

Urinary Catheterisation Policy

Insertion and Care of Urinary Catheters/devices and care of Nephrostomies in Male and Female Adults

Approved By:	Policy and Guideline Committee
Date of Original Approval:	13th August 2007
Trust Reference:	B29/2007
Version:	V3
Supersedes:	V2 Approved 2015
Trust Lead:	Clair Riddell Urology Matron Janet Browning Continence Lead Nurse, Liz Collins Infection prevention Lead Nurse
Board Director Lead:	Chief Nurse
Date of Latest Approval	January 2019
Next Review Date:	January 2022

CONTENTS

Section		Page
1	Introduction and Overview	
2	Policy Scope	
3	Definitions and Abbreviations	
4	Roles- Who Does What	
5	Policy Implementation and Associated Documents Indications for Catheterisation	
6	Education and Training	
7	Process for Monitoring Compliance	
8	Equality Impact Assessment	
9	Supporting References, Evidence Base and Related Policies	
10	Process for Version Control, Document Archiving and Review	

Appendices		Page
One	Catheter Selection	
Two	Procedure for the insertion of a Male urethral urinary Catheter	
Three	Procedure for the insertion of a Female urethra urinary Catheter	
Four	Continuing Care of a Urinary urethral Catheter	
Five	Guidance on Urine cultures/sampling (Public Health England May 2017)	
Six	Procedure for taking a Catheter Sample Urine (CSU)	
Seven	Urinary Catheter not Draining – Performing a Bladder Washout	
Eight	Problems and Complications of Urethral Catheters	
nine	Procedure for Trial Without Catheter (TWOC) and removal of Catheter	
ten	Trial Without Catheter Pathway	
eleven	SAMPLE – Care plan to Reduce the Risk of urinary Catheter Associated Urinary Tract Infections (CAUTI)	
twelve	Procedure for teaching Intermittent Self Catheterisation (ISC)	
thirteen	Flushing and care of nephrostomies	
fourteen	Procedure for changing a Supra Pubic Catheter	

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V3 July 2018 – review V2 and community policy, rewritten.

V2 – 2015 - review of V1, complete rewrite of Policy and Procedures

V1 – approved by Policy and Guideline Committee on 13th August 2007

KEY WORDS

Catheter, catheterisation, indwelling, intermittent, urinary, continence,

1 INTRODUCTION AND OVERVIEW

- 1.1. This document sets out the University Hospitals of Leicester (UHL) NHS Trust policy and procedures for;
 - the insertion, care of and removal of an indwelling urinary urethral catheter in male and female adult patients.
 - the changing and care of supra pubic indwelling urinary catheters for male and female adult patients
 - teaching adults intermittent urethral catheterisation which is the preferred option for patients requiring long term management.
 - Care of nephrostomies
- 1.2. Urinary catheterisation is the insertion of a hollow tube into the bladder via the urethra using an aseptic no touch technique (ANTT)
- 1.3. Indwelling urinary catheters should only be used when no suitable alternative is available and must be left in for as short a time as possible
- 1.4 This policy aims to ensure male and female patients who have a urinary catheter or other urinary device are:
 - a) Catheterised safely, appropriately and in accordance with clinical need
 - b) Protected as much as possible from catheter related infections
 - c) Assessed daily for the need for a catheter and have the catheter removed as soon as it is no longer required
 - d) Referred for appropriate long term care should there be an ongoing need for an indwelling catheter or other urinary device.
- 1.5 This policy also provides guidance on the care of nephrostomies, urostomies, performing bladder washouts and managing continuous bladder irrigation.
- 1.6 This policy also provides guidance on appropriate urine testing and sampling.
- 1.7 If a member of staff is required to catheterise a patient of the opposite sex, it is essential that every effort is made to offer the patient choice where possible of a chaperone. as per the Chaperone Policy (Trust Reference B39/2008)

2 POLICY SCOPE

2.1 This policy applies to Doctors, Registered Nurses, Registered Midwives, Operating Department Practitioners (ODP's) Nursing Associates and Assistant Practitioners **who insert/remove** urinary catheters/devices (including bank, agency and locum) and are employed by the University Hospitals of Leicester NHS Trust. This policy applies to Doctors, Registered Nurses, Registered Midwives, Operating Department Practitioners (ODP's), Nursing Associates, Assistant Practitioners and Healthcare Assistants (HCA's) **who care for or remove** urinary catheters/devices (including bank, agency and locum) and are employed by the University Hospitals of Leicester NHS Trust.

2.2 This policy does not cover the insertion of 3-way catheters, this is a Medically led procedure - please refer to the Urology Medical Team for advice.

2.3 This policy does not cover the care of neo bladders or bladder reconstruction, please refer to the urology nurse specialist team for advice.

2.4 This policy does not cover the insertion of nephrostomies, this is a radiology led procedure

– please refer to radiology guidelines.

[http://insitetogether.xuhl-tr.nhs.uk/corp/migrated/Documents/Radiology%20and%20Imaging/Radiology%20Requesting%20Guidance%20for%20Junior%20Doctors%20\(UHL\)%20v2.doc](http://insitetogether.xuhl-tr.nhs.uk/corp/migrated/Documents/Radiology%20and%20Imaging/Radiology%20Requesting%20Guidance%20for%20Junior%20Doctors%20(UHL)%20v2.doc)

2.5 This policy does not cover the urethral urinary catheterisation of children (as defined by the Childrens Act 2004), infants and neonates. Please refer to the UHL Childrens Nursing Guideline on Urethral catheterisation, Trust Reference number C44/2006

2.6 UHL is a teaching hospital and provides placement or work based learning for Pre-registration students such as Medicine, Nursing, Midwifery, Paramedic, Radiography, Physiotherapy, Occupational Therapy and Pharmacy and Trainees in the workplace such as Assistant Practitioners and Nursing Associates. This policy applies to these learners in the following circumstances:

- a) If urinary catheterisation and/or care of a specific competency requirement of their placement or programme then the pre-registration student / trainee is able to perform the skill under direct supervision of their mentor / supervisor once they have received the relevant underpinning theory and passed a simulated practice
- b) If the pre-registration student / trainee has passed an LCAT competency assessment in practice they may be able to perform the skill with indirect supervision at the discretion of their mentor / supervisor and the Registered Professional delegating the task.
- c) If urinary catheterisation and/or care of is not a specific competency requirement of their placement or programme then the pre-registration student / trainee must only participate in the process as an observer.
- d) Please also see section 6 for education and training requirements

3 DEFINITIONS AND ABBREVIATIONS

ANP	Advanced Nurse Practitioner
ANTT	Aseptic Non Touch Technique
AUR	Acute Urinary Retention
BWO	Bladder Wash Out
Body Fluid splashes	Blood / blood stained body fluids or body fluids which have the potential for carrying blood borne viruses which could have the potential for transmitting infection by being splashed into the eyes, nose or mouth.
CAUTI	Catheter Acquired Urinary Tract Infection
CSU	Catheter Specimen of Urine
MSU	Mid Stream Urine
HCAI	Health Care Associated Infection
ISC	Intermittent Self-Catheterisation
LCAT	LEICESTER CLINICAL procedure ASSESSMENT TOOL
LPT	Leicestershire Partnership Trust

Mucocutaneous exposure	Where the eye(s), the inside of the nose or mouth, or an area of non- intact skin of the healthcare worker are contaminated by blood or other body fluid.
NICE	National Institute for Health Care Excellence
NMC	Nursing and Midwifery Council
Personal Protective	Gloves, aprons, gowns, masks and eye protection.
Equipment (PPE)	
PTFE	Polytetrafluorethylene
TAP / AP	Trainee / Assistant Practitioner
TNA / NA	Trainee Nursing Associate / Nursing Associate
UHL	University Hospitals of Leicester
UTI	Urinary Tract Infection
Neo bladder	A continent urinary reservoir constructed from a detubularized bowel segment or from a segment of the stomach, with implantation of the ureters and urethra; used to replace the bladder following cystectomy.

