient contact, remove plastic apron; dispose into waste
  - Clean hands; sanitise or wash appropriately; dispose paper towels into waste
  - Minimises infection risk

#### Environmental preparation

- Clean hands appropriately
- Don disposable plastic apron
- Prepare treatment room/patient area:
  - Appropriately screen treatment room/patient area 10 minutes before procedure
  - Minimise other activities (e.g. cleaning, family/pets)
  - Switch off any fans
  - Close windows
  - Clean treatment room/bed space/patient environment with detergent wipes; allow to dry
  - Decontaminate aseptic procedure trolley with 70% isopropyl alcohol wipes (Hospitals/health-centres) or clean specific work surface for aseptic procedure with detergent wipes (Community)
  - Minimising activity allows dust to settle prior to aseptic technique reducing infection risk

#### Equipment & patient preparation

- If apron previously removed following environmental decontamination, don disposable plastic apron
- Check expiry dates & packaging of sterile equipment/fluids is intact
- Put required equipment on bottom of aseptic procedure trolley (Hospitals/health-centre) or in prepared work area near patient (Community)
- Wash & dry hands; dispose paper towels into waste
- Open outer cover of catheterisation pack; slide inner pack onto top shelf of aseptic procedure trolley/work area without touching it
- Open sterile field; do not touch the upper surface of the sterile field
- Open the outer pack of the 1st pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field
- Protects uniform/work wear
- Minimise infection risk
- Prevents contamination of sterile field
- If contaminated start again
• Open the outer packing of the other required sterile equipment and drop onto sterile field
• Clean the outer package of 0.9% sterile sodium chloride around the tear mark with 70% isopropyl alcohol wipe prior to opening; allow to dry thoroughly
• Tear the package where indicated, pour sterile saline into the sterile container in catheter pack
• Clean hands
• Put on non-sterile gloves
• Remove patient bed clothes/clothes (maintain dignity)
• Position patient; preferably supine, place disposable pad under patient
• Wash and dry abdominal area paying particular attention to the suprapubic catheter insertion site
• Remove gloves; dispose into waste
• Wash & dry hands; dispose paper towels into waste
• Put on 1st pair sterile gloves
• Arrange & prepare sterile equipment on sterile field
• Make a small tear along the perforation of the sterile plastic cover at the tip-end of the urinary catheter ready for later use (do not touch or expose the catheter)
• Put the urinary catheter (still inside sterile plastic cover) into the sterile receiver
• Place sterile towel on patient's abdomen; take care not to contaminate sterile gloves

**Remove existing suprapubic catheter**
• Take catheter specimen urine (CSU) if required (see section 34 Urine sampling) prior to catheter removal
• Connect sterile syringe (correct size for volume of water to be withdrawn) securely into the catheter inflation valve; slowly withdraw water; dispose into waste

  *If the catheter balloon will not deflate seek medical help; do not attempt to burst it by over inflating, do not cut the catheter (See appendix 9) Check list for problems in catheter with removal*
• Remove the catheter slowly; dispose into waste

  *Check condition of the removed catheter, document any anomalies and report appropriately, document in patient's record.*
• Remove PPE; dispose into waste
• Wash and dry hands; dispose into waste

**Clean the abdominal meatus**
• Open the outer pack of the 2nd pair sterile gloves; slide onto the aseptic procedure trolley/work area to the side of the main sterile field
• Don 2nd pair sterile gloves
• Pick up sterile gauze from sterile pack with NDH & wet this with 0.9% sterile sodium chloride, squeeze

