| Document Details | |
|---|---|
| **Title** | Urinary Catheter Care Policy for Adult Patients |
| Trust Ref No | 1242-85638 |
| Main points the document covers | This policy has been developed as a resource and framework for healthcare professionals who undertake urinary catheterisation care as part of their role, with adult patients |
| Who is the document aimed at? | Healthcare professionals employed by Shropshire Community Health NHS Trust who undertake urinary catheterisation care as part of their role, with adult patients |
| Author | Nicola Head, Continence Nurse Specialist |
| **Approval process** | |
| Approved by (Committee/Director) | Clinical Policy Group |
| Approval Date | 13/11/23 |
| Initial Equality Impact Screening | Yes |
| Full Equality Impact Assessment | N/A |
| Lead Director | Director of Nursing and Operation DIPC |
| Category | Clinical |
| Sub Category | Continence Pathway |
| Review date | 13/11/26 |
| **Distribution** | |
| Who the policy will be distributed to | Community nurse teams and community hospitals |
| Method | Electronically via managers / Datix, available to all staff via Trust website and key clinicians |

**Amendments History**

| No | Date | Amendment |
|---|---|---|
| 1 | July 2012 | Adopted by Shropshire Community Health NHS Trust previously was an NHS Telford & Wrekin and Shropshire County PCT Policy. Version 1.1 approval date 30.3.2011 review date 30.3.2013 |
| 2 | November 2012- June 2013 | Revised to reflect Shropshire Community Health Trust policy framework. Additions to the policy include the catheter daily diary record for community hospitals and catheter passport as part of the CAUTI work stream |
| 3 | June 2016 | Reviewed as date approaching Revised to reflect role of student nurse and current practice within the Trust |
| 4 | March 2018 | General review |
| 5 | Nov 2023 | Change of title. Change of format to include x16 Standard Operating Procedures and a competency document. Amendments to IPC guidance |

**Contents**

## 1 Introduction

Urinary catheterisation is a common procedure both in acute and community care settings. Catheterisation is not without risk. Indwelling catheters should only be used after alternative methods of management have been considered. Catheter associated urinary tract infections (CAUTIs) are the most common healthcare associated infections (HCAIs) worldwide.

This policy has been compiled using a systemic review of literature and evidence based research to provide best practice.

## 2 Purpose

The aim of this policy is to ensure that all patients with indwelling urinary catheters receive optimum care, using best practice guidelines, therefore minimising risk and reducing the incidence of CAUTIs.

## 3 Definitions

| Term / abbreviation | Explanation / Definition |
|---|---|
| CSU | Catheter Specimen of Urine |
| CAUTI | Catheter Associated Urinary Tract Infection |
| CMS | Catheter Maintenance Solution |
| ESBL | Extended Spectrum Beta-lactamase |
| ISC | Intermittent Self Catheterisation |
| HCAIs | Healthcare Associated Infections |
| HCP | Health Care Professional |
| MC&S | Microscopy Culture and Sensitivity |
| MRSA | Meticillin Resistant *Staphylococcus aureus* |
| NMC | Nursing Midwifery Council |
| RCN | Royal College of Nursing |
| UTI | Urinary Tract Infection |
| ANTT | Aseptic Non-Touch Technique |
| SCHT | Shropshire Community Health Trust |
| SOP | Standard Operating Procedure |

## 4 Duties

### 4.1 The Chief Executive

The Chief Executive has overall responsibility for maintaining staff and patient safety and is responsible for the Trust governance and patient safety programs

### 4.2 Director of Quality Nursing, Clinical Delivery and Workforce

Has overall responsibility for this clinical policy, ensuring that it is fully implemented across the Trust as best practice.

### 4.3 Divisional Managers, Service Leads and Team Leads

Managers and Service Leads have the responsibility to ensure that their staff including bank and locum staff are aware of this policy, adhere to it at all times, and have access to the appropriate resources in order to carry out the necessary procedures.

They are responsible for ensuring that systems are in place to ensure that this policy, practices and guidance are carried out reliably within their area of responsibility; and local investigation of practice which presents a risk to patient safety.

Managers and Service Leads will ensure that compliance with this policy is monitored locally, and they have a responsibility to ensure that their staff attend the relevant catheter training. Ward managers / team leaders must keep a record of their staff attending Trust catheter training and assessment of their competence

### 4.4 Staff

All staff have a personal and corporate responsibility for ensuring their practice and that of staff they manage or supervise comply with this policy

## 5 Initial reason for insertion of indwelling catheter, and consideration of trial without catheter (TWOC)

- The clinical reason for indwelling urinary catheterisation must be clearly documented on:

  - Patients notes / CONT005 Catheter Care Pathway (refer to Appendix 1) - kept in the patient's home or on ward in the community hospital

  Refer to Trust document on Staffzone:
  **CONT005 Catheter Care Pathway**
  **https://www.shropscommunityhealth.nhs.uk/content/doclib/11156.doc**
  Refer to Appendix 1

  - Patient notes on Rio

  - CNT014 Indwelling Urinary Catheter Card

  This card must be updated / replaced at each catheter change, if lost, or when clinically indicated
  Refer to Trust document on Staffzone:
  CONT014 **Indwelling Urinary Catheter card**
  **https://www.shropscommunityhealth.nhs.uk/content/doclib/11214.docx**
  Refer to Appendix 8

- It is not sufficient to simply document 'urinary retention' as the clinical reason for catheterisation. It must also be documented why the patient is experiencing urinary retention, such as benign prostatic hyperplasia, spinal cord injury etc. This will help identify whether there is a treatable cause of the

urinary retention, such as commencing an alpha blocker or treating constipation. This will consequently promote a trial without catheter, where appropriate

- If it is not clear why the indwelling urinary catheter has been inserted, the nursing staff must liaise with the patient's GP / urology department / hospital ward where the catheter was inserted, to establish this

- If it is still not clear why the indwelling urinary catheter has been inserted, the nursing staff must liaise with the patient's GP / urologist to establish whether a trial without catheter (TWOC) is appropriate

- Contraindications for a TWOC in the community:

  - Radical prostatectomy within the last 3 months
  - Transurethral resection of prostate (TURP) within the last 8 weeks
  - Bladder neck incision within the last 8 weeks
  - Optical urethrotomy within the last 8 weeks
  - Open or endoscopic prostatectomy within the last 8 weeks
  - Transurethral resection of bladder tumour (TUR-BT) within the last 4 weeks
  - History of urethral stricture
  - Undiagnosed haematuria
  - Clot retention
  - Patient systemically unwell
  - Known pathology of the lower urinary tract, such as cancer
  - Patients who withhold consent
  - Patients, families, or carers who are unable to alert the community nurses of any difficulties when undergoing a TWOC
  - Patients who are constipated, with no bowel movement for 3 days or more
  - Patients with a suspected or confirmed urinary tract infection

  Refer to Trust
  **Male Acute Urinary Retention and Trial Without Catheter Policy (2022) 1876-42267**
  **https://staffzone.shropcom.nhs.uk/smii/doclib/11319.pdf?ac=4**

- **If a patient is transferred to a community hospital, or community nurse caseload with an insufficient discharge summary / insufficient clinical information / insufficient catheter equipment, a DATIX must be completed, detailing action taken**

## 6 Clinical indications for indwelling urethral catheterisation, in the community

- Acute and chronic urinary retention
- Intractable urinary incontinence
- Congenital or acquired dysfunction of urinary system
- Measurement of residual urine (if bladder scanner not available)
- Dilatation of urethral stricture (if patient is unable to undertake intermittent self dilatation)
- Patients who are no longer able to carry out intermittent self catheterisation, to manage their voiding dysfunction / residual urine

## 7 Contra-indications for indwelling urethral catheterisation in the community

- Patients must be catheterised by urology in the following circumstances:
- Post radical prostatectomy within the last three months
- Transurethral resection of the prostate (TURP) within the last eight weeks
- Open or endoscopic prostatectomy within the last eight weeks
- Bladder neck incision within the last eight weeks
- Optical urethrotomy within the last eight weeks
- Transurethral resection of bladder tumour (TUR-BT) within the last four weeks
- Urologist has stated that the patient's catheter must be changed in hospital
- Undiagnosed haematuria
- No consent

## 8 Limitations for urethral re-catheterisation in the community

- Clinical judgement should be used, and medical advice sought in the following circumstances:
- Trans urethral resection of the prostate more than eight weeks ago
- Bladder neck incision more than eight weeks ago
- Optical urethrotomy more than eight weeks ago
- Transurethral resection of bladder tumour (TUR-BT) more than four weeks ago
- Open or endoscopic prostatectomy more than eight weeks ago
- Post radical prostatectomy undertaken more than three months ago
- Previous urethral trauma or fractured pelvis
- Previous difficult catheterisation
- One failed attempt
- Known pathology of the lower urinary tract, for example cancer, phimosis, urethral trauma / stricture / obstruction / disease
- Mental health issues or cognitive dysfunction may affect the patient's ability to give consent or cope with catheter changes and care. Confused patients may attempt to forcibly remove the catheter which can lead to urethral trauma and increased risk of infection
- The patient may have dexterity and mobility problems which may affect the ability to manage the catheter and drainage systems. Carer availability must be considered to undertake catheter care in these circumstances

## 9 Suprapubic catheter changes in the community

- The initial formation of a cystostomy stoma and insertion of suprapubic catheter is always undertaken in secondary care.
- The first catheter change can be undertaken in the community, only if urology state this on the patient's discharge summary.
- If it is not clear who is going to change the patient's catheter, the community HCPs must contact urology to seek clarification.
- Urology instructions must be followed relating to when the first catheter change, and subsequent catheter changes are due.
- If a patient needs to present themselves / be transferred to A&E regarding their supra pubic catheter (for example, community nurses are unable to remove old catheter / insert new catheter, or catheter is not patent and urology always change the catheter); the patient must only attend Royal Shrewsbury Hospital, where urology are based

## 10 Contraindications for change of suprapubic catheters in the community

- Urologist has stated that the patient's catheter must only be changed in hospital
- Lack of consent

## 11 Limitations for change of suprapubic catheters in the community

- Clinical judgement should be used, and medical advice sought in the following circumstances:
- Previous difficult recatheterisation

## 12 Intermittent self-catheterisation (ISC)

- Intermittent self-catheterisation (ISC) must only be assessed for, and taught by the Continence Nurse Specialists

- They will support learning, problem solving, and will follow up and review progress, as required

## 13 Key principles of a closed urinary system

- Every attempt should be made to keep the drainage system closed, to reduce the risk of CAUTI
- Ensure effective connection between catheter and drainage bags / catheter valves, by securing them effectively
- Do not change the catheter more frequently than clinically appropriate
- Do not administer catheter maintenance solutions (CMSs), more frequently than clinically appropriate
- Do not change / disconnect the drainage bags / catheter valves, more frequently than clinically appropriate
- Obtain CSUs from the sampling ports on the drainage bags
- Use ANTT to change catheters, bags, catheter valves, to obtain CSUs, and to administer CMSs

## 14 HOUDINI

- Assess at every care input whether catheter can be removed (Trial without Catheter – TWOC)
- When a catheter is already being used you should consider if it is necessary. This can be established using the HOUDINI (Adams et al, 2012) indicators:

**H** – Haematuria
**O** – Obstructed (urinary tract / urinary retention)
**U** – Urological or major pelvic surgery (recent)
**D** – Decubitus ulcers (open sacral or perineal sore in an incontinent patient)
**I** – Input/output (hourly fluid balance monitoring)
**N** – Not for resus/end of life care – comfort (alternatives must be considered)
**I** – Immobility (unstable fracture)

**IF NONE OF THE ABOVE ARE PRESENT…MAKE THE CATHETER DISAPPEAR (the urinary catheter disappearing act!)**

## 15 Documentation

- All catheter care must be recorded in the following document:

CONT005 Catheter Care Pathway. Which must be kept in the patient's home or on the ward in the community hospital

- Rio Progress Notes must also be updated (and any relevant documents, images, correspondence uploaded to Rio Documents)

Refer to Trust document on Staffzone:

**CONT005 Catheter Care Pathway**

**https://www.shropscommunityhealth.nhs.uk/content/doclib/11156.doc**

Refer to Appendix 1

- The following documents must be used to support appropriate assessment, interventions, procedures and patient education:

Refer to Trust document on Staffzone:
**CONT023 Bladder diary**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/11172.pdf**
Refer to Appendix 2

Refer to Trust document on Staffzone:
**CONT027 Bowel Diary**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/11184.doc**
Refer to Appendix 3

Refer to Trust document on Staffzone:
**Hydration leaflet**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/13222.pdf**
Refer to appendix 4

Refer to Trust document on Staffzone:
**What Colour is your Wee?**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/13221.pdf**
Refer to Appendix 5

Refer to Trust document on Staffzone:
**Top 10 Hydrating Fruit and Veg**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/13223.pdf**
Refer to appendix 6

Refer to Trust document on Staffzone:
**CONT013 Patient Information – Indwelling Catheters**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/11213.docx**
Refer to Appendix 7

Refer to Trust document on Staffzone:
**CONT014 Indwelling Urinary Catheter card**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/11214.docx**
Refer to Appendix 8

Refer to Trust document on Staffzone:
**UTI Assessment Form**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/14049.docx**
Refer to Appendix 9

Refer to Trust document on Staffzone:
**CONT054 Flow Chart for Management of Suspected or Confirmed CAUTI**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/14210.pdf**
Refer to Appendix 10

Refer to Trust Records and document management policy (2022) 1348-47170
**https://staffzone.shropcom.nhs.uk/smii/doclib/10562.pdf**

## 16 Catheter equipment

- When catheter equipment is prescribed, the following formulary must be adhered to:

  Trust **Shropshire Continence Prescribing Guideline 1982-43673 (2017)**
  **https://staffzone.shropcom.nhs.uk/smii/doclib/12090.pdf?ac=10**

- **Catheter length**

- Standard length
  - for use in male urethras
  - for use in female urethras
  - for use in suprapubic cystostomy stomas

- Female length
  - for use in female urethras only

- **Catheter material**

- Catheters must not be left insitu for longer than they are licenced for
- If using a catheter in suprapubic cystostomy, ensure it is licenced for suprapubic use

- Silicone
  - Licensed for use up to 12 weeks
  - They have a bigger lumen, and are more rigid than hydrogel or PTFE catheters
  - They are useful for advancing through occlusive prostates
  - Latex free

- Hydrogel
  - Licensed for use up to 12 weeks
  - They have a smaller lumen, they are softer, and smoother than silicone catheters
  - Contains latex

- PTFE
  - Licensed for use for up to 28 days
  - They have a smaller lumen, they are softer and smother than silicone catheters
  - Contains latex
  - Useful for short term use

- Silver “Bardex IC”
  - Licensed for use for up to 28 days
  - They have a smaller lumen, they are softer and smother than silicone catheters
  - Contains latex
  - Useful for short term use
  - Helps to reduce bacterial colonisation

- **Catheter size**

- Catheter diameter is identified by charriere (ch) size
- Use the smallest possible size, to allow adequate drainage, and to minimise risk of urethral trauma

- Female urethral
  - Ideally use size12-14ch catheters

- Male urethral
  - Ideally use size 12-16ch catheters
  - Urology recommend 16ch silicone catheters to advance through occlusive prostates

- Suprapubic
  - Use size 16-18ch catheters
  - Follow instructions from urology, and recatheterise with same size as existing catheter

- **Catheter balloons**

- Standard balloons
  - Must be inflated with 10ml of sterile water

- Catheters are only licensed for one inflation and one deflation

- Inflate balloon with the exact volume of water specified by the manufacturer (underinflation or over inflation will result in catheter being used out of license)

- Balloons should not be under inflated as this can lead to the balloon inflating asymmetrically, which will potentially cause irritation to the trigone and bladder spasm

- They should not be over inflated as this will potentially cause the balloon to burst and will leave fragments of catheter balloon in the patient's bladder which will need to be removed via cystoscopy

- Deflating and inflating catheter balloons more than once, and over or underinflating catheter balloons will result in the catheter being used out of license and the manufacturer will not be liable for any associated clinical issues

- However, Midlands Centre for Spinal Cord Injury (MCSCI) or urology may occasionally request over or under inflation of catheter balloons. This must be a documents request (not verbal) and be placed in the patients notes (uploaded to Rio documents). It must also be documented in the patient's notes that the nurse has discussed the risks of under / over inflated balloons, and that the catheter is being used out of license, with the patient, and that informed consent has been gained

- If the amount of water in silicone catheter balloons is reducing significantly via osmosis, and is leading to catheters falling out – DO NOT deflate and reinflate the balloon. Instead, consider switching to a hydrogel or PTFE catheter. These are less likely to lose a significant amount of water via osmosis. If the patient must continue with a silicone catheter due to latex allergy – consider using a silicone catheter that is inflated with a 5% glycerine solution, which helps reduce premature balloon deflation

- Catheters with 30ml balloons must not be used in the community. They must only be used on a urology ward, post prostatic surgery. The heavier weight and larger balloon may cause bladder spasm, irritation of the trigone and trauma / necrosis to the bladder neck

- **Catheter types**

- Intermittent catheters
- For patients to undertake intermittent self catheterisation, catheters are removed from the bladder as soon as the residual urine has been drained, single use

- Short term catheters
- Licensed for use up to 28 days

- Long term catheters
- Licensed for use up to 12 weeks

- **Catheter tips**

- Rounded tip
- Available in silicone, hydrogel, and PTFE
- Standard tip, with drainage holes above the catheter balloon

- Open ended
- Only available in silicone
- Offers improved drainage with both an open-ended tip and two drainage holes above the balloon

- Optitip
- Only available in silicone
- Offers improved drainage with both an open-ended tip and two drainage holes below the balloon, reduces the residual urine that sits above the balloon in a catheter that only has drainage holes above the balloon

- Tiemann tipped
- Has a curved tip to promote easy insertion through the prostate or a urethral stricture
- They must not be inserted in the community
- They are only to be inserted / changed in a urology setting)

## 17 Ordering catheter equipment on prescription

- If patient is registered with a Telford and Wrekin GP, register the patient with Proact (0800 917 9865) to request prescription for catheter supplies

- When registering patients with Proact, the health care professional must also contact the Continence Nurse Specialists (01743 444062 **shropcom.continence@nhs.net** ) to provide information on clinical background, and future clinical plan

- If patient is registered with a Shropshire GP, request prescription for catheter supplies from GP

## 18 Infection, prevention and control relating to indwelling catheter care

- A catheter associated urinary tract infection (CAUTI) is a symptomatic infection of the bladder or kidneys, in a person with an indwelling urinary catheter who has had a urinary catheter in place within the previous 48 hours. NICE (2023)
- The longer a catheter is in place, the more likely bacteria will be found in the urine; after one month, nearly all people have bacteriuria
- Antibiotic treatment is not routinely needed for asymptomatic bacteriuria in people with an indwelling catheter
- **Urinalysis / urine dipstick must not be used to assess whether a patient with an indwelling catheter, has a CAUTI.** Catheterised patients will be colonised with bacteria in their bladder, and will be positive for nitrite and leucocytes upon urinalysis, even if they do not have a urinary tract infection
- **If a CAUTI is suspected, the following document must be used to assess the clinical symptoms:**
  Trust **Urinary Tract Infection (UTI) Assessment form**
  **https://www.shropscommunityhealth.nhs.uk/content/doclib/14049.docx**
  Refer to Appendix 9

- If a CAUTI is identified by the UTI assessment form, the following flow chart must be used to prompt appropriate treatment:

  CONT054 **Flow chart for suspected or confirmed CAUTI**
  **https://www.shropscommunityhealth.nhs.uk/content/doclib/14210.docx**
  Refer to appendix 10

  - **Patients identified as having a CAUTI should ideally have their catheter removed (**Removal of the catheter during antibiotic treatment will ensure that bacteria in the biofilm, on the catheter, are minimised. A new catheter without a biofilm which is inserted under antibiotic therapy, will promote more effective treatment of the CAUTI)
  - **However, if the catheter can not be removed for clinical reasons (such as urinary retention), and has been in place for more than 7 days, it must be changed within 48 to 72 hours of starting antibiotic treatment**
  - **If the catheter can not be removed for clinical reasons (such as urinary retention), and it has been in place for 7 days or less, it does not need to be changed during the course of the antibiotics**
  - **Do not allow catheter removal or change, to delay antibiotic treatment**
  - Obtain a specimen of urine, before antibiotics are commenced
  - If the catheter has been changed, obtain the sample from the sampling port on the new catheter, using ANTT
  - If the catheter has been removed, obtain a midstream specimen of urine
  - Send the urine sample for MC&S, noting a suspected CAUTI, and listing any current antibiotics prescribed

- Refer to additional document:
  **National Institute for Health and Clinical Excellence (2018). Urinary tract infection (catheter-associated): antimicrobial prescribing NG113**
  **https://www.nice.org.uk/guidance/ng113/chapter/recommendations**

- Refer to Trust **Meticillin Resistant Staphylococcus Aureus (MRSA) Policy 1372-70895 (2022)**
  **https://staffzone.shropcom.nhs.uk/smii/doclib/10499.pdf?ac=8**

- Refer to Trust document:
  **Standard Operating Procedure for taking a catheter specimen of urine (CSU)**
  **Page 50**

- Refer to Trust **Aseptic Technique Policy 766-70215 (2021)**
  **https://staffzone.shropcom.nhs.uk/smii/doclib/10250.pdf**

- Refer to Trust **Administration of intravenous antimicrobial treatment for the management of adults with extended spectrum beta-lactamase (ESBL) urinary tract infections Policy 2247-81002 (2023)**
  **https://staffzone.shropcom.nhs.uk/smii/doclib/14644_1.pdf**

## 19 Patient Education

- All patients must be issued with a copy of:
  **CONT013 Patient Information – Indwelling Catheters**
  **https://www.shropscommunityhealth.nhs.uk/content/doclib/11213.pdf**
  Refer to Appendix 7
  - Health care professionals must check for understanding, and document this in the patient's notes

## 20 Consent

Refer to Trust **Consent to examination or treatment policy (2022) 1542-48761**
**https://staffzone.shropcom.nhs.uk/smii/doclib/10305.pdf?ac=5**

## 21 Dissemination, Implementation, Training and Competence

This policy and guidelines will be disseminated to staff by the following methods:

- Deputy Director – cascading to Divisional Managers and Heads of Nursing
- Inform article
- Published to Web Site
- Ratification by the clinical policy group
- Dissemination via Datix administrator / Director of Corporate affairs
- Implementation will be via a rolling program of training delivered by the Continence Nurse Specialist

- All clinical staff delivering catheter care must attend catheter training provided by the Trust, via the Continence Nurse Specialists
- Bookings are taken and managed by the Clinical Education Team
  **shropcom.clinicaleducationteam@nhs.net**
- All training will be logged on Electronic Staff Record (ESR)
- Training will also be delivered via Partners in Care (PIC) for the independent care sector, across Shropshire

- Training in the following subjects will be provided:
  - Indwelling urinary catheterisation (Including female, male, and suprapubic catheterisation, troubleshooting, theory and practical)
  - Acute Urinary Retention (AUR) & Trial Without Catheter (TWOC)
- After they have attended Trust training, staff must have their competency assessed using the 'Competency: Indwelling catheterisation (adult patients)' document, listed in the appendices below
- The Standard Operating Procedures (SOPs) listed in the appendices below, must be followed when assessing competency
- Should a member of staff become involved in a catheter related incident; the original competency document will be used to reassess competency within the specific area that was involved in the incident. Ward Managers / team leaders will keep a record of healthcare professionals involved catheter related incidents and lessons learned, to help identify individual training needs
- Ward managers / team leaders must keep a record of their staff attending Trust training and assessment of their competence
- For advice and guidance on this policy or training information, contact the Continence Nurse Specialist Service on 01743 444062 or **shropcom.continence@nhs.net**

## 22 Consultation

The policy was developed by The Continence Nurse Specialist Team in association with the Infection Prevention and Control Team and Consultant Microbiologist at Shrewsbury and Telford Hospitals SaTH. It has been circulated widely by consultation with the following:

- Microbiologist at Shropshire and Telford Hospitals Stephanie Damoa-Siakwan
- Infection Prevention and Control Team, Sharon Toland
- Community Nurses Jayne Carter, Sarah-Jane Jones, Sandra Parkes, Emma Parker, Vicky Hinks, Gareth Biggs, Natasha Carthy
- Community Hospital Leads, Karen Maynard, Nikki Ryder, Amy Stevens
- Team Lead Continence Advisory Service for Shropshire and Telford & Wrekin, Jemma Brown
- Chief Pharmacist, Shropshire Community Health Trust, Susan Watkins
- Community Service Managers Rebecca Shepherd, Donna Jones, Sam Townsend, Rachel Mole, Jane Hollins
- Clinical Lead Rapid Response and Virtual Ward, Julie Roper
- Advance Care Planning in Care Home Team, Sarah Venn, Nicky Hirst
- Urology Clinical Nurse Specialist SaTH, Karen Kirton
- Dr Emily Peer, Associate Medical Director Shropshire Community Health NHS Trust

## 23 Monitoring Compliance

- Compliance will be monitored through annual audit and using peer review
- Completion of clinical competencies relating to indwelling urinary catheter care
- Audit of clinical competency: Indwelling catheterisation (adult patients)
- Audit of clinical care
- Review of DATIX

## 24 References


- Adams D, Bucior H, Day G and Rimmer J-A (2012) HOUDINI: make that urinary catheter disappear – nurse-led protocol, Journal of Infection Prevention 13(2): 44-46
- Department of Health (2010) High impact interventions: No 6 urinary catheter care bundle, London: DH
- Feneley R, Hopley I, Wells P (2015) Urinary catheters: history, current status, adverse events and research agenda. Journal of Medical Engineering and Technology 39(8): 459-70
- Medical devices regulations: compliance and enforcement (updated 2017), London: MHRA
- National Institute for Health and Clinical Excellence (2018) Urinary tract infection (catheter-associated): antimicrobial prescribing NG113, London: NICE
- National Institute for Health and Clinical Excellence (2012) Healthcare-associated infections: prevention and control in primary and community care CG139, London: NICE
- National Institute for Health and Clinical Excellence (updated 2023) Urinary tract infections in adults QS90, quality statement 2: diagnosing urinary tract infections in adults with catheters, London: NICE
- National Patient Safety Agency (2009) Hospital alerted to risks of inserting suprapubic catheters incorrectly, London: NPSA
- Nursing and Midwifery Council (2018) The Code: standards for conduct, performance and ethics for nurses and midwives, London: NMC
- NHS England (2018) Excellence in Continence Care: practical guidance for commissioners, and leaders in health and social care, Leeds: NHS England
- Royal College of Nursing: Catheter Care, RCN guidance for healthcare professionals (2021), London: RCN

## Appendix 1: CONT005 Catheter Care pathway

### CONT 005 CATHETER CARE PATHWAY

Shropshire Community Health NHS
NHS Trust

| | |
|---|---|
| Patient name: _____ | Consultant: _____ |
| Address: | GP: |
| _____ | NHS No: _____ |
| Date of birth: _____ | Assessor: _____ |
| Tel: | Contact no: |

**Reason for catheterisation**

**Initial catheterisation date**

**Can catheter be removed? Consider Trial Without Catheter**

| Standard statement | State variation from standard statement with reason / comment and action taken | initial | date |
|---|---|---|---|
| Patient has no contraindications to catheterisation | | | |
| Consent: doctor has consented to catheterisation | | | |
| Full discussion has taken place with patient to explain the reason why catheterisation is required, including the related risks and benefits. Check for understanding, and state if verbal consent obtained | | | |
| **General Assessment** | | initial | date |
| Relevant medication and medical history<br><br>(if taking antibiotics for a UTI, assess and discuss with GP whether these are appropriate and still required) | | | |
| Health status of patient prior to catheterisation<br><br>(use UTI assessment form if UTI is suspected, discuss with GP and document outcomes / plan)<br><br>(refer to CONT999 flow chart for management of suspected or confirmed CAUTI) | Well / unwell | | |
| Assess fluid intake. Consider using:<br>CONT023 Bladder diary<br>Hydration leaflet<br>What colour is your wee chart<br>Top 10 Hydrating fruit and veg | | | |
| If patient has problems with their bowels, give appropriate advice Consider using:<br>CONT027 Bowel Diary | | | |
| If patient has mobility, dexterity, or environmental problems, record any action taken | | | |
| If patient is sexually active, patient give advice | | | |
| If patient has signs of cognitive dysfunction seek specialist advice | | | |
| Does patient have an allergy to latex, soap or anaesthetic gel | | | |
| Patient is able to self-care, or carer support required | | | |

*CONT005 Catheter Care Pathway* Page 1 of 4 Mar 2023

| Patient name: | Dob: | NHS No: |
|---|---|---|

| Catheter insertion | | initial | date |
|---|---|---|---|
| Patient catheterised with: | Urethral / suprapubic catheter<br>Short term (28 days) / long term (12 weeks) catheter | | |
| Catheter inserted without difficulty<br>(record any meatal or genital abnormalities, including discharge)<br>(record if patient experiencing localised discomfort / pain)<br>(inform GP and document outcomes / plan) | | | |
| If unable to catheterise, inform GP immediately and document clinical plan | | | |
| If catheter is NOT draining urine within 30 minutes after insertion, seek medical advice | | | |

| Patient and carer advice | | initial | date |
|---|---|---|---|
| Patient/carer instructed in catheter care<br>Provided with CNT013 Patient information – Indwelling catheter leaflet<br>Check for understanding | | | |
| Patient / carer given advice on the importance of handwashing | | | |
| CONT014 Indwelling Urinary Catheter Card completed and given to patient | | | |
| Patient given information on how to obtain further catheter supplies | | | |
| If patient is registered with a Telford and Wrekin GP, register the patient with Proact (0800 917 9865) to request prescription for catheter supplies. Also contact the Continence Nurse Specialists (01743 444062 shropcom.continence@nhs.net ) to provide information on clinical background, and future plan<br><br>If patient is registered with a Shropshire GP, request prescription for catheter supplies from GP | | | |

**Complete Catheter Care Pathway Continuation Sheet, overleaf**

**To be completed by all staff using the assessment form (sign to confirm you have met all standards or recorded variances)**

| Full name: | Designation: | Initials: | Signature: | Date: |
|---|---|---|---|---|
| | | | | |

| Patient name: | Dob: | NHS No: |
|---|---|---|

## Catheter Care Pathway - Continuation sheet:

Remember to prescribe from Shropshire Continence Prescribing Formulary where appropriate

| CATHETER DETAILS | | | |
|---|---|---|---|
| MANUFACTURER | STICK ADHESIVE CATHETER LABEL HERE | SITE OF INSERTION URETHRAL OR SUPRAPUBIC | |
| NAME OF CATHETER | | MEATAL CLEANSING SOLUTION DETAILS | |
| CATHETER MATERIAL | | NAME OF CLEANSING SOLUTION: | |
| CATHETER LENGTH | | LOT NO: | |
| SIZE OF CATHETER (CH) | | EXPIRY DATE: | |
| SIZE OF BALLOON (MLS) | | | |
| LICENSED DURATION OF USE | | | |
| LOT NUMBER | | | |
| EXPIRY DATE | | | |

| WATER TO INFLATE BALLOON DETAILS (IF NOT PREFILLED) | | LUBRICANT AND MANUFACTURER DETAILS: | |
|---|---|---|---|
| MANUFACTURER: | | NAME OF LUBRICANT USED | |
| LOT NO: | | LOT NO | |
| EXPIRY DATE: | | EXPIRY DATE: | |

| DRAINAGE DETAILS | | FIXATION DETAILS: STATE MANUFACTURER AND NAME OF PRODUCT | | |
|---|---|---|---|---|
| LEG BAG: MANUFACTURER & NAME OF PRODUCT. | | VELCRO LEG STRAPS | | |
| LEG BAG CAPACITY | | LEG SLEEVE | | |
| LEG BAG: LENGTH OF TUBING SHORT/LONG | | ABDOMINAL /UPPER THIGH FIXATION | | |
| CATHETER VALVE: MANUFACTURER & NAME OF PRODUCT | | | | |
| BELLY BAG: MAUFACTURER & NAME OF PRODUCT | | Previous catheter was insitu for: | Weeks: | Days: |
| DRAINABLE BED BAG: (FOR ~~NON-AMBULATORY~~ PATIENTS) MANUFACTURER & NAME OF PRODUCT | | | | |
| SINGLE USE NIGHT BAG: MANUFACTURER & NAME OF PRODUCT | | | | |

| STANDARD STATEMENT | STATE VARIATION FROM STANDARD STATEMENT WITH REASON /COMMENTS AND ACTION TAKEN | DATE: | INITIALS: |
|---|---|---|---|
| Review ~~patients~~ clinical needs for continued re-catheterisation. Consider a trial without catheter | | | |
| Patient has given consent for re-catheterisation | | | |
| Reason for re-catheterisation | | | |
| Health status of patient prior to re-catheterisation (~~use~~ UTI assessment form if UTI is suspected, discuss with GP and document outcomes / plan) (~~refer~~ to CONT999 flow chart for management of suspected or confirmed CAUTI) | | | |
| Document any problems encountered during re- catheterisation (~~record~~ any meatal or genital abnormalities, including discharge) (~~record~~ if patient experiencing localised discomfort / pain) (~~inform~~ GP and document outcomes / plan) | | | |
| Observe urine drainage after catheterisation. Seek medical advice if no urine drainage is observed after 30 mins | | | |
| If previous catheter was not patent, cut it open length ways to examine lumen to identify the presence of encrustation/crystals. Identify need for catheter maintenance solution or ~~open-ended~~ catheter | | | |
| Update Indwelling Urinary Catheter Card, and hand back to patient / carer | | | |
| Duration and date of next planned catheter change | WEEKS: | DATE: | |

| FULL NAME: | DESIGNATION: | INITIALS: | SIGN: | DATE: |
|---|---|---|---|---|
| | | | | |

| Patient name: | Dob: | NHS No: |
|---|---|---|
| | | |

## Catheter Maintenance Solutions (CMS)

### Principles of Practice

The procedure for the administration of catheter maintenance solutions will vary with different manufactures. It is essential that clinicians make themselves aware of the manufacturers recommendations for use. Staff must be aware of product liability and its relevance in the use of catheter maintenance solutions

| STANDARD STATEMENT | STATEMENT VARIATION FROM STANDARD STATEMENT WITH REASON/COMMENTS AND ACTION TAKEN | DATE | INITIALS |
|---|---|---|---|
| Patient has given consent to administration of CMS | | | |
| **Catheter Patency** | | | |
| To establish whether catheter is patent instil saline 0.9% C.M.S | | | |
| Record manufacturer name of product Lot no and expiry date | | | |
| **Mechanical Blockage** | | | |
| To remove small blood clots and debris following surgery or to remove mucus following bladder reconstructions instil 30-100mls of saline 0.9% CMS | | | |
| Record manufacturer name of product Lot no and expiry date | | | |
| **External Encrustation** | | | |
| To remove external encrustation on the catheter tip/balloon instil 30-50mls of Citric Acid 6% CMS prior to catheter removal to reduce pain and tissue trauma when the catheter is withdrawn. | | | |
| Record manufacturer name of product Lot no and expiry date | | | |
| **Internal Encrustation** | | | |
| If internal catheter encrustation is suspected, test the pH of the urine and record | | | |
| If the pH of the urine is above 6.8 administer, x 2 sequential, 30-50mls Citric Acid 3.23% CMS as per manufacturers guidelines, monitor effectiveness, discuss with Continence Nurses if ineffective | | | |
| Record manufacturer name of product Lot no and expiry date | | | |

| FULL NAME: | DESIGNATION: | INITIALS: | SIGN: | DATE: |
|---|---|---|---|---|
| | | | | |

## Appendix 2: CONT023 Bladder Diary

**CNT023** **BLADDER DIARY** NHS

FULL NAME: _____ Date of Birth _____ NHS No: _____

(This is page 2 of 2. See page 1 for instructions on completion.)

| | | DAY 1 DATE_____ | | | | DAY 2 DATE_____ | | | | DAY 3 DATE_____ | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time | Drinks In | Urine Out | Wet | Urge | Drinks In | Urine Out | Wet | Urge | Drinks In | Urine Out | Wet | Urge |
| Morning | 6am | | | | | | | | | | | | |
| | 7am | | | | | | | | | | | | |
| | 8am | | | | | | | | | | | | |
| | 9am | | | | | | | | | | | | |
| | 10am | | | | | | | | | | | | |
| | 11am | | | | | | | | | | | | |
| Afternoon | 12md | | | | | | | | | | | | |
| | 1pm | | | | | | | | | | | | |
| | 2pm | | | | | | | | | | | | |
| | 3pm | | | | | | | | | | | | |
| | 4pm | | | | | | | | | | | | |
| | 5pm | | | | | | | | | | | | |
| Evening | 6pm | | | | | | | | | | | | |
| | 7pm | | | | | | | | | | | | |
| | 8pm | | | | | | | | | | | | |
| | 9pm | | | | | | | | | | | | |
| | 10pm | | | | | | | | | | | | |
| | 11pm | | | | | | | | | | | | |
| Night | 12mn | | | | | | | | | | | | |
| | 1am | | | | | | | | | | | | |
| | 2am | | | | | | | | | | | | |
| | 3am | | | | | | | | | | | | |
| | 4am | | | | | | | | | | | | |
| | 5am | | | | | | | | | | | | |
| Totals | | | | | | | | | | | | | |

**Chart completed by:** (name and signature)…….

**Chart seen by assessor**(name,signature,date)……..

# BLADDER DIARY

**On the next page of this leaflet, you will find a bladder diary.**
**Keeping**
INSTRUCTIONS FOR USE –
(This is page1 of 2. Page 2 is your bladder diary to complete.)

Please complete the diary for 3 days (consecutive if possible) and have it available for your appointment. It is important that you provide as much information as possible, as this will form part of your clinical assessment.

**Time** - Enter the information nearest to the time it occurred. For example if you have a drink at 4.25pm, write it down in the box next to 4pm.

**Drinks In** - Please record the amount you drink each time in millilitres (mls) and what type of fluid you are drinking, e.g. tea, coffee, juice etc. If you are not able to measure in mls please indicate cup, mug or glass.

**Urine Out** – Using a jug, please measure and record your urine output in mls, each time you pass urine. If you go to the toilet and forget to do this or are unable to do this please put a ✓.

Every time you pass urine, please put a letter on the chart from the list below that describes how urgency you had to get to the toilet

A. I felt no need to empty my bladder, but did so for other reasons.
B. I could postpone voiding (emptying my bladder) as long as necessary without fear of wetting myself.
C. I could postpone voiding for a short while, without fear of wetting myself.
D. I could not postpone voiding, but had to rush to the toilet in order not to wet myself.
E. I leaked before arriving to the toilet.

Below is an example of how to complete the bladder diary:

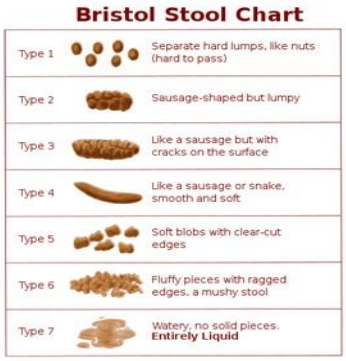
| Time | In | Out | Wet | Urgency |
|---|---|---|---|---|
| 07.00 | | 300mls | | D |
| 08.00 | Tea 1 cup | | | |
| 09.00 | | | | |
| 10.00 | | 200mls | | B |
| 11.00 | Water 1 cup | | | |
| 12.00 | | 50mls | ✓ | E |
| 13.00 | | | | |

## Appendix 3: CONT027 Bowel Diary

**CONT027**

NHS

# BOWEL DIARY




## INSTRUCTIONS FOR USE

(This is page1 of 2. Page 2 is your bowel diary to complete.)

Please complete the diary and have it available for your appointment.
It is important that you provide as much information as possible, as this will form part of your clinical assessment.
Your assessing nurse will discuss this diary with you at your next appointment.

The length of time for which you need to complete the diary, will be recorded at the top of the diary by your assessing nurse.

Please refer to and use the Bristol Stool Scale (BSS).
A copy of this will be given to you by your assessing nurse if you do not already have access to this.

Fill in each column **every time** you have your bowels opened.

**EXAMPLE**

| DATE | TIME | Number of days since bowels last opened | BSS | Did you get the feeling you needed to have your bowels opened? | Length of time spent on the toilet | Amount passed<br>Small<br>Medium<br>Large | Did you need to strain a lot?<br>Yes / No | Did you get any pain?<br>Yes / No | Did you leak any stools before you reached the toilet? Yes / No | Any bowel medication taken? What and when did you take it. | Any bowel emptying techniques used? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| June 25th | 10am | 4 | 2 | Yes | 15 minutes | Small | Yes | No | No | No | No |
| June 28th | 4 pm | 3 | 2 | Yes | 10 minutes | Medium | Yes | Yes | No | No | No |

NHS

# BOWEL DIARY

**FULL NAME:** _____ **Date of Birth:** _____ **NHS No:** _____ **Diary Sheet No**_____

(This is page 2 of 2. See page 1 for instructions on completion.)
Please complete the diary recording **all** your bowel movements for the next____weeks/days.
Please refer to the Bristol Stool Scale (BSS).

| DATE | TIME | Number of days since bowels last opened | BSS | Did you get the feeling you needed to have your bowels opened? | Length of time spent on the toilet | Amount passed<br>Small<br>Medium<br>Large | Did you need to strain a lot?<br>Yes / No | Did you get any pain?<br>Yes / No | Did you leak any stools before you reached the toilet? Yes / No | Any bowel medication taken? What and when did you take it. | Any bowel emptying techniques used? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
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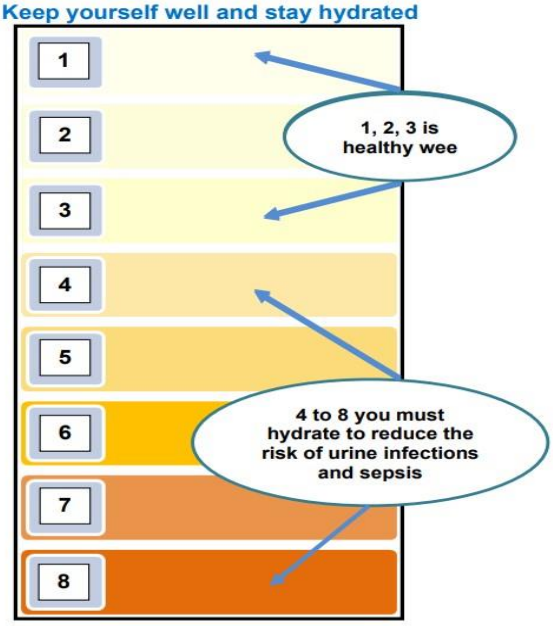
| | | | | | | | | | | | |

**Chart completed by:** (name and signature) .....
**Chart seen by assessor and outcomes discussed** (name, signature, date) .....

## Appendix 4: Hydration Leaflet

### What colour is your wee?

**Keep yourself well and stay hydrated**




Publication Date: 19 March 2021
Review Date: March 2024
Datix number: 2137-65140

Shropshire and Telford: Reducing infection for all

# Are You Drinking Enough Fluids?

### What is Dehydration and What Causes it?

Water makes up over two thirds of the healthy human body. It is essential for lubricating the joints and eyes, aiding digestion, flushing out waste and toxins and keeping skin healthy.

Dehydration occurs when the normal fluid content of your body is reduced and is generally caused by not drinking enough fluid or by losing fluid and not replacing it.

You can lose fluid through vomiting, diarrhoea, sweating, and frequent urination due to an underlying medical condition and some medication.

### Drink Plenty of Fluids

Adults should drink a minimum of 1.2 to 2.0 litres (six to eight glasses) of fluid every day.

Higher intakes of total fluid will be required for those who are physically active or who are exposed to hot environments. Obese adults may also require higher intake of total fluid.

Individuals with certain conditions e.g. heart failure and kidney failure can retain fluid, and may need fluid to be limited, your GP or consultant will advise on optimal levels in these instances.

### Symptoms of Dehydration Include:

- Dry mouth or lips
- Dry skin
- Thirst
- Dizziness
- Tiredness
- Headache
- Dark coloured, strong smelling urine
- Light-headedness
- Reduced alertness
- Reduced ability to concentrate

Increase your intake of fluid (e.g. decaffeinated tea/coffee, herbal/fruit tea, squash, milk, juice) if you experience any signs of dehydration, or if you experience bladder or bowel urgency or frequency.

A simple method to track your body's hydration levels is by monitoring your urine; the colour of your urine can reflect how much water your body needs. (See 'what colour is your wee chart' overleaf)

### Good Hydration Can Help With the Treatment and Prevention of:

- Sepsis - a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion. For more information please visit https://www.nhs.uk/conditions/sepsis/.
- Pressure ulcers
- Constipation
- Confusion
- Kidney and gallstones
- Urinary Tract Infection (UTI)
- Circulatory problems
- Diabetes control
- Incontinence
- Low blood pressure
- Heart disease

Some individuals with a UTI may experience mild urinary incontinence and it may be tempting to reduce your fluid intake. However, this may exacerbate your symptoms and you should continue to maintain your fluid intake.

### Practical Tips

- Have water at meal times and at least hourly
- Try hot water with a piece of fruit in e.g. lemon or orange for a change
- Fruit or herbal teas make a change for those who like hot drinks
- Try warm squash e.g. blackcurrant or orange
- Try 'traditional' flavours of drinks e.g. dandelion and burdock, cream soda, ginger ale
- Eat hydrating foods such as custard, soup, juice of tinned fruit, ice cream, jelly, ice lollies and smoothies.
- Also eat fruit and vegetables that have a high fluid content e.g. pears, melon, orange, peach, tomatoes, cucumber, pineapple

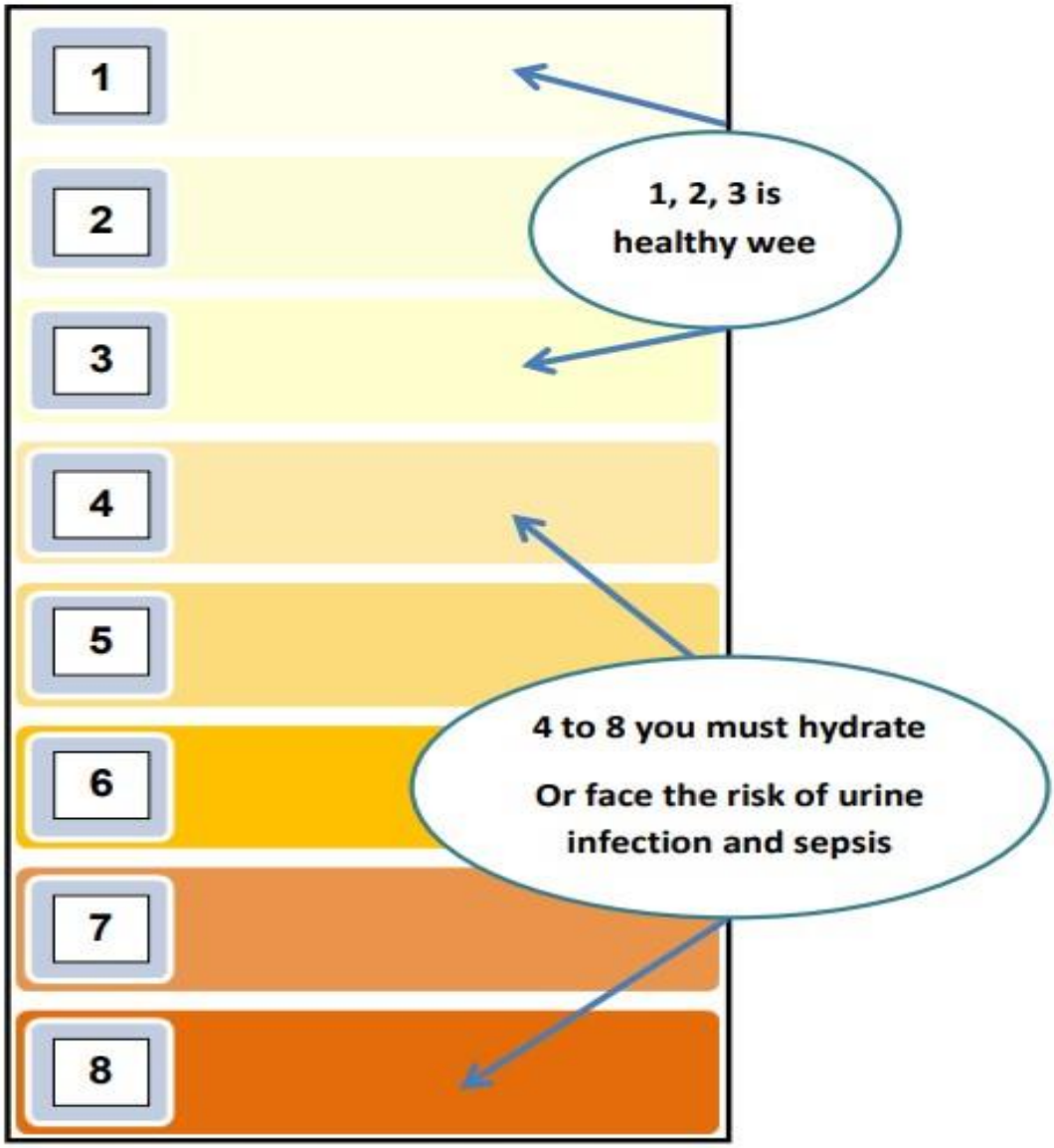
## Appendix 5: What Colour is Your Wee?

Shropshire and Telford:
Reducing infection for all

### What colour is your wee?

Dehydration can reduce the flow of blood to the kidneys causing acute kidney injury and infection. In the UK, up to 100,000 deaths a year are associated with acute kidney injury, of which up to a third of those deaths could be avoided (*NHSE 2017)

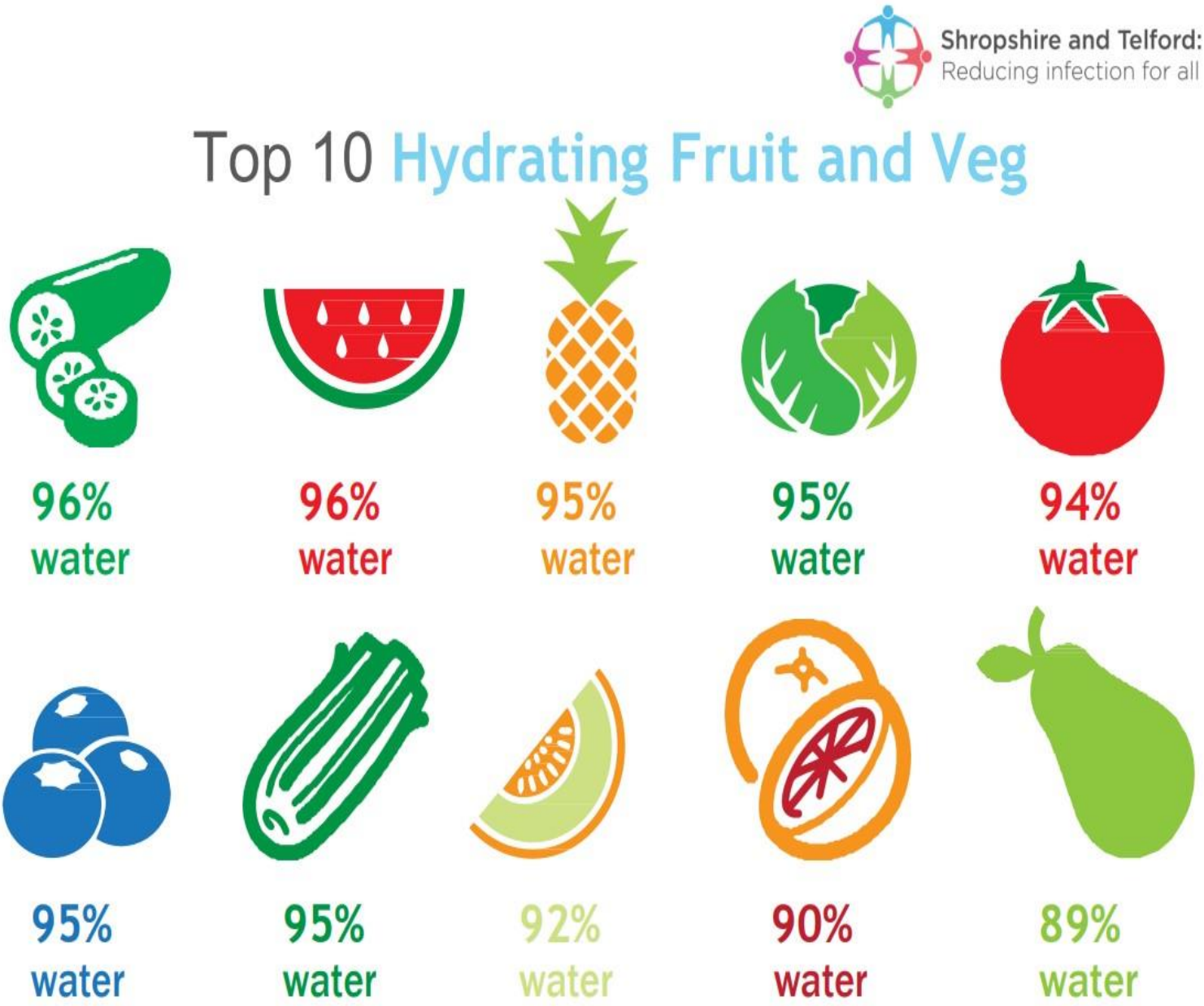
### Keep yourself well and stay hydrated




*NHS England and UK Renal Registry (2017) Acute Kidney Injury and Hydration: A Learning Guide for Care Homes

Publication Date: February 2021 Review Date: February 2024
Datix Number: 2139-55515

**Appendix 6: Top 10 Hydrating Fruit and Veg**



## Appendix 7: CONT013 Patient Information – Indwelling Catheters

Shropshire Community Health NHS
NHS Trust

CONT 013

# Patient Information Leaflet

# Indwelling Catheters.

This leaflet provides advice and support to patients and carers about indwelling urinary catheters and key contact details.

www.shropscommunityhealth.nhs.uk

Index — Page No:



For any queries or concerns you have regarding your catheter please discuss with your healthcare professional who can give you further detailed information and individualised care and advice.

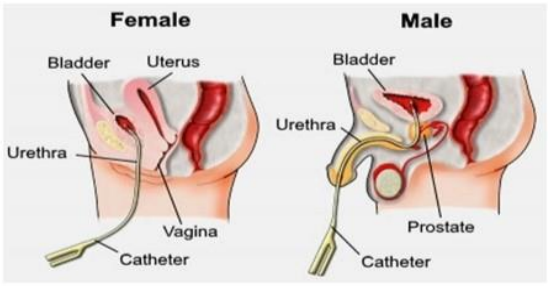
CONTACT NUMBERS

| | |
|---|---|
| Ward / department | Tel: |
| Community nurse | Tel: |
| GP | Tel: |
| Out of Hours: | Tel: 111 |

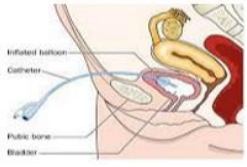


## What is an indwelling Catheter?

A catheter is a thin, hollow, flexible tube designed to drain urine from the bladder. The catheter is kept in place by a small balloon at its tip filled with sterile water, which prevents it from falling out. It is inserted into the bladder through the urethra (water pipe). This is a small opening above the vagina in women and runs through the length of the penis in men.




In some people it may be necessary to insert the catheter into the bladder through an incision (cut) through the abdominal wall. This is called a supra pubic catheter:




## Why are catheters used?

Some people find it difficult to empty their bladder, so a catheter is inserted to drain urine away. Catheters are also used before or after surgery, for instilling medication into the bladder and occasionally for managing urinary leakage if this cannot be managed in another way.



## Caring for your Indwelling Catheter

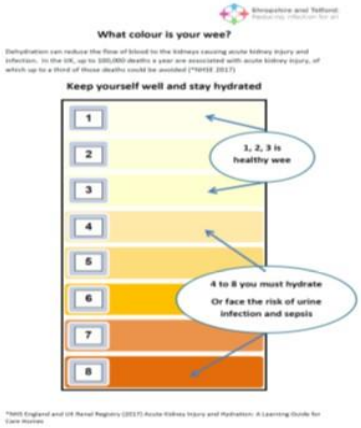
1. ***Maintain hygiene***

Good personal hygiene is important when you have a catheter in place to help prevent a urine infection.

- Wash and dry your hands before and after handling the catheter or drainage bag.
- With mild soap and water wash the skin in the area where the catheter enters the body front to back and, in men, under the foreskin (but ensure this is rolled back in place after washing to prevent complications) at least daily and/or after a bowel motion.
- Avoid using talc or creams on the area around the catheter.
- You can bathe, but a shower is advisable, if possible, to help prevent infection. Before you shower or bathe, empty the drainage bag, but leave it connected.
- For supra pubic catheters, initially you may need to wear a dressing around the incision site, usually for the first 24-48 hours, however once healed this is not necessary and should be cleaned daily with mild soap and water.

2. ***Have a good fluid intake.***

Unless told otherwise by your nurse or doctor, aim to drink 1.5-2 litres (3 pints) of fluid a day to help in the prevention of infection and help avoid constipation. You can use the below guide to ensure you are hydrated:




3. ***Diet and bowel care***

A healthy balanced diet rich in fresh fruit, vegetables and fibre is recommended as this will help to maintain a regular bowel pattern. Constipation can prevent your catheter draining freely as a full bowel can press on the catheter. This is a common cause of urinary leakage around the catheter.

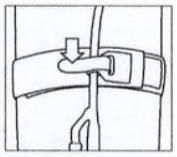
4. ***Activity and exercise***

Having a catheter in place should not restrict your daily activities. Gentle exercise will help your catheter to drain. You can swim with an indwelling catheter in place. Ensure your catheter is comfortably secured with a retaining device.



5. ***Securing the catheter***

It is important that both the catheter and leg bag are both well supported to reduce traction and trauma to the bladder neck/urethra and to promote comfort.
A G-strap can be used as a retaining strap which secures the catheter tubing firmly and comfortably against the upper thigh. Ensure positioned to allow for natural movement.



Upper thigh retaining strap

6. ***Securing the leg bag:***

Leg bag straps are supplied within the boxes of leg bags, a longer one to be used at the top of the bag and shorter one for the bottom of the bag- they can be cut to size if required. There are leg bag sleeves available as an alternative (a calf or thigh measurement will determine appropriate size). These are particularly good for frail skin, problems with straps digging in or rubbing, as the weight of the urine is distributed evenly. All the straps and sleeves are washable/reusable.
Talk to your health professional who can demonstrate use and advise.

CONT013 Patient Information Leaflet. Indwelling Catheters. Version 3 June 2022

## Drainage Bags

Leg bags should be worn in a comfortable position against the thigh, knee or calf area (according to individual preference) and secured to your leg by straps or a sleeve as discussed above. Short or long tube leg bags are available with t-tap or lever tap drainage systems (patients preference). For some patients who are unable to use a leg bag there is an alternative in the form of a Belly Bag which is worn as a bum bag and is secured by a soft belt around the waist.


Lever Tap T Tap

To minimize the risk of infection it is essential to wash your hands before and after emptying or changing the bag. You should empty/drain your bag when it is 3/4s full. When emptying the bag try to make sure that the outlet does not come into contact with the toilet or other receptacle and the outlet tap is dried with clean tissue paper following emptying.

The drainage bag should only be disconnected from the catheter when absolutely necessary to reduce the risk of introducing infection. **It should be changed every 5 – 7 days** unless discoloured/soiled. (If using a belly bag, this should be changed every 28 days). When applying a new drainage bag to the catheter it is important, when removing the cap not to touch the sterile connector.

All drainage bags attached directly to the catheter are designed for single use only and must not be re-used. For what ever reason a drainage bag is disconnected from the catheter a fresh bag must always be re applied.

At night it is recommended that you connect a single use larger capacity bag onto the leg bag. The outlet tap on the leg bag should be in the open position to allow the urine to flow into the night bag. When removing the protective cap from the night bag do not touch the sterile connector which attaches to the outlet tap. A stand for the night bag should be utilised to promote effective drainage and hygiene by preventing the bag from being on the floor.

To disconnect the night bag from the leg bag, wash your hands, close the outlet tap on the leg bag and disconnect the tubing from the tap. Dry the outlet tap with clean tissue paper. Empty night bag according to manufacturer's instructions and dispose of the bag. A new night bag should be used each night.
If you are immobile/always in bed, you will not use a leg bag. You will use a drainable 2 litre bag, attached directly to your catheter, which will need changing every 5-7 days.

## Disposing of Drainage Bags

Drainage bags may be disposed of in the normal household waste, provided they have been emptied and wrapped in newspaper or a plastic bag.

CONT013 Patient Information Leaflet. Indwelling Catheters. Version 3 June 2022

## Catheter Valves

Catheter valves are used as an alternative to a leg bag for some people. They are not suitable for everyone so you should ask your nurse for advice on whether a valve would be suitable for you.

A catheter valve is a tap that is connected directly to the catheter. It allows drainage of urine from the bladder to be controlled and helps maintain bladder muscle tone and a good bladder capacity.

It is very important that the valve is opened at regular intervals throughout the day, every 3 – 4 hours to allow the bladder to empty. If you do not empty the bladder regularly you may experience some abdominal discomfort as the bladder becomes full or you may experience leakage of urine around the catheter.

## Care of the Catheter Valve

Change the catheter valve every 5 – 7 days. In order to minimize the risk of infection it is essential to wash your hands before and after emptying or changing the valve. When emptying the valve try to make sure that the outlet does not come into contact with the toilet or other receptacle and the outlet tap is dried with clean tissue paper following emptying.

You should attach an overnight bag to the valve. Once the night bag is connected, the valve should be in the open position to allow urine to drain.

## Disposing of Catheter Valves

Catheter valves may be disposed of in the general household waste, provided they have been wrapped in newspaper or a plastic bag.

CONT013 Patient Information Leaflet. Indwelling Catheters. Version 3 June 2022

## Frequently Asked Questions:

- ***How often does the catheter need changing?***

Indwelling catheters need changing at regular intervals between 4 – 12 weeks. It will be changed by a health professional. The frequency of changes will depend on the material the catheter is made of and whether you experience problems with it blocking. Your nurse will discuss with you when and where your catheter will be changed.

- ***How long will I have my catheter in for?***

You might need an indwelling catheter temporarily, for example before or after an operation. You may need to have one for a longer period or even the rest of your life. Please discuss this with your doctor or nurse as you should know why you need a catheter and when its use will be reviewed.

- ***Is it possible to have sex with a catheter in place?***

Yes. However, it may be helpful to discuss further with your nurse as there may be alternatives available such as the use of a supra pubic catheter or you could be taught to remove and replace the catheter yourself.
But men and women can continue to have a normal love life with a catheter in place. In women, be reassured that the catheter is in the urethra and not the vagina. An indwelling catheter can be taped out of the way, across the abdomen in women or along the penis in men. It is also advisable for men to use a condom and water based lubricating gel to reduce the risk of soreness developing. Men should be aware that after ejaculation their urine may be cloudy. Because of this, catheter blockage can occur so you may want to discuss catheter maintenance solutions with your healthcare professional.

- ***What should I do if the Catheter falls out ?***

Do not try to replace your catheter yourself. Contact your nurse, doctor or out of hours service as soon as possible.

- ***What problems may I experience? /Possible complications:***

**Initial discomfort/blood in urine:**

Initially people with a catheter can experience bladder spasm or cramp and / or the desire to pass urine. These sensations usually subside within a few days. If they persist it is advisable to discuss this with your nurse. It is quite common to notice small flecks of blood in your urine after being catheterised/re-catheterised. This should resolve within a couple of days. If it does not resolve, or if you are concerned about blood in your urine contact your district nurse or out of hours service

**Paraphimosis:**

Paraphimosis occurs when the retracted foreskin of an uncircumcised man cannot be returned to its normal position. Occasionally this can occur after catheterisation or cleansing of the penis. If you are not able to return your foreskin yourself, you need to seek medical advise urgently as this can cause serious complications.



**Urinary tract infection (also known as a UTI):**

People with an indwelling catheter have an increased risk of developing a urinary tract infection. Urinary tract infections can cause you to experience stinging or burning in your bladder, abdominal or lower back pain, give you a temperature and make you feel generally unwell. Your urine may become cloudy, contain blood, or smell offensive. You may experience new or worsening confusion. If you are concerned you have a urine infection you should contact your GP or out of hours service.

**Blockage of the catheter / leakage around catheter:**

This may occur if your catheter or tubing becomes kinked, there is irritation in the bladder, a build-up of debris in the catheter or if you are constipated. You should:

- Check your catheter and tubing, release any kinks.
- Check the drainage bag is not too full.
- Follow previous dietary and fluid advice mentioned to avoid constipation.
- Movement can dislodge minor blockage, walking around may help.
- Medication can sometimes help relieve bladder spasm. Although it is not suitable for everyone this would need to be discussed with your doctor or nurse.
- Make sure your leg or night bag is positioned below the level of your bladder / waist to allow urine drainage.
- If no urine drains from your catheter and you become uncomfortable you should contact the district nurse or out of hours service. If urine is draining from your catheter but leaks around it, do not worry this is not a medical emergency, follow the previous advice mentioned in this document and it may resolve. Discuss with your district nurse if it persists.

**PLEASE DO NOT ATTEMPT TO REMOVE YOUR CATHETER UNDER ANY CIRCUMSTANCES WITHOUT PROFESSIONAL ADVICE**

CONT013 Patient Information Leaflet. Indwelling Catheters. Version 3 June 2022

## Catheter Card

When you are initially catheterised, you should be provided with a catheter card by your healthcare professional:


This acts as a form of communication regarding the details of your catheter between healthcare professionals. If you do not have one, or if you need a new one, ask your district nurse or hospital nurse for one.

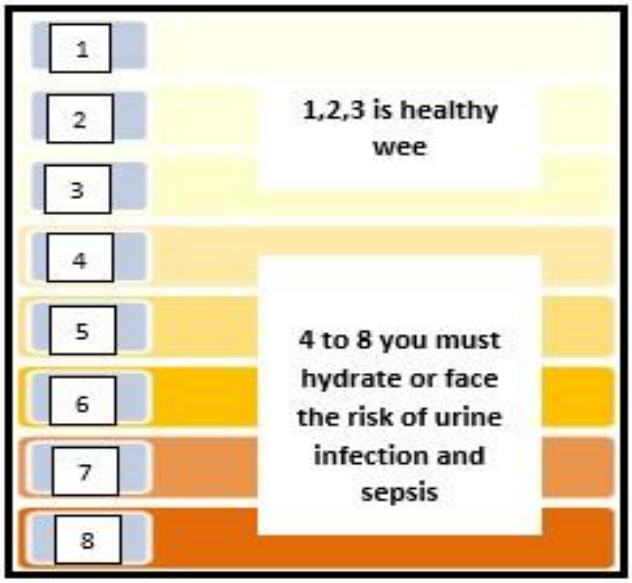
## Equipment you should have via prescription:

- X2 catheters
- X2 lubrication gel for use during change of catheter
- Retaining strap ie G Strap- available in packs of 5- are washable and reusable.
- One box of sterile leg bags.
- Leg bag straps (a new set of 2 comes in each box of leg bags) or sleeve- both are washable and reusable.
- One months supply of single use night bags
- Night bag stand (available via your prescription dispensing appliance contractor (DAC) or by calling freephone 08000854957 or emailing info@clinisupplies.co.uk)

## Appendix 8: CONT014 Indwelling Urinary Catheter Card

**What colour is your wee?**

Shropshire and Telford:
Reducing infection for all




Patient name
.....

Patient NHS number
.....

GP Practice.....

Phone no .....

District nurse phone no
.....

Out of hours contact number
111

**CARRY THIS CARD WITH YOU AT ALL TIMES AND PRESENT IT WHEN YOU ATTEND HOSPITAL, YOUR GP PRACTICE OR WHEN YOU SEE YOUR DISTRICT NURSE**

V.1 June 2019

### Indwelling Urinary Catheter Card

**REASON FOR CATHETERISATION:**

- **Retention – state reason for retention (e.g. spinal injury, neurological illness, benign prostatic hyperplasia/other)…….**
- **Intractable urinary incontinence**

Date of initial insertion ..... / ..... / .....
Location of patient at initial insertion e.g. hospital .....

Site: suprapubic / urethral Size of catheter:.....ch

Type of catheter: 28 days PTFE / 12 week all silicone/hydrogel

Length of catheter: female/standard

**DATE OF PLANNED TRIAL WITHOUT CATHETER: ..... / ..... / .....**

## Appendix 9: UTI Assessment Form

# Urinary Tract Infection (UTI) Assessment Form for all Patients with and without urinary catheters in situ (to be completed for each patient with a suspected UTI)

NHS
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NHS Trust

Patient.....

NHS No.....

Ward/Team.....

Date.....

Diagnosis of a UTI must always involve assessing for clinical signs and symptoms of a UTI.

- **NEVER** dipstick catheter specimens of urine for suspected UTI
- **DO NOT** perform urine dipstick on patients aged 65yrs or older for suspected UTI
- If the urine is clear UTI is very unlikely
- Consider sending a urine specimen if more than 2 signs/symptoms of urinary tract infection are present
- Complete microbiology form with clinical signs and symptom

| Signs and Symptoms of Urinary Tract Infection (UTI) | Tick if present |
|---|---|
| Pain on urinating | |
| Need to pass urine urgently/new incontinence | |
| Need to urinate more often than usual | |
| Pain in lower tummy/above pubic area | |
| Blood in urine | |
| Passing smaller/ bigger volumes of urine than usual | |
| Lower back pain | |
| Offensive smelling urine | |
| Discoloured/cloudy urine | |
| New onset or worsening behaviour, confusion or agitation (discuss with family and carers) | |

| Signs and symptoms of any other infection | Tick if present |
|---|---|
| Cough | |
| Shortness of breath | |
| Sputum production | |
| Nausea/vomiting | |
| Diarrhoea | |
| Abdominal pain | |
| Red/warm/swollen area of skin | |

| Record of observations | Tick if present |
|---|---|
| Temperature more than 38C or below 36C or shaking chills (rigors), clammy skin in past 24 hours | |
| Heart rate less than 50 beats/min | |
| Respiratory rate more than 20 breaths/min | |
| Capillary Blood Glucose more than 7.7mmols in absence of diabetes | |
| Bloods taken to check White Cell Count (WCC) & C-Reactive Protein (CRP) | |
| Increased falls | |
| NEWS2 Score | |
| Has a urine sample been sent? | |

Urinary catheter Yes ☐ or No ☐ Short ☐ or long term? ☐ Reason for catheter :

GP notified: Yes or No GP/NMP Action Taken.....

Name of Nurse .....

Signature.....

Course of action .....

Antibiotic Prescribed .....

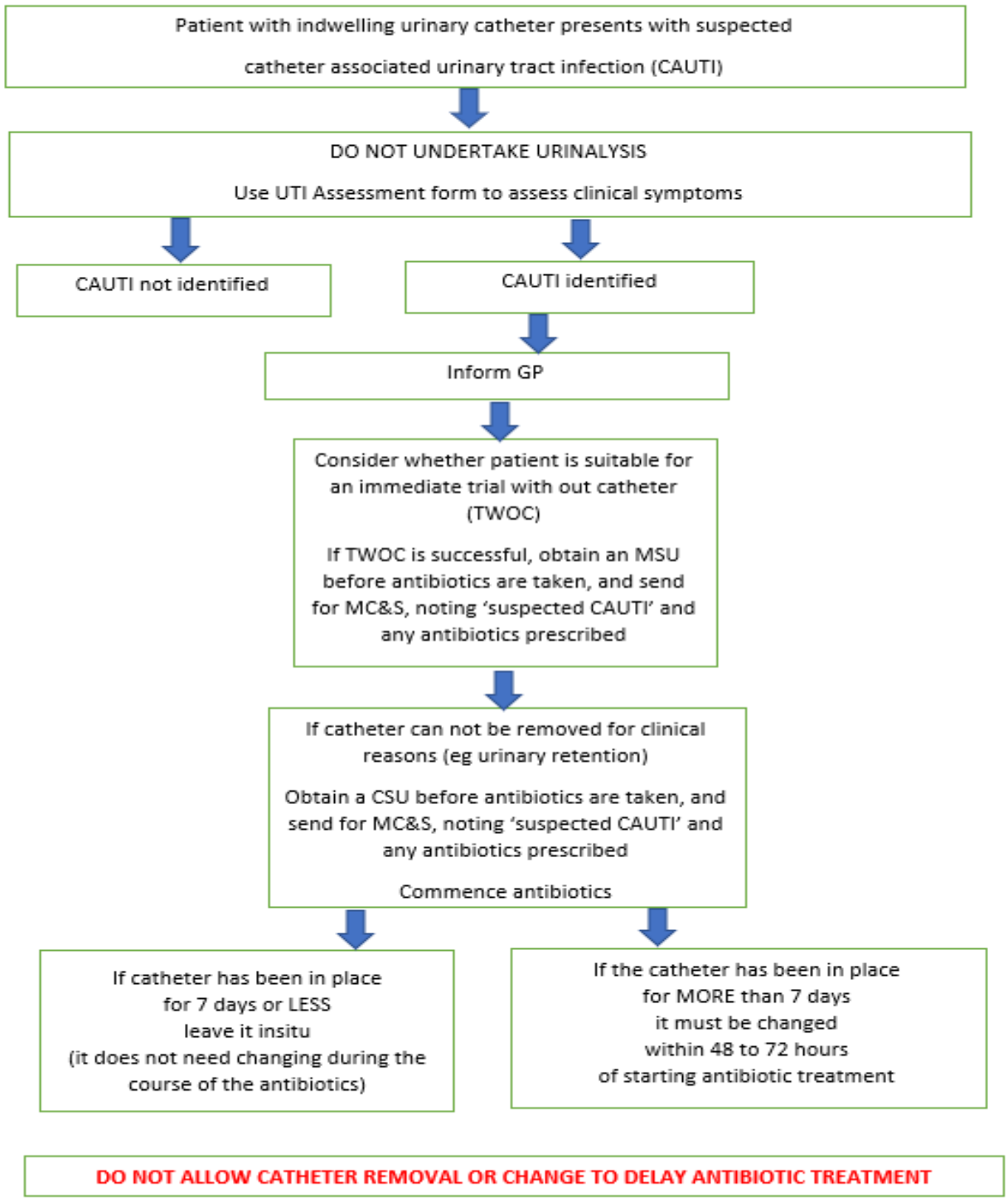
Clinical Reason .....

Urinary Tract Infection (UTI) Assessment Form V2.2Jan 2022

## Appendix 10: CONT 054 Flow Chart for Management of Suspected or Confirmed CAUTI

Shropshire Community Health NHS
NHS Trust

**CONT054 Flow Chart for management of suspected or confirmed CAUTI (urethral or supra pubic indwelling urinary catheters)**




Version 1 March 2023

**Standard Operating Procedure for indwelling male catheterisation (adult patients)**

| |
|---|
| • **Catheterisation must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **Tiemann catheters must not be inserted in the community. They are only to be inserted / changed in a urology setting** |
| **Equipment:**<br>Sterile catheterisation pack<br>Catheter (licensed for urethral use)<br>11ml Sterile lubricating gel (licensed for urethral use)<br>Disposable procedure sheet<br>Non-sterile nitrile gloves<br>Sterile nitrile gloves<br>10ml sterile water in sterile 10 ml syringe, to inflate new catheter balloon<br>Sterile 10ml syringe, to deflate existing catheter balloon<br>Single use apron<br>0.9% sodium chloride (saline) for meatal cleansing<br>Catheter valve / urine drainage bag, with adjustable straps or a leg bag holder<br>Fixation device (eg G-strap)<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put apron on |
| Open catheterisation pack, and open the equipment onto the sterile field |
| Prepare the patient, maintaining their dignity<br>(procedure sheet underneath their bottom, underwear removed, drainage bag emptied, patient lying down with legs straight) |
| Decontaminate hands and apply sterile gloves |
| Place sterile towel across the patient's thighs, ensuring the scrotal area is covered and place the receiver between the patient's legs |
| Wrap a sterile swab around the penis and with non-touch technique, retract the foreskin if present |
| Clean the urethral meatus with sterile saline, ensuring that fingertips do not touch the glans penis |
| Position the penis at 90 degrees to the patient's abdomen |
| Place the tip of the syringe into the urethral meatus and slowly insert all of the 11ml of the gel. Remove the syringe and discard.<br>Wait 3-5 minutes (according to manufacturers instructions) for the gel to take effect |
| Remove gloves, decontaminate hand and put on a second pair of sterile gloves |
| Remove packaging from the end of the catheter and attach the sterile drainage bag / catheter valve (in open position) |

| |
|---|
| Remove packaging from the tip of the new catheter |
| Position the penis at 90 degrees to the patient's abdomen and insert the catheter into the urethra for 15 to 25cm, ensuring the fingers do not touch the glans penis. If resistance is felt at the external sphincter, ask the patient to cough or strain gently as if trying to pass urine.<br>When urine begins to flow, advance the catheter to its bifurcation |
| Slowly inflate the balloon, according to manufacturer's instructions. Balloon inflation should be pain free. If discomfort is displayed during balloon inflation stop and recheck the position of the catheter.<br>Withdraw the catheter slightly until it is felt against the bladder wall |
| Ensure that the glans penis is clean, then replace the foreskin, and ensure that the patient is comfortable and dry |
| Observe the colour and measure the amount of urine drained |
| Secure the drainage system to the patient, with adjustable straps or a leg bag holder, and a fixation device (eg G-strap)<br>Ensure that the catheter tubing does not become taut when the patient is mobilising and that the patient's clothing has been repositioned and is comfortable |
| Retain the sticky labels from the catheter packaging. Dispose of waste, remove gloves and apron. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure, and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

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**Standard Operating Procedure for suprapubic recatheterisation (adult patients)**

| |
|---|
| • **Catheterisation must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **It is optional to clamp the existing drainage bag tubing for 15 to 30 minutes before the catheter change. Using a single patient use disposable clamp applied immediately below the sampling port on the drainage bag tubing. This ensures the presence of urine in the bladder and promotes effective placement of the new catheter**<br>• **DO NOT CLAMP THE CATHETER IF PATIENT HAS A SPINAL CORD INJURY AT T6 OR ABOVE. CHANGE SUPRA PUBIC CATHETER AS PER INSTRUCTIONS FROM CENTRE FOR SPINAL CORD INJURIES** |
| **Equipment:**<br>Sterile catheterisation pack<br>Catheter (licensed for supra pubic use, and the same charriere size as the existing catheter)<br>6ml Sterile lubricating gel (licensed for suprapubic use, Lidocaine not required)<br>Disposable procedure sheet<br>Non-sterile nitrile gloves<br>Sterile nitrile gloves<br>Sterile water in 10ml syringe, to inflate new catheter balloon<br>Sterile 10ml syringe, to deflate existing catheter balloon<br>Single use apron<br>0.9% sodium chloride (saline) for meatal cleansing<br>Catheter valve / urine drainage bag, with adjustable straps or a leg bag holder<br>Fixation device (eg G-strap)<br>Alcohol hand gel<br>Protective eye wear<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put apron on |
| Open catheterisation pack, and open the equipment onto the sterile field |
| Prepare the patient, maintaining their dignity (procedure sheet underneath their bottom, underwear removed, drainage bag emptied, patient lying down with legs straight) |
| Decontaminate hands and apply non-sterile gloves and protective eye wear |
| Tie a piece of gauze around the existing catheter, close to the abdominal wall, and then deflate the catheter balloon with syringe |
| Place index and middle finger either side of the catheter, applying gentle pressure to the abdomen and remove existing catheter (maintaining the position of the gauze, noting the lie of the existing catheter and the angle of insertion). Lay removed catheter on edge of sterile field<br>(there may be a gush of urine from the cystostomy stoma, as the catheter is removed) |
| Remove gloves, decontaminate hands and put sterile gloves on |
| Place sterile towel immediately below the cystostomy stoma, ensuring that the genital area is covered. Place the receiver between the patient's legs |

| |
|---|
| Clean the cystostomy stoma site with gauze soaked in sterile saline |
| Insert lubrication gel into cystostomy stoma (as Lidocaine gel is not being used, do not wait 3-5 minutes before inserting catheter) |
| Remove gloves, decontaminate hands and put on second pair of sterile gloves |
| Remove packaging from the end of the new catheter and attach the sterile drainage bag / catheter valve (valve in open position). Remove packaging from the tip of the new catheter |
| Measure the new catheter against the old catheter, to assess the insertion length.<br>Insert the new catheter as quickly as possible, at the same angle as the old catheter.<br>Do not allow the new and old catheters to touch each other |
| Advance the catheter into the tract 3cm deeper than the removed catheter |
| If no urine drains, gently apply pressure just above the pubic symphysis area |
| Once urine starts to drain, slowly inflate the balloon, according to manufacturer's instructions. Balloon inflation should be pain free. If discomfort is displayed during balloon inflation stop and recheck the position of the catheter. Withdraw the catheter slightly until it is felt against the bladder wall |
| Failure to reinsert suprapubic catheter, must prompt immediate transfer of patient to urology at Royal Shrewsbury Hospital |
| Ensure that the patient's abdomen is clean and that the patient is comfortable and dry |
| Observe the colour and measure the amount of urine drained |
| Secure the drainage system to the patient, with adjustable straps or a leg bag holder, and a fixation device (eg G-strap). Ensure that the catheter tubing does not become taut when the patient is mobilising and that the patient's clothing has been repositioned and is comfortable |
| Retain the sticky labels from the catheter packaging. Dispose of waste, remove gloves and apron. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

| |
|---|
| The first catheter change can be undertaken in the community, only if urology state this on the patient's discharge summary. |
| If it is not clear who is going to change the patient's catheter, the community HCPs must contact urology to seek clarification. |
| Urology instructions must be followed relating to when the first catheter change, and subsequent catheter changes are due. |
| If a patient needs to present themselves / be transferred to A&E regarding their supra pubic catheter (for example, community nurses are unable to remove old catheter / insert new catheter, or catheter is not patent and urology always change the catheter); the patient must only attend Royal Shrewsbury Hospital, where urology are based |

Shropshire Community Health NHS Trust

**Standard Operating Procedure for indwelling female catheterisation (adult patients)**

| |
|---|
| **Catheterisation must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure** |
| **Equipment:**<br>Sterile catheterisation pack<br>Catheter (licensed for urethral use)<br>6ml sterile lubricating gel (licensed for urethral use)<br>Disposable procedure sheet<br>Non-sterile nitrile gloves<br>Sterile nitrile gloves<br>10ml sterile water in sterile 10 ml syringe, to inflate new catheter balloon<br>Sterile 10ml syringe, to deflate existing catheter balloon<br>Single use apron<br>0.9% sodium chloride (saline) for meatal cleansing<br>Catheter valve / urine drainage bag, with adjustable straps or a leg bag holder<br>Fixation device (eg G-strap)<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put apron on |
| Open catheterisation pack, and open the equipment onto the sterile field |
| Prepare the patient, maintaining their dignity<br>(procedure sheet underneath their bottom, underwear removed, drainage bag emptied, patient lying down with knees flexed and hips externally rotated) |
| Decontaminate hands and apply sterile gloves |
| Place sterile towel across the patient's thighs and place the receiver between the patient's legs |
| Using non dominant hand, part the labia so that the urethral meatus can be seen. This hand should be used to maintain labial separation until instillation of gel is complete is complete |
| Using dominant hand, clean around the meatus with five gauze swabs soaked in the sterile saline.<br>Use five separate, single, downward strokes. Use one swab for each stroke, and discard each swab after stroke<br>(firstly the labia majora x2, then the labia minora x2, and then the urethral meatus) |
| Prime the syringe of the lubricating gel. Place the tip of the syringe into the urethral meatus and slowly insert all of the 6ml of the gel. Remove the syringe and discard.<br>Wait 3-5 minutes (according to manufacturers instructions) for the gel to take effect |
| Remove gloves, decontaminate hands and put on a second pair of sterile gloves |
| Remove packaging from the end of the new catheter and attach the sterile drainage bag / catheter valve (in open position) |
| Remove packaging from the tip of the new catheter |

| |
|---|
| Introduce the tip of the catheter into the urethral meatus in an upward and backward direction. Advance the catheter until 5 to 6cm has been inserted.<br>When urine begins to flow advance the catheter a further 5cm |
| Slowly inflate the balloon, according to manufacturer's instructions. Balloon inflation should be pain free. If discomfort is displayed during balloon inflation stop and recheck the position of the catheter.<br>Withdraw the catheter slightly until it is felt to be firm against the bladder wall |
| Ensure that the genital area is clean and that the patient is comfortable and dry |
| Observe the colour and measure the amount of urine drained |
| Secure the drainage system to the patient, with adjustable straps or a leg bag holder, and a fixation device (eg G-strap)<br>Ensure that the catheter tubing does not become taut when the patient is mobilising and that the patient's clothing has been repositioned and is comfortable |
| Retain the sticky labels from the catheter packaging. Dispose of waste, remove gloves and apron. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure, and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

The balloon must not be inflated until urine drains via the catheter

Instillation of a catheter maintenance solution must not be used as a way of establishing whether the newly inserted catheter has been positioned correctly

If catheter drainage issues persist or appear unusual, the HCP needs to offer a visual examination of the patient's genital area, including the urethral meatus, to check for correct positioning of the catheter and to look for any abnormalities

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**Standard Operating Procedure for removal of indwelling urethral catheter (adult patients)**

| |
|---|
| **Equipment:**<br>Disposable procedure sheet<br>Non-sterile nitrile gloves<br>Sterile 10ml syringe<br>Single use apron<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Decontaminate hands and put apron and gloves on |
| Prepare the patient, maintaining their dignity<br>Procedure sheet underneath their bottom, underwear removed<br>Male patients – with legs extended<br>Female patients – with knees flexed and hips externally rotated |
| Release urine drainage bag / catheter valve, and support straps / fixation devices<br>If catheter valve is being used, drain the bladder<br>If urine drainage bag is being used, empty it |
| Attach syringe to inflation port with a firm push and twist motion, and slowly deflate catheter balloon<br>Allow the water to flow into the syringe naturally. Do not pull back on the syringe as this may increase the risk of ridges forming on the deflated balloon<br>(Due to osmosis, there may be less water present in the catheter balloon, than the initial volume used to inflate the balloon) |
| Male patients – extend the penis at 90 degrees to the patient's abdomen<br>Withdraw the catheter gently, as the patient exhales, without using any force<br>It may help to ask the patient to bear down gently as if they are trying to pass urine, as the catheter is removed |
| If the catheter is due to be replaced straight away, check condition of the removed catheter<br>Consider cutting the removed catheter lengthways, to check for encrustation in the lumen |
| Ensure that the genital area is clean and that the patient is comfortable and dry |
| Dispose of waste, remove gloves and apron. Decontaminate hands |
| If catheter is not being replaced, follow the Trust Trial Without Catheter (TWOC) Policy |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure and outcomes in the patient's catheter care pathway or TWOC pathway documentation<br>Complete / update the patient's Catheter Card |

**Standard Operating Procedure for suprapubic recatheterisation using a warm bladder infill, for patients with a spinal cord injury (adult patients)**

| |
|---|
| • **Catheterisation must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **The Midlands Centre for Spinal Injury (MCSI), change suprapubic catheters using a warm saline infill for some patients, to reduce bladder spasm and help maintain the cystostomy stoma tract**<br>• **Patients requiring catheter change in the community using bladder infill, will be identified by MCSI, who will liaise directly with the community nursing team involved in the patient's care**<br>• **The nurses from MCSI will teach the community nurses how to undertake bladder infill, on a named patient basis**<br>• **This procedure requires two people to perform it. The second person may be a health care assistant, assistant practitioner, another nurse, or the patient**<br>• **The saline used for the bladder infill must be warmed in tap water to body temperature. Infilling with cold saline increases the risk of autonomic dysreflexia and bladder spasm which may cause the tract to close**<br>• **This SOP has been written in collaboration with MSCI** |
| **Equipment:**<br>Sterile catheterisation pack<br>Catheter (licensed for supra pubic use, and the same charriere size as the existing catheter)<br>6ml sterile lubricating gel containing Lidocaine (licensed for suprapubic use)<br>Disposable procedure sheet<br>Non-sterile nitrile gloves<br>Sterile nitrile gloves<br>Sterile water in 10ml syringe to inflate new catheter balloon **(the nurses from MCSI will identify how much water to inflate the balloon with)**<br>x2 100ml B/braun Uro Tainer Saline catheter maintenance solutions **(the nurses from MCSI will identify the volume of saline to be administered for each individual patient. The volume is approximately 200ml, hence x2 bags of saline catheter maintenance solutions, may be required)**<br>Sterile 10ml syringe to deflate existing catheter balloon<br>Single use apron<br>0.9% sodium chloride (saline) for meatal cleansing<br>Urine drainage bag, with adjustable straps or a leg bag sleeve<br>Fixation device (eg G-strap)<br>Alcohol hand gel<br>Protective eye wear<br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent<br>Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put apron on |
| Leave the x2 saline catheter maintenance solutions in the outer packaging, and bring the solution up to body temperature by immersing them in warm tap water |
| Open catheterisation pack, and open the equipment onto the sterile field, including the warmed saline |
| Prepare the patient, maintaining their dignity (procedure sheet underneath their bottom, underwear removed, drainage bag emptied, patient lying down with legs straight) |
| Nurse and assistant to decontaminate hands and apply protective eye wear<br>Nurse to apply sterile gloves. Assistant to apply non sterile gloves |

| |
|---|
| Nurse to remove packaging from the end of the new catheter and attach the sterile drainage bag.<br>Catheter must remain on 'free drainage' for 24 hours post catheter change<br>(DO NOT use catheter valves for 24 hours, post catheter change)<br>Nurse to remove packaging from tip of new catheter, and apply lubrication gel to first 5cm of catheter |
| Nurse to clean the cystostomy stoma site with gauze soaked in sterile saline, and apply lubricating gel to the cystostomy stoma site |
| Nurse to place sterile towel immediately below the cystostomy stoma, ensuring that the genital area is covered. Place the receiver between the patient's legs |
| Nurse to administer the warmed saline into the bladder, via the existing catheter (do not drain the saline back)<br>**If autonomic dysreflexia occurs during bladder infill, STOP instilling the saline immediately, and continue the catheter change, to empty the bladder** |
| Nurse to tie a piece of gauze around the existing catheter, close to the abdominal wall |
| Nurse to remove gloves, decontaminate hands and apply second set of sterile gloves |
| Assistant to deflate the catheter balloon with syringe, and place their index and middle finger on either side of the catheter, applying gentle pressure to the abdomen |
| Assistant to slowly remove existing catheter, maintaining the position of the gauze on the catheter, with the nurse noting the lie of the existing catheter and the angle of insertion.<br>Assistant to lay removed catheter on edge of sterile field<br>(there may be a gush of urine from the cystostomy stoma, as the catheter is removed) |
| Nurse to measure the new catheter against the old catheter, to assess the insertion length.<br>Immediately, insert the new catheter, at the same angle as the old catheter.<br>Do not allow the new and old catheters to touch each other |
| Nurse to advance the catheter into the tract, 3cm deeper than the removed catheter |
| Once urine starts to drain, and while the nurse holds the catheter insitu, the assistant to slowly inflate the balloon with the required volume of water. Balloon inflation should be pain free. If discomfort is displayed during balloon inflation stop and nurse to recheck the position of the catheter.<br>Nurse to withdraw the catheter slightly until it is felt to be firm against the bladder wall |
| **If unable to insert suprapubic catheter, insert a urethral catheter and transfer patient to urology at Royal Shrewsbury Hospital for reinsertion. If unable to insert a urethral catheter, arrange urgent transfer to Royal ShrewsburyHospital, as a medical emergency** |
| Ensure that the patient's abdomen is clean and that the patient is comfortable and dry<br>Observe the colour and measure the amount of urine drained |
| Secure the drainage system to the patient, with adjustable straps or a leg bag holder, and a fixation device (eg G-strap)<br>Ensure that the catheter tubing does not become taut when the patient is mobilising and that the patient's clothing has been repositioned and is comfortable |
| Retain the sticky labels from the catheter packaging. Dispose of waste, remove gloves and apron.<br>Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

Shropshire Community Health NHS
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**Standard Operating Procedure for assessing and treating autonomic dysreflexia (adult patients)**

**Autonomic dysreflexia is a life threatening, medical emergency**

**Autonomic dysreflexia (AD) is one of the most serious life-threatening conditions that can affect people with a spinal cord injury (SCI), at the 6th thoracic vertebrae and above**

The 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 blood pressure to rise. Above the level of injury, the body senses the high blood pressure and tries to relax the blood vessels (it can only influence the blood vessels above the level of injury), which causes flushing and blotchiness of skin and pounding headache

**If patient has a SCI at T6 or above, add an alert to Rio stating:**
**patient is at risk of autonomic dysreflexia**

| **SYMPTOMS** |
|---|
| **Symptoms may be mild or severe, and patients may present with one or more of the following:** |
| Sudden and rapidly rising hypertension (20-30mmHg above resting level)<br>Patients with a spinal cord injury at T6 and above, typically have low BP (eg 90-100/60mmHg)<br>Hypertension may be severe enough to lead to seizures, stroke or ultimately death |
| Bilateral pounding headache (which gets worse as blood pressure rises) |
| Bradycardia |
| Flushing and or blotching above the level of cord damage |
| Profuse sweating above level of injury |
| Pallor below the level of injury |
| Goosebumps below the level of injury |
| Palpitations |
| Visual changes or disturbances |
| Nasal congestion |
| Feeling of impending doom / death |
| Respiratory distress or bronchospasms |
| Metallic taste in mouth |
| Irritability or aggression (in people with impaired cognitive and communication skills) |

**CAUSES / TRIGGERS**

**Patients at risk of autonomic dysreflexia should know about autonomic dysreflexia, what their common triggers are, how they manage their autonomic episodes, and they will be prescribed medication to treat it**
**Any noxious stimuli below the level of injury may result in autonomic dysreflexia**
**Bladder and bowel problems are the most common cause of autonomic dysreflexia**
**The following are examples:**

| Bladder irritation | Bowel irritation | Skin irritation |
|---|---|---|
| -distended bladder<br>-urological procedure<br>-urine infection<br>-bladder or kidney stones<br>-inserting a catheter<br>-removing a catheter | -faecal impaction<br>-constipation<br>-rectal procedure such digital<br>-rectal examination<br>-administration of enemas<br>-administration of suppositories | -pressure sore<br>-ingrown toenail<br>-burns<br>-blisters<br>-sunburn<br>-constrictive clothing |

**TREATMENT**

**Request assistance / call 999 if you are on your own and need help**

Check blood pressure (BP)

- If systolic BP >150mmHg administer medication as prescribed. Midlands Centre for Spinal Injuries (MCSI) recommend GTN spray x2 sprays sublingual, repeat every 20-30 minutes if required
- Reduce blood pressure by sitting patient up and lower legs
  -If bladder or catheter problems are suspected, only sit patient to 45 degrees (sitting at 90 degrees may cause increased pressure on the full bladder and exacerbate AD)
- Monitor BP every 2-5 minutes while symptoms persist
- **Identify the source of the noxious stimulus**
- **Removing the stimulus will cause the symptoms to settle – see below:**

| Bladder | Bowel | Skin |
|---|---|---|
| **For patients with catheter:**<br>-Empty leg bag<br><br>-Check tubing not blocked / kinked<br><br>-If catheter is blocked remove catheter immediately and recatheterise using Lidocaine 2% gel, and leave it on free drainage<br><br>MCSI advise to use Lidocaine gel for recatheterisation, but DO NOT wait 3-5 minutes for the Lidocaine to take effect<br><br>-DO NOT attempt to instill a catheter maintenance solution (this will only distend the bladder further) | -For faecal mass in rectum, gently undertake digital removal of faeces<br><br>-If autonomic dysreflexia worsens with digital removal of faeces, STOP immediately, and recheck the rectum for the presence of stool after approximately 20 minutes | -Loosen any tight clothing<br><br>-Loosen catheter leg straps<br><br>-Remove compression hosiery<br><br>-Alter patient position to relieve pressure |
| **For patients without catheter:**<br>-If bladder distended, insert urethral catheter using Lidocaine 2% gel, and leave on free drainage<br><br>MCSI advise to use Lidocaine 2% gel for catheterisation, but DO NOT wait 3-5 minutes for the Lidocaine to take effect | | |
| **If UTI is suspected:**<br>-Follow Trust CAUTI Assessment form | | |

**If any medication is used, administer as prescribed**
**Know where the medication is stored in patient's home, and check regularly to ensure medication is within expiry dates**

**If symptoms do not resolve quickly, patient should be admitted to hospital as a medical emergency, for further assessment and management**
**Contact Centre for Spinal Injuries for further advice**

**Follow up**

- Inform GP of autonomic episode and outcomes
- Blood pressure should be monitored every 15 minutes for 2-4 hours after an episode to ensure no rebound hypotension, and no autonomic dysreflexia recurrence
- Document symptoms, cause, treatment, recordings of BP, and outcomes in patient notes

This SOP has been written in collaboration with MCSI

NHS
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**Standard Operating Procedure for administration of B Braun Uro-Tainer Twin Suby G 3.23% Citric Acid catheter maintenance solutions (adult patients)**

| |
|---|
| • **Administration of catheter maintenance solutions (CMS) must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **Suby G dissolves the mineral deposits composed of struvite and calcium phosphate which are formed in alkaline urine. Suby G contains magnesium oxide to reduce irritation of the bladder mucus caused by an acidic solution**<br>• **Suby G promotes a reduction in urinary pH. Normal urinary pH is 6.0. If urinary pH is elevated above 6.8 (alkaline), patients' catheters will be more susceptible to blocking with debris. Administration of Suby G twice a week promotes a reduction in urinary pH, and thus promotes a reduction in catheter blockage, and promotes extended catheter life**<br>• **Suby G CMS must only be administered if urinary pH is elevated above 6.8, and if catheter life is being extended**<br>• **Two sequential solutions of Suby G are more clinically effective than one** |
| **Equipment:**<br>Sterile dressing pack (including sterile gloves)<br>Non-sterile nitrile gloves<br>Sterile Uro-Tainer Twin Suby G 3.23% Citric Acid catheter maintenance solution<br>pH indicator strips or Multistix 8 SG strips<br>Single use apron<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Check that a 'Patient Specific Direction' PSD (Authority to Administer) Authorisation Community Drug Sheet', or Medication Administration Record (MAR chart), or Drug Chart, has been completed by the prescriber, and that it is up to date |
| Assess whether there are any precautions to administration of Suby G CMS:<br>- Undiagnosed haematuria<br>- Known urological cancer<br>- Fistula<br>- Recent radiotherapy to the lower urinary tract / pelvis<br>- Recent urological surgery<br>- Spinal cord injury at T6 or above (risk of autonomic dysreflexia)<br>Use clinical judgment and seek advice from urology / GP / continence nurse specialists, if required |
| Explain the procedure to the patient, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands, and put on apron and non sterile gloves<br>Help the patient into a sitting or supine position, protect the bed / chair, and ensure privacy |
| Obtain a catheter specimen of urine (CSU) - refer to Trust Standard Operating Procedure for obtaining a CSU, and determine urinary pH |
| **Using pH indicator strips:**<br>Remove a test strip and replace top of box<br>Completely immerse test strip in urine, to cover all the reagent areas<br>Remove the test strip immediately and tap off any residual urine by running its underside along the rim of the container<br>Hold the test strip horizontally to avoid cross contamination of the reagent squares<br>Lay the test strip flat on a paper towel<br>Wait 15 seconds for the colour to develop, read while still moist, compare the test strip with the corresponding colour chart on the box to establish urinary pH |

| |
|---|
| **Using Multistix 8 SG:**<br>Remove a test strip and replace top of canister (do not remove the desiccant sachet)<br>Completely immerse the test strip in urine, to cover all the reagent areas<br>Remove the test strip immediately and tap off any residual urine by running its underside along the rim of the container<br>Hold the test strip horizontally to avoid cross contamination of the reagent squares<br>Lay the test strip flat on a paper towel<br>Wait 60 seconds for the colour to develop on the pH reagent square, compare the test strip with the corresponding colour chart on the canister to establish urinary pH |
| If urinary pH is elevated above 6.8, proceed to administration of Suby G CMS<br>If urinary pH is normal / below 6.8 do not administer CMS |
| Leave the Suby G CMS in the outer packaging, and bring the solution up to body temperature by immersing it in lukewarm tap water |
| If catheter valve is being used, drain the bladder and lay valve on the bed or chair<br>If urine drainage bag is being used, empty it and lay bag on the bed or chair |
| Remove gloves and decontaminate hands |
| Open sterile dressing pack, open Suby G CMS and bag / valve onto sterile field, place dressing field under catheter, and put on sterile gloves |
| Disconnect bag / valve from catheter<br>Open the white clamp on the CMS and administer the first chamber, via the catheter<br>Do not squeeze or force the solution in. Use gravity to instill the warmed solution into the bladder<br>Close the white clamp on the CMS bag and leave in position for 5 minutes |
| Ensure the CMS bag is below the level of the bladder, re open the white clamp and allow the solution to drain back into the bag<br>Repeat with the other chamber, using the green clamp, and drain the solution back into the bag |
| Re close the green clamp on the CMS bag, disconnect it from the catheter, connect a new sterile urine drainage bag or catheter valve and attach straps or other retention device, to ensure catheter is secure |
| Remove gloves and apron. Dispose of waste. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, urinary pH, batch number, expiry date, solution used, manufacturer, procedure and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |
| Shropshire Community Health NHS Trust Prescribing Formulary for Continence, suggests that B/braun Urotainer Twin Suby G 3.23% citric acid CMS, should be prescribed / administered<br><br>This product has two chambers of Citric Acid, which means that x2 sequential solutions can be administered, but the closed system is only broken once<br><br>However, sometimes these on formulary B/braun Twin Suby G 3.23% Citric Acid CMS are out of stock, and Bard Optiflo 3.23% Citric Acid (single chamber) CMS, or Uroflush G 3.23% Citric Acid (single chamber) are prescribed / administered as an alternative<br><br>Please note that x2 sequential solutions of Optiflo / Uroflush 3.23% Citric Acid (single chamber) CMSs, should be administered. This involves, administering and draining back one Opiflo / Uroflush 3.23% Citric Acid CMS, disconnecting it from the catheter, and administering and draining back a second Opiflo / Uroflush 3.23% Citric Acid CMS |

**Standard Operating Procedure for administration of B Braun Uro-Tainer NaCl Saline 0.9% catheter maintenance solutions (adult patients)**

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| • **Administration of catheter maintenance solutions (CMS) must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **Saline can be used to irrigate catheters that block with pus, blood clots or debris by gently washing this material out**<br>• **Saline can be used to establish whether a catheter is patent or not**<br>• **Saline has a neutral pH and will not dissolve catheter encrustation and therefore is not recommended if a catheter is regularly blocking due to encrustation by mineral deposits** |
| **Equipment:**<br>Sterile dressing pack (including sterile gloves)<br>Non-sterile nitrile gloves<br>Sterile Uro-Tainer NaCl Saline 0.9% catheter maintenance solution<br>Sterile urine drainage bag or catheter valve<br>Single use apron<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Check that a 'Patient Specific Direction' PSD (Authority to Administer) Authorisation Community Drug Sheet', or Medication Administration Record (MAR chart), or Drug Chart, has been completed by the prescriber, and that it is up to date<br><br>The exception to this rule is if a Urotainer NaCl 0.9% catheter maintenance solution is being administered as a Homeley Remedy<br>Refer to Trust Medicines Policy Part 9. Procedure for the administration of homely remedies in community hospitals and community service teams (Uro-tainer NaCl 0.9% CMS) 2022 |
| Assess whether there are any precautions to administration of Saline CMS:<br>- Undiagnosed haematuria<br>- Known urological cancer<br>- Fistula<br>- Recent radiotherapy to the lower urinary tract / pelvis<br>- Recent urological surgery<br>- Spinal cord injury at T6 or above (risk of autonomic dysreflexia)<br>Use clinical judgment and seek advice from urology / GP / continence nurse specialists, if required |
| Explain the procedure to the patient, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put non-sterile gloves and apron on |
| Help the patient into a sitting or supine position, protect the bed / chair, and ensure privacy |
| Leave the Saline CMS in the outer packaging, and bring the solution up to body temperature by immersing it in lukewarm tap water |
| If catheter valve is being used, drain the bladder and lay valve on the bed or chair<br>If urine drainage bag is being used, empty it and lay bag on the bed or chair |
| Remove gloves and decontaminate hands |
| Open sterile dressing pack, open Saline CMS and bag / valve onto sterile field, place dressing field under catheter, and put on sterile gloves |

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| Disconnect bag / valve, and administer the solution via the catheter<br>Do not squeeze or force the solution in. Use gravity to instill the warmed saline into the bladder |
| Ensure the empty CMS bag is below the level of the bladder, and allow the solution to drain back |
| Close the clamp on the CMS bag, disconnect the CMS bag and connect a new sterile urine drainage bag or catheter valve |
| Attach straps or other retention device, to ensure catheter is secure |
| Remove gloves and apron. Dispose of waste. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, batch number, expiry date, solution used, manufacturer, procedure and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

**Standard Operating Procedure for administration of B Braun Uro-Tainer Solutio R Twin 6% Citric Acid catheter maintenance solutions (adult patients)**

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| • **Administration of catheter maintenance solutions (CMS) must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **Solutio R can be effective at dissolving severe encrustation, and should be used with caution, as it is more acidic than Suby G, and does not contain magnesium oxide to reduce tissue irritation**<br>• **It can be used prior to catheter change for patients who experience discomfort or trauma when the catheter is withdrawn because of encrustation on and around the tip of the catheter**<br>• **It is not recommended that Solutio R is used on a frequent and regular basis as a prophylactic catheter care regime** |
| **Equipment:**<br>Sterile dressing pack (including sterile gloves)<br>Non-sterile nitrile gloves<br>Sterile Uro-Tainer Solutio R Twin 6% Citric Acid catheter maintenance solution<br>Single use apron<br>Alcohol hand gel<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Check that a 'Patient Specific Direction' PSD (Authority to Administer) Authorisation Community Drug Sheet', or Medication Administration Record (MAR chart), or Drug Chart, has been completed by the prescriber, and that it is up to date |
| Assess whether there are any precautions to administration of Solutio R CMS:<br>- Undiagnosed haematuria<br>- Known urological cancer<br>- Fistula<br>- Recent radiotherapy to the lower urinary tract / pelvis<br>- Recent urological surgery<br>- Spinal cord injury at T6 or above (risk of autonomic dysreflexia)<br>Use clinical judgment and seek advice from urology / GP / continence nurse specialists, if required |
| Explain the procedure to the patient, and gain consent |
| Check the patient has no known allergies to any of the equipment to be used |
| Decontaminate hands and put non-sterile gloves and apron on |
| Help the patient into a sitting or supine position, protect the bed / chair, and ensure privacy |
| Leave the Solutio R CMS in the outer packaging, and bring the solution up to body temperature by immersing it in lukewarm tap water |
| If catheter valve is being used, drain the bladder and lay valve on the bed or chair<br>If urine drainage bag is being used, empty it and lay bag on the bed or chair |
| Remove gloves and decontaminate hands |
| Open sterile dressing pack, open Solutio R CMS and bag / valve onto sterile field, place dressing field under catheter, and put on sterile gloves |
| Disconnect bag / valve from catheter |

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| Open the white clamp on the CMS and administer the first chamber, via the catheter<br>Do not squeeze or force the solution in. Use gravity to instill the warmed solution into the bladder<br>Close the white clamp on the CMS bag and leave in position for 5 minutes |
| Ensure the empty CMS bag is below the level of the bladder, open the white clamp and allow the solution to drain back into the bag<br>Re close the white clamp |
| Repeat with the other chamber, using the green clamp on the CMS, and drain the solution back into the bag<br>Re close the green clamp, and leave the CMS attached to the catheter |
| Gently remove the catheter from the patient's bladder |
| Remove gloves and apron. Dispose of waste. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, batch number, expiry date, solution used, manufacturer, procedure and outcomes in the patient's catheter care pathway documentation<br>Complete / update the patient's Catheter Card |

Shropshire Community Health NHS Trust

**Standard Operating Procedure for taking a catheter specimen of urine (CSU), (adult patients)**

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|---|
| • **Taking a CSU must be undertaken as a Standard Aseptic Non-Touch Technique (ANTT) procedure**<br>• **The urine sample must be taken from the sampling port on the drainage bag**<br>• **Do not take a CSU from the bottom of the drainage bag**<br>• **Do not undertake urinalysis on a catheterised patient to establish whether they have a urinary tract infection (UTI), as catheterised patients will be positive for nitrite and leucocytes whether they have a UTI, or not. Use UTI assessment form to establish whether they have a UTI**<br>• **Only take a CSU to determine urinary pH, glucose, blood, specific gravity, ketones, protein, if a CSU needs sending off for microscopy, culture and sensitivity (MC&S), or as part of a screening programme** |
| **Equipment:**<br>Single use plastic apron<br>Non-sterile nitrile gloves<br>Sterile 10ml slip tip syringe<br>x2 70% alcohol wipe suitable for medical devices (2% Chlorhexidine in 70% Isopropyl alcohol)<br>Scissor style clamp, for single patient use,<br>Red topped (boric acid preservative) 10ml specimen container<br>Laboratory request form<br>Detergent wipe for decontaminating clamp<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Decontaminate hands, put and apron and gloves |
| Clamp catheter bag tubing, 2-3 inches below the sampling port, using the clamp<br>• The single patient use clamps for taking CSUs can be sourced through Oracle<br>• Patients in their own home require one clamp, which can be decontaminated and used multiple times throughout the patient's ongoing catheter care<br>• Patients in Community Hospitals, and residential care settings, require a new clamp at every care intervention |
| Decontaminate sampling port with an alcohol wipe, for 30 seconds contact time. Allow port to dry |
| Attach the syringe to the sampling port, and aspirate 10ml of urine |
| Remove syringe and decontaminate the sampling port with a new alcohol wipe, for 30 seconds contact time |
| Place urine in red topped specimen container, avoiding contact between the syringe and the container. Fill to the line marked on the container. Replace the lid and tighten firmly |
| Remove clamp from catheter bag tubing and decontaminate it with a detergent wipe, or dispose of it (see above) |
| Remove gloves and apron, and decontaminate hands |
| Label the specimen. Complete laboratory request form stating clinical history and symptoms. Send to microbiology immediately after collection, for MC&S. Keep refrigerated in specimen fridge for up to 24 hours, if it can not be transported immediately |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Document consent, procedure and outcomes in patient's notes |
| If CSU is being taken for urinalysis, to determine urinary pH, glucose, blood, specific gravity, ketones, or protein – use white topped specimen container |

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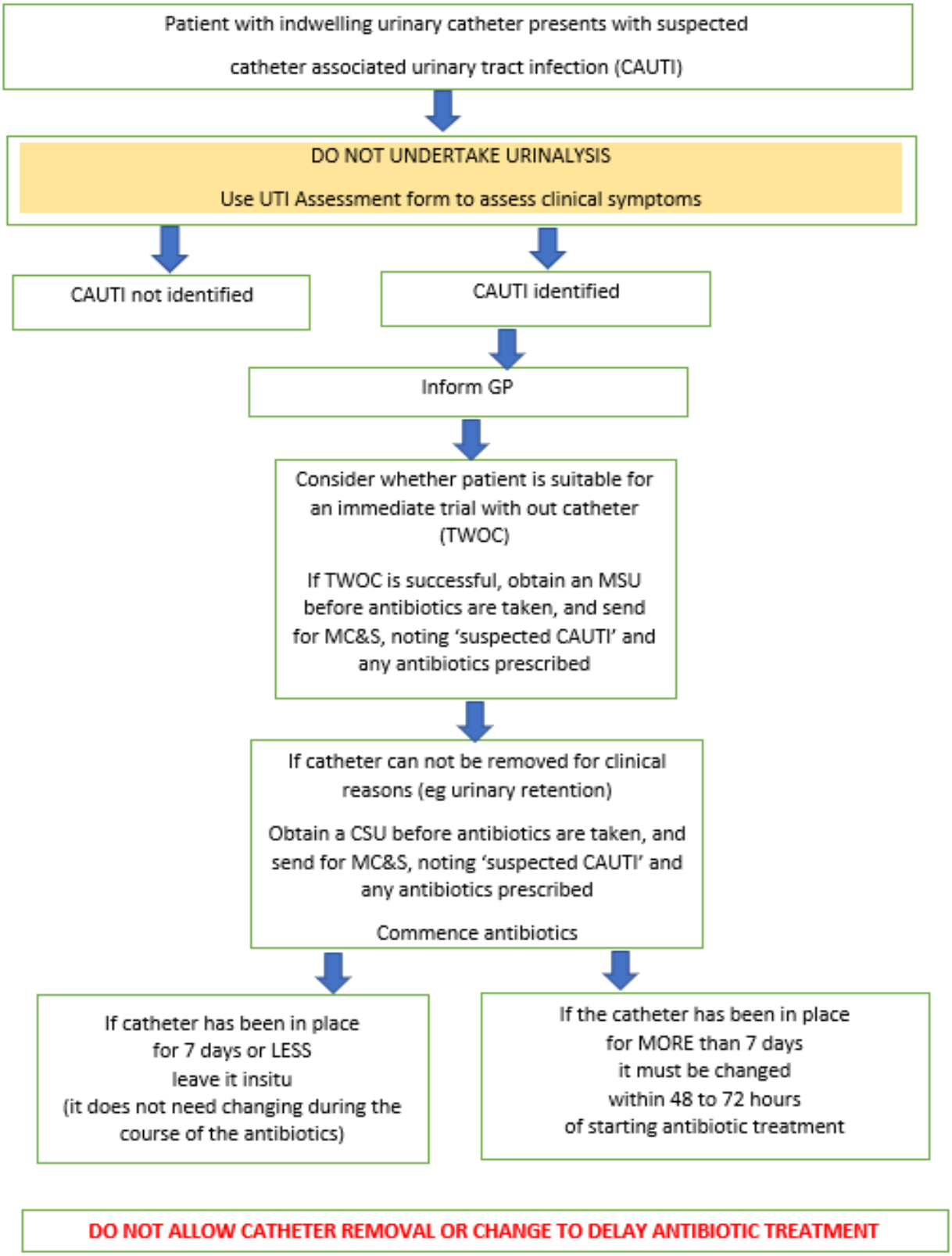
CONT054

**Standard Operating Procedure for management of suspected or confirmed CAUTI (urethral or suprapubic indwelling urinary catheters, adult patients)**



Shropshire Community Health NHS Trust

**Standard Operating Procedure for trouble shooting of indwelling catheters (adult patients)**

**Non deflating catheter balloons**

- Try attaching a different syringe to the inflation valve
- Leave syringe attached to the inflation valve, with the plunger removed, for 20 mins
- 'Milk' the catheter along its length to dislodge debris occluding the inflation channel
- Insert a 25-gauge orange needle attached to a syringe, into the inflation chamber just behind the inflation valve, and draw back to bypass a faulty valve (be aware that this is using catheter out of license)
- Contact GP, arrange transfer to urology (urology may puncture the balloon suprapubically using a needle, under ultrasound visualisation)
- Inform the catheter manufacturer if a faulty catheter / balloon / valve is suspected

**DO NOT** burst the balloon by over inflating it – this will break it into fragments within the bladder
**DO NOT** cut the catheter or inflation arm or catheter – as the catheter may retract into the bladder, and further attempts at deflation with a syringe will be jeopardised
**DO NOT** leave the catheter insitu for longer than it is licensed for

**Failure of urine to drain upon insertion of catheter into female urethra**

- When inserting the catheter, the balloon must not be inflated until urine drains via the catheter

**DO NOT** instill a catheter maintenance solution to establish whether a newly inserted catheter has been positioned correctly in the female urethra

- If catheter drainage issues persist or appear unusual, the HCP needs to offer a visual examination of the patient's genital area including the urethral meatus to check for correct positioning of the catheter and to look for any abnormalities

**Allergy**

- Latex – if patient has an allergy to the latex in hydrogel or PTFE catheters, silicone catheters must be used

Standard catheterisation gel contains two active ingredients, Lidocaine and Chlorhexidine (such as Optilube Active, 6ml or 11ml)

- Lidocaine - If the patient has an allergy to Lidocaine, use an alternative gel with no Lidocaine in (such as Optilube, 6ml or 11ml)
- Chlorhexidine - If the patient has an allergy to Chlorhexidine, use an alternative gel with no Chlorhexidine in (such as Optilube Active CHG free, 6ml or 11ml)

**Urinary bypassing due to blockage**

There are two reasons for bypassing:

- catheter is blocked
- bladder spasm
- Establish reason for bypassing by instilling a Saline catheter maintenance solution:

If saline can not be instilled, catheter is not patent, and bypassing is due to **blockage**

- Check for obstruction (kinked tubing, occlusion by leg bag straps)
- Address constipation
- Change catheter

If catheter is persistently blocking, consider:

- Promote dilute urine (provide patient with 'Are you drinking enough fluids' leaflet, and check for understanding)
- Following catheter removal, cut it catheter lengthways to establish if blockage / debris is predominantly confined to tip of catheter or throughout the lumen
- Consider an open-ended catheter (useful if blockage is predominantly confined to tip of catheter)
- Consider a silicone catheter (which has a larger lumen than a hydrogel or PTFE catheter, so useful if blockage / debris is throughout the lumen)
- Consider a PTFE catheter if catheter changes are occurring every 1 to 28 days
- Implement proactive catheter changes, before catheter is due to block
- Saline can be used to gently flush catheters that block with pus, blood clots or debris. Refer to Standard Operating Procedure for administration of B Braun Uro-Tainer NaCl Saline 0.9% catheter maintenance solutions, for adult patients
- If urinary pH is elevated above 6.8, consider administering two sequential solutions of 3.23% citric acid (Suby G) catheter maintenance solution twice a week
  Refer to Standard Operating Procedure for administration of B Braun Uro-Tainer Twin Suby G 3.23% Citric Acid catheter maintenance solutions, for adult patients

Catheter maintenance solutions must only be administered if there is an Authority to Administer Community Drug Sheet completed by the prescriber.
Refer to Trust Medicines Policy Part 1: General principles (2022)
Authority to Administer for community Services. Authorisation – Community Drug Sheet
https://staffzone.shropcom.nhs.uk/smii/doclib/10468.pdf?ac=7

The exception to this rule is if a Urotainer NaCl 0.9% catheter maintenance solution is being administered as a Homeley Remedy.
Refer to Trust Medicines Policy Part 9. Procedure for the administration of homely remedies in community hospitals and community service teams (Uro-tainer NaCl 0.9% catheter maintenance solution) 2022
https://staffzone.shropcom.nhs.uk/smii/doclib/11450.pdf

The Trust Catheter Care Pathway, Catheter Maintenance Solution document must be used to assess for, and to document, administration of all CMS
Refer to Trust document on Staffzone:
CONT 005 Catheter Care Pathway
https://www.shropscommunityhealth.nhs.uk/content/doclib/11156.doc

**Urinary bypassing due to bladder spasm**

There are two reasons for bypassing:

- catheter is blocked
- bladder spasm
- Establish reason for bypassing by instilling a Saline catheter maintenance solution:

If saline can be instilled, catheter is patent, and bypassing is due to **bladder spasm**

- Advise patient to switch to decaf fluids
- Promote dilute urine (provide patient with 'Are you drinking enough fluids' leaflet, and check for understanding)
- Address constipation
- Consider smaller charriere catheter
- Consider switching from silicone to hydrogel or PTFE catheter if no latex allergy (which are softer, more comfortable)
- Discuss antimuscarinic or Mirabegron medication with GP (if patient already on an antimuscarinic or Mirabegron, discuss with GP whether the patient would be a suitable candidate to try an alternative, or higher dose)
- Discuss with patient and GP whether the patient would benefit from referral to urology for consideration of intravesical botox

- Catheter balloons should be inflated with the exact volume of sterile water as specified by the manufacturer
- They should not be under inflated as this can lead to the balloon inflating asymmetrically, which will potentially cause more irritation to the trigone, and increase bladder spasm
- Underinflating catheter balloons will result in the catheter being used out of license and the manufacturer will not be liable for any associated clinical issues
- However, Midlands Centre for Spinal Cord Injury (MCSCI) or urology may occasionally request under inflation of catheter balloons. This must be a documented request (not verbal) and be placed in the patients notes (uploaded to Rio documents). It must also be documented in the patient's notes that the nurse has discussed the risks with the patient, of under inflated balloons, that the catheter is being used out of license, and that informed consent has been gained

**Previous history of external encrustation causing trauma upon catheter removal**

- Administer 6% citric acid (Solutio R) catheter maintenance solution immediately prior to removing future catheters, to dissolve the encrustation, and hence minimize the risk of further trauma.
  Refer to Standard Operating Procedure for administration of B Braun Uro-Tainer Solutio R 6% Citric Acid catheter maintenance solutions, for adult patients

Catheter maintenance solutions must only be administered if there is an Authority to Administer Community Drug Sheet completed by the prescriber.
Refer to Trust Medicines Policy Part 1: General principles (2022)
Authority to Administer for community Services. Authorisation – Community Drug Sheet
https://staffzone.shropcom.nhs.uk/smii/doclib/10468.pdf?ac=7

The Trust Catheter Care Pathway, Catheter Maintenance Solution document must be used to assess for, and to document, administration of all CMS
Refer to Trust document on Staffzone:
CONT 005 Catheter Care Pathway
https://www.shropscommunityhealth.nhs.uk/content/doclib/11156.doc

**Purple urine bag syndrome**

Rare condition, with purple discoloration of the urine, within the catheter drainage system. The purple colour is derived from metabolites of tryptophan which are found in high levels in the gut of constipated patients. The formation of purple pigments are also derived as a result of recurrent CAUTIs. Enzymes produced from bacteria containing sulphatase and phosphatase enzymes, produce a combination of red and blue pigments

- Address constipation
- Promote effective catheter care which minimises the risk of further CAUTIs
- Reassure the patient that purple urine bag syndrome is not harmful and that no active interventions are required / it can be addressed conservatively (treatment of asymptomatic bacteriuria is not indicated)
- If current CAUTI is suspected, follow CONT054 Standard Operating Procedure for management of suspected or confirmed CAUTI (urethral or supra pubic indwelling urinary catheters, adult patients)

**Spontaneous catheter expulsion from urethra, with balloon intact**

Most common in female patients with a neurological condition, such as multiple sclerosis

- Advise patient to switch to decaf fluids
- Promote dilute urine (provide patient with 'Are you drinking enough fluids' leaflet, and check for understanding)
- Address constipation, and advise patient to avoid straining to stool
- Consider smaller charriere catheter
- Consider switching from silicone to hydrogel or PTFE catheter if no latex allergy (which are softer, more comfortable)
- Consider a PTFE catheter if catheter changes are occurring every 1 to 28 days
- If the amount of water in silicone catheter balloons is reducing significantly via osmosis, and leading to catheters falling out – **DO NOT** deflate and reinflate the balloon. Instead, consider switching to a hydrogel or PTFE catheter. These are less likely to lose a significant amount of water via osmosis. If the patient must continue with a silicone catheter due to latex allergy – consider using a silicone catheter that is inflated with a 5% glycerin solution, that helps reduce premature balloon deflation
- Discuss antimuscarinic or Mirabegron medication with patient and GP (if patient is already on an antimuscarinic or Mirabegron, discuss with GP whether patient would be a suitable candidate to try an alternative, or higher dose)
- Discuss with patient and GP whether they are a suitable candidate for referral to urology, for consideration of formation of a cystostomy stoma / suprapubic catheter, or intravesical botox

- Catheter balloons should be inflated with the exact volume of sterile water as specified by the manufacturer
- They should not be over inflated as this will potentially cause the balloon to burst and will leave fragments of catheter balloon in the patient's bladder, which will need to be removed via cystoscopy
- Catheters with more than 10ml of water in them will also significantly increase the risk of trauma to the bladder, bladder neck and the urethra
- Deflating and inflating catheter balloons more than once, or overinflating catheter balloons will result in the catheter being used out of license, and the manufacturer will not be liable for any associated clinical issues
- However, urology may very occasionally request over inflation of 10ml catheter balloons or use of larger catheter balloons, to help prevent spontaneous catheter expulsion from the urethra. This must be a documented request (not verbal) and be placed in the patients notes (uploaded to Rio documents). It must also be documented in the patient's notes that the nurse has discussed the risks with the patient, of over inflated balloons / larger balloons, that the catheter is being used out of license, and that informed consent has been gained
- Indwelling catheters with 30ml balloons must not be inserted in the community. They should only be used on a urology ward, post prostatic surgery. The heavier weight and larger balloon may cause bladder spasm, irritation of the trigone and trauma / necrosis to the bladder neck

**Spontaneous catheter expulsion, with balloon deflated**

- Examine the expelled catheter and balloon closely
- If the balloon is ruptured, it is likely that bladder calculi are present in the bladder and they have burst the balloon. Inform GP and request referral to urology to assess further
- If the balloon is intact / not ruptured, it is likely that the catheter / balloon was faulty. Save the catheter and inform the catheter manufacturer

**Haematuria**

May be caused by trauma, infection or renal / bladder pathology
It commonly occurs post urological surgery, and post catheterisation for acute urinary retention (particularly if the residual volume was very significant, and the bladder was very distended)

- If the haematuria is severe, arrange urgent transfer of patient to urology, at Royal Shrewsbury Hospital. The patient should be monitored for shock, clots and associated blockage
- If CAUTI is suspected, follow CONT054 Standard Operating Procedure for management of suspected or confirmed CAUTI (urethral or supra pubic indwelling urinary catheters, adult patients)
- If trauma is suspected, ensure catheter is secured appropriately (refer to Standard Operating Procedure for securing indwelling catheters - adult patients) and ensure that patient / family / carers have been provided with CONT013 'Patient Information – indwelling catheters' leaflet, and check for understanding
- If haematuria is related to known renal / bladder pathology, and you are concerned about it, liaise urgently with urology / GP
- If haematuria is of unknown origin and is persistent, inform GP for further assessment / referral to urology, to establish underlying aetiology

**Phimosis**

Phimosis is the inability to retract the foreskin over the glans

- Gently pull back foreskin as far as it will comfortably go, to clean glans and to visualise the urethral meatus, prior to urethral catheterisation
- Inform GP if pain and inflammation is present or infection is suspected
  - ➢ Balanitis inflammation of the glans
  - ➢ Posthitis inflammation of the foreskin
  - ➢ Balanoposthitis inflammation of the glans and foreskin
- Discuss with the patient and GP whether they are a suitable candidate to be referred to urology, for consideration of circumcision surgery

**DO NOT** force foreskin back, further than it will comfortably go

**Paraphimosis**

Paraphimosis occurs when the foreskin becomes trapped behind the corona of the glans. This leads to strangulation of the glans, painful vascular compromise, distal venous engorgement, oedema, and even necrosis

Paraphimosis is a medical emergency

- ➢ Patient must be transferred immediately to A&E at Royal Shrewsbury Hospital, where urology are based

**DO NOT** attempt to reduce the foreskin

**Unable to remove catheter from supra pubic cystostomy stoma, following deflation of balloon**

PREVENTION

- Consider using a hydrogel or PTFE catheter, if no latex allergy (as they are less likely to cuff upon removal, compared to silicone catheters)
- If the patient has a latex allergy, consider using a silicone catheter, with an integral balloon (as they are less likely to cuff than standard silicone catheters)

TREATMENT

- Leave catheter insitu for 5 minutes after deflating balloon, to allow balloon to regain its original shape
- Rotate catheter as it is slowly removed
- Consider reinflating the catheter balloon with 1ml of sterile water (be aware that this is using the catheter out of license. However, it may be clinically appropriate to consider this approach following multidisciplinary discussion, when a patient can not be transferred to urology – eg end of life care)
- Consider inserting a temporary urethral catheter (this may not be appropriate if patient is known to have a non patent urethra – eg due to stricture, cancer)
- ➢ Arrange transfer of patient to urology, at Royal Shrewsbury Hospital
- ➢ If the patient is at risk of autonomic dysreflexia, the transfer must be undertaken immediately, as a medical emergency

**Unable to insert new catheter into suprapubic cystostomy stoma**

- Consider inserting a temporary urethral catheter (this may not be appropriate if patient is known to have a non patent urethra – eg due to stricture, cancer)
- ➢ Arrange urgent transfer of patient to urology, at Royal Shrewsbury Hospital
- ➢ If the patient is at risk of autonomic dysreflexia, the transfer must be undertaken immediately, as a medical emergency

**Over-granulation around suprapubic cystostomy stoma site**

PREVENTION

- Rotate the direction of the lay of the catheter against the abdomen (use a catheter fixation device, alternate which leg the bag is attached to)

TREATMENT

- Use a dressing which is appropriate for addressing over granulation (eg Inadine, Lyofoam)
- Liaise with the tissue viability nursing team, if required

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**Standard Operating Procedure for assessing the suitability of a catheter valve (adult patients)**

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|---|
| **Catheter valves can be used as an alternative to a urine drainage bag**<br><br>**Catheter valves are inserted into the end of the catheter, allowing normal bladder filling and intermittent drainage. They promote patient comfort and independence**<br><br>**Catheter valves must be changed every 7 days**<br><br>**Catheter valves should be opened / drained 4-7 times per 24 hours, or when the patient feels their bladder is comfortably full**<br><br>**Catheter valves are suitable for male patients, female patients, urethral and suprapubic catheters**<br><br>**Catheter valves must be secured against the patient's abdomen or thigh, with a retention strap / device** |
| Catheter valves are contraindicated in the following circumstances:<br><br>• Impaired bladder capacity<br>• Detrusor over activity<br>• Ureteric reflux<br>• Renal impairment<br>• Cognitive dysfunction<br>• Poor dexterity / inability to release the valve independently<br>• If the patient has recently been catheterised following an episode of acute urinary retention (seek advice from the urology department to establish if, and when, catheter valves are appropriate)<br>• If the patient has recently undergone urological surgery (seek advice from the urology department to establish if, and when, catheter valves are appropriate)<br>• If the patient is unable to manipulate the valve and empty it themselves, at appropriate intervals |
| The use of a catheter valve should be a multidisciplinary decision involving patient's GP, urologist and hospital / community nurse, and continence nurse specialist, where appropriate |

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**Standard Operating Procedure for securing indwelling catheters (adult patients)**

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|---|
| **All suprapubic and urethra catheters, and associated drainage bags and catheter valves must be secured appropriately**<br>**This will minimise risk of:**<br>• **Pain**<br>• **Bleeding**<br>• **Swelling, necrosis, erosion or tearing to the urethra and penile / labial tissues**<br>• **Damage to the bladder neck**<br>• **Bladder spasm and associated urinary bypassing**<br>• **Catheter falling out**<br>• **Unplanned catheter changes**<br>• **Urinary tract infections** |
| **Patients should be encouraged and taught how to secure their own catheters, if clinically appropriate** |
| If the catheter and drainage bag / catheter valve is being secured to the patient's thigh or calve, discussion must be undertaken with the patient, to decide which leg to use<br><br>Male genitals, naturally rest to the left or right of their trouser crotch. So this must be taken into account<br><br>Clinical judgment must be applied if the patient has a leg amputation, impaired skin integrity in their genital area, wounds / impaired circulation / neuropathy or significant oedema in their legs |
| All leg bag straps / bag sleeves / retaining straps / retaining adhesive devices must be left insitu during bathing or showering, to support the catheter<br><br>They can then be changed following the bath / shower, for a dry one |
| Ensure that all catheters, Belly bags, leg bags, catheter valves, leg bag straps, leg bag sleeves, retaining straps and retaining adhesive devices, are positioned appropriately to avoid pressure damage to the skin, when the patient is mobilising, standing, sitting or lying |
| Leg bags must be secured below the level of the patient's bladder (thigh or calve), with x2 velcro leg bag straps or a leg bag sleeve, to support the weight of the bag |

Leg bag straps must be threaded 'under' the bag, so that urine flow is not occluded

Straps and sleeves must be changed / washed as soon as they become soiled, damaged or loose their elasticity

Clinical judgement should be used and discussion undertaken with the patient / wider multidisciplinary team, to identify whether patient is going to be more comfortable using leg bag straps or leg bags sleeves. Especially if the patient has impaired skin integrity / wounds / impaired circulation / neuropathy or significant oedema in their legs

The patient's thigh / calve circumference must be measured, to ascertain which size of leg bag sleeve is required

Follow manufacturers instructions to apply and remove leg bag straps and leg bag sleeves

Belly bags must be secured with the integral strap, around the patient's abdomen, and adjusted to fit comfortably, to support the weight of the bag

Follow manufacturers instructions to apply and remove the Belly bag strap

Catheters must also be secured against the patient's thigh or abdomen with a retaining strap or adhesive device

Coloplast G-strap

Clinifix Universal Tube Fixation device

Bard Statlock Foley Stabilisation device


Retaining straps must be changed / washed as soon as they become soiled, damaged or loose their elasticity

Adhesive devices must be changed as soon as they become soiled, damaged or loose their adherence; and at least every 7 days

Clinical judgement should be used and discussion undertaken with the patient / wider multidisciplinary team, to identify whether patient is going to be more comfortable using a strap or adhesive device. Especially if the patient has impaired skin integrity / fragile skin / allergies to adhesive / wounds / impaired circulation / neuropathy or significant oedema in their legs

The retaining strap or adhesive device, must be applied so that catheter can still move with the patient. The catheter must not be pulled taught by the retaining strap or adhesive device

Follow manufacturers instruction to apply and remove the retaining straps and adhesive devices

Catheter valves must be secured against the patient's thigh or abdomen, with a retaining strap or adhesive device, as above

Offer patient / family / carer education about securing catheters effectively, and check for understanding

Supply 'Patient Information - Indwelling Catheters' leaflet to patient

Refer to Trust document on Staffzone:
**CONT013 Patient Information – Indwelling Catheters**
**https://www.shropscommunityhealth.nhs.uk/content/doclib/11213.docx**

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**Standard Operating Procedure for emptying a catheter urine drainage bag or releasing a catheter valve (adult patients)**

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| **Patients should be encouraged and taught how to empty their own urine drainage bags / release their catheter valves, if clinically appropriate** |
| **Urine drainage bags should be emptied when three quarters full** |
| **Catheter valves should be emptied 4-7 times per 24 hours, or when the patient feels their bladder is comfortably full** |
| **Equipment:**<br>Non-sterile nitrile gloves<br>Single use apron<br>Alcohol hand gel<br>Urinal bottle / clean receptacle (single patient use)<br><br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Decontaminate hands and put apron and gloves on |
| Prepare the patient, maintaining their dignity |
| Release the tap at the bottom of the drainage bag / catheter valve and empty urine into the urinal bottle / clean receptacle<br>Ensure that the tap does not come into contact with the urinal bottle / clean receptacle |
| Close the tap, wipe excess urine from the tap using a single use tissue or paper towel |
| Dispose of urine into toilet or sluice |
| Wash urinal bottle / receptacle in water and detergent after each use, in patient's home<br>Place disposable urinal bottle in macerator, in community hospitals |
| Ensure that the patient is comfortable |
| Remove gloves and apron. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure and outcomes (including volume of urine, if clinically indicated) in the patient's notes |
| Offer patient / family / carer education about emptying catheter bags / releasing catheter valves effectively, and check for understanding<br><br>Supply 'Patient Information - Indwelling Catheters' leaflet to patient<br><br>Refer to Trust document on Staffzone:<br>**CONT013 Patient Information – Indwelling Catheters**<br>**https://www.shropscommunityhealth.nhs.uk/content/doclib/11213.docx** |

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**Standard Operating Procedure for changing a catheter urine drainage bag or catheter valve (adult patients)**

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|---|
| **Patients should be encouraged and taught how to change their own urine drainage bags / catheter valves, if clinically appropriate** |
| **Leg bags, catheter valves, and drainable 2 litre bags must be changed every 7 days** |
| **'Belly Bags' must be changed every 28 days** |
| **Single use night bags must be changed every 24 hours** |
| **When connecting a bag or valve to a silicone catheter, ensure that the ridged connector is only inserted by two ridges, to avoid over stretching the end of the catheter** |
| **If attaching a single use night bag, the leg bag or catheter valve must remain in place over night, and the night bag must be attached to the open tap of the leg bag or catheter valve** |
| **If attaching a drainable 2 litre bag, it must be attached directly to the catheter** |
| **If a 2-litre bag is being used, it must be positioned off the floor, attached to a bag stand** |
| **Equipment:**<br>Non-sterile nitrile gloves<br>Single use apron<br>Alcohol hand gel<br>Catheter urine drainage bag or catheter valve<br>Bag straps or support sleeve<br>Fixation device such as a G-strap or Statlock<br>Check that all items are within their expiry date and that packaging is undamaged |
| Explain the procedure to the patient including the consideration of a chaperone, and gain consent |
| Decontaminate hands and put apron and gloves on |
| Help the patient into a sitting or supine position, protect the bed / chair, and ensure privacy |
| Release existing bag straps / support sleeves / fixation devices<br>If catheter valve is being used, drain the bladder and lay valve on the bed or chair<br>If urine drainage bag is being used, empty it and lay bag on the bed or chair |
| With non dominant hand, squeeze the end of the catheter between thumb and forefinger, behind the funnel area, to reduce risk of urine leakage<br>Maintain this until the new bag / valve has been attached<br>Avoid touching the end of the bag / valve, and the end of the catheter |
| With dominant hand, disconnect the used bag from the catheter with a gentle twisting action<br>Remove the protective cap from the new bag or valve, and connect it into the catheter |
| Secure the bag or valve with straps or support sleeve, and a fixation device such as a G-strap or Statlock<br>Ensure that the patient is comfortable |
| Remove gloves and apron. Dispose of waste. Decontaminate hands |
| Seek advice from other health care professionals about any clinical concerns, queries or outcomes |
| Record consent, procedure and outcomes in the patient's notes |
| Offer patient / family / carer education about changing their catheter bags / catheter valves effectively, and check for understanding<br>Supply 'Patient Information - Indwelling Catheters' leaflet to patient<br>Refer to Trust document on Staffzone: **CONT013 Patient Information – Indwelling Catheters**<br>**https://www.shropscommunityhealth.nhs.uk/content/doclib/11213.docx** |

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**Competency**: Indwelling catheterisation (adult patients)

| Name: | Role: |
|---|---|
| Base: | Date initial training completed: |

**Competency Statement:**

- The practitioner demonstrates clinical knowledge and skill of catheterisation, catheter care / management without assistance or direct supervision
- This competency document is aimed at band 2 practitioners and above, who will be undertaking these skills
- Assessment in practice must be by a Registered Health Care Professional, band 5 and above
- Should the practitioner become involved in a catheter related incident then the original competency document will be used to reassess competency within the specific area that was involved in the incident. Ward Managers / team leaders will keep a record of healthcare professionals involved catheter related incidents and lessons learned, to help identify individual training needs
- This competency document must be used in conjunction with the Trust Indwelling catheterisation (adult patients) policy, and the Standard Operating Procedures (SOPs) within the policy
- There are no band 2 practitioners in the community nursing teams, involved with catheter care
  There are no band 3 practitioners in the community hospitals
  Therefore, please refer to the relevant 'community hospital' and 'community nursing team' sections, of this competency document

**The participant needs to be able to demonstrate the following clinical knowledge and practical skills:**

Level 1: **COMMUNITY HOSPITALS band 2**

Responsible for delivering agreed programmes of care, under the supervision of a registered practitioner

| | Performance criteria | Assessment method (questioning / observation) | Skill achieved ✓ | Date | Assessor |
|---|---|---|---|---|---|
| | **Clinical knowledge:** | | | | |
| | Attend Trust catheterisation training: | | | | |
| | Demonstrate how to access catheterisation related documents and the Trust Indwelling Catheterisation Policy (adult patients) on Staffzone, and to locate the Standard Operating Procedures (SOPs) within the policy | observation | | | |
| | Demonstrate knowledge and understanding of the anatomy and physiology of the lower urinary tract, in relation to indwelling catheterisation | questioning | | | |
| | Discuss the key principles of closed urinary systems | questioning | | | |
| | Discuss how to complete CONT005 catheter care pathway' documentation | questioning | | | |
| | **Complete the following SOPs to demonstrate the clinical skills:** | | | | |
| | SOP for emptying a catheter urine drainage bag or releasing a catheter valve | observation | | | |
| | SOP for securing indwelling catheters | observation | | | |
| | SOP for changing a catheter urine drainage bag or catheter valve | observation | | | |

| Level 1: **COMMUNITY NURSING TEAMS band 3**<br>Responsible for delivering agreed programmes of care, under the supervision of a registered practitioner | | | | |
|---|---|---|---|---|
| **Performance criteria** | **Assessment method (questioning / observation)** | **Skill achieved** ✓ | **Date** | **Assessor** |
| **Clinical knowledge:** | | | | |
| Attend Trust catheterisation training: | | | | |
| Demonstrate how to access catheterisation related documents and the Trust Indwelling Catheterisation Policy (adult patients) on Staffzone, and to locate the Standard Operating Procedures (SOPS) within the policy | observation | | | |
| Demonstrate knowledge and understanding of the anatomy and physiology of the lower urinary tract, in relation to indwelling catheterisation | questioning | | | |
| Discuss the key principles of closed urinary systems | questioning | | | |
| Discuss how to complete CONT005 catheter care pathway documentation | questioning | | | |
| Discuss how to provide patient education, using the following leaflets:<br>• CONT013 Patient information-indwelling catheters<br>• Hydrating fruit and veg<br>• What colour is your wee?<br>• Are you drinking enough fluids? | questioning | | | |
| **Complete the following SOPs to demonstrate the clinical skills:** | | | | |
| SOP for emptying a catheter urine drainage bag or releasing a catheter valve | observation | | | |
| SOP for securing indwelling catheters | observation | | | |
| SOP for changing a catheter urine drainage bag or catheter valve | observation | | | |
| SOP for taking a catheter specimen of urine (CSU) | observation | | | |
| SOP for administration of **pre planned** B Braun Uro-tainer Twin Suby G 3.23% citric acid catheter maintenance solutions | observation | | | |
| SOP for administration of **pre planned** B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to flush debris | observation | | | |
| SOP for **pre planned** removal of indwelling urethral catheter | observation | | | |

| Level 2: **COMMUNITY HOSPITALS band 4 and 5**<br>Responsible for Co-ordinating and delivering effective quality clinical care following a patient centred model of practice and ensuring the work area runs smoothly | | | | |
|---|---|---|---|---|
| **Performance criteria** | **Assessment method (questioning / observation)** | **Skill achieved** ✓ | **Date** | **Assessor** |
| **Clinical knowledge:** | | | | |
| **Complete level 1 and:** | | | | |
| Discuss the importance of identifying the reason for initial catheterisation, and removing the catheter as soon as possible<br>• Use HOUDINI to assess whether the catheter can be removed<br>• Discuss the contraindications for a trial without catheter (TWOC)<br>• DATIX all poor catheter discharges from secondary care (no referral to community nurses, no catheter supplies sent home with patient, inadequate clinical information in discharge letter) | questioning | | | |
| Discuss how to complete and use CONT014 indwelling urinary catheter card | questioning | | | |
| Discuss how to provide patient education, using the following leaflets:<br>• CONT013 Patient information-indwelling catheters<br>• Hydrating fruit and veg<br>• What colour is your wee?<br>• Are you drinking enough fluids? | questioning | | | |
| Discuss the contraindications for indwelling urethral catheterisation in the community | questioning | | | |
| Discuss the limitations for indwelling urethral catheterisation in the community | questioning | | | |
| Discuss who changes the first and subsequent suprapubic catheters in the community | questioning | | | |
| Discuss the contraindications for changing suprapubic catheters in the community | questioning | | | |
| Discuss the limitations for changing suprapubic catheters in the community | questioning | | | |
| Discuss how to source catheter equipment on prescription<br>• GP – Shropshire<br>Proact – Telford & Wrekin | questioning | | | |
| Demonstrate understanding of the terms:<br>• Intermittent catheters<br>• Short term catheters<br>• Long term catheters | questioning | | | |

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| | Discuss the different types of catheters and their clinical indications:<br>• Hydrogel coated latex<br>• PTFE coated latex<br>• Silver alloy latex<br>• Silicone<br>• Female length<br>• Standard length<br>• Charriere size<br>• Balloon size and appropriate inflation<br>• Open tip, round tip, Opti tip<br>• Tiemann tip catheters must not be inserted in the community | | | | |
| | ***BAND 5 ONLY***<br>Discuss your role in assessing staff who are learning this knowledge and skills, to ensure they are competent and deliver safe practice in line with Trust policy | questioning | | | |
| | **Complete the following SOPs to demonstrate the clinical skills:** | | | | |
| | SOP for taking a catheter specimen of urine (CSU) | observation | | | |
| | SOP for administration of **pre planned** B Braun Uro-tainer Twin Suby G 3.23% citric acid catheter maintenance solutions | observation | | | |
| | SOP for administration of **pre planned** B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to flush debris | observation | | | |
| | SOP for **pre planned** removal of indwelling urethral catheter | observation | | | |
| | SOP for **routine, simple, pre planned** indwelling female recatheterisation | observation | | | |
| | SOP for **routine, simple, pre planned** indwelling male recatheterisation | observation | | | |
| | SOP for **routine, simple, pre planned** supra pubic recatherisation | observation | | | |
| | SOP for administration of B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to check catheter patency **during a simple SOS intervention** | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for complex or unplanned SOS indwelling female recatheterisation<br>(including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, history of spontaneous catheter expulsion) | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for complex or unplanned SOS indwelling male recatheterisation<br>(including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, history of spontaneous catheter expulsion, phimosis, history of paraphimosis) | observation | | | |

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| | ***BAND 5 ONLY*** SOP for complex or unplanned SOS suprapubic recatheterisation (including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, over granulation around suprapubic cystostomy stoma site) | observation | | | |
| | ***BAND 5 ONLY*** SOP for SOS unplanned removal of indwelling urethral catheter | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration of SOS unplanned B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to flush debris | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration SOS unplanned B Braun Uro-tainer Twin Suby G 3.23% citric acid catheter maintenance solutions | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration of B Braun Uro-tainer Solutio R 6% citric acid catheter maintenance solutions, to remove external encrustation from catheter tip, prior to catheter removal | observation | | | |
| | ***BAND 5 ONLY*** SOP for assessing the suitability of a catheter valve | observation | | | |
| | ***BAND 5 ONLY*** SOP for assessing and treating autonomic dysreflexia | observation | | | |
| | ***BAND 5 ONLY*** SOP for suprapubic recatheterisation using warm bladder infill, for patients with a spinal cord injury | observation | | | |
| | ***BAND 5 ONLY*** SOP for management of suspected or confirmed CAUTI (urethral or suprapubic indwelling urinary catheters)<br>• Use UTI assessment form | observation | | | |
| | ***BAND 5 ONLY*** SOP for trouble shooting of indwelling catheters<br>• Non deflating balloons<br>• Failure of urine to drain upon insertion of catheter in female urethra<br>• Allergy<br>• Urinary bypassing due to blockage<br>• Urinary bypassing due to bladder spasm<br>• Previous history of external encrustation causing trauma upon removal<br>• Purple urine bag syndrome<br>• Spontaneous catheter expulsion with balloon intact/deflated<br>• Unable to remove catheter from suprapubic cystostomy stoma<br>• Unable to insert new catheter into suprapubic cystostomy stoma<br>• Over granulation around suprapubic cystostomy stoma site | observation | | | |

| Level 2: **COMMUNITY NURSING TEAMS band 4 and 5**<br>Responsible for co-ordinating and delivering effective quality clinical care following a patient centred model of practice and ensuring the work area runs smoothly | | | | |
|---|---|---|---|---|
| Performance Criteria | **Assessment method (questioning / observation)** | **Skill achieved** ✓ | **Date** | **Assessor** |
| **Clinical knowledge:** | | | | |
| **Complete level 1 and:** | | | | |
| Discuss the importance of identifying the reason for initial catheterisation, and removing the catheter as soon as possible<br>• Use HOUDINI to assess whether the catheter can be removed<br>• Discuss the contraindications for a trial without catheter (TWOC)<br>• DATIX all poor catheter discharges from secondary care (no referral to community nurses, no catheter supplies sent home with patient, inadequate clinical information in discharge letter) | questioning | | | |
| Discuss how to complete and use CONT014 indwelling urinary catheter card | questioning | | | |
| Discuss the contraindications for indwelling urethral catheterisation in the community | questioning | | | |
| Discuss the limitations for indwelling urethral catheterisation in the community | questioning | | | |
| Discuss who changes the first and subsequent suprapubic catheters in the community | questioning | | | |
| Discuss the contraindications for changing suprapubic catheters in the community | questioning | | | |
| Discuss the limitations for changing suprapubic catheters in the community | questioning | | | |
| Discuss how to source catheter equipment on prescription<br>• GP – Shropshire<br>• Proact – Telford & Wrekin | questioning | | | |
| Demonstrate understanding of the terms:<br>• Intermittent catheters<br>• Short term catheters<br>• Long term catheters | questioning | | | |
| Discuss the different types of catheters and their clinical indications:<br>• Hydrogel coated latex<br>• PTFE coated latex<br>• Silver alloy latex<br>• Silicone<br>• Female length<br>• Standard length<br>• Charriere size<br>• Balloon size and appropriate inflation<br>• Open tip, round tip, Opti tip<br>• Tiemann tip catheters must not be inserted in the community | questioning | | | |

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| | ***BAND 5 ONLY*** Discuss your role in assessing staff who are learning this knowledge and skills, to ensure they are competent and deliver safe practice in line with Trust policy | questioning | | | |
| | **Complete the following SOPs to demonstrate the clinical skills:** | | | | |
| | SOP for **routine, simple, pre planned** indwelling female recatheterisation | observation | | | |
| | SOP for **routine, simple, pre planned** indwelling male recatheterisation | observation | | | |
| | SOP for **routine, simple, pre planned** supra pubic recatherisation | observation | | | |
| | SOP for administration of B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to check catheter patency **during a simple SOS intervention** | observation | | | |
| | ***BAND 5 ONLY*** SOP for complex or unplanned SOS indwelling female recatheterisation (including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, history of spontaneous catheter expulsion) | observation | | | |
| | ***BAND 5 ONLY*** SOP for complex or unplanned SOS indwelling male recatheterisation (including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, history of spontaneous catheter expulsion, phimosis, history of paraphimosis) | observation | | | |
| | ***BAND 5 ONLY*** SOP for complex or unplanned SOS suprapubic recatheterisation (including patients at risk of autonomic dysreflexia, history of previous difficult removal / insertion, history of non deflating balloons, history of allergies to catheter related equipment, over granulation around suprapubic cystostomy stoma site) | observation | | | |
| | ***BAND 5 ONLY*** SOP for SOS unplanned removal of indwelling urethral catheter | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration of SOS unplanned B Braun Uro-tainer NaCl Saline 0.9% catheter maintenance solutions, to flush debris | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration SOS unplanned B Braun Uro-tainer Twin Suby G 3.23% citric acid catheter maintenance solutions | observation | | | |
| | ***BAND 5 ONLY*** SOP for administration of B Braun Uro-tainer Solutio R 6% citric acid catheter maintenance solutions, to remove external encrustation from catheter tip, prior to catheter removal | observation | | | |

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| | ***BAND 5 ONLY***<br>SOP for assessing the suitability of a catheter valve | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for assessing and treating autonomic dysreflexia | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for suprapubic recatheterisation using warm bladder infill, for patients with a spinal cord injury | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for management of suspected or confirmed CAUTI (urethral or suprapubic indwelling urinary catheters)<br>Use UTI assessment form | observation | | | |
| | ***BAND 5 ONLY***<br>SOP for trouble shooting of indwelling catheters<br>• Non deflating balloons<br>• Failure of urine to drain upon insertion of catheter in female urethra<br>• Allergy<br>• Urinary bypassing due to blockage<br>• Urinary bypassing due to bladder spasm<br>• Previous history of external encrustation causing trauma upon removal<br>• Purple urine bag syndrome<br>• Spontaneous catheter expulsion with balloon intact/deflated<br>• Unable to remove catheter from suprapubic cystostomy stoma<br>• Unable to insert new catheter into suprapubic cystostomy stoma<br>• Over granulation around suprapubic cystostomy stoma site | observation | | | |

| Level 3: **COMMUNITY HOSPITALS & COMMUNITY NURSING TEAMS band 6**<br>Responsible for co-ordinating, delivering and maintaining high standards of day-to-day clinical care for all patients in the designated clinical area. Provide support to the team leader and clinical leadership to the team | | | | |
|---|---|---|---|---|
| **Performance criteria** | **Assessment method (questioning / observation)** | **Skill achieved** ✓ | **Date** | **Assessor** |
| **Clinical knowledge:** | | | | |
| **Complete levels 1, 2 and:** | | | | |
| Continence Nurse Specialists to provide specialist training and education in catheterisation, to clinical staff | questioning | | | |
| Continence Nurse Specialists to write Indwelling Catheterisation Policy, Standard Operating Procedures and Competency document, and update them every 3 years, or sooner if required | questioning | | | |
| Act as a supervisor to band 5 staff who are mentoring and assessing practitioners for this competency | questioning | | | |
| Discuss the importance of appropriate delegation of these clinical skills, to team members | questioning | | | |
| Act as an expert role model, demonstrating the ability to problem solve and support staff with any issues relating to catheterisation | questioning | | | |

| Level 4: **COMMUNITY HOSPITALS & COMMUNITY NURSING TEAMS band 7 and 8a**<br>Lead & manage a clinical team and patient services, developing clear systems to ensure delivery of evidenced based care. To provide support to senior management /clinical leads and clinical leadership to the ward or team | | | | |
|---|---|---|---|---|
| **Performance criteria** | **Assessment method (questioning / observation)** | **Skill achieved** ✓ | **Date** | **Assessor** |
| **Clinical knowledge:** | | | | |
| **Complete levels 1, 2, 3 and:** | | | | |
| To investigate any clinical incidents related to indwelling catheterisation, and ensure that appropriate changes are made to ensure safe and appropriate working practices | questioning | | | |
| Promote systems in the clinical area to ensure that staff are competent in catheterisation and kept informed of developments in practice | questioning | | | |
| Monitor performance and any adverse events to improve and develop practice | questioning | | | |
| Demonstrate expertise and act as a role model and subject matter expert for staff | questioning | | | |
| Liaise with specialist and multi-professional staff, to contribute to an integrated approach to indwelling catheter management and to promote a reduction in CAUTIs | questioning | | | |

**Competency Sign-Off:**

**Name: _____ Signature: _____ Status: _____ Date: _____**

I confirm that I have assessed the above named individual and can verify that he/she demonstrates competency in indwelling catheterisation (adult patients)

**Assessor: _____ Signature: _____ Status: _____ Date: _____**

| Review Dates | Competent Yes/No | Registered Nurse signature | Verifier signature | Comments |
|---|---|---|---|---|
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**References:**

Benner's Stages of Clinical Competence: Novice to Expert (1984)

Care Quality Commission (Registration) Regulations 2009 (Part 4)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Royal Marsden (2017) The Royal Marsden Manual of Clinical Nursing Procedures (9th ed)

Steinaker and Bell's Experiential Taxonomy (1979)