4 ROLES

4.1 Executive Lead: Chief Nurse

4.2 Clinical Management Group (CMG) Clinical Directors and Heads of Nursing

- a) To ensure their areas of responsibility have a workforce who is fit for purpose and staff have the required education and training to insert and care for urinary catheters and devices.
- b) To ensure the appropriate dissemination of the urinary catheterisation Policy.

4.3 Line Managers are responsible for:

- a) Ensuring all their staff are aware of their responsibilities regarding urethral catheterisation and ongoing care.
- b) Identifying and supporting the appropriate staff to attend the necessary training and complete the assessment of competence in practice
- c) Maintaining a record of staff who are competent in the insertion, care of and removal of a urethral catheter ensuring that numbers of staff trained meet service need

4.4 Staff who insert urethral catheters:

- a) Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role. This must be identified at appraisal.
- b) Have undertaken competency based training and assessment in practice (see section 6)
- c) Adhere to the procedures and clinical care requirements set out in this policy and comply with the care pathways to reduce the risk of Urinary Tract Infections

(UTI's)

4.5 Staff who care for and / or remove urinary catheters:

- a) Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role.
- b) Have undertaken competency based training and assessment in practice (see section 6)
- c) Adhere to the procedures and clinical care requirements set out in this policy and comply with the relevant care pathways and guidance to reduce the risk of Urinary Tract Infections (UTI's)

POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 Patients will be catheterised safely, in accordance with clinical need and have the catheter in place for the shortest time possible. Urethral Catheterisation of patients should be AVOIDED wherever possible and alternatives should be considered first.

5.2 Indications for Urinary Catheterisation

- To bypass an obstruction To relieve retention of urine
- To measure urine output accurately
- To allow irrigation of the bladder
- To empty the contents of the bladder To introduce intravesical drugs
- To enable bladder function tests to be performed
- To determine residual urine, when bladder scan unavailable or inappropriate
- To relieve intractable incontinence that hasn't responded to *all* other methods of care and the patient has been assessed by UHL Medical / Urology / Uro-gynaecology continence team
- In the presence of sacral / perineal wounds (stage 3 – 4) where urinary incontinence is delaying healing and when no other methods are practicable
- For urinary incontinence in End of Life care to reduce distress or discomfort and there are no other methods are practicable During prolonged or pelvic surgery During labour
- Following urinary tract surgery.
- Following spinal cord injury/surgery

5.3 Caution should be exercised if:

- Previous urethral trauma/fractured pelvis
- Known history of urethral stricture
- Previous difficulty with catheterisation.
- A history of Radical Prostatectomy or Bladder Reconstruction
- Urethral reconstruction surgery
- Implantation of urethral sphincter/penile rods
- Undiagnosed haematuria
- A history of lower urinary tract cancers Undiagnosed urethral discharge
- Congenital abnormalities (e.g. Hypospadias or epispadias)
- Consent is not given
- A patient has been given unsealed sources of radiation (e.g. Iodine 131 for thyroid cancer).

Advice in these circumstances can be obtained from the Urology Nurse Specialists or the on call Urology Registrar who is available at the Leicester General Hospital via the switchboard.

5.4 If on the first attempt the catheter meets resistance on gentle pressure and cannot be inserted there should be a full re-evaluation before a second attempt is considered. If after two attempts catheterisation fails senior advice should be sought from a practitioner with more extensive relevant experience.

Special Note - Following radical prostatectomy, urethral reconstruction, implantation of urethral sphincters or, if the catheters cannot be removed ask for advice before attempting catheterisation from the appropriate Consultant or SPR at the Urology Unit, Leicester General Hospital. Contact via switchboard.

5.5 Use of a Sterile lubricating gel

- a) A Sterile lubricating anaesthetic gel containing 2% Lignocaine may be used in both male and female catheterisation to minimise associated trauma, pain, discomfort and catheter-associated infection, however, this must be prescribed. A sterile lubricating gel with no Lignocaine is a suitable alternative and has been shown to be as effective.
- b) The only exception to this is for women in labour who are at an increased risk of toxicity. A sterile lubricating gel without anaesthetic must be used in all pregnant women.
- c) The anatomy of the urethra makes it sensitive to minor injuries and urethral bruising and trauma can occur during trans-urethral intervention which can then serves as an entry point for micro-organisms into the blood and lymphatic system
- d) Lignocaine gel is a prescription only medication (POM) and **must** be prescribed prior to use.
- e) The sterile lubricating anaesthetic gel contains a high dose lignocaine and **great care must be taken** in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity
- f) Patients must be observed post procedure for signs of toxicity include loss of consciousness, fitting and cardiac arrest if lignocaine has been used.

5.6 The procedures that support this policy are attached as the following appendices and must be used by all staff within the scope of this policy.

Appendices:	
One	Catheter Selection
Two	Procedure for the insertion of a Male urethral urinary Catheter
Three	Procedure for the insertion of a Female urethra urinary Catheter
Four	Continuing Care of a Urinary urethral Catheter
Five	Guidance on Urine cultures/sampling (Public Health England May 2017)
Six	Procedure for taking a Catheter Sample Urine (CSU)
Seven	Urinary Catheter not Draining – Performing a Bladder Washout
Eight	Problems and Complications of Urethral Catheters
Nine	Procedure for Trial Without Catheter (TWOC) and removal of Catheter
Ten	In patient Trial Without Catheter Pathway for non-urology wards

Eleven	Care bundle to Reduce the Risk of urinary Catheter Associated Urinary Tract Infections (CAUTI)
Twelve	Intermittent Self Catheterisation guide for nursing staff (ISC)
Thirteen	Flushing and ongoing care of nephrostomy pigtail catheter.
Fourteen	Procedure for changing a Supra Pubic Catheter

6. EDUCATION AND TRAINING REQUIREMENTS

6.1 Registered nurses/midwives/operating department practitioners/nursing associates/assistant practitioners must have received an underpinning theory study day relating to urinary catheter insertion and had opportunities to practice under supervision prior to completing a UHL LCAT assessment. Registered nurses must only practice if they have been assessed as competent and feel confident to perform the procedure as outlined in this document.

6.2 Healthcare Assistants receive training in the care of catheters in their Trust Induction programme.

6.3 Staff who are new to the Trust but have been trained elsewhere, or newly qualified practitioners who have been assessed as competent within their pre-registration training must:

- a) Provide evidence of the training and assessment programme they have successfully completed
- b) Comply with the relevant Trust policies and undertake additional training relating to equipment and documentation as required
- c) Undertake a one off practical assessment by an appropriate assessor within own CMG/Ward/Unit if deemed necessary or insufficient evidence of previously competence provided

6.4 There may be circumstances and further training involved for specific specialities relating to catheterisation with further local additional assessments may be required.

6.5 Medical staff are expected to be competent to insert a urinary urethral catheter in uncomplicated patients of either gender as part of their registration process.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.