---

**Decontaminates outer packing & prevents contamination of sterile fluid**

**PPE prevents risk of contact with body fluid**

**Patient comfort, ease of procedure, bedding protected.**

**Creates a sterile work area to place the sterile receiver and catheter**
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Pass wet gauze to DH to clean abdominal meatus using circular stroke; discard gauze into waste</td>
</tr>
<tr>
<td>2.</td>
<td>Use NDH to pick up sterile gel from sterile field</td>
</tr>
<tr>
<td>3.</td>
<td>Pass gel to DH</td>
</tr>
<tr>
<td>4.</td>
<td>Use DH to insert the nozzle of sterile gel around/into abdominal meatus; leave at least 4 minutes; dispose into waste</td>
</tr>
<tr>
<td>5.</td>
<td>Use NDH to pick up the receiver containing the new sterile catheter (still inside plastic cover); place receiver/catheter on the sterile towel on the patient's abdomen (take care not to contaminate the sterile gloves)</td>
</tr>
<tr>
<td>6.</td>
<td>Use NDH to pick up sterile catheter</td>
</tr>
<tr>
<td>7.</td>
<td>Gradually feed the catheter out of the sterile plastic cover as you gently insert into the abdominal tract into the bladder (5-6 cm)</td>
</tr>
<tr>
<td>8.</td>
<td>When urine flows, advance catheter further (6-8 cm)</td>
</tr>
<tr>
<td>9.</td>
<td>Gently inflate catheter balloon following manufacturer's instructions</td>
</tr>
<tr>
<td>10.</td>
<td>Withdraw catheter slightly &amp; attach to the closed drainage system</td>
</tr>
<tr>
<td>11.</td>
<td>Support catheter with support or tape</td>
</tr>
<tr>
<td>12.</td>
<td>Ensure catheter is not stretched tight when patient is mobile</td>
</tr>
<tr>
<td>13.</td>
<td>Catheter lumen must not be occluded by fixation device or tape</td>
</tr>
<tr>
<td>14.</td>
<td>Clean &amp; dry abdominal area</td>
</tr>
<tr>
<td>15.</td>
<td>Dispose of used equipment into bag</td>
</tr>
<tr>
<td>16.</td>
<td>Remove gloves; dispose into waste</td>
</tr>
<tr>
<td>17.</td>
<td>Remove apron; dispose into waste</td>
</tr>
<tr>
<td>18.</td>
<td>Wash &amp; dry hands; dispose paper towels into waste</td>
</tr>
<tr>
<td>19.</td>
<td>Post-catheterisation, check catheter is:</td>
</tr>
<tr>
<td>20.</td>
<td>Draining</td>
</tr>
<tr>
<td>21.</td>
<td>Not stretched tight when patient is mobile</td>
</tr>
<tr>
<td>22.</td>
<td>Lumen is not occluded by fixation device or tape</td>
</tr>
<tr>
<td>23.</td>
<td>Return patient to ward/department/draw back curtains/settle patient</td>
</tr>
<tr>
<td>24.</td>
<td>Catheter specimen of urine (CSU)</td>
</tr>
<tr>
<td>25.</td>
<td>If CSU is required for laboratory examination:</td>
</tr>
<tr>
<td>26.</td>
<td>Don plastic apron</td>
</tr>
<tr>
<td>27.</td>
<td>Use sterile equipment to take sample</td>
</tr>
</tbody>
</table>
Policy for Urinary Catheterisation (Ongoing Care and Management)

<table>
<thead>
<tr>
<th>Action</th>
<th>Environmental care</th>
<th>Record keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wash and dry hands; dispose paper towels into waste</td>
<td>Don non-sterile gloves &amp; apron</td>
<td>Record relevant information:</td>
</tr>
<tr>
<td>Don non sterile gloves</td>
<td>Clear equipment appropriately</td>
<td>• Reasons for catheterisation, date &amp; time</td>
</tr>
<tr>
<td>Decontaminate urine sampling port with 70% isopropyl alcohol wipe</td>
<td>Clean aseptic procedure trolley or work surface identified for aseptic procedure with detergent wipes</td>
<td>• Catheter type, length, size batch number, manufacturer, amount of water in the balloon</td>
</tr>
<tr>
<td>Use aseptic technique to take urine sample from needle free sampling port</td>
<td>Dispose of any final waste appropriately</td>
<td>• Problems encountered during the procedure</td>
</tr>
<tr>
<td>Put urine sample into sterile container</td>
<td></td>
<td>• Review date to assess need for continued catheterisation or date to change catheter</td>
</tr>
<tr>
<td>Clean sampling port with detergent wipe; dispose wipe into waste</td>
<td></td>
<td>Legal requirement &amp; reference point</td>
</tr>
<tr>
<td>Remove PPE; dispose into waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wash and dry hands; dispose paper towels into waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Label urine sample, complete laboratory form, send sample to laboratory, record in patients record</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ensures sample not contaminated
Maintains closed drainage system
Needle free system prevents needlestick injury.

