

Document Control

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STOP!

At each episode of care:

THINK!

Does this patient need a catheter?

Could they be managed differently?

REVIEW previous attempts at a trial
without catheter.

Is a chronic residual causing bothersome symptoms?

THINK Intermittent Self-Catheterisation

THINK Sheath

THINK Treatment

1. Introduction

‘Continence is one of the fundamentals of basic nursing care’

RCN guidance for nurses catheter care 2012

By definition, a **urethral catheter** is a flexible hollow tube inserted into the bladder via the urethra to drain urine or instil fluids as part of medical treatment. It may be intermittent, for periodic insertion or retaining for continuous drainage.

Catheterisation should form part of a holistic assessment based on the patient’s diagnosis and nursing needs.

The decision to catheterise a patient is made by the nurse/doctor and the patient following holistic assessment and assessment of capacity.

This includes for the purpose of obtaining specimens of urine, to assess residual volume and maintaining an accurate fluid balance etc.

Catheterisation should only be carried out by registered nurses and authorised non-registered staff that have been assessed as competent in the procedure.

First time catheterisation should **only** be undertaken by a **registered practitioner**

Indications for urethral catheterisation:

Drainage:

- Prostatic hyperplasia
- Acute or chronic retention
- Hypotonic bladder
- Pre and post pelvic surgery
- Measure urine output
- To empty bladder during labour
- Management of intractable incontinence (last resort)
- Where it is viewed as ‘better’ for the patient to have a catheter, such as end of life care, disability, unfit for surgery.

Investigations:

- To obtain an uncontaminated urine specimen
- In urodynamic (bladder studies) investigations
- X-ray investigation

Instillation:

- To irrigate the bladder
- Chemotherapy/Immunotherapy

Contra indications for catheterisation:

- Never catheterise or continue catheterisation for nursing or carer convenience.
- Catheterisation should be based on a balanced decision, with more benefits than disadvantages.
- Catheterisation of patients who are agitated and or cognitively impaired is best avoided where possible.
- Nurses must **never** totally base the decision to catheterise on residual urine status, even if the amount is considerable. Where a residual volume of urine is identified, the patient's symptom and severity profile along with their renal function and cognitive status must be considered, prior to considering catheterisation.
- Routine catheterisation must not be supported by nurses, particularly in specific patient groups such as fractured neck of femur or stroke patients. Nursing has no defence in stating 'The doctor told me to do it'

When a catheter is inserted, the nurse should consider earliest possible removal as infection risk and other catheter related problems increases on a daily basis.

Competence

'Recognise and work within the limits of your competence'

"Be accountable for your decisions to delegate tasks and duties to other people" Nursing and Midwifery Council 2015

'Proper standards of care lie at the heart of protecting patients'

Frances Inquiry final report 2013

Consent

Urinary catheterisation is an invasive procedure and the need for the patient to have capacity to give informed consent underpins the whole of this document. The clinician must be conversant with the Trust consent policy
<http://www.northdevonhealth.nhs.uk/2012/04/consent-policy/>

Where the patient is unable to give informed consent a 'Best Interest' decision should be sought but only if there is a clear medical reason for the catheterisation.

Patients can withdraw consent at any time and it is especially important to review consent whenever a catheter is changed.

2. Guidelines for clinicians and assessors

Relating to knowledge and understanding for all aspects of catheter care (core competency)

Each number relates to the number on the competency.

The following list is designed to support and guide clinicians and assessors to achieve the competency, it is not an exhaustive list but is intended to promote discussion, check understanding and identify areas that require further input.

1. Key documents, publications and Agencies which influence this aspect of care. (This is not an exhaustive list)
Royal College of Nursing Catheter care Guidance for Nurses (2012)

Medicines and Healthcare Products Regulatory Agency

International Continence Society (ICS)

Association for Continence Advice (ACA)

Department of Health (DOH) including good practice in consent, mental capacity act saving lives etc.

National Institute for Clinical Effectiveness (NICE) including urinary incontinence, infection control, urinary tract infection etc.

Nursing and Midwifery Council (NMC) including record keeping, delegation and The Code: Professional standards of practice and behaviour for nurses and midwives.

Local documentation - Urinary Catheterisation in Adults policy, Antibiotic policy, Infection control policy and Standard Operation Procedures.
2. See RCN documentation on interpreting accountability.
3. The importance of working within own sphere of competency. Assess with questioning, i.e. a scenario or situation described when you would feel it was necessary to seek assistance or advice from a senior colleague or medical staff.
4. The conditions and constraints around who should undertake questioning around knowledge and training, who can undertake male/supra-pubic catheterisation, first time catheterisations etc.
5. The importance of applying standard infection control precautions, what these are and what are the risks of not applying them.
6. Questioning about the structures of the urethra, bladder ureters and kidneys, you could use diagrams to label etc.

7. Questioning about the basic functions of each of the above, what happens to the bladder when a person is catheterised? What is a normal/healthy urine production i.e. mls/min? Why is it important to know this? (Trials without catheter, bladder scans, is patient dehydrated)
8. Chaperoning: the role of the nurse and the rights of the patient (RCN Guidance if unsure) Also DOH guidance on good practice in consent and the role and effective use of chaperones. Local policy on Consent, DOH Mental Capacity Act.
9. Assess through discussion- How to maintain comfort and dignity, position, the use of lubricating gels, analgesia clear and appropriate instruction, monitor patient throughout the procedure etc.
13. Discussion- Ethics i.e. who is requesting catheterisation? Carers, relatives or patient? Is there a more appropriate alternative?
14. Be familiar with Catheter Policy.
16. Documentation- , consider the NMC 'The Code': Professional standards of practice and behaviour for nurses and midwives and Trust documentation policy. All patients with an indwelling catheter for longer than a hospital admission must be given a catheter passport. Assess by asking what details should be recorded.

Catheter Passport

Once a decision has been made that a catheter is going to remain insitu beyond discharge from hospital the patient should be given a Catheter Passport. These are available through Web Basket requisition number ND0050 . Normally supplied as A5 documents they are available in A4 format for those who need a larger print version. The catheter passport is a record of all catheter interventions but also provided the patient with written information about how to care for their catheter and when to seek help/advice.

Patients can also access further guidance from:

NHS Choices : <https://www.nhs.uk/conditions/urinary-catheters/living-with/>

Bladder And Bowel UK: www.bladderandboweluk.co.uk

3. Competency - Knowledge & Understanding

Competency: Knowledge and understanding relating to all aspects of catheterisation and catheter care

Name and Designation:	
Team/ward:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager/Ward Manager	

Aim and Objectives:	
Training Prerequisite:	<p>Prior to this assessment, I have successfully completed the following: Catheterisation training access via STAR Bladder and bowel management level 1 via STAR Bladder and bowel management level 2 (optional) via STAR</p> <p>DATE COMPLETED....</p>
Your responsibility:	<p>All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow their Code of Conduct.</p>
<p>Employee Signature/print name:.....</p> <p>Date:</p>	

Description of Assessment (knowledge and understanding)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
<p>1. Demonstrate a factual knowledge of local/national policies guidelines and SOPs relating to urethral catheterisation, supra-pubic catheterisation and catheter management.</p> <p>2. Demonstrates an understanding of personal responsibilities and accountability in relation to urethral, supra-pubic catheterisation and catheter management.</p> <p>3. The importance of working within your own sphere of competence and when to seek advice when faced with situations outside your sphere of competence.</p> <p>4. The conditions and constraints which might denote who undertakes the procedure and why.</p> <p>For Assistant practitioners (AP) and Clinical Support workers (Higher Level) (CSW) this role should be appropriately delegated by the registered nurse accountable for the patients care, for the task to be appropriately delegated it must be:</p> <ul style="list-style-type: none"> • Necessary and in the patients best interests • Delegated on a named patient basis. • The CSW/AP understands the task and how it should be performed. • The CSW/AP has the skills and abilities to perform the task competently. • The CSW/AP accepts the responsibility to perform the task competently. <p>(NMC advice on accountability 2015, RCN delegation and accountability 2008)</p>		
<p>For Non registrants: The CSW/AP understands the need for observing and implementing the patients care plan and importance of the patient safety handover at each episode of care.</p>		

5.	The importance of applying standard precautions.		
6.	The potential consequences of poor practice		
7.	The anatomy of the male and female genito-urinary system.		
8.	The physiology of the male and female genito-urinary system.		
9.	The need for chaperones, individualised care and the need for consent.		
10.	Ensure patient has the capacity to consent to the procedure. If patient lacks capacity follow Trust guidance on consent and best interest decisions.		
11.	The importance of adapting communication to meet individual's needs and the importance of offering effective verbal and non-verbal support and reassurance to patients.		
12.	The effects of catheterisation on the individuals comfort and dignity and ways of minimising any adverse effects.		
13.	Ethical issues surrounding catheterisation.		
14.	Types of catheters that can be used and why you should select the appropriate catheter.		
15.	The use of and types of lubricating/anaesthetic agent		
16.	The importance of keeping accurate, up to date records.		
17.	The importance of reporting immediately any issues which are outside your own sphere of competence to relevant parties/members of staff. The importance and process of escalating any adverse incidents.		