Compliance with UHL catheter care bundle	Lead nurse infection prevention	CAUTI audit	Quarterly	LCCC CMG heads of nursing

8 EQUALITY IMPACT ASSESSMENT

- 8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
- 8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 Policies

Chaperone Policy (Trust Reference B39/2008)

Standard For The Completion Of Fluid Balance Charts In Adult Patients (Trust Reference B34/2010)

Anti-biotic guidance for treatment of UTI

<http://insite.xuhl->

[tr.nhs.uk/antibiotic/Full%20Guidelines/Adult%20Urinary%20Tract%20Infection%20\(UTI\)%20Treatment%20Guidelines%20and%20UTI%20Urine%20Dipstick%20Algorithm.pdf](http://insite.xuhl-tr.nhs.uk/antibiotic/Full%20Guidelines/Adult%20Urinary%20Tract%20Infection%20(UTI)%20Treatment%20Guidelines%20and%20UTI%20Urine%20Dipstick%20Algorithm.pdf)

<http://insite.xuhl-tr.nhs.uk/antibiotic/>

9.2 References

Addison R. (2000) Catheterisation using Lignocaine gel. Nursing Standard 20:8 2005

Bardsley A. (2005) Use of lubricant gels in urinary catheterisation. Nursing Standard. 20:8 41-46

Lo E et al 2014 Strategies to Prevent Catheter-Associated Urinary Tract Infections in Acute Care Hospitals: 2014 Update Infection Control and Hospital Epidemiology 35. 464-479

NICE (2003) Prevention of health care associated infections in primary and community care

Scottish Intercollegiate Guidelines Network (SIGN) July2006, 88 Management of suspected bacterial urinary tract infection in adults

The management of lower urinary tract symptoms in men NICE (May 2010)

EPIC (2000) Developing national evidence based guidelines for preventing healthcare associated infections (revised 2004, 2007)

Urinary incontinence in women .NICE (2006)

Bardsley A. Gauging the efficacy of a new intermittent catheter (2007) . Contenance UK, Vol.1, no 2:74

RCN Catheter care guidance for nurses (May 2012) www.rcn.org.uk

Additional competencies related to bladder and bowel assessments can be found on the following link www.skillsforhealth.org.uk

Diagnosis of urinary tract infection - Public Health England (2018)

Blandy, J (1980) Urethral Stricture Post Graduate Medical Journal 56; 383-418

Britton, P & Wright, E (1990) Catheter Care The Professional Nurse Feb;231-234

Catheter Associated Urinary Tract Infection Device Associated Module, CDC, January 2014.

Foster, H, Ritchey, M, Bloom, D (1992) Adventitious knots in urethral catheters: report of five cases. The Journal of Urology. 148(5);1496-1498

Loveday H Wilson JA, Pratt RJ, Golsorkhi M, Tingle A, Bak A, Browne J, Prieto J, Wilcox M (2014) Epic 3 - National Evidence-based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England

Medical Devices Agency (2001) Problems removing urethral catheters Safety Notice 2001(02) MDA, London

NICE (2012) Healthcare-associated infections: prevention and control in primary and community care CG 139

Nursing & Midwifery Code of professional conduct (2004) NMC Standards 07.04

Parish, C (2006) Men Only Nursing Times Feb 24 89(8);55-58

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This Policy will be uploaded and available through PAGL on INsite and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived Through the Trusts PAGL system

10.2 This policy will be reviewed every three years or sooner in response to identified clinical risks.

1. Catheter Types: There is a range of catheters available. Each type of catheter is recommended for use up to a certain length of time and this will usually dictate the type of catheter used.

Foley Catheter Types (Guide Only, please refer to manufacturers guidelines)	
Material	Length of Use
Plastic (PVC) Nelaton. For Intermittent catheterisation	Use to drain urine from the bladder and is disposed of immediately
Latex only Must not be used in people with a latex allergy	Short term, up to 7 days May produce urethral irritation.
Latex with Silicone Coating Must not be used in people with latex allergy	Short term, usually 7-14 days. (Although Rusche is only 7 days)
Latex with (Teflon) PTFE coating Must not be used in people with latex allergy	Short to medium term, up to 28 days.
Hydrogel or Hydromer Coating Must not be used in people with latex allergy	Long term, up to 12 weeks.
Pure Silicone/ 100% Silicone The only catheter which can be used for patients with latex allergies.	Long term, up to 12 weeks.
Silicone Elastomer coating	Long term, up to 12 weeks.

2. Catheter Size

2.1 As a general rule the smallest lumen catheter that will allow urine to drain is adequate. Patients with large amounts of debris or clots may require a larger size. The following sizes are recommended:

Female: 12 Charriere short / long term, or Intermittent

Male: 12-14 Charriere short / long term or Intermittent

2.2 Larger bore catheters may be advocated for long term use in order to reduce incidence of lumen blockage.

2.3 Patients with haematuria may need up to an 18 or 20 Charriere size or a 3-way catheter, following medical advice.

3. Catheter Length

3.1 The Standard length (40 cm) is usually for male use but can be used for females in some circumstances (for example ladies in wheelchairs) and is used in all supra pubic catheterisations male or female.

3.2 The Female length (23cm) **must** only be used for female patients as it may cause severe urethral trauma if the balloon is inflated in the male urethra.

4. Balloon Sizes

A catheter with a **10 ml balloon only** should be used, reducing bladder neck pressure and irritation. Larger sizes up to 30 ml are only used in 3 way catheterisation and with specialist urological advice.

1. Patient Preparation

- a) The patient must be informed of the reason and **risks** for the procedure, give their consent and given the choice regarding a chaperone.
- b) A full explanation must be given and time allowed for patients to ask questions.
- c) Ensure the patient is in a comfortable position, preferably supine.

2. The use of Sterile Anaesthetic lubrication gel

- a) A Sterile lubricating anaesthetic gel must be used to minimise associated trauma, pain, discomfort and catheter-associated infections, if gel containing lignocaine is used **must** be prescribed prior to use.
- b) If the sterile lubricating anaesthetic gel which contains a high dose lignocaine is used, then **great care must be taken** in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity.
- c) Patients must be observed post procedure for signs of toxicity include loss of consciousness, fitting and cardiac arrest if lignocaine gel has been used.

3. Equipmen t

All equipment must be checked to ensure that it is in date, intact and not contaminated

- a) An aseptic field large enough to facilitate the procedure which must be cleaned with chlorclean prior to the procedure and allowed to air dry.
- b) Sterile catheterisation pack containing gallipots, receiver, gauze and disposable towels
- c) Sterile gloves x 2
- d) Selection of appropriate catheters
- e) Sterile lubricating gel
- f) Universal specimen collecting container (if specimen is indicated)
- g) Sterile normal saline
- h) Alcohol based sanitiser
- i) Sterile water
- j) 10 ml syringe
- k) Disposable plastic apron
- l) Drainage bag and stand or holder
- m) Clinical waste bag

There should never be more than two unsuccessful attempts to catheterise the patient by the same practitioner. If a practitioner is unable to carry out the procedure inform a more experienced practitioner and reassure the patient

Never reinsert the same catheter after an abortive attempt

Urethral Urinary Catheterisation Insertion Procedure for Male Patients	
No	Action
1	<ul style="list-style-type: none"> • Clean hands • Prepare equipment using ANTT • Put on sterile gloves and disposable plastic apron, maintain ANTT through out the procedure • Drape area with sterile towels • Retract foreskin and clean glands penis with sterile normal saline. If the patient is visibly soiled they must be washed prior to performing the catheterisation procedure
2	<ul style="list-style-type: none"> • Insert the sterile lubricating gel into the urethra, using the pre-filled syringe (11ml for men) • Allow gel 5 minutes to take effect if using lignocaine based lubricant. • Nelaton catheters for intermittent use usually have a pre-lubricating coating, which may require activating by the use of water. Please read the manufacturer's instructions
3	<ul style="list-style-type: none"> • Remove gloves, decontaminate hands, put on second pair of gloves • Hold the penis vertically and under tension • Pass the catheter slowly along the urethra into the bladder, if resistance is felt increase the traction on the penis or ask the patient to cough
4	<ul style="list-style-type: none"> • Once urine starts to flow advance the catheter another 5 cm before inflating the balloon with 10 ml sterile water to avoid inflating the balloon in the urethra (Do not use normal saline) <p>NB: Do not inflate the balloon if urine is not flowing</p>
5	<ul style="list-style-type: none"> • Replace the foreskin
6	<ul style="list-style-type: none"> • Attach selected drainage system and date the catheter bag. Ensure the patient is comfortable post procedure • Ensure that the catheter is attached securely to the thigh with a catheter strap if using a leg bag or to a portable stand if using a large bag for monitoring. Correctly dispose of waste material • Remove protective clothing • Clean hands (use soap and water if there has been contact with bodily fluids)

7	<p>Record procedure in patient notes using green catheterisation sticker and on Catheter Care Pathway (for patient bedside notes) to include:</p> <ul style="list-style-type: none">• Clinical indication for catheterisation• Verbal consent and allergy information obtained• Date and time of catheterisation• Type and size of catheter used• Amount of water inserted into the balloon• Manufacturer and batch number (use peel off label where available)• Any problems during the procedure• Colour and consistency of urine drained• Residual drained• Specimen obtained or not and documented rationale• Planned date of removal
----------	---

Urethral Catheterisation Policy

V3 Approved by Policy and Guideline Committee on xxxxx Trust Ref: xxxxx

Next Review: xxxxx

1. Patient Preparation

- a) The patient must be informed of the reason for the procedure, give their consent and given the choice regarding a chaperone.
- b) A full explanation must be given and time allowed for patients to ask questions.
- c) Ensure the patient is in a comfortable position, preferably supine.

2. The use of Sterile lubrication gel

- a) A Sterile lubricating gel containing must be used to minimise associated trauma, pain, discomfort and catheter-associated infections and if using lignocaine based lubrication this **must** be prescribed prior to use.
- b) The only exception to this is for women in labour who are at an increased risk of toxicity due to the numerous catheterisations that may be required. A sterile lubricating gel without anaesthetic must be used instead.
- c) If sterile lubricating anaesthetic gel which contains high dose lignocaine has been used **great care must be taken** in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity
- d) Patients must be observed post procedure for signs of toxicity include loss of consciousness, fitting and cardiac arrest if lignocaine has been used.

3. Equipment: All equipment must be checked to ensure that it is in date, intact and not contaminated

- a) An aseptic field large enough to facilitate the procedure which must be cleaned with chlorclean prior to the procedure and allowed to air dry.
- b) Sterile catheterisation pack containing gallipots, receiver, gauze and disposable towels
- c) Sterile gloves x 2
- d) Selection of appropriate catheters
- e) Sterile lubricating gel
- f) Universal specimen collecting container (if specimen is indicated)
- g) Sterile normal saline
- h) Alcohol based hand sanitiser
- i) Sterile water
- j) 10 ml syringe
- k) Disposable plastic apron
- l) Drainage bag and stand or holder
- m) Clinical waste bag

There should never be more than two unsuccessful attempts to catheterise by the same practitioner. If a practitioner is unable to carry out the procedure inform a more experienced practitioner and reassure the patient

Never reinsert the same catheter after an abortive attempt

Urethral Catheterisation Insertion Procedure for Female Patients

No	Action
1	<ul style="list-style-type: none"> • Clean hands • Prepare equipment using ANTT • Put on sterile gloves and disposable plastic apron, maintain ANTT throughout the procedure • Drape area with sterile towels • Part labia and clean from front to back around urethral meatus with sterile normal saline. If the patient is visibly soiled they must be washed prior to performing the catheterisation procedure
2	<ul style="list-style-type: none"> • Insert the sterile lubricating gel into the urethra, using the pre-filled syringe (6ml for females) • Allow gel 5 minutes to take effect if using lignocaine. • Nelaton catheters for intermittent use usually have a pre-lubricating coating, which may require activating by the use of water. Please read the manufacturer's instructions
3	<ul style="list-style-type: none"> • Remove gloves, decontaminate hands, put on second pair of gloves • Pass the catheter slowly along the urethra into the bladder and if resistance is felt ask the patient to cough
4	<ul style="list-style-type: none"> • Once urine starts to flow advance the catheter another 5 cm before inflating the balloon with sterile water to avoid inflating the balloon in the urethra (Do not use Normal saline) NB: Do not inflate the balloon if urine is not flowing
5	<ul style="list-style-type: none"> • Attach selected drainage system and date the catheter bag .Ensure the patient is comfortable post procedure • Ensure that the catheter is attached to the thigh with a catheter strap if a leg bag or a portable stand if using a large drainage bag for monitoring purposes. • Correctly dispose of waste material • Remove protective clothing • Clean hands (use soap and water if there has been contact with bodily fluids)
6	<p>Record procedure in patient notes using green catheterisation sticker and on Catheter Care Pathway (for patient bedside notes) to include:</p> <ul style="list-style-type: none"> • Clinical indication for catheterisation • Verbal consent and allergy information obtained • Date and time of catheterisation • Type and size of catheter used • Amount of water inserted into the balloon • Manufacturer and batch number (use peel off label where available) • Any problems during the procedure • Colour and consistency of urine drained • Residual drained • Specimen obtained or not and documented rationale • Planned date of removal

- 1) The closed system should be maintained to minimise the risk of infection It should only be broken if there is a clinical need.
- 2) The drainage bag attached to directly to the catheter must be sterile. This must only be removed for a clinical procedure or when the bag requires changing. Patients who are using leg drainage bags during the day need to have non-sterile single-use 2 litre drainage bag attached to the leg bag for overnight use
- 3) The use of non-sterile gloves plus hand decontamination needs to be done before and after all contact with urinary drainage
- 4) Encourage patient to maintain high levels of personal hygiene with a daily shower if possible
- 5) If patient is unable to meet own hygiene needs wearing clean non sterile gloves and apron clean the catheter, urethral meatus or glans penis at least daily with soapy (or equivalent) water in a clean bowl or as part of the patient's bath/shower. In women, ensure that the meatus inside the labia is cleaned ensuring that any visible faecal soiling is removed. In men ensure that the area under the foreskin is cleaned and their foreskin is returned to normal position. Always clean the catheter away from the urethra
- 6) Ensure the drainage system is appropriate to the individual's needs. If the patient is sitting out or is mobile, use leg drainage bags or flip flow valve for dignity and to aid rehabilitation, unless contra-indicated.
- 7) Ensure patient is well hydrated. Encourage patient to drink at least 1½ to 2 litres of fluid in 24 hours or has adequate IV hydration unless contraindicated by clinical condition.
- 8) Prevent tension / traction on drainage tube by using correct straps or drainage bag stand
- 9) Empty bags when 2/3 full or every 4 hours, whichever comes first, do not allow bags to overflow. Urinary drainage bags must be emptied frequently enough to prevent reflux and maintain flow. (NICE)
- 10) Wearing non sterile disposable gloves and apron, empty drainage bag into a clean receptacle or toilet ensuring that the bag outlet does not touch receptacle or the floor and drying the outlet after emptying.
- 11) Accurately measure and record urine output if required. as per UHL Fluid Balance Guidelines (Trust Reference B34/2010)
- 12) Drainage bags and catheter valves attached directly to the catheter need to be changed every 7 days or more frequently if outlet becomes blocked or following bladder washout.
- 13) The need for the patient's indwelling catheter **must** be reviewed daily as the risk of infection increases the longer the catheter is left in situ.
- 14) To ensure all documents are completed on the catheter care pathway (appendix 11)

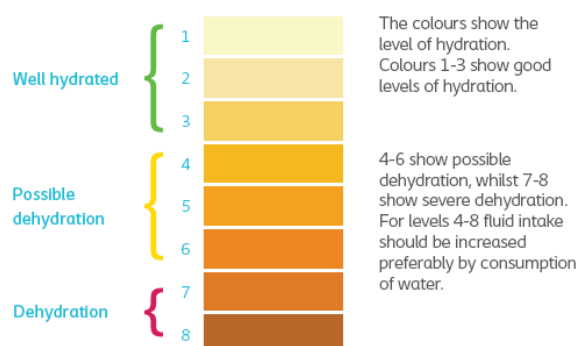
Catheterised patients:

- Do not routinely perform urine dip in catheterised patients.
- **Do not** culture routinely.
- **Do not treat** ASYMPTOMATIC bacteriuria in those with indwelling catheters as bacteriuria is very common and antibiotics **increase side effects** and **antibiotic resistance**.
- Check hydration status of patient prior to assuming UTI present
- **Only** send urine for culture in catheterised patients if features of **systemic** infection, however, always exclude other sources.
- Consider changing catheter before/when starting antibiotics.
- Consider awaiting cultures and follow microbiology guidance on any known positive urine culture **prior** to prescribing antibiotics.
- Do not give prophylactic antibiotics for routine catheter changes unless there is a history of symptomatic UTIs post catheter changes.

Non catheterised patients :

- Severe or >3 symptoms of UTI:
 - Dysuria
 - Frequency
 - Supra pubic tenderness
 - Urgency
 - Polyuria
 - Haematuria
- Suspected pyelonephritis
- Suspected UTI in men
- Failed anti biotic treatment or persistent symptoms post treatment of proven UTI
- Pregnant women with symptoms of UTI

Am I hydrated urine colour chart*



1. Procedure for Taking a CSU from a Drainage Bag

All catheter bags used should have needle free ports. Urine samples must be obtained from a sampling port using ANTT.

Equipment

- a) Two swabs saturated with 2% Chlorhexidine gluconate and isopropyl alcohol 70%
- b) Sterile syringe – 10 ml or larger
- c) Appropriate specimen container
- d) Disposable non sterile gloves

Procedure for Taking a CSU from a Drainage Bag	
No	Action
1	Explain and discuss the procedure with the patient. Ensure patient's privacy
2	Perform hand hygiene as per policy. Put on disposable gloves
3	If there is no urine in the tubing – bend or clamp the tubing until sufficient urine collects. Do not clamp the catheter itself or leave the patient if the tube has been clamped
4	Clean the sample port with for 30 second contact time with a swab saturated with 2% chlorhexidine and 70% isopropyl alcohol. Allow to dry.
5	Insert sterile syringe into the catheter sampling port. Slowly draw out urine sample Re-clean the sample port with a swab saturated with 2% chlorhexidine 70% isopropyl alcohol. Allow to dry.
6	Place the specimen in appropriate sterile container dependent on reason for sample
7	Unbend or unclamp the tubing if necessary. Remove gloves and perform hand hygiene Ensure the patient is comfortable
8	Label the container and complete appropriate form. Send to laboratory.
9	Document that a sample has been taken and reason for the sample.

4. Procedure for taking a CSU using a Catheter Valve

A catheter valve attaches to the drainage port of an indwelling catheter to provide an alternative to a leg or drainage bag, there is no sample port on a catheter valve.

In order to prevent contamination of the sample by encrustation within the valve, a new, sterile valve should be inserted, and the urine allowed to drain through the new valve into the specimen container. A catheter valve cannot be clamped.

Equipment

- Appropriate specimen container
- Sterile catheter valve
- Sterile disposable gloves

Procedure for Taking a CSU from a catheter valve	
No	Action
	Explain and discuss the procedure with the patient. Ensure patient's privacy
2	Perform hand hygiene policy. Put on sterile disposable gloves
3	Remove the previous catheter valve without opening. Replace with closed sterile one, without touching the end of the catheter.
4	Open the catheter valve and allow the urine to drain into the specimen bottle
5	Remove gloves and perform hand hygiene as per hand washing policy Ensure the patient is comfortable
6	Label the container and complete appropriate form. Send to laboratory.
7	Document that a sample has been taken and reason for the sample.

1. Why might the catheter not be draining?

1.1 Things to consider:

- a) The patient's general condition, could they be dehydrated?
- b) Does this catheter regularly block? If it is a long term catheter investigate if patient is normally on catheter maintenance solutions

1.2 Check the following:

- a) Is the drainage bag below bladder level? Reposition
- b) Is the tubing twisted? Reposition
- c) Is the patient sitting on the tubing? Reposition
- d) A vacuum may have occurred in the bladder causing blockage of eyelets by bladder mucosa - Lift the drainage bag above bladder level and then down back to below
- e) If the catheter is still not draining, is a rectal examination required to rule out impaction/faecal loading? Treat as necessary

1.3 Registered nurses should only perform bladder washouts if they have been taught at ward level and been assessed by a competent Practitioner using the UHL LCAT assessment tool.

2. When to perform a Bladder Washout

- a) Remember disconnecting the catheter from drainage bag puts the patient at risk of Catheter associated urinary tract infections (CAUTI).
- b) Bladder washouts should not be used for catheters blocked due to infection or to treat CAUTIs.
- c) Saline bladder washouts should only be used for mechanical blockages
- d) All bladder washouts / catheter maintenance solutions should be used with caution in patients with spinal injury particularly above T6 due to the possibility of autonomic dysreflexia.
- e) If catheter still not draining after doing all the checks in section 1.2 then the following should be done:
 - Inform Doctor
 - Is the catheter definitely blocked? Is the bladder palpable? Is the patient in discomfort? Could the patient's urinary output be low? If in doubt perform a bladder scan before using a bladder washout
 - Check in catheter bag tubing for blood clots and debris. If blood or debris present then using ANTT, warmed saline 0.9% can be GENTLY instilled into the bladder using 50ml syringe and using ANTT to dislodge any debris from eyelets. **Do not aspirate** as it may cause damage to the bladder mucosa
 - Saline used - Catheter still not draining – change catheter.
 - No blood or debris in catheter bag tubing – Change catheter
- f) If catheter still not draining

- Inform Doctor
- NB – Registered Nurses should only perform bladder washouts if competent to do so. The practitioner should be experienced in urinary urethral catheterisation and assessed as competent using UHL LCAT assessment.

1. Bypassing

- a) Bypassing occurs when urine leaks between the catheter and the urethral wall. The cause of this may be:
 - blocked catheter - forcing urine down an alternative route
 - bladder spasm - forcing urine down an alternative route
 - the use of a catheter which is too large or has a large balloon resulting in residual urine lying below the eye of the catheter
- b) Bladder spasm can be reduced by the selection of small lumen and small balloon size catheters. In addition the use of silicone or hydrogel catheters can also reduce spasm
- c) If bladder spasm persists anticholinergic medication can be given to the patient unless this is contraindicated.

2. Blockage

- a) Blockage may occur as a result of debris or encrustation, urinary tract infections, as a result of the catheter eyes becoming occluded with bladder mucosa, because the catheter has kinked or the patient is sitting on the tubing or because the rectum is loaded with faeces.
- b) If blockage by debris or encrustation persists it is advisable to treat any proven UTI's
- c) The position of the patient and the tubing should be checked to ensure that there is no kinking; if the catheter does not drain following the position change then it is advisable to change the catheter.
- d) In some circumstances, (for example, clot retention) a bladder wash out may be indicated using a 50ml bladder syringe and saline see appendix 7
- e) It has been advocated that the risk of encrustation can be reduced and the catheter life extended by lowering the pH of urine by dietary means, e.g. Ascorbic Acid
- f) (Vitamin C) cranberry juice, pulses and cereals and ensuring a good urine output may help maintain catheter patency. The use of a catheter maintenance product (e.g. Urotainer) has **NOT** been shown to be effective

3. Infection

- a) Invasion of the bladder by micro-organisms may result in colonisation with no clinical symptoms or invasion of the bladder tissues causing clinical symptoms. Generally treatment with antibiotics is only advocated if there are clinical symptoms present
- b) Bacteria gain entry to the bladder at the time of catheterisation, immediately following catheterisation or at a later time due to bacteria colonizing the catheter surface (as a bio film), becoming invasive and causing an infection.
- c) Prevention of infection relies upon;
 - Compliance with high impact intervention care bundles during insertion and ongoing care of the device.
 - Maintenance of a closed system
 - Positioning the drainage system to prevent reflux

- Using the sampling port to obtain urine samples, cleaning the port with a 70% alcohol swab and allowing time to dry prior to sampling.
- Ensuring that the drainage system does not come into contact with the floor
- Good standards of patient personal hygiene, the meatus should be cleansed daily
- Adequate fluid intake

4. Discomfort

Following initial insertion of a catheter, the patient may experience some discomfort which should settle after 24 hours. If discomfort continues this may be due to bladder spasm, irritation and subsequent inflammation following catheterisation. This can be minimised by using the smallest catheter for the purpose and less irritant products.

5. Stricture Formation

Strictures may be caused by: -

- a) Urethritis resulting from trauma on insertion, inflating the balloon in the urethra, traumatic removal of the catheter or sensitivity to the products used.
- b) Attention to technique and theoretical knowledge relating to asepsis and catheter selection will reduce the risks of stricture formation.
- c) Tissue Necrosis can be caused by pressure on blood vessels in the urethra. Practitioners should be aware that the incidence of this might be increased in the vascular compromised patient.
- d) Using a catheter which is too large and blocks the Para urethral ducts may cause Para-urethral abscess.

6. Creation of a False Passage

The mucosal lining of the urethra is delicate and at risk of trauma during catheterisation. Though some resistance may be felt in men when 15-20 cm of the catheter has been inserted (which can be overcome by asking the patient to cough or bear down) undue force should not be used. Advice should be sought from an experienced nursing or medical practitioner, should the patient complain of more than discomfort.

7. Pain or Haematuria from Traumatic Insertion

The instillation of local anaesthetic lubricant into the urethra should reduce pain and friction on insertion of the catheter if it is allowed to work effectively (i.e. it is left for at least 5 minutes to become effective). Attention to technique and correct selection of catheter will reduce risks of trauma. Full explanation to the patient and reassurance will help the patient to relax making the procedure less difficult.

8. Potential Psychological Problems

Catheterisation is an invasive procedure and requires full explanation and consent obtained wherever possible. For some patients there may be cultural implications which require understanding and sensitivity. Some female patients may prefer a female practitioner to perform the catheterisation and male patients may require a male practitioner. Whenever possible their wishes should be respected.

Practitioners should provide reassurance, emotional support and practical advice to catheterised patients. It is desirable that staff performing the procedure should be chaperoned by a member of staff of the same sex as the patient

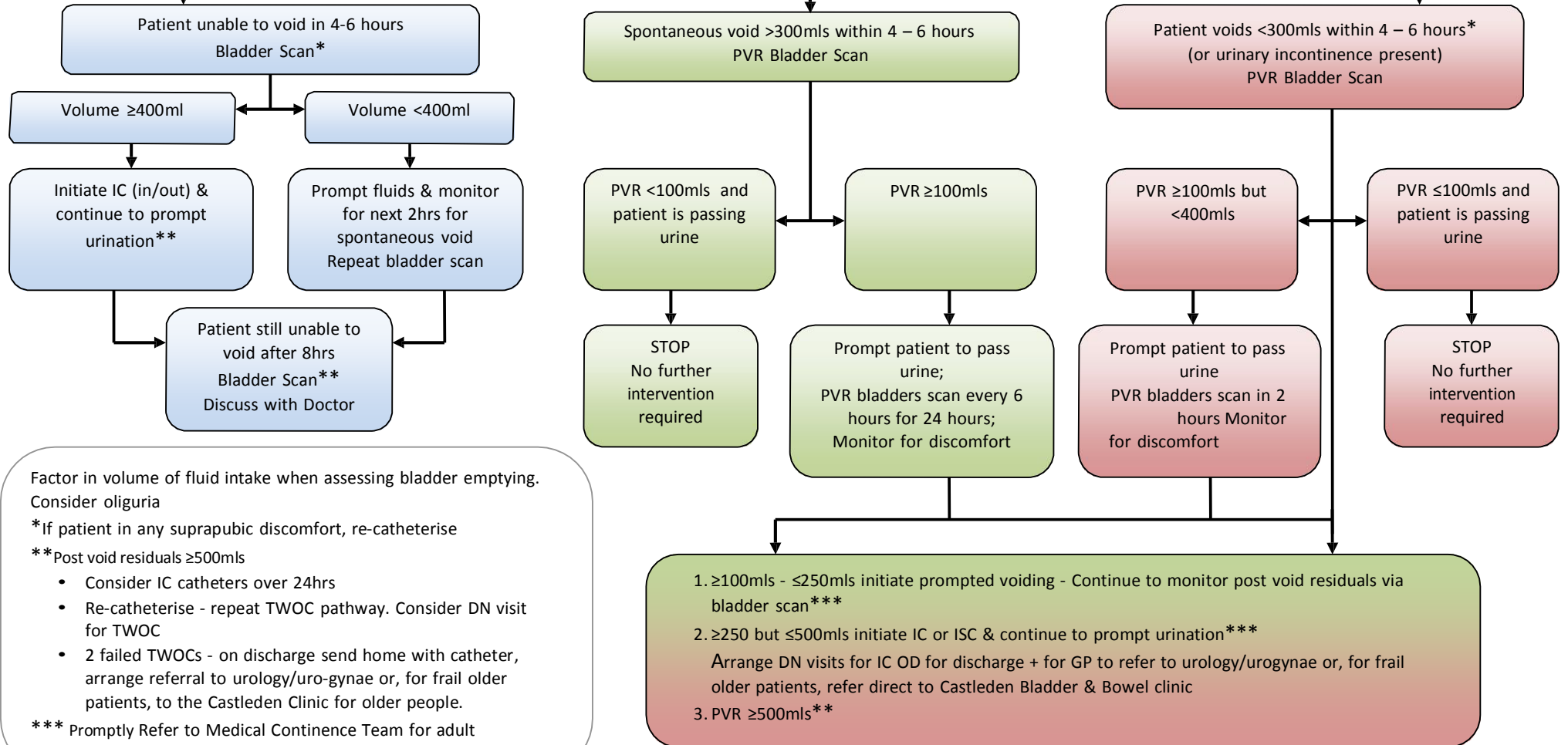
Equipment

- Personal protective equipment
- Collecting vessel (eg. disposable cardboard tray)
- Sterile normal saline 0.9%
- Syringe for deflating the balloon

Removal of a Male / Female Urethral Catheter	
No	Action
1	Remove catheter at midnight (this will allow the bladder to fill naturally, allowing the patient to wake with a full bladder) or early morning (any retention problems can be addressed during the day). Catheters must not be removed just prior to discharge or transfer from hospital.
2	Explain the procedure to the patient and inform him/her of possible post –catheter symptoms. (urgency, frequency, discomfort) which may have been caused by irritation of the urethra, by the catheter.
3	Check the documentation in the patient’s notes to establish the amount of water that was used to inflate the balloon to ensure that it is fully deflated before removal. Remember that a silicone catheter balloon will allow water to permeate through the balloon wall and be lost. Therefore the volume may be lower after a period of time.
4	Perform hand hygiene as per policy. Put on gloves and apron. Release any leg support. Use the Normal Saline 0.9% to clean the meatus and catheter always cleaning away from the urethral opening
5	Deflate balloon by attaching syringe to valve and allowing pressure of the water to push the plunger out – if water is withdrawn forcibly, it may cause vacuum and cause the balloon to cuff making removal difficult and painful. If water filling is slow or no water is removed, gently re-site the syringe If no water is withdrawn seek medical assistance/ refer to urology registrar
6	Ask the patient to breathe in and then out to help relax the pelvic floor muscles As the patient exhales, gently, but quickly, withdraw the catheter.
7	Ask the patient to drink approximately 2litre fluid in the following 24 hours – if their medical condition allows to ensure that the patient is sufficiently hydrated to pass urine
8	Leave the patient clean and dry and has access to a toilet or the call buzzer if necessary Tidy away equipment. Document the procedure in the patient’s notes and on Catheter Care Pathway. Date and sign it.
9	Observe patient regularly following Trial Without Catheter Care Guidance (Appendix Nine) To ensure patient is passing urine and is not developing urinary retention. Assess for any incontinence and provide appropriate pads if necessary (referral to community nurses will be required on discharge if pads are necessary following a formal continence assessment on the ward)

Inpatient Trial Without Catheter Pathway Outside of Urology Wards

- Before any removal of catheter, have reversible causes of retention been treated? Ensure that bowels are empty & that enlarged prostates have been investigated & treatment commenced as appropriate
- Remove catheter at Midnight or 06:00hrs – MN allows bladder filling overnight; 06:00 allows monitoring in the day
- Re-catheterise if any suprapubic discomfort
- If possible prompt the patient to drink 1 litre of fluids before lunch unless contra-indicated
- IMPORTANT! Measure & document accurately all fluid input & output on fluid balance chart



Factor in volume of fluid intake when assessing bladder emptying. Consider oliguria

*If patient in any suprapubic discomfort, re-catheterise

**Post void residuals ≥500mls

- Consider IC catheters over 24hrs
- Re-catheterise - repeat TWOC pathway. Consider DN visit for TWOC
- 2 failed TWOCs - on discharge send home with catheter, arrange referral to urology/uro-gynae or, for frail older patients, to the Castleden Clinic for older people.

*** Promptly Refer to Medical Continence Team for adult

PVR = Post void residual - Volume of urine left in bladder 10-20 minutes after passing urine
IC = Intermittent catheterisation
ISC – Intermittent self-catheterisation

Care bundle to reduce the risk of Catheter Associated Urinary Tract Infection

Date of catheterisation

or catheter in situ on admission Y if yes; ongoing need reviewed by Medical team Y N

Clinical indication for catheterisation (if urinary retention record volume drained:.....)

Type of catheter: Long term short term (short term must have a removal plan, or review date)

Size..... (gauge is the smallest that will allow urinary outflow Y)

Inserted by..... (Please print legibly)

Planned removal/review date (*remove the catheter as soon as no longer clinically indicated*)

If not removed as planned the rationale for ongoing catheterisation must be documented daily overleaf

If patient is to be discharged with the catheter in situ information for both patients & carers must be provided;

Tick to evidence information given to patient Y tick to evidence information given to carer Y

Daily review and care delivery record

Free text or ✓ each element as indicated daily to evidence care given

Date	Record the <u>clinical indication</u> for ongoing catheterisation or arrange TWOC <i>Free text</i>	Daily hygiene for meatal cleansing ✓	Drainage bag dated ✓	Drainage bag changed every 7 days (if applicable) ✓	Catheter bag is below the bladder level and not in contact with the floor ✓	Samples collected via sampling port using Aseptic Technique ✓	Print name	Signature

Date removed .../.../... Time removed..... Signature Print name.....

Retain in medical notes once catheter removed

Intermittent catheterisation is the intermittent passing of a small catheter into the bladder to assist with the drainage of urine when normal voiding is not possible or complete (Bardsley 2007) It is a clean clinical procedure which can be undertaken by patients or carers.

- NB. When intermittent catheterisation is undertaken/taught by a health care professional, a sterile technique must be used to prevent cross infection.
- Only staff assessed as competent in urethral catheterisation and who have an in depth knowledge of the urinary tract and the principals of catheterisation should perform/teach this procedure. If unsure, please discuss with your local continence advisor.

If there is any doubt, please refer to urology nurse specialists/DNs/medical continence service for advice. All patient information regarding ISC is available at ward 28a or the Coleman Centre LGH and should be related to the product of choice.

1.	Check rationale/indication for ISC
2.	<p>Check no contra indications to ISC</p> <ul style="list-style-type: none"> • Known urethral obstruction • Prostatic stent <p>Caution should be exercised in</p> <ul style="list-style-type: none"> • Active inflammation of urinary tract – recent UTI, urethritis, prostatitis • Recent radiotherapy • Penile/vaginal pain or discharge • Haematuria • Autonomic dysreflexia (in spinal injuries) • Congenital abnormalities
3	Patient information. Ensure patient has received verbal, written or visual information prior to commencing teaching
4	Consent. Patient consent must be valid (as per UHL consent policy) and consent must also be obtained from the Doctor responsible for the patient's care and documented in the medical notes.
5	<p>Assessment of patient should include</p> <ul style="list-style-type: none"> • Fluid balance/bladder chart record pre ISC • Patients understanding of their individual indications for requiring ISC and complications if non-compliance of ISC • Patients understanding of complication signs and symptoms to look for (Retention/UTI/Haematuria/stricture formation) and how to seek advice. • Patients mobility/dexterity/eyesight etc. – assess for ability to perform safely and compliantly and consider if any deterioration of existing

	<p>conditions could affect this. i.e memory loss. And if any further support/tools can be implemented to assist in maintaining compliance.</p> <ul style="list-style-type: none"> • Physical examination is important as identification/location of the urethral opening is not always obvious. • Pre and post void bladder scan can be helpful in monitoring effectiveness in the teaching stage of emptying bladder fully. Staff should be competent in the use of the bladder scanner. • Sexual activity discussion – This should be discussed with all patients requiring catheters and is not contra indicated in ISC or indwelling. • Bowel habit assessment should include advice on constipation and this should be addressed prior to commencing ISC as it can adversely affect bladder emptying.
6.	<p>Catheter selection – type, size, length. There is a wide variety of sizes and types of intermittent catheter. Consider your individual patients needs i.e dignity, poor dexterity and select most appropriate catheters with your patient, taking into account local formulary for patient to trial. The ideal catheter should be simple and easy to use with no touch technique.</p>
7	<p>The use of a lubricating gel will depend upon the type of catheter selected as many are pre lubricated. Always check manufacturers guidance on lubrication.</p>
8	<p>Demonstrate to patient how to drain the bladder completely – first with the use of diagrams/videos/leaflets and then practically on the patient. Ensure you have obtained all equipment needed prior to teaching and that the environment is conducive to maintaining dignity. Demonstrate that urine can continue to flow on withdrawal of the catheter and to wait for full drainage and place a finger over the tip of the catheter to prevent dribbles or spillages.</p>
9	<p>Each patient should have a personalised care plan regarding frequency of catheterisation. As a general rule, the residual urine should not be >400mls, however, this can be assessed and adjusted to the individual patient’s needs. The plan upon learning will need to be reassessed and updated.</p>
10	<p>Record keeping – ISC teaching to patient should be clearly documented in patients’ Medical/Nursing notes and on discharge paperwork for follow up purposes. These should be detailed and legible and include patient specific regime.</p> <p>Patients should be encouraged to keep records of volumes passed, frequency of catheterisation (to monitor compliance against regime recommended) complications and other problems encountered</p>
11	<p>Obtaining equipment - intermittent catheters are only available on prescription. Patients should be advised on monthly quantities required and the importance of not running out. The catheters can be ordered through chemists and home delivery services which can offer quick delivery to the patients’ home. Contact your local continence advisor for more information.</p>

12	Manufacturers' guidance on storage should be followed – generally not to remove from box and store at room temperature. Disposal guidance should also be followed but generally used catheters can be disposed of in general waste (clinical waste in acute settings) – do not flush down the toilet!
13	<p>Complications tend to be inability to insert catheter or haematuria.</p> <ul style="list-style-type: none"> • Difficulty inserting - Advising on using additional lubricating gel, coughing, sneezing can help. If patient or carer unable to insert, refer to GP/DN for reassessment or insertion of indwelling catheter until reassessment. • Haematuria – usually settles with good hydration. If clots are seen or haematuria continuous, insert indwelling catheter and seek medical advice from patients responsible Doctor. If urine rose in colour, offer reassurance.
14	Follow up and reassessment – Arrange appropriate follow up and reassessment of patient either via community continence team, district nurses, urology services or medical continence clinic and provide contact details to patient for support at home.

1. Introduction

Flushing should be necessary only if the Nephrostomy is blocked. This procedure can be performed by interventional radiology staff, urologists and medical staff.

Registered nurses/midwives/operating department practitioners/nursing associates/assistant practitioners must have received an underpinning theory relating to nephrostomies and had an opportunities to practice under supervision prior to completing and being assessed as competent using the UHL LCAT assessment. This is only likely to occur on the urology wards.

Prior to commencing nephrostomy flushing,

- check insertion site to ensure pigtail catheter has not fallen out. If it is not in situ, contact radiology/medical team urgently.
- Check both the catheter and tubing is not bent, broken, or positioned badly, potentially causing reduced drainage. If this is the case, reposition tubing and check for drainage. If still no drainage, proceed to flushing using ANTT.

2. Equipment:-

- 20ml Syringe
- 10mls Normal
- Saline *70%
- alcohol swab x2
- Sterile J Tray x 2
- Sterile gloves

3. Procedure

Wearing sterile gloves

Draw up 10mls Normal Saline

Disconnect tubing from catheter, placing end in J tray to keep it clean

Clean catheter end with 70% alcohol swab

Attach syringe to catheter and aspirate

Inject 10mls Normal Saline slowly into pigtail catheter.

If the patient complains of any pain stop procedure immediately

Wipe end of tubing with 70% alcohol swab and connect to pigtail catheter

NB Ensure patient is well hydrated prior and post procedure.

On flushing, if resistance is felt and you are unable to inject or if it is ineffective, contact interventional radiology or urology on call SPR via switchboard.

4.Ongoing care

Follow the principals of ongoing care for urinary catheter bundle by documenting daily checks of indication, site, drainage bag position, change of drainage bag weekly and sampling information.

Utilise the care bundle for urinary catheters and change the heading to nephrostomy. If your patient has a urethral catheter and bilateral nephrostomies, you will require 3 care bundles to be in use, one for each device.

Maintain accurate fluid balance measurements clearly indicating source of output. i.e Left nephrostomy, urethral catheter.

If drainage is less than expected (check with medical team as expected nephrostomy output may be different to **total** expected urine output) and flushing has not improved urine output, escalate to medical team **urgently** even if the total urine output meets the expected volume.

Patient information leaflets on nephrostomy care are available on in-site at

http://insitetogether.xuhl-tr.nhs.uk/pill/Patient%20Information%20Library/Export%20from%20SharePoint%202010/Having%20a%20percutaneous%20nephrostomy%200021_102015.pdf

http://insitetogether.xuhl-tr.nhs.uk/pill/Patient%20Information%20Library/Export%20from%20SharePoint%202010/Having%20your%20Nephrostomy%20Catheter%20Changed%200102_022017.pdf

1. Introduction

This procedure can be performed by staff trained and **experienced** in urinary urethral catheterisation, who have underpinning theory relating to supra pubic catheters and have been assessed as competent following an opportunity to practice under supervision and a UHL LCAT assessment

2. Equipment:

3. Procedure for Changing a Supra Pubic Catheter

3. Procedure for Changing a Supra Pubic Catheter	
Action	
1	Explain and discuss the procedure with the patient and gain consent. Allow time for questions and provide clear understandable answers. This will ensure that the patient understands the procedure and gives their valid consent and help reduce anxiety
2	Check the patient has no known allergies to prevent anaphylaxis or skin irritation
3	Throughout this procedure ensure hands are cleaned and wear personal protective equipment (PPE) as per UHL IP standards (available on INsite) changing them as needed. Prepare the trolley and equipment for and perform the procedure using aseptic no-touch technique (ANTT) Ensure there is appropriate protection on the bed. Screen the bed. Ensure/assist the patient into a comfortable supine position, allowing the nurse access to the catheter by removing clothing to the area.
4	Clean hands and wear PPE. Open the outer wrappings of the packs and put it on the top shelf of the dressing trolley at patient bedside or within easy reach.
5	Check catheter is licensed for Supra pubic use, not all urinary catheters are licensed for this procedure..
6	Place small amount of instillagel or alternative sterile lubricant on tip of catheter to be inserted. This will lubricate the catheter to ensure smoother insertion down tract.
7	Fill catheter tip 50ml syringe with 50mls of sterile water 0.9% sodium chloride for instilling into the bladder.
8	Drape sterile towel around cystostomy site and clean area using 0.9% sodium chloride or suitable anti bacterial agent, maintaining ANNT
9	Place a small amount of instillagel around cystostomy site. Disconnect and discard leg bag from old catheter, maintaining ANNT to catheter tip. Pre fill bladder slowly until patient is aware of filling sensation or until 50mls inserted. This relaxes the detrusor muscle and aids the removal of the existing supra pubic catheter.
10	The HCA assisting removes the existing catheter by deflating the balloon as per manufacturer's instructions – deflate catheter balloon with 10 ml syringe allowing the syringe to fill without applying traction. This will prevent cuffing of the balloon and thus reducing cystostomy site trauma.

3. Procedure for Changing a Supra Pubic Catheter

Action	
11	Gently insert new catheter via the cystostomy channel into the bladder to the length of the removed catheter or until urine drains, some resistance may be felt which will ease at the catheter enters the bladder.
12	Do not inflate the balloon until urine drains. Once urine drains, slowly inflate the balloon with 5mls of pre filled syringe – no resistance should be felt. This will ensure catheter is in the bladder and not the urethra.
13	Gently withdraw catheter until it is felt to be firm against the bladder wall, then completely fill the balloon with the remainder of the pre filled syringe. Total of 10mls.
14	Attach the catheter to previously selected drainage system or valve, maintain a closed drainage system and secure to limb to reduce erosion and increase comfort.
15	Ensure the patient comfortable by checking the cystostomy site is clean and dry. Dampness around the site can cause redness and irritation to skin. Avoid dressing the site which can make this worse.
16	Remove used and unnecessary equipment and dispose of as per UHL waste policy and clean the trolley.
17	Clean hands.
18	Document procedure in nursing/medical documentation, ensuring date, type, size and rational are clearly explained. Any other instructions, difficulties encountered must be clearly documented and follow up plans discussed, made and documented.