Prevents environmental contamination

Legal requirement & reference point
CATHETERISATION PATHWAY (FIRST SEVEN DAYS – HOSPITAL)  

APPENDIX 5

Please follow link below to access pathway:

http://intranet/Directorates/CorporateDirectorates/NursingDirector/infectionControl/Shared%20Documents/Catheter%20Documentation/Catheter%20Pathway%20July%202011(first%20seven%20days).doc

CATHETERISATION PATHWAY (CONTINUATION - HOSPITALS)  

APPENDIX 6

Please follow link below to access pathway:

## CATHETER MAINTENANCE SOLUTIONS

<table>
<thead>
<tr>
<th>Solution</th>
<th>Description</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citric acid 3.23% (pH 4)</td>
<td>For the dissolution of struvite crystals which form on the catheter tip under alkaline conditions (pH 7.5-9.5)</td>
<td>Charting of urinary pH over time will allow development of an individual catheter care plan</td>
</tr>
<tr>
<td>Citric acid 6% (pH 2)</td>
<td>Stronger citric acid solution for more persistent crystallisation</td>
<td>Strongly acidic – potential mucosal irritation</td>
</tr>
<tr>
<td>Mandelic acid 1% (pH 2)</td>
<td>For the reduction of microorganisms which produce urease creating alkaline conditions (mostly proteus species). Acidic pH also counters the effect of proteus on the urinary pH.</td>
<td>Strongly acidic – potential mucosal irritation. Evidence shows that 19 days treatment of twice daily instillations are required to effect treatment, but the licence is for maximum 14 days’ use.</td>
</tr>
<tr>
<td>Sodium chloride 09%</td>
<td>For the washing of debris (blood, mucus, pus) from the catheter</td>
<td>Will not dissolve crystal formation</td>
</tr>
<tr>
<td>Chlorhexidine 0.02%</td>
<td>For the treatment of pseudomonas infections</td>
<td>Limited value as the infections will exist in a biofilm which resists surface washing of antibiotics. Likely to lead to flourishing of resistant organisms.</td>
</tr>
</tbody>
</table>
## Procedure guidelines - Urinary catheter: maintenance solution administration

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Sterile dressing pack.</td>
<td>To begin to prepare the equipment for the procedure.</td>
</tr>
<tr>
<td>2 Antiseptic solution.</td>
<td>To prepare equipment for the procedure. Two 50 ml maintenance solution containers have been found to be the most effective way of treating encrustation (Getliffe et al. 2000). Warm solutions to prevent bladder spasm (Rew 1999).</td>
</tr>
<tr>
<td>3 Hand sanitizer (at least 60% alcohol)</td>
<td>To prepare patient for procedure. To detect for signs of infection, skin excoriation or displacement of catheter. If any signs noted, record in nursing notes and report to medical staff as appropriate.</td>
</tr>
<tr>
<td>4 Absorbent sheet.</td>
<td>To ensure that the patient understands the procedure and gives his/her valid consent (NMC 2006).</td>
</tr>
<tr>
<td>5 New catheter bag.</td>
<td>For the patient's privacy.</td>
</tr>
<tr>
<td>6 Catheter maintenance solution.</td>
<td>To minimize the risk of infection.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Explain and discuss the procedure with the patient.</td>
<td>To ensure that the patient understands the procedure and gives his/her valid consent (NMC 2006).</td>
</tr>
<tr>
<td><strong>2</strong> Ensure that the patient is in a comfortable position, allowing the nurse access to the catheter but maintaining the privacy and dignity of the patient.</td>
<td>For the patient's privacy.</td>
</tr>
<tr>
<td><strong>3</strong> Perform the following procedure using aseptic technique.</td>
<td>To minimize the risk of infection.</td>
</tr>
<tr>
<td><strong>4</strong> Open the outer wrappings of sterile dressing pack and put them within easy access of the patient.</td>
<td>To begin to prepare the equipment for the procedure.</td>
</tr>
<tr>
<td><strong>5</strong> Remove outer packaging from catheter maintenance solution and warm solution to body temperature by immersing package in water.</td>
<td>To prepare patient for procedure. To detect for signs of infection, skin excoriation or displacement of catheter. If any signs noted, record in nursing notes and report to medical staff as appropriate.</td>
</tr>
<tr>
<td><strong>6</strong> Expose the whole length of the catheter and observe for any signs of discharge, meatal problems and length of catheter in patient. If patient is using a leg bag, remove straps and place bag on the bed before exposing the catheter. Place the absorbent pad under catheter drainage bag junction.</td>
<td>To reduce the risk of infection (DoH 2005).</td>
</tr>
<tr>
<td><strong>7</strong> Wash hands according to Trust Policy and put on sterile gloves. Place sterile towel under catheter junction.</td>
<td>To reduce the risk of infection (DoH 2005).</td>
</tr>
<tr>
<td></td>
<td>Task Description</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8</td>
<td>Instill catheter maintenance solution using strict aseptic technique according to manufacturer’s guidelines.</td>
</tr>
<tr>
<td>9</td>
<td>When all the solution has been drained back out of the bladder disconnect the solution container and connect a new drainage bag. Note the amount of any fluid retention.</td>
</tr>
<tr>
<td>10</td>
<td>Make the patient comfortable, remove and dispose of equipment and wash hands according to trust Policy</td>
</tr>
<tr>
<td>11</td>
<td>Complete documentation as per Trust Policy and note any complication or problems encountered with the procedure.</td>
</tr>
</tbody>
</table>
CHECKLIST FOR PROBLEMS WITH URINARY CATHETER REMOVAL