This document should be completed in full and the employee should be signed off as

competent for all of the above assessment before they are deemed competent to undertake the clinical intervention.

Once competency has been established please ensure that the below signature box is completed.

If the member of staff is unable to fulfil all of the assessment criteria, the appropriate actions should be discussed with the assessor and line manager and an agreed plan should be implemented to assist successful completion.

Employee Signature/print name:.....

Assessor Signature/print name:.....

Line Manager Signature/print name:.....

Date competency fully completed:

On completion of this document: One copy should be given to the employee for their portfolio, one copy should be retained in the team's competency log folder and one copy should be stored in the employee's personal file.

4. Competency - Urethral catheterisation of male and female

Competency: Changes, secures, monitors and responds to the effects of urethral catheterisation (Male and Female)

NB. Delete male if only assessing for female catheterisation.

Name and Designation:	
Team:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager	

Aim and Objectives:	The participant will demonstrate clinical knowledge and skill in male and female urethral catheterisation without assistance or direct supervision.
Training Prerequisite:	Catheterisation training via STAR Bladder and bowel management level 1 via STAR Bladder and bowel management level 2 via STAR Complete core competency: Knowledge and understanding relating to all aspects of catheterisation and catheter care. DATE COMPLETED.....
Your responsibility:	All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow The Code: Professional standards of practice and behaviour for nurses and midwives. (NMC 2015)
Employee Signature/print name:.....	
Date:	

Description of Assessment (knowledge and practice)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
Demonstrate knowledge and skill in urethral catheterisation.		NB: all this section can be assessed through questioning.
<ol style="list-style-type: none"> 1. State when it is appropriate to use a urethral catheter, discuss the mechanism and appropriate use of urethral catheters. 2. State when this should be reviewed 3. State what must be considered when selecting the right catheter for the patient 4. Demonstrate an understanding of the terms: <ol style="list-style-type: none"> i. Intermittent ii. Short term iii. Medium term iv. Long term v. Foley catheter vi. Nelaton catheter In reference to catheter use. 5. Demonstrate an understanding of the materials used to make catheters and the circumstances in which they are most appropriately used. <ol style="list-style-type: none"> i. PVC or plastic ii. Latex iii. PTFE(Teflon) coated latex iv. Hydrogel coated 100% silicone. v. 100% silicone vi. Hydrogel-coated Latex. 6. Demonstrate an understanding of the range of catheter length and appropriate safe choice for patients: <ol style="list-style-type: none"> i. Female ii. Standard iii. Paediatric. 7. Demonstrate an understanding of the process used to select Charriere size 8. Discuss the use of catheter valves and the criteria for use in the individual patient 		

<p>9. Discuss the options of drainage systems, considerations and appropriate choices for patients.</p> <p>10. Describe the process of deflating the catheter balloon and safe actions to take if the balloon fails to deflate.</p> <p>11. Discuss/demonstrate the principles of safe effective catheter care and maintenance. (Standard operating procedure for catheter care in appendix A)</p> <p>12. Discuss the causes and solutions to catheter blockage:</p> <ul style="list-style-type: none"> i. Mucosal occlusion ii. Hydrostatic suction iii. Occlusion due to spasm iv. Mechanical causes v. Encrustation <p>13. Discuss the causes for and solutions to</p> <ul style="list-style-type: none"> i. Bypassing ii. Cramping pain iii. Urethral discomfort iv. Haematuria v. Purple bag syndrome vi. Pain on removal of catheter <p>14. Discuss the need to review the general and bladder health of an individual using a urinary catheter including the importance of assessing the need for continued catheter usage at each catheter change.</p> <p>15. Discuss the causes of urinary tract invasion from bacteria and how to minimise this in all care settings.</p>		
<p>Demonstrates practical skill in male and female catheterisation. (This may be observed by other</p>		<p>NB: This section should be assessed through</p>

members of the team)		direct observation.
<ol style="list-style-type: none"> 1. Applies Trust Standard Infection Control Precautions Policy for infection control including aseptic no-touch technique. Takes appropriate health and safety measures 2. Complies with local policies and Standard Operating Procedure (SOP) relating to the changing of a male and female catheter. (see appendix) 3. Ensures the environment is clean and suitable, and that comfort and dignity of the patient is maintained throughout the procedure 4. Assesses the appropriateness for catheterisation and identifies appropriate rationale for intervention. 5. Removes the previous indwelling catheter in accordance with local policy and guidelines 6. Observe catheter on removal making note of any encrustation, bleeding etc. and contain any leakage of urine 7. Inserts and secures the catheter safely and correctly according to Trust SOP(appendix A) 8. Monitor the individual's condition as part of catheter care 9. Recognise any adverse effects and potential complications and take appropriate action 10. Record clearly, accurately and correctly any relevant information in the patient's catheter passport and care plan. 11. Records catheter details on change record sheet. 12. Check that all catheterisation equipment and materials are functioning correctly and take appropriate action to remedy any problems. 		

<p>14. Disposes of all waste and soiled products appropriately in line with the local waste policy</p> <p>15. Advise the individual and relevant others in the care and use of their catheter, common complications and actions to take.</p> <p>16. Checks and supports patient to arrange for adequate supplies for future requirements.</p> <p>17. Provide the individual and relevant others with lifestyle advice including fluid intake, type of fluid activity, travel and holidays to minimise catheter associated complications.</p>		

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Line Manager Signature/print name:.....

Date competency fully completed:

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5. Competency - Changing an established supra-pubic catheter

Competency: Changes, secures, monitors and responds to the effects of supra pubic catheterisation

Name and Designation:	
Team:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager	

Aim and Objectives:	The participant will demonstrate clinical knowledge and skill in supra-pubic catheterisation without assistance or direct supervision.
Training Prerequisite:	Catheterisation training via STAR Bladder and bowel management level 1 via STAR Bladder and bowel management level 2 via STAR Complete core competency: Knowledge and understanding relating to all aspects of catheterisation and care. DATE COMPLETED.....
Your responsibility:	All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow The Code: Professional Standards of practice and behaviour for nurses and midwives (NMC 2015)
Employee Signature/print name:..... Date:	

Description of Assessment (knowledge and practice)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
Demonstrate knowledge and skill in supra-pubic catheterisation.		NB: all this section can be assessed through questioning.
<ol style="list-style-type: none"> 1. State when it is appropriate to use a supra-pubic catheter, discuss the mechanism and appropriate use of supra-pubic catheters. 2. State when this should be reviewed 3. State what must be considered when selecting the right catheter for the patient 4. Demonstrate an understanding of the terms: <ol style="list-style-type: none"> i. Intermittent ii. Short term iii. Medium term iv. Long term v. Foley catheter vi. Nelaton catheter In reference to catheter use. 5. Demonstrate an understanding of the materials used to make catheters and the circumstances they are most appropriately used. <ol style="list-style-type: none"> i. PVC or plastic ii. Latex iii. PTFE(Teflon) coated latex iv. Hydrogel coated % silicone v. 100% silicone vi. Hydrogel-coated Latex 6. Demonstrate an understanding of the range of 3 catheter lengths routinely available and appropriate safe choice for patients. The lengths are: <ol style="list-style-type: none"> i. Female ii. Standard iii. Paediatric 7. Demonstrate an understanding of the process used to select Charriere size. 		
8. Discuss the use of catheter valves and the		

<p>criteria for use in the individual patient</p> <p>9. Discuss the options of drainage systems, considerations and appropriate choices for patients.</p> <p>10. Describe the process of deflating the catheter balloon and safe actions to take if the balloon fails to deflate.</p> <p>11. Discuss/demonstrate the principles of safe effective catheter care and maintenance</p> <p>12. Discuss the causes and solutions to catheter blockage:</p> <ul style="list-style-type: none"> i. Mucosal occlusion ii. Hydrostatic suction iii. Occlusion due to spasm iv. Mechanical causes v. Encrustation <p>13. Discuss the causes for and solutions to</p> <ul style="list-style-type: none"> i. Bypassing ii. Cramping pain iii. Urethral discomfort iv. Haematuria v. Purple bag syndrome vi. Pain on removal of catheter <p>14. Discuss why it is important to review the general and bladder health status of the individual using a catheter and how this links to the need to assess the need for on-going catheter usage at each catheter change.</p> <p>15. Discuss the causes of urinary tract invasion from bacteria and how to minimise this in all care settings.</p>		
<p>Demonstrates practical skill in Supra-pubic catheterisation</p>		<p>NB: This section should be assessed through</p>

		direct observation.
<ol style="list-style-type: none"> 1. Applies Trust Standard Infection Control Precautions Policy for infection control including aseptic no-touch technique. Takes appropriate health and safety measures. 2. Complies with local policies and procedure relating to the changing of a supra-pubic catheter. (see Appendix D) 3. Ensures the environment is clean and suitable, and that comfort and dignity are maintained throughout the procedure. 4. Observe the cystostomy site for any abnormalities and take the appropriate action. 5. Removes the previous indwelling supra-pubic catheter in accordance with guidelines. (Appendix D) 6. Observe catheter on removal making note of any encrustation, bleeding etc. and contain any leakage from the cystostomy. 7. Inserts and secures the catheter safely and correctly according to Trust guidelines. (Appendix 3) 8. Monitor the individual's condition as part of catheter care. 9. Recognise any adverse effects and potential complications and take appropriate action. 10. Record clearly, accurately and correctly any relevant information in the catheter passport/care plans. 11. Records the catheterisation on change record sheet. The sticker on the catheter pack may be used for this. 12. Advise the individual and relevant others in the care and use of their catheter, common complications and actions to take. 		

13. Check all catheterisation equipment and materials are functioning correctly and take appropriate action to remedy any problems.		
14. Checks and supports patient to arrange for adequate supplies for future requirements.		
15. Provide the individual and relevant others with lifestyle advice including fluid intake, type of fluid activity, travel and holidays to minimise catheter associated complications.		

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6. Competency - Clean Intermittent Catheterisation (CISC)

Competency: Supports and teaches patients to perform Clean Intermittent Catheterisation (CISC)

Name and Designation:	
Team:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager	

Aim and Objectives:	The participant will demonstrate the skills required to assess the patient's ability to perform CISC and to teach the patient the necessary skills required to perform CISC. This may be the individuals performing the intervention on themselves, or by carers of the individual requiring CISC.
Training Prerequisite:	Catheterisation training via STAR Bladder and bowel management level 1 via STAR Bladder and bowel management level 2 (Optional) via STAR Complete core competency: Knowledge and understanding relating to all aspects of catheterisation and care.
Your responsibility:	All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow The Code: Professional standards of behaviour and practice for nurses and midwives (NMC 2015)
Employee Signature/print name:.....	
Date:	

Description of Assessment (knowledge and practice)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
Knowledge and understanding specific to CISC		NB: all this section can be assessed through questioning.
<ol style="list-style-type: none"> 1. The causative factors which determine the need for CISC. 2. Why a risk assessment is important prior to the decision to catheterise or use CISC is important and what contributes to this. 3. How to advise individuals who undertake CISC. 4. The effects of CISC on a person's comfort and dignity and ways of handling this. 5. The adverse effects and potential complications during CISC and appropriate actions to take. 6. The short and long term risks and health implications associated with CISC and how to resolve or minimise these. 7. The types of intermittent catheters and associated equipment available and how to advise the individual to choose an appropriate type to meet their specific clinical needs and lifestyle. 8. How individuals will need to obtain, store to maintain sterility, dispose of intermittent catheter equipment and check it is fit for purpose before usage. 9. The advice and support that should be provided to individuals undertaking CISC. 10. Applies Trust Standard Precautions for Infection Control and takes appropriate health and safety measures. 11. Complies with local policies and procedure relating to CISC. 		
Demonstrates practical skill in teaching		NB: This section should

and supporting individuals with Clean Intermittent Catheterisation (CISC)		be assessed through direct observation.
<p>12. Obtains the individual's valid consent to demonstrate and teach CISC, ensure they are aware of the rationale, benefits and associated complications.</p> <p>13. Enables the individual to complete a risk assessment prior to the decision to perform CISC.</p> <p>14. Assesses the individual's ability to perform CISC.</p> <p>15. Ensure the environment is clean and suitable for the individual to carry out CISC.</p> <p>16. Enables the individual to develop the necessary skills and actions to carry out CISC.</p> <p>17. Ensures the individual and relevant others know how to obtain the necessary equipment and materials to meet the individual's frequency of catheterisation needs.</p> <p>18. Provide the individual and relevant others with lifestyle advice including fluid intake, type of fluid activity, travel and holidays to minimise catheter associated complications.</p> <p>19. Ensure arrangements are made for the appropriate service to monitor the individual's condition as part of planned catheter care reviews. Ensure individual can recognise adverse effects and complications and knows how to take appropriate action if required.</p> <p>20. Review the continued need and frequency of CISC with all its associated risks with the symptom improvement, quality of life indicators and volumes drained. (At a minimum annually)</p> <p>21. Records clearly and accurately any relevant information in the care plan.</p>		
<p>This document should be completed in full and the employee should be signed off as competent for all of the above assessment before they are deemed competent to undertake the clinical intervention.</p>		

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Assessor Signature/print name:.....

Line Manager Signature/print name:.....

Date competency fully completed:

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7. Competency – Undertake a trial without catheter (TWOC)

Competency: Undertakes a trial without catheter and supports patient during the process.

Name and Designation:	
Team:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager	

Aim and Objectives:	The participant will demonstrate clinical knowledge and skill in performing a trial without catheter including establishing the individuals suitability for the trial and identifying appropriate treatments based on the results.
Training Prerequisite:	Catheterisation training via STAR Bladder and bowel management level 1 via STAR Bladder and bowel management level 2 (optional) via STAR Complete core competency: Knowledge and understanding relating to all aspects of catheterisation and care.
Your responsibility:	All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow The Code: Professional Standards of practice and behaviour for Nurses and midwives (NMC 2015)
Employee Signature/print name:.....	
Date:	

Description of Assessment (knowledge and practice)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
Knowledge and understanding specific to TWOC		NB: all this section can be assessed through questioning.
<p>You will need to know and understand:</p> <ol style="list-style-type: none"> 1. How to advise individuals in the use, function and sensation of the catheter. 2. The reasons why the trial without catheter is necessary. 3. When to proceed or abandon a trial without catheter and what actions to take. 4. The effects of a trial without catheter on a patient's comfort and dignity and ways of handling this. 5. The adverse effects and potential complications during a trial without catheter and appropriate actions. 6. The different risk and health issues that will influence how and where a trial without catheter is performed. 7. The reasons why intermittent bladder draining is the better option if the trial without catheter is unsuccessful. 8. Consider using a catheter valve if the patient has had a long-term catheter in situ to allow the bladder to retain its compliance. 9. The signs and symptoms of urinary retention. These can include; a palpable bladder that is dull on percussion, discomfort, pain, a desire to void with an inability to pass enough urine to satisfy the desire and poor urinary output. 10. Establishes the individual's health needs and suitability for a trial without catheter. 		
Demonstrates practical skill performing		NB: This section should

TWOC		be assessed through direct observation.
<p>11. Undertakes a risk assessment and uses the outcomes to determine a suitable method for a trial without catheter, i.e. setting, time, ability to monitor effects etc.</p> <p>12. Applies Trust Standard Precautions for Infection Control Policy and takes appropriate health and safety measures.</p> <p>13. Complies with local policies and procedure relating to undertaking a trial without catheter.</p> <p>14. Ensures the environment is clean and suitable, and that comfort and dignity are maintained throughout the procedure.</p> <p>15. Obtains valid consent and confirms sufficient information has been provided on which to base the decision to perform a trial without catheter.</p> <p>16. Removes the previous catheter in accordance with guidelines.</p> <p>17. Observes catheter on removal making note of any encrustation, bleeding etc.</p> <p>18. Provide the individual with charts to measure input and output and encourages the individual to drink 1½-2 L fluid spaced evenly throughout the day to challenge the bladder to fill effectively.</p> <p>19. Ensures individuals understand the importance of reporting discomfort immediately, particularly if associated with problems passing urine:</p> <ul style="list-style-type: none"> i. Instructs individual not to drink more if this occurs. ii. Instructs individual they may experience discomfort the first time they pass urine. iii. Informs individual that the urine may be blood-stained as a result of trauma following catheter removal. 		

<p>20. Monitor the individual's condition as part of catheter care. Ensure individuals are aware of who to contact if they experience difficulties.</p> <p>21. If suitably trained practitioner is available, bladder scanning should be performed 4 hours after TWOC to assess for a residual of urine. Intermittent catheterisation to assess for residual urine should be undertaken if no scanning equipment is available.</p> <p>22. Reviews intake/output charts, intake should be roughly equal to output and voided volumes should be consistently greater than 100mls.</p> <p>23. If trial without catheter is unsuccessful consider options for future management such as re-catheterising, intermittent self-catheterisation, consider individual's views, severity of incontinence or voiding success. Discuss with Bladder and Bowel Service or medical practitioner if residual is over 100ml.</p> <p>24. If a catheter is reinserted a repeat trial without catheter is discussed and arranged with the patient.</p> <p>25. Records clearly interventions, outcomes and any complications in Catheter Passport and care plan.</p>		
<p>This document should be completed in full and the employee should be signed off as</p>		

competent for all of the above assessment before they are deemed competent to undertake the clinical intervention.

Once competency has been established please ensure that the below signature box is completed.

If the member of staff is unable to fulfil all of the assessment criteria, the appropriate actions should be discussed with the assessor and line manager and an agreed plan should be implemented to assist successful completion.

Employee Signature/print name:.....

Assessor Signature/print name:.....

Line Manager Signature/print name:.....

Date competency fully completed:

On completion of this document: One copy should be given to the employee for their portfolio, one copy should be retained in the teams competency log folder and one copy should be stored in the employees personal file.

9. Competency – Performs administration of catheter maintenance solutions

Name and Designation:	
Team:	
Assessor Name and Designation:	
Line Manager Name and Designation:	
Community Nurse Team Manager	

Aim and Objectives:	The participant will demonstrate clinical knowledge and skill in administering catheter maintenance solutions without assistance or direct supervision.
Training Prerequisite:	Bladder and bowel management level 1 (e-learning) via STAR Bladder and bowel management level 2 (optional) via STAR Complete core competency: Knowledge and understanding relating to all aspects of catheterisation and care.
Your responsibility:	All staff should ensure that they keep their knowledge and skills up to date by accessing up to date information through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own sphere of competence relevant to their job role and to follow The Code : Professional standards of behaviour and practice for nurses and midwives (NMC 2015)
Employee Signature/print name:.....	
Date:	

Description of Assessment (knowledge and practice)	Competent: Yes or No	Assessor signature, name, designation and date of assessment.
Demonstrate knowledge and understanding in the administration of catheter maintenance solutions		NB: all this section can be assessed through questioning.
1. Demonstrates an in-depth understanding of conditions and reasons which may lead to a catheter maintenance solution being administered.		
2. Demonstrates a working knowledge of the adverse effects which may be associated to conducting administration of catheter maintenance solution.		
3. Demonstrates knowledge of the types of catheter maintenance solutions available and in which situation to use each type.		
4. Demonstrates the importance of keeping accurate records and reporting any issues outside your sphere of competence.		
Demonstrates practical skill in administering catheter maintenance solutions.		NB: This section should be assessed through direct observation.
5. Applies Trust Standard Precautions for Infection Control Policy and takes appropriate health and safety measures.		
6. Complies with local policies and procedure relating to the administration of catheter maintenance solutions. (see Appendix C)		
7. Ensures the environment is clean and suitable, and that comfort and dignity are maintained throughout the procedure.		
8. Ensures any fluid to be administered during the process of catheter maintenance has been prescribed.		
9. Discusses and explains the procedure with the patient ensuring informed consent has been acquired.		
10. Disconnects and drainage bag/valve		

appropriately and attaches the catheter maintenance solution as per manufacturer's instructions, once attached allows fluid to flow into the bladder. Only applying slight pressure to the container if required.		
11. Once instilled follows instructions appropriately according to whether fluid is to be retained for a period or drained immediately.		
12. Monitor the individual's condition as part of catheter care.		
13. Once fluid has been drained remove bag/container and attach a new drainage bag or valve.		
14. Record clearly, accurately and correctly any relevant information in the care records.		
15. Advise the individual and relevant others in the care and use of their catheter, common complications and actions to take at each intervention.		
12. Disposes of all clinical waste appropriately.		
13. Recognises own role, responsibilities and events that need immediate action and reports these appropriately.		
14. Reviews effectiveness of the intervention between 4 to 6 weeks after commencing treatment and discontinues if no improvement in symptoms.		

This document should be completed in full and the employee should be signed off as competent for all of the above assessment before they are deemed competent to undertake the clinical intervention.

Once competency has been established please ensure that the below signature box is completed.

If the member of staff is unable to fulfil all of the assessment criteria, the appropriate actions should be discussed with the assessor and line manager and an agreed plan should be implemented to assist successful completion.

Employee Signature/print name:.....

Assessor Signature/print name:.....

Line Manager Signature/print name:.....

Date competency fully completed:

On completion of this document: One copy should be given to the employee for their portfolio, one copy should be retained in the teams competency log folder and one copy should be stored in the employees personal file.

10. Appendix A: Indications for urinary catheterisation

Indications for urinary catheterisation

- After discussion with Consultant, GP, continence or urology nurse specialist.
- For Community Nurses as above but also within individual's knowledge base and clinical competence in conjunction with family and carers.
- Bladder drainage, pre, peri and post op.
- Fluid monitoring in critically ill patient.
- Fluid monitoring in acute oliguria.
- Acute, chronic retention.
- Difficulty emptying/controlling bladder e.g. MS, neurogenic bladder dysfunction, acute spinal injury.
- Outlet obstruction distal to bladder, e.g. stricture.
- Instillation of prescribed drugs.
- Investigations.
- Measurement of residual urine.
- Continuous irrigation for urinary tract haemorrhage.
- Urinary incontinence posing a risk to the patient, e.g. major skin breakdown or protection of nearby operative site.
- Palliative care for terminally ill.
- Aid the control of urinary incontinence where other methods have failed.
- When advised by continence or urology specialist nurses or Medical Urologist.

11. Appendix B: Catheter Care SOP

1. Introduction

Cleaning a urethral catheter and surrounding area should be considered as an integral part of personal care. It is important to remember that where possible, patients should be taught to attend to their own meatal and perineal care to limit the effect of cross infection and in line with Essence of Care (2004). Guidelines relating to Health and Safety (1974) and the Standard Infection Control Precautions Policy should be adhered to when performing this practice.

2. Purpose

This Standard Operating Procedure (SOP) has been written to

- Identify the procedure for assessment, delivery and frequency of urethral catheter care
- To promote optimal care

3. Equipment

- Soap and water
- Disposable wash cloth
- Clean towel
- Clinical waste and linen bags

4. Procedure

- Explain and discuss the procedure with the patient to gain consent and co-operation.
- Ensure that privacy and dignity is respected for the individual.
- Assist the patient into a comfortable position. Ideally the patient should be in a supine position (lying on their back) with knees and hips flexed and slightly apart.
- Wash and dry hands thoroughly or use alcohol gel as per Trust policy.
- Apply gloves and apron.

- Use a fresh wipe with soap and water to clean the area.
- Clean the vulval area for females downwards away from the meatus.
- In males, retract the foreskin before cleansing and replace afterwards.
- Clean the catheter away from the catheter meatal junction.
- Ensure the area is rinsed well.
- Pat the area dry with a clean towel.
- When the procedure has been completed ensure that the patient is left in a comfortable position.
- Dispose of any used equipment as per Trust policy.
- Document the delivered care in the patient's personal care records.

On-going/ continuing catheter care

Re-iterate advice at each intervention

- Ensure patient drinks at least 2 (preferably 3) litres of mixed fluids a day. Caffeine, artificial sweeteners, alcohol and fizzy drinks can be irritant to the bladder and possibly exacerbate spasm which can cause pain and bypassing. Concentrated urine can also cause this to happen.
- Ensure the connection between the catheter and the urinary drainage system is not broken except for good clinical reason.
- If a catheter valve is used it should be opened and emptied regularly (frequency documented in the care plan)
- Urinary drainage bags should be positioned below the level of the bladder but not in contact with the floor. A catheter bag stand should be used (available from bed/night bag manufacturers) for bed/night bags.
- A strap or adhesive fixation device should be used to anchor the catheter to the leg to prevent urethral and bladder neck trauma, the catheter should not be able to move up and down in the fixation device once it is applied.
- The bag should be secured in place with straps or a sleeve.
- If a drainage bag is used it should be emptied frequently enough to maintain urinary flow and prevent reflux. The patient, carer or nurse needs to check the volume of urine in it every 3-4 hours. Empty when approx. half full.
- When emptying the bag use a clean container each time, avoid contact between the urinary drainage tap and the container. In the patient's own home encourage the patient to empty the bag into the toilet or suitable container, avoiding contact between tap and receptacle.
- Each patient must have a care plan and a catheter passport designed to minimise the problems of blockage and encrustation. The tendency for catheter blockage should be documented (The life span of at least

3 catheters and findings on removal) and catheter changes should be planned prior to blockage.

- A link/extension drainage bag system should be used to facilitate overnight drainage to keep the original system intact.
- Overnight drainage bags should be single use disposable (see formulary)
- If patient is nursed in bed a bed/ night bag can be used in place of a leg bag this can be changed weekly to prevent frequent breaking of closed system.
- Change catheter bags or valves as infrequently as possible but in accordance with manufacturer's instructions and DOH guidelines (usually 5 to 7 days).

12. Appendix C: Resolving catheter related problems

Cramping pain

It is fairly common for some patients to experience abdominal cramps/bladder spasm when a catheter is first inserted. It is possible that the catheter can become dislodged causing pain. Persistent overactive detrusor muscle contractions can also cause pain and may respond to anticholinergic drugs. It is also possible that the tip of the catheter could be irritating the bladder wall. A catheter valve can solve this problem. Changing leg bag from right to left leg instead of leaving the same side all the time may also help.

Urethral discomfort

This may be caused by distension of the urethra by too large a catheter, or occlusion of the para-urethral glands. This may lead to infection, urethritis and an offensive discharge around the catheter. Ensure appropriate catheter selection, i.e. size, length and material. A smaller hydrogel coated latex catheter should relieve any discomfort.

Haematuria

Small amounts of blood are quite commonly found in the urine of catheterised patients as a result of trauma or infection. Severe bleeding, however, warrants an **urgent** medical opinion. Ensure catheter and tubing is well supported and not 'pulling'. Check medical history – carcinoma/bladder/prostate or stones.

Purple bag syndrome

Older patients who are immobile may develop purple urinary bag syndrome. This condition is harmless and is brought about by the bacterial decomposition of tryptophan, an essential amino acid, so do not be alarmed.

Catheter Leakage

Check whether catheter is blocked. See [Algorithms for dealing with catheter blockage and catheter leakage \(below\)](#).

If no catheter blockage check:

- The patient is not constipated.
- That the catheter is no bigger than a size FG14 and Balloon is size 10mls.
- That the tubing is not kinked or obstructed and full bladder causing leakage.
- If all of the above are eliminated, liaise with the Bladder & Bowel Care Service for further clinical advice, as it may be that the patient has underlying bladder overactivity.

Catheter Blocking

Short Term Action (Sudden Blockage)

- Check that the drainage bag is below the level of the bladder.
- Check to ensure catheter or tubing is not kinked or obstructed or cap is left on the bag.
- Check that catheter bag is not overfull.
- Check to ensure there is no faecal impaction.
- If the above actions do not relieve the obstruction, change the catheter.

Preventing Catheter Blocking

- Ensure good fluid intake (more than 2 litres /24 hours) for adults if able.
- For children, 6-7 drinks spread throughout the day. Approx. 150mls each aged 6yrs increasing to 250mls for teenagers.
- Advise adults that the drinking of cranberry juice (300mls a day) might be beneficial. This is contra-indicated in diabetes and for those patients taking warfarin medications.
- Suggest to licensed prescriber (could be non-medical prescribers) the commencement for adults of high dosage Vitamin C (Ascorbic Acid)* 1 gram three times a day.
- Plan the change of catheter before it blocks. It is reasonable in these cases to change catheters every 3-4 weeks if necessary. However, this could be as much as twice weekly, in these instances you must use short term PTFE Catheters.
- Catheter patency solutions are of doubtful value, should be used with extreme care and discontinued if not successful.
 - Catheter Patency Solutions should only be considered after monitoring the catheter history and accurate assessment and documentation as part of a care regime and not as a one-off measure.
 - Clinical Indications for Catheter Patency Solutions:
- Catheters are blocking more than once a month.
- Where sediment is visibly present in catheter tubing.
- Increased fluid intake has proved ineffective.

- Where frequent catheter changes are painful/traumatic to patient.
- Constipation, if present, has been resolved with no benefit to catheter problem.
 - See table for [catheter patency solutions \(next page\)](#)
- If on-going problems persist, contact the Bladder & Bowel Care Service, or urology nurse.
- Discuss 'repeated blockers' with the Bladder & Bowel Care Team, or urology nurse, as leakage/blockage may be due to other causes. Ask the patient to keep a diary of blocking.
- Consider use of a catheter valve for patients – (discuss with Bladder & Bowel Care Team).

Catheter patency solutions

Use a Suby G solution: UroTainer (Braun) or Optiflow (Bard).

Document frequency and type of catheter patency solutions plus batch number in catheter care records.

Solution	Indications for use	Recommended regime
Uro-Tainer	A Citric Acid (3.23%) solution used to prevent or dissolve crystallisation in the catheter.	Use no more than 3 times a week and leave a break of a day.
Suby G		
Twin	A double instillation in a single device which has 2 x 30mls twin chamber.	Work out individual regime using 20-30mls of solution depending on severity of case. Clamp and leave in for 5 minutes and document in patient's records.
Optiflow	A Citric Acid solution used to prevent crystallisation in the catheter.	Use no more than 3 times a week and leave a break of a day. A course should be for 6-8 weeks then evaluated before continuing. If no effect <u>either</u> consider frequent catheter changes <u>or</u> contact the Bladder & Bowel Care Service.

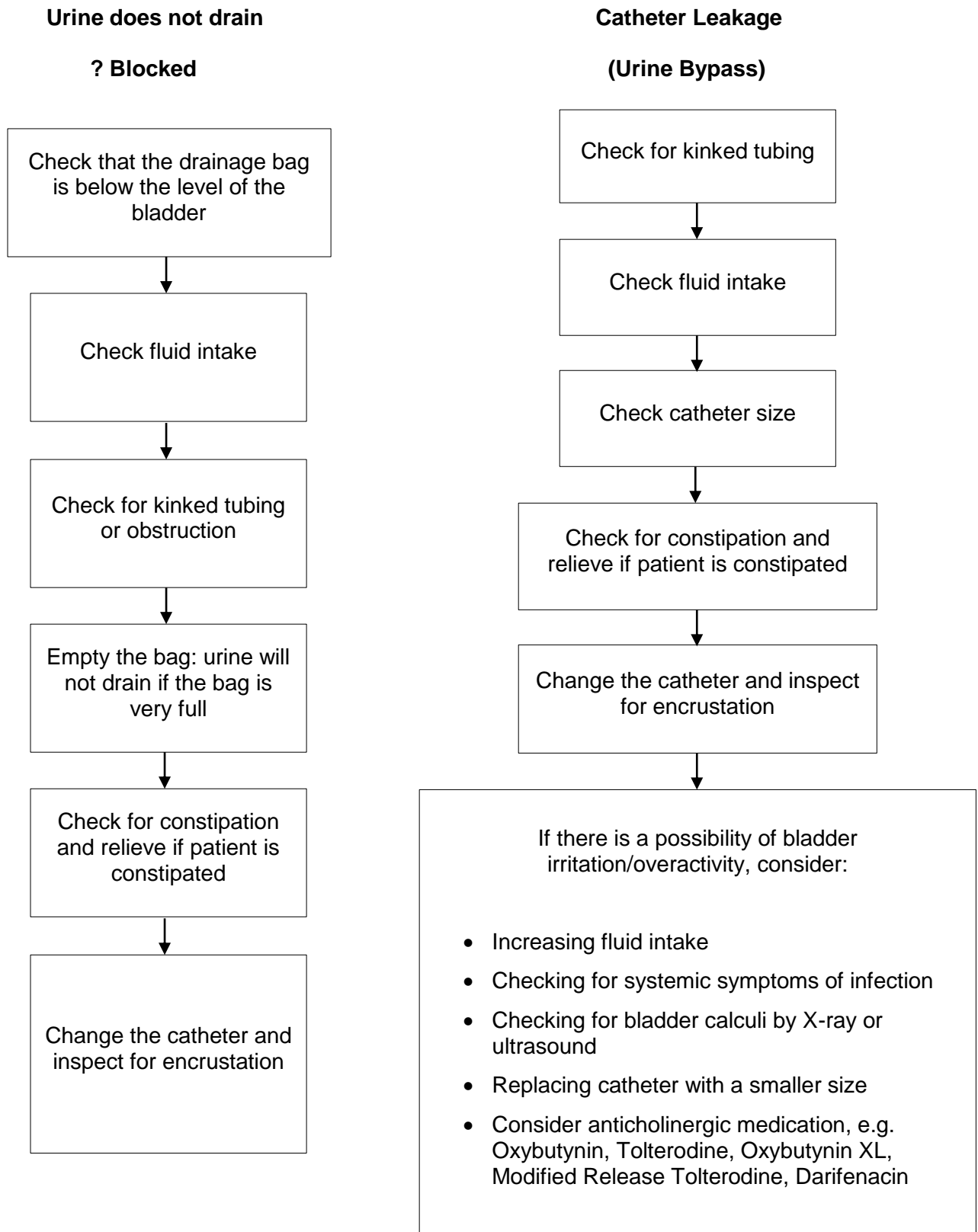
When instilling a catheter patency solution warm it to body temperature (37°) prior to instillation. Place the container in a jug of lukewarm water.

Syringes should not be used for bladder irrigation except when under in-patient urological care.

Do Not use saline (except if patient has had bladder augmentation or blood clots).

Do not use Mandelic Acid.

Do Not use Solution R except under specific circumstances and with the involvement of the Bladder & Bowel Care Services. Appendix D: Resolving catheter related problems algorithm.



13. Appendix D: SOP Changing established supra-pubic catheter

Note: If this is the first change since initial insertion it will need to take place in hospital.

Purpose

This Standard Operating Procedure has been written to:

- Identify the procedures for changing established supra-pubic catheter
- Minimise the risks associated with the performance of female urethral catheterisation by identifying evidence-based safe systems of work. Purpose
- Assess the need for continued catheterisation.

Scope

This procedure applies to the following staff groups who may be expected to perform supra-pubic catheterisation:

- Registered nurses
- Midwives
- Operating Department Practitioners
- Medical Staff

Staff undertaking this task must be able to demonstrate attendance at relevant in-house training or have received appropriate one-to-one work based teaching. This should be supported by continued competence as per the Trust's policy on assessing and maintaining competence. Staff should have achieved the competency. **“Changes, secures, monitors and responds to the effects of supra-pubic catheterisation**

Equipment

- Catheter tray (recommended option) OR
- 2 pairs sterile gloves
- Dressing/catheterisation pack
- Normal saline
- Lubricating gel (optional)

- Catheter of choice- standard or female length
- Sterile receiver
- Drainage bag
- Apron
- Sterile 10ml syringe
- Sterile water (10ml) and sterile 10ml syringe for balloon inflation.
- Catheter retaining device and straps.

Action

- a. Check and document that the patient has given informed consent to the procedure
- b. Position patient in a comfortable, semi-supine or supine position with legs extended, where possible and put on apron
- c. Wash/gel hands put on non-sterile gloves and empty the catheter bag or drain the bladder if patient usually uses a valve.
- d. Wash/gel hands and prepare sterile field.
- e. Put on a pair of sterile gloves, deflate the balloon of the existing catheter using a 10ml syringe allow the plunger to depress under gravity do not use pressure. Wait 3 minutes before removing catheter to allow the balloon to deflate. It may be necessary to rotate the catheter prior to removal.
- f. Note how much of the catheter is outside the abdominal wall and gently remove the catheter. A slight resistance may be felt as the deflated balloon passes into the supra-pubic tract.
- g. Clean the supra-pubic site with saline working in single wipes away from the site.
- h. Remove first pair of gloves. Decontaminate hands, apply new sterile gloves.
- i. Lubricate the sterile catheter with sterile lubricating gel (optional)
- j. Gently pass the new catheter into the existing tract until urine drains.
- k. Inflate the balloon only when urine has begun to drain using sterile water (10ml)

- l. Wait for urine to drain (keep supporting the catheter during this time as bladder contraction may partly expel the catheter). This may take up to 20mins.
- m. Ensure the catheter is secured using a catheter retaining device and ensure leg bag is well supported using straps or sleeve.
- n. Dispose of old catheter/ equipment as per infection control guidelines
- o. Remove PPE and decontaminate hands
- p. Ensure patient is comfortable.
- q. Record on the care plan and catheter passport:
 - If any problems with removal of old catheter
 - Any stone formation or blockage around the catheter tip
 - The type and size, batch, expiry date and lot number of the new catheter.
 - The amount of water inserted into the balloon
 - Any problems with the insertion of the new catheter
 - Retaining devices used
 - Organise and document the date of the next catheter change
 - Community patients: plan with patient for restocking of supplies.
 - Ensure patient/ carer are aware of how to care for their catheter/ this information and contact details for support should be provided in the catheter passport. Introduction

General points of practice

The catheter packs should contain the following sterile items:

- Receptacle
- Dressing towel
- Sterile field
- Gallipot
- Swabs

When choosing a catheter to be inserted, the smallest possible size should be selected. A second catheter is suggested in case the first insertion fails, consideration of catheter material must also be done upon selection.

The volume required to fill the balloon will be indicated on the catheter, generally this is 10mls and most catheters come with pre-filled syringes. If a pre-filled syringe is not available sterile water must be used.

In order to maintain a strict aseptic technique particularly when performing urethral cleansing and instilling lubricating gel, sterile gloves should be changed prior to insertion of the new catheter.

If 0.9% saline is not available to clean, then the use of tap water should be considered.

14. Appendix E: SOP for performance for Female Urethral Catheterisation

Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for performance of Female Urethral Catheterisation; this procedure replaces all existing guidance/superseded procedures.

Purpose

This Standard Operating Procedure has been written to:

Identify the procedures for the performance of female urethral catheterisation.
Minimise the risks associated with the performance of female urethral catheterisation by identifying evidence-based safe systems of work.

Scope

This procedure applies to the following staff groups who may be expected to perform female urethral catheterisation.

- Registered nurses
- Assistant Practitioners and Clinical Support Workers (Higher Level)
- Midwives
- Operating Department Practitioners
- Medical Staff

Staff undertaking this task must be able to demonstrate attendance at relevant in-house training or have received appropriate one-to-one work based teaching. This should be supported by continued competence as per the Trust's policy on assessing and maintaining competence. Staff should have achieved the competency **Changes, Secures, monitors and responds to the effects of urethral catheterisation.**

Location

Performance of female urethral catheterisation may be performed in all clinical settings where competent staff are available to perform the procedure.

Procedure for performance of female urethral catheterisation

- a. Assess the needs for urinary catheterisation/re-catheterisation and any risk factors.
- b. Wash and decontaminate hands in accordance with Trust policy
- c. Assemble all equipment including:
 - Clean trolley or appropriate surface
 - Catheter tray (preferred option) or
 - Sterile catheterisation or dressing pack
 - Two urinary catheters of the appropriate size and material
 - Sterile saline 0.9%
 - Lubricating gel
 - 10ml syringe x 2
 - Sterile water for injection 10ml
 - Appropriate catheter collection system and stand/securing device
 - 2 pairs of sterile gloves of the appropriate size
 - Waterproof bed protection
 - Alcohol gel or appropriate hand washing facilities
 - Good light source
- d. Explains the procedure to the patient, checking patient identity against individual's notes and gains informed consent and documents this appropriately.
- e. Position the patient appropriately, ensuring they are comfortable, respecting individuals privacy and dignity.
- f. Decontaminate hands
- g. Prepare equipment on the left or right side of the bed depending on the practitioner's dominant hand.
- h. Raise the bed if possible to a safe working height ensuring you have a good light source.
- i. Assist or ask the patient to adopt a supine position with knees flexed and thighs relaxed which externally rotates the hip joints. If the patient is unable to adopt this position, she can be assisted onto her side with the uppermost leg flexed at the hip and knee.
- j. Arrange any clothing or bedding to expose the genital area and place a disposable pad beneath the buttocks.
- k. Decontaminate Hands and put on an apron.
- l. Open catheter tray or catheter pack and put on 1 pair of sterile gloves. Open catheter, keeping it within its internal wrapping and place on the sterile field.
- m. Pour sachet of 0.9% saline into the gallipot.

- n. If not using catheter tray attach leg bag or valve to catheter maintaining sterility of connection and sterile field.
- o. If not using catheter tray and if there is a pre-filled syringe with the catheter ensure this is accessible on the sterile field. If a pre-filled syringe is not available, draw up the correct amount of sterile water into a syringe.
- p. Open the sterile lubricating gel onto the sterile field.
- q. Place sterile dressing towels onto the bed area between the patient's legs and over the patient's thighs.
- r. Using a gauze swab in the non-dominant hand, retract the labia minora and expose the urethral meatus, this hand is no longer sterile.
- s. Clean the perineal area with 0.9% saline using a new swab with each stroke, cleaning from front towards the anus.
- t. Insert the lubricating gel into and around the urethra,
- u. Decontaminate hands and apply new pair of sterile gloves.
- v. Place the receiver and catheter with tip exposed onto the sterile towel between the patient's legs.
- w. Holding the catheter so that the distal end remains in the receiver and gradually advancing it out of its wrapper, introducing the catheter into the urethra in an upward and backward direction for approximately 5-7cm or until urine flows out of the catheter end. Advance the catheter a further 5cm, do not force the catheter.
- x. Inflate the balloon with the correct amount of water.
- y. Dispose of all consumables as appropriate and according to local policy and hands.
- z. Assist the patient to get into a comfortable position.
- aa. Wash hands
- bb. Document procedure in catheter passport and care plan.

General points of practice

If not using Foley catheter tray

The catheter packs should contain the following sterile items:

- Receptacle
- Dressing towel
- Sterile field
- Gallipot
- Swabs

When choosing a catheter to be inserted, the smallest possible size should be selected. A second catheter is suggested in case first insertion fails, consideration of catheter material must also be assessed upon selection.

The volume required to fill the balloon will be indicated on the catheter, generally this is 10mls and most catheters come with pre-filled syringes, if a pre-filled syringe is not available sterile water must be used.

If a catheter is accidentally inserted into the vagina leave in situ to prevent this happening again, once successful catheterisation the catheter can be removed.

15. Appendix F: SOP for performance of Male Urethral Catheterisation

Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for performance of Male Urethral Catheterisation; this procedure replaces all existing guidance/superseded procedures.

Purpose

This Standard Operating Procedure has been written to:

Identify the procedures for the performance of male urethral catheterisation.
Minimise the risks associated with the performance of male urethral catheterisation by identifying evidence-based safe systems of work.

Scope

This procedure applies to the following staff groups who may be expected to perform male urethral catheterisation.

- Registered nurses
- Assistant Practitioners
- Operating Department Practitioners
- Medical Staff

Staff undertaking this task must be able to demonstrate attendance at relevant in-house training or have received appropriate one-to-one work based teaching. This should be supported by continued competence as per the Trust's policy on assessing and maintaining competence. Practitioners should have achieved the competency **Changes, secures, monitors and responds to the effects of urethral catheterisation.**

Location

Performance of male urethral catheterisation may be performed in all clinical settings where competent staff are available to perform the procedure.

Procedure for performance of Male urethral catheterisation

- a. Assess the needs for urinary catheterisation/re-catheterisation and any risk facts.
- b. Decontaminate hands in accordance with Trust policy
- c. Assemble all equipment including:
 - Clean trolley or appropriate surface
 - Catheter tray (Preferred option) or...
 - Sterile catheterisation or dressing pack
 - Two urinary catheters of the appropriate size and material
 - Sterile saline 0.9%
 - Single use sterile lubricating gel
 - Appropriate catheter collection system and stand/securing device
 - 10ml syringe x2
 - Sterile Water for injection 10ml
 - 2 Pairs sterile gloves of the appropriate size
 - Disposable waterproof absorbent pad
 - Alcohol gel or appropriate hand washing facilities
 - Good light source
- d. Explain the procedure to the patient, checking patient identity against individual's notes and gains informed consent and documents this appropriately.
- e. Decontaminate hands in accordance with Trust policy.
- f. Position the patient appropriately, ensuring they are comfortable, respecting individuals privacy and dignity.

- g. Prepare equipment on the left or right side of the bed depending on the practitioner's dominant hand.
- h. Raise the bed if possible to a safe working height ensuring you have a good light source.
- i. Arrange any clothing or bedding to expose the genital area and place a disposable pad beneath the buttocks.
- j. Decontaminate hands and put on an apron.
- k. Now open catheter tray or catheter pack and put on 1 pair of sterile gloves. Open catheter, keeping it within its internal wrapping and place on the sterile field.
- l. If not using catheter tray Pour sachet of 0.9% saline into the gallipot.
- m. If not using catheter tray attach bag or valve to catheter maintaining sterility of connection and field.
- n. If there is pre-filled syringes with the catheter ensure this is accessible on the sterile field. If a pre-filled syringe is not available, draw up the correct amount of sterile water into a syringe.
- o. Open the sterile lubricating gel onto the sterile field.
- p. Tear a hole in the sterile dressing towel; cover the patient's abdomen and thighs with the towel, with the penis protruding through the hole.
- q. Using a gauze swab in the non-dominant hand and using a piece of sterile gauze, grasp the shaft of the penis and retract the foreskin.
- r. Clean the glans penis with 0.9% saline using a new swab with each stroke.
- s. Insert the lubricating gel into and around the urethra.
- t. Remove sterile gloves, decontaminate hands and apply a new pair of sterile gloves.
- u. Place the receiver and catheter with tip exposed onto the sterile towel between the patient's legs.
- v. Hold the penis in the non-dominant hand upwards so to extend the peno-scrotal flexure whilst holding the catheter in dominant hand so that the distal end remains in the receiver and gradually advancing it out of its wrapper, introducing the catheter for approximately 15-25cm or until urine flows out, if resistance is met at the external sphincter extend the penis further towards the abdomen. Ask the patient to cough or strain gently as if passing urine.
- w. If resistance continues stop the procedure and seek medical help.
- x. Once urine is observed insert the catheter 5cm further and inflate the balloon with the correct amount of water.
- y. Assist the patient to get into a comfortable position, ensuring the foreskin is placed back over the glans penis. Remove gloves and wash hands in accordance with trust policy.
- z. Dispose of all consumables as appropriate and was hands, both in accordance with Trust policy.
- aa. Document procedure in catheter passport and care plan.

General points of practice

If not using a Foley catheter tray

The catheter packs should contain the following sterile items:

- Receptacle
- Dressing towel
- Sterile field
- Gallipot
- Swabs

When choosing a catheter to be inserted, the smallest possible size should be selected. A second catheter is suggested in case first insertion fails, consideration of catheter material must also be done upon selection.

The volume required to fill the balloon will be indicated on the catheter, generally this is 10mls and most catheters come with pre-filled syringes, if a pre-filled syringe is not available sterile water must be used.

To maintain a strict aseptic technique particularly when performing urethral cleansing and instilling water soluble gel two pairs of sterile gloves should be donned (one pair over the top of the first) the outer pair removed prior to insertion of catheter.

16. Appendix G: Procedure for Intermittent Catheterisation

Introduction

This document sets out Northern Devon Healthcare NHS Trust's Standard Operating Procedure for the performance of Male/Female Intermittent Catheterisation (IC) and Intermittent Self-Catheterisation (ISC).

IC is where registered practitioner performs catheterisation using a nelaton catheter to relieve a significant residual urine (see below).

ISC is where the patient will be taught by the registered practitioner to perform the procedure.

Purpose

This Standard Operating Procedure has been written to:

Reduce the unnecessary insertion of indwelling Foley catheters. To promote the safe practice for Intermittent Catheterisation and Intermittent Self-Catheterisation (male/female) by registered practitioners and medical staff.

With patient consent, IC is the preferred management option. The aim is to minimise the risks associated with the procedure using evidence based practice guidelines. For registered practitioners to be able to teach and support patients in the procedure of ISC.

Scope

This procedure applies to the following staff groups who may be carers of individuals requiring intermittent catheterisation.

- Registered nurses
- Assistant Practitioners
- Midwives
- Medical Staff

Staff undertaking IC and ISC must be able to demonstrate attendance at relevant in-house training or have received appropriate one-to-one work based teaching. This should be supported by continued competence as per the Trust's policy on assessing and maintaining competence.

Location

Performance of Intermittent IC and ISC may be performed in all clinical settings and in the community setting where competent staff are available to teach and assess the ability of the individual undertaking the procedure.

Procedure for performance of clean intermittent self- catheterisation (CISC)

For IC follow the NDHT Standard Operating procedure (SOP) for male/female urethral catheterisation.

To teach and support patients to perform CISC

- a. The individual must be fully assessed, understand why they have to undertake the procedure and what is involved. Consent must be obtained and recorded.
- b. Training should be provided at the patient's own pace and may take a number of sessions.
- c. Individuals should identify apposition comfortable for themselves to undertake CISC, for example sitting on the toilet, standing over the toilet, sitting on a chair or side of the bath, one leg slightly elevated on a stool, sitting in a wheelchair or lying on their side in bed. It is possible to use a urine collection bag attached to the catheter, speak to the Bladder and Bowel Nurse specialist for further advice on this.
- d. Patients should be instructed on hand hygiene, including cleaning their nails and not to touch anything other than the items needed until the procedure is complete.
- e. Individuals should prepare the catheter according to the manufacturer's instructions and should try to pass urine prior to the catheterisation if this is possible.
- f. Wash the genital area. Women should clean away from the urethra towards the anus. Advise them to part the labia with the index and middle finger of the non-dominant hand and identify the urethra. Some women like to use a mirror; others prefer to identify the urethra by touch. Men should retract the foreskin to clean the glans. Advise them to hold the penis with the non-dominant hand pointing in an upward direction towards the stomach, this helps to extend the urethra and makes it easier to insert the catheter.
- g. Gently insert the catheter into the bladder pointing the funnel end into the toilet or collection receptacle.
- h. If the individual finds it difficult to insert the catheter it may be helpful to cough or advise them to try to pass urine. Continue to insert the catheter until urine starts to flow.

- i. When urine stops flowing slowly remove the catheter, if urine starts to flow again wait and then gently begin to withdraw the catheter to catch any last drops. To avoid any dribbles or spillage place a finger over the funnel before finally removing the catheter.
- j. Dispose of the catheter according to manufacturer's/Trust's instructions.
- k. Provide individuals with information leaflets and monitoring charts. They should be advised on hygiene needs, fluid advice, signs of infection, the make and type of catheter they use and how to order further supplies.
- l. Patients who perform CISC need regular support and reviews, once established with performing the procedure reviews should be at least annually.

Discharge from hospital

Patients should be given a choice of using their own local pharmacy or dispensing appliance contractors (DAC) DACs provide home delivery service of products. The patient can be registered on to the DAC prior to discharge.

Patients need to be referred to the Bladder and bowel care service prior to discharge.

17. Appendix H: SOP for trial without catheter. (TWOC).

Introduction

This document sets out Northern Devon Healthcare NHS Trust's procedure for performing a TWOC; this procedure replaces all existing guidance/superseded procedures.

Purpose

This standard operating procedure has been written to:

Identify the most effective procedure for performing a TWOC

To minimise the risks associated with the performance of a TWOC and achieve best possible outcome by identifying evidence based safe systems of work.

Scope

This procedure applies to the following staff groups who may be expected to perform a TWOC

- Registered Nurses
- Clinical Support workers (Higher level)
- Assistant Practitioners
- Midwives
- Medical staff

Staff undertaking this procedure must be able to demonstrate attendance at relevant in house training or have received one to one work based teaching. This should be supported by continued competence as per the Trust's policy on assessing and maintaining competence. Staff should have achieved the NDHT competency **undertakes a trial without catheter and supports the patient during the process.**

Location

TWOC may be performed in all clinical settings where competent staffs are available to undertake the procedure, including the patient's own home or GP surgery.

Required skills of patient

It is vital that the patient is able to store urine in their bladder and have the potential to pass urine urethrally.

(Previous acute urinary retention does not exclude the patient from a TWOC)

If the TWOC is taking place in a community setting the patient will need to be able to communicate any discomfort or difficulties with passing urine, or be carefully monitored by a relative, carer or member of the community nursing team if unable to do so.

Procedure for performance of trial without catheter.

- a. Establish the individuals health needs and suitability for a TWOC
- b. Undertake a risk assessment and use the outcome to determine a suitable method for a trial without catheter, i.e. Setting, time, ability to monitor effects etc.

- c. Consider using a catheter valve for at least 1 week before the TWOC if the patient has had a long-term catheter in situ, to allow the bladder to retain its compliance.
- d. Obtain valid consent and confirm that sufficient information has been provided on which to base the decision to perform a TWOC.
- e. Ensure the environment is suitable and that comfort and dignity are maintained throughout the procedure.
- f. Apply Trust Standard Precautions for Infection Control and take appropriate health and safety measures.
- g. Remove the existing catheter and dispose of waste in accordance with local guidelines.
- h. Observe catheter on removal making note of any encrustation, bleeding etc.
- i. Provide the individual with charts to measure input and output and encourage the individual to drink 1.5 -2 litres of fluid spaced evenly throughout the day.
- j. Ensure the individual and/or carer understands the importance of reporting discomfort immediately, particularly if associated with problems passing urine:
 - 1. Instruct the individual not to drink more if this occurs.
 - 2. Explain that it is normal to experience mild discomfort the first few times they pass urine.
 - 3. Explain that the urine may be blood stained as a result of trauma following catheter removal.
 - 4. Ensure the individual and their carers are aware of who to contact if they experience difficulties outside of normal working hours.
- k. In hospital settings monitor individual's condition as part of regular care, in community setting visit patient 4 hours after TWOC.
- l. Review intake/output chart, intake should be roughly equal to output and voided volumes consistently higher than 100mls.
- m. Observe for signs of urinary retention, these can include
 - 1. A palpable bladder that is dull on percussion.
 - 2. Pain.
 - 3. A desire to void with an inability to pass enough urine to satisfy the desire.
 - 4. Poor urinary output.
- n. A post-void bladder scan should be performed
- o. Ask the individual to attempt to pass urine prior to the procedure and perform a bladder scan in accordance with the Trust Bladder Scanning policy. Document results and take action as necessary.

- p. Intermittent catheterisation should be performed to assess for residual urine if clinically indicated and no scanning equipment available.
- q. Clearly record any interventions, outcomes and complications in catheter passport and care plan.
- r. If the outcome of the TWOC is unclear at this stage a further visit to perform a further scan/IC may be required in a further 2 hours(approx.)

General points of practice

If a trial without catheter is unsuccessful consider options for future management such as, intermittent catheterisation or re-catheterisation. Consider individuals views, severity of incontinence or voiding success. Discuss with bladder and bowel practitioner if you suspect patient has a significant post void residual.

If a catheter is re-inserted a repeat TWOC is discussed and arranged with the patient.

References and Key Documents/ Professional Organisations

Association for Continence Advice (ACA) <https://www.aca.uk.com>

Department of Health (DOH) including good practice in consent, mental capacity act saving lives etc. <https://www.gov.uk/government/organisations/department-of-health>

Dougherty, L & Lister, S (2008) **Royal Marsden Hospital Manual of Clinical Nursing** 7th Edition, London.

International Continence Society (ICS) www.ics.org

Medicines and Healthcare Products Regulatory Agency
<https://www.gov.uk/.../medicines-and-healthcare-products-regulatory-agency>

National Institute for Clinical Effectiveness (NICE) including urinary incontinence, infection control, urinary tract infection etc. <https://www.nice.org.uk/>

Nicol, M et al, (2008) **Essential Nursing Skills** 3rd Edition Mosby, Edinburgh

Nursing and Midwifery Council (NMC) including record keeping, delegation and The Code: Professional standards of practice and behaviour for nurses and midwives.
<https://www.nmc.org.uk>

Royal College of Nursing Catheter care Guidance for Nurses (2012)
<https://www.rcn.org.uk/professional-development/publications/pub-003237>

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