Does the balloon deflate?  
Yes ☐  No ☐

If YES withdraw the catheter.

If NO
• Try to relax the patient
• Insert the catheter further into the bladder
• Insert syringe into catheter valve and leave for 10 minutes

Does the balloon now deflate?  
Yes ☐  No ☐

If YES withdraw the catheter.

If NO
• Seek medical advice
• Complete Incident Form
• Complete Nursing Records

Is the catheter able to be withdrawn?  
Yes ☐  No ☐

If NO
• Try to relax the patient
• Insert the catheter further into the bladder and rotate the catheter

Is the Catheter now able to be withdrawn?  
Yes ☐  No ☐

If NO
• Seek medical advice
• Complete Incident Form
• Complete Nursing Records
# Equality Analysis/Impact Assessment

<table>
<thead>
<tr>
<th>Full Assessment Form</th>
<th>v2/2011</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Division/Department:</th>
<th>Infection Control</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title of policy, procedure, decision, project, function or service:</th>
<th>Policy for Urinary Catheterisation (Ongoing Care and Management)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lead person responsible:</th>
<th>Senior Nurse Infection Control</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>People involved with completing this:</th>
<th>Catheter Group, Continence Specialist Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Infection Control Team (Acute and Community)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of policy, procedure, decision, project, function or service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing</td>
</tr>
<tr>
<td>New/proposed</td>
</tr>
<tr>
<td>Changed</td>
</tr>
</tbody>
</table>
### Step 1 – Scoping your analysis

#### What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

This policy applies to all staff within County Durham & Darlington NHS Foundation Trust who have responsibility for catheterising patients and for their on-going care and management.

#### Who is the policy, procedure, project, decision, function or service going to benefit and how?

Staff and patients.

#### What outcomes do you want to achieve?

Safe and appropriate on-going care and management of patients requiring urinary catheterisation.

#### What barriers are there to achieving these outcomes?

None.

#### How will you put your policy, procedure, project, decision, function or service into practice?

Policy will be disseminated Trustwide and available on the Trust intranet.

#### Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Step 2 – Collecting your information

What existing information / data do you have?

The Policy is based on National Guidance and is relevant to all groups.

Who have you consulted with?

Catheter Group, Continence Specialist Nurses, Infection Control Team (Acute and Community)

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No impact or potential for impact on any group

Sex/Gender

No impact or potential for impact on any group
<table>
<thead>
<tr>
<th>Category</th>
<th>Impact or Potential for Impact on Any Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Disability</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Pregnancy and Maternity</td>
<td>No impact or potential for impact on any group</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>No impact or potential for impact on any group</td>
</tr>
</tbody>
</table>
Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No impact or potential for impact on any group

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No.

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

Yes ❏ No ❌

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service, clearly show how this has been decided.

Following consultation with Catheter Group Members and Infection Control Team/Infection Control Committee. Approved at Quality & Healthcare Governance Committee.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:
How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Compliance with this policy will be monitored annually by the Infection Control Team (ICT) using the Infection Prevention Society (IPS) audit tool. Additionally healthcare teams will conduct Saving Lives High Impact Interventions or Essential Steps audits (DH 2007) to be reported appropriately (i.e. monthly or three monthly) as key performance indicators (KPI) on the Trust dashboard or the current means of measurement.

Step 6 Completion and Central Collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk