## Minimum Data Set For Approval Process

<table>
<thead>
<tr>
<th>Title</th>
<th>Guideline for urethral catheterisation and care of the catheterised patient</th>
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<tbody>
<tr>
<td>Author/s</td>
<td>Continence Matron</td>
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<tr>
<td>Responsible officer</td>
<td>Continence Matron</td>
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<tr>
<td>Purpose</td>
<td>To provide guidance on urinary catheterisation using aseptic technique</td>
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<tr>
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<td>Page 21</td>
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<tr>
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<td>For information to</td>
<td>Directorate Managers, Matrons, Clinical Directors, Professional development nurses</td>
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<td>Competency assessment using device by formal training and clinical supervision</td>
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<td>Financial consequences</td>
<td>N/A</td>
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<td>Urethral catheterisation and care of patient, version 02</td>
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<td>Equality impact assessment</td>
<td>May 2009</td>
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1. Introduction

The urinary tract is the most common site of a hospital acquired infection, the majority of which follow instrumentation of the urinary tract particularly catheterisation. Serious damage to the urethra with stricture formation may result from the use of inappropriate size of catheter, trauma resulting from excessive force, unskilled technique used at the time of the catheter insertion or from an inflammatory reaction to the catheter material. The first step in reducing catheter-associated urinary tract infections is to avoid unnecessary catheterisation; the second is to remove the catheter as soon as possible (Niël-Weise 2005). Once a catheter is in place, the aim is to minimise the risk of infection.

2. Indication for Urethral Catheterisation

1. To relieve acute or chronic urine retention
2. Pre/post operative bladder drainage where an empty bladder is required
3. Bladder drainage in a paralysed patient when there is no suitable alternative
4. When an accurate urine measurement or fluid input and output measurement is required
5. When there is excessive skin excoriation/wounds/grafts sites and incontinence aids have failed
6. To promote comfort in rare cases such as palliative care
7. Diagnostic purpose e.g. to instill contrast media for x-ray procedures
8. Single dose drug instillations
9. To empty an atonic bladder

Prior to catheterisation the nurse should speak with the doctor. The doctor must write in the medical notes that catheterisation can go ahead and justify why this procedure is necessary. Where possible the patient should be informed of the procedure, including risks, benefits and alternatives and give their consent.

3. Risks Associated with Urethral Catheterisation

Each act of catheterisation imposes serious risk to the patient; this risk is increased the longer the catheter is in the bladder.

When catheterising a patient if you are unsuccessful after two attempts do not proceed any further and contact a nurse experienced in urology/catheterisation or member of the medical team.

Infection
Infection may be local or bacteraemia may develop (bacteremia occurs when bacteria enter the bloodstream). Urinary tract infection is the most prevalent hospital acquired infection (HAI). 19.7% of all HAI relate to urinary tract infections and may be life threatening (Smyth cited in DH 2007). Most are caused by Gram negative bacilli commonly found in the human gut and contaminating the perineum and genitalia.

The risk of infection increases proportionately to the length of time a catheter is left in, therefore, it should be removed as soon as possible.

Catheterisation must be performed aseptically and every care taken to prevent the introduction of micro-organisms at the time of catheterisation and later via the catheter itself.

**Trauma**

It is possible to traumatisé the delicate urethral mucous by using a catheter which is the wrong size, wrong material, or by unskilled insertion (this risk is increased by the presence of urethral stricture). Urethral strictures may result from the trauma.

**Urethritis (Pain)**

Bladder spasm, pain and discomfort may develop as a result of infection or irritation by the catheter.

**Autonomic Dysreflexia**

This condition is unique to a spinal injured patient. Autonomic dysreflexia is a vascular reflex which occurs in response to a stimulus from the bladder, bowel or other internal organ below the level of the lesion in a patient with a spinal injury above T6. True autonomic dysreflexia is potentially life threatening and is considered a medical emergency.

**Possible causes are**: distended bladder (the most common cause is a blocked catheter), distended bowel (usually caused by constipation), ingrowing toe nail, pressure ulcer, urinary tract infection, bladder spasm, renal calculi, bladder calculi, visceral pain or trauma, pregnancy or delivery, deep vein thrombosis, pulmonary embolism, severe anxiety or emotional distress.

**The symptoms are**: pounding headache caused by acute hypertension, bradycardia, sweating above the level of injury, goose bumps, blotching of the skin, or nasal congestion.

**Treatment**: raise the patients’ head, feel for a distended bladder- the bladder can be very gently tapped but do not express the bladder and do not perform bladder washouts as these techniques will only increase pressure, change the catheter immediately, check blood pressure if still significantly increased over any known normal
blood pressure for the patient, the practitioner must seek urgent medical advice for continued treatment.

**Procedures such as clot evacuation, bladder washouts and irrigation are specialist procedures. Contact the Urology Department for further advice.**

4. **Performed by**

A registered nurse, senior health care assistant, doctor, midwife, operating theatre practitioner or assistant practitioner new to the skill of catheterising or who needs updating (i.e. 'return to nursing') should undertake training, complete the individual learning contract (See Appendix A), catheter competency framework (See Appendix B) and the relevant Knowledge, Skills and Framework (See Appendix C). They will then be deemed competent and may undertake urethral catheterisation.

Staff in training such as student nurses/midwives, medical students and assistant practitioners may perform the procedure (male or female) under supervision of a competent medical staff, registered nurse/midwife or operating theatre practitioner.

Senior health care assistants can be deemed competent to undertake routine/planned changes for **FEMALE** urethral catheterisation only by a registered practitioner after undertaking a period of documented supervised practice (completion of individual learning contract and competency framework) and demonstrating the necessary knowledge and skills for safe practice. Every effort will be taken to meet the specific requirements of the patient in relation to the gender of the member of staff who assists them.

Registered practitioners are responsible for updating their practice to maintain competency (NMC 2008).

5. **Selection of catheter**

Catheters are available in a wide range of sizes, materials and type each with a specific purpose. It is essential to select a sterile catheter of the appropriate size, type and material at the outset.

Catheters should be of the smallest charriere (CH) size suitable for the purpose required. Catheters, drainage bags and catheter valves have a shelf life of five years, pre-inflated catheters three years: they must be discarded if out of sterilisation date. The packaging of sterile items must be checked to ensure it is intact and discarded if damaged.

**Non Retention (without a retaining balloon)**
Use only if the catheter is not to remain in situ after the bladder has been drained for diagnostic purposes on intermittent catheterisation. Single use only, this catheter may be hydrophilic or plastic Nelaton. Catheters should be of the smallest charriere (CH) size suitable for the purpose required e.g. 10Ch for female and 12CH for male.

Female length intermittent catheters continue to be used throughout the Trust as they have no balloon insitu therefore do not pose a risk.

Intermittent bladder drainage allows the bladder to expand to store urine and contract to empty, thus maintaining the muscular effect, stimulate blood supply and maintain normal bladder health.

If the patient has a residual urine status it is imperative that the importance of cause is not overlooked and that the patient has further investigations or onward referral to reach a formal diagnosis.

**Indwelling or Self Retaining Catheter (Foley balloon catheter)**

Use if the catheter is to remain in situ for any length of time. It incorporates a retention mechanism and should be the smallest size capable of providing adequate drainage e.g. for clear urine 12CH standard (female patient) and 14CH standard (male patient) should be used.

**Male standard length** is now used for male and female patients throughout this Trust. Due to the National Patient Safety Agency alert (090430/30 April 2009) female length catheters have been withdrawn from this Trust with the exception of A1 Urology Suite and Maternity Unit.

Foley catheters are used for continuous drainage and have an inflatable balloon near to its tip. Balloon catheters are filled with sterile water from a syringe inserted in a luer valve at the distal end of the catheter or may be pre-filled with sterile water thus eliminating the need for needle and syringe. Only the correct amount of water should be used as under inflation will cause the balloon to distend asymmetrically and cause irritation to the bladder wall, or the balloon may be over inflated and rupture. Balloon sizes over 10ml should not be routinely used. Foley catheters are only licensed to have the balloon inflated once, therefore, NEVER, re-inflate the balloon.

If debris or blood clots are anticipated an 18-22CH 3 way standard catheter may be necessary. A ‘three way’ Foley catheter is available which has an additional third channel through which fluid can be administered for bladder irrigation.

**NB:** If bladders are allowed to remain on long term continual/free drainage, bladder function can be lost and may not return if a trial without catheter is considered in the future.

**Material of Catheter**
The material of which catheters are made influences the amount of irritation and inflammation caused to the urethra. Selection of material therefore, is determined by the length of time the catheter is to remain in situ.

**Single use** should be hydrophilic or PVC with lubrication. **Short or medium term use** up to four weeks should be **PTFE or silicone coated** and may have 10ml pre-filled balloon. Short term catheters are recommended by the Department of Health for hospital settings.

**Long term catheterisation** up to three months should be **all silicone or Hydrogel (BIOCATH)** and may have 10ml pre-filled balloon.

**Catheter Valve**

A catheter valve is a tap like device which fits directly into the end of an indwelling Foley catheter. The valve is an alternative to a catheter drainage bag. The bladder continues to store urine and is emptied intermittently by releasing the valve and draining the urine. The valve therefore helps to maintain normal function of the bladder.

Catheter valves must only be given to alert and orientated patients who understand the importance of releasing the valve intermittently (at least every three to four hours during the day) and to patients who have good manual dexterity to operate the valve. Do not use a catheter valve with a cognitive impaired patient. The valve should be changed 5 – 7 days or as stated in the manufacturers’ guidelines. Catheter bags can be attached at night to a catheter valve to aid a patients’ sleep.

**6. Anaesthetic lubricant**

Current guidelines from the British Association of Urological Nurses (BAUN), the European Association of Urological Nurses (EAUN) and NHS Quality Improvement Scotland, advocate the use of a single use anaesthetic lubricant gel. The National Institute for Health and Clinical Excellence (NICE) advise an appropriate lubricant from a single use container. Instillagel® is an anaesthetic gel for surface anaesthesia. It contains 2% lidocaine hydrochloride and chlorhexadine gluconate solution 0.25%. The gel anesthetises, has antiseptic properties and dilates the urethra thus reducing the risk of trauma and infection.

**Indications for Use**

This is a prescription only drug. Lidocaine gel with chlorhexadine (Instillagel®) is clinically indicated for catheterisation, cystoscopy, exploratory and intra-operative investigation, exchange of fistula catheters (supra-pubic), protection against iatrogenic damage in the rectum and colon and for use during gynaecological investigation.

**Exclusion criteria**
• Patients known to be allergic to lidocaine or other local anaesthetics, hydroxybenzoates or chlorhexadine
• Patients with complete heart block
• Patients with injury to the urethra or bladder mucosa.

Cautions for use

• patients with liver or renal impairment
• patients with epilepsy
• patients with respiratory impairment
• patients with acute porphyria

Adverse reactions

Convulsions, unconsciousness, respiratory depression, cardiac arrest have been associated with lidocaine when there is severe injury to the mucosa and absorption may occur.

If an adverse reaction occurs:

• Inform the medical staff straight away
• Complete a clinical incident form as per trust policy
• If the reaction is serious a yellow card should be completed as detailed in the British National Formulary (BNF). Electronic yellow cards can be completed at www.yellowcard.gov.uk.

An alternative to lidocaine gel is plain sterile lubricant gel.

7. Documentation

To maintain an accurate record of catheterisation and to ensure care plans are up to date, document details of catheterisation including

- The reason for catheterisation
- Verbal consent obtained from patient
- Evidence that the patient understands the decision to catheterise
- Date and time of catheterisation
- Type, size of catheter and lot number
- Method undertaken (Aseptic non-touch technique)
- The type of lubricating gel used (Instilagel or plain sterile)
- The volume of water used to inflate the retaining balloon
- Any problems with insertion i.e. trauma, bleeding or resistance
- Colour of urine drained and volume
- Plan for removal of catheter
- Signature of nurse who undertook catheterisation and same name printed
During all forms of communication alternative formats are available on request for use throughout any of the procedures (e.g. translation services, sign language services or induction loop). Special consideration will be taken when dealing with patients with learning disabilities or other disabilities which affect their understanding of the procedure.

8. Procedure for urethral catheterisation

Equipment

- Dressing trolley (aseptically cleaned)
- Catheterisation pack/dressing pack
- 0.9% sodium chloride
- Sterile gloves
- Clean plastic apron
- Catheter of choice, appropriate length and size
- Sterile urinary drainage bag or catheter valve
- 10ml sterile syringe unless a large balloon is indicated
- 10ml sterile water*
- Prescribed anaesthetic lubricant i.e. Instillagel (11ml male or 6ml female)
- Stabilisation strap
- Leg straps or sleeve
- *not required if pre-filled catheters are used.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Explain the procedure, including risks, benefits and alternatives to the patient. Document valid consent has been given.</td>
<td>Reduce patients stress and anxiety, consequently reducing the risk of trauma. Consent of patient to undertake procedure. To ensure patient has fully understood the procedure via the appropriate communication method.</td>
</tr>
<tr>
<td>2. Ask the patient to shower if possible pre-procedure. If not possible wash the area with soap and water and dry thoroughly.</td>
<td>To reduce bacterial contamination of the perineum.</td>
</tr>
<tr>
<td>3. If possible, perform procedure in a treatment room, if not screen bed to maintain privacy.</td>
<td>Ensuring privacy. Reduce infection risks.</td>
</tr>
<tr>
<td>4. Decontaminate hands using soap and water or use alcohol gel if visibly clean.</td>
<td>Reduce the risk of cross infection and achieve decontaminated hands.</td>
</tr>
<tr>
<td>Step</td>
<td>Action</td>
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<tr>
<td>5.</td>
<td>Prepare trolley aseptically as per policy and take to patient. Check all packaging for expiry date and damage before opening. Following the aseptic non-touch technique (ANTT) open the outer wrapping of the dressing/catheterisation pack placing it on the trolley top. Empty the Instillagel out of the outer packaging onto the sterile field.</td>
</tr>
<tr>
<td>6.</td>
<td>Decontaminate hands using soap and water or use alcohol gel if visibly clean.</td>
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<tr>
<td><strong>Female catheterisation</strong></td>
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<td>12.</td>
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</table>
NB. Should the catheter tip accidentally touch the labia before insertion, or be passed into the vagina, the catheter MUST be discarded. It is for this reason, adequate lighting must be used.

**Continue steps 18-21**

### Male catheterisation

<table>
<thead>
<tr>
<th>Step</th>
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<tbody>
<tr>
<td>14.</td>
<td>Don a pair of sterile gloves, retract the foreskin (if present) cleans the glans and external meatus, the shaft of the penis and the scrotum with 0.9% sodium chloride.</td>
</tr>
<tr>
<td>15.</td>
<td>Remove gloves and decontaminate hands with alcohol gel.</td>
</tr>
<tr>
<td>16.</td>
<td>Put on fresh pair of sterile gloves and arrange the sterile field around the scrotum leaving the penis exposed. Holding the shaft of the penis with sterile gauze. Select the 11 ml Instillagel syringe and before removing the blue cap from the end of the syringe, free the plunger by gently pressing it. Remove the blue cap and apply a small amount of gel around the urethral opening. Insert the nozzle into the urethra and administer the gel slowly and evenly into the urethra. <strong>N.B.</strong> Full effect from the anaesthetic is achieved approximately 5 minutes after insertion.</td>
</tr>
<tr>
<td>17.</td>
<td>Open the catheter and connect to drainage bag. Holding the penile shaft (using a sterile gauze swab) erect and slightly forward introduce the catheter into the urethra until urine begins to flow. Inflate balloon with the recommended amount of sterile water. Replace the foreskin.</td>
</tr>
<tr>
<td>18.</td>
<td>Secure drainage tubing to inner aspect of patient’s thigh with catheter stabilization strap and attach leg bag (with straps or sleeve) or attach catheter valve.</td>
</tr>
</tbody>
</table>
20. Clear equipment away. Measure urine and discard. Record amount and time of catheterisation on fluid balance chart and care plan after decontaminating hands. Record catheterisation as stated in point 6 in the main body of the policy. 

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<td>1. The patient must be fully assessed, understand why they have to undertake the procedure and what is involved. Obtain verbal consent and record in notes.</td>
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<td>2. If possible, perform procedure in a treatment room, if not screen bed to maintain privacy.</td>
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<td>3. Ask the patient to pass urine prior to catheterisation if at all possible.</td>
<td>To empty the bladder as much as possible ensuring only residual urine is in the bladder.</td>
</tr>
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<td>4. Patients should identify a position comfortable for them to undertake ISC (e.g. 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 on the bed).</td>
<td>To ensure the patient is comfortable when undertaking the procedure.</td>
</tr>
<tr>
<td>5. Instruct the patient on importance of hand hygiene (including nails) and not to touch anything other than items needed until the procedure is complete.</td>
<td>To reduce the risk of infection. When teaching ISC it is acceptable for the patient to use a clean technique.</td>
</tr>
</tbody>
</table>

21. If patient alert and orientated discuss catheter care and allow patient to empty own catheter bag/valve. 

To promote patients dignity and reduce risks of infection.

9. Procedure for teaching intermittent self-catheterisation (ISC)

When a patient is undertaking this procedure a clean technique should be used throughout.

**Equipment**

- Catheter of choice
- Mirror if required
- Collection receptacle if required
- Soap and wipes

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</table>
6. Ask the patient to prepare the catheter according to the manufacturer’s instructions.  
   To ensure the catheter is used correctly and safely.

7. Ask the patient to wash the genital area using soap and water and clean wipes.  
   Women – wash 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. Offer a mirror.  
   Men – 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.  
   To reduce bacterial contamination of the perineum.  
   To aid observation.  
   This extends the urethra and makes it easier to insert the catheter.

8. Ask the patient to gently insert the catheter into the urethra pointing the funnel end into the toilet or collection receptacle. If the patient finds it difficult inserting the catheter, ask them to cough or to try to pass urine. Ensure they continue to insert the catheter until urine starts to flow.  
   To drain the residual urine from the bladder.  
   Reduce patients stress and anxiety, consequently reducing the risk of trauma.

9. When urine stops flowing, ask the patient to slowly remove the catheter. If urine starts to flow again, wait and then ask the patient to gently begin to withdraw the catheter to catch any last drops.  
   To ensure all the residual urine is drained from the bladder.

10. Ask the patient to place a finger over the funnel end of the catheter before finally removing from the urethra.  
   To avoid any spillages or dribbles.

11. Observe the patient post ISC if this is the first time catheterising.  
    Decompression of the bladder may cause bleeding and/or shock.

12. Ask the patient to dispose the catheter according to manufacturer’s instructions (single use catheters should be placed back in their sleeve and discarded in general waste). Do not flush down toilet.  
    To reduce infection and avoid any blockages.

13. Offer hand washing facilities.  
    To reduce infection.

14. Provide the patient with information leaflets and monitoring charts (including hygiene needs, fluid advice, signs of infection, the make and type of catheter they use and how to order further supplies).  
    To ensure the patient fully understands the procedure and when to undertake ISC.

15. Document procedure in notes recording type of catheter, size and batch  
    Documentation of procedure.
15. Several sessions are required to teach ISC – arrange next appointment or refer to community continence advisors for follow up.  

To support learning, problem solving, review experiential learning and related habits.

### 10. Procedure for health care professionals to undertake intermittent catheterization

Intermittent catheterisation has a reduced infection rate when compared to indwelling catheters although there is still a risk (Patel et al 2001). When undertaking this procedure on a patient aseptic non touch technique (ANTT) should be used throughout.

#### Equipment

- Dressing trolley (aseptically cleaned)
- Catheter of choice
- Sterile gloves
- Clean disposable apron
- 2 litre non drainable bag
- Dressing pack
- 0.9% sodium chloride

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</tr>
<tr>
<td>2. Ensure bladder scan undertaken prior to procedure. If less than 300 mls in the bladder discontinue procedure.</td>
<td>To have evidence a residual of urine is present.</td>
</tr>
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<td>3. If possible, perform procedure in a treatment room, if not screen bed to maintain privacy.</td>
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<td>4. Decontaminate hands using soap and water or use alcohol gel if visibly clean.</td>
<td>Reduce the risk of cross infection and achieve decontaminated hands.</td>
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5. Prepare trolley aseptically as per policy and take to patient. Check all packaging for expiry date and damage before opening. Following the aseptic non-touch technique (ANTT) open the sterile dressing pack and outer packaging of the catheter pack and prepare the sterile field.
To reduce contamination risk and cross infection. To maintain asepsis and check that equipment is not damaged.

### Female catheterisation

6. Don a pair of sterile gloves and clean the genitalia with 0.9% sodium chloride using a separate swab for each stroke, in a downward direction from the pubis to the perineum. Cleaning the outer and inner aspects of the labia majora and minor. The final stroke being downwards over the urethral orifice.
To remove micro-organisms

7. Position patient comfortably and safely with heels together, knees flexed and wide apart.
Ensure patient safety and comfort. To allow good visual access to the area.

8. Position bed linen.
To maintain privacy and dignity.

9. Remove gloves and decontaminate hands with alcohol gel.
Reduce the risk of cross infection.

10. Put on fresh pair of sterile gloves and arrange the sterile field.
To provide a clean working area, preventing contamination of the catheter.

11. Connect the catheter to the drainage bag. Insert catheter following ANTT into the urethra and continue gentle insertion until urine begins to flow.
To prevent introduction of bacteria into the bladder.

**NB.** Should the catheter tip accidentally touch the labia before insertion, or be passed into the vagina, the catheter MUST be discarded. It is for this reason, adequate lighting must be used.

**Continue steps 16-18**

### Male catheterisation

12. Don a pair of sterile gloves, retract the foreskin (if present) cleans the glans and external meatus, the shaft of the penis and the scrotum with 0.9% sodium chloride.
To remove micro-organisms

13. Remove gloves and decontaminate hands with alcohol gel.
Reduce the risk of cross infection.

14. Put on fresh pair of sterile gloves and arrange the sterile field around the...
15. Open the catheter and connect to drainage bag. Holding the penile shaft (using a sterile gauze swab) erect and slightly forward introduce the catheter following the ANTT into the urethra until urine flows.  
To prevent introduction of bacteria  
To prevent paraphimosis occurring.

16. When urine stops flowing slowly remove the catheter (for male patients replace the foreskin). If urine starts to flow again, wait and allow urine to flow then gently begin to withdraw the catheter to catch any last drops.  
To ensure all the residual urine is drained from the bladder.

17. Ensure patient clean, dry and comfortable. Replace bed linen.  
Maintain patient comfort.

18. Clear equipment away. Measure urine and discard. Record amount and time of catheterisation on fluid balance chart and care plan after decontaminating hands. Record the batch number of catheter used, size of catheter, date and time of procedure and nurse’s name in the patient’s notes.  
To prevent infection.  
Documentation of procedure.  
Measurement and recording of the amount of urine in the bladder on catheterisation is essential in order to assess bladder function and fluid balance.

11. Guidelines for the catheterised patient

General advice

1• Encourage fluid intake 2-3 litres a day (unless there are medical contraindications) to dilute the urine and reduce debris.  
1• Avoid constipation, encourage high fibre diet which helps to reduce the risk of the catheter bypassing.  
1• Shower daily, or if not possible thoroughly wash and dry the genital area twice daily. Showers are preferable to taking a bath with an indwelling catheter. If bathing is unavoidable the drainage bag should not be disconnected, a catheter valve can be attached.  
2• Instruct the patient to inform nursing staff if they experience any pain, burning, discomfort or leakage of urine.

Care of urinary drainage system
1. If the patient is mobile ensure a leg bag is used and that there are no kinks in the tubing.
   - For the mobile patient at night attach a 2 litre non-drainable bag to the leg bag (ensuring tap left open on the leg bag) and secure safely to a stand checking there are no kinks in the tubing. The drainage tap must never touch the floor.
2. If the patient is nursed in bed ensure a 2 litre drainable bag is used or an urometer if strict fluid balance is required, secure safely to a stand and that there are no kinks in the tubing. The drainage tap must never touch the floor.
   - The catheter should always remain connected to a sterile closed drainage system and not disconnected, regardless of the planned duration of the catheterisation. This is one of the main factors in reducing infection and should be observed at all times.
1. Ensure there is no tension on the catheter thus exposing a section that has been inside the sterile urethra. When the catheter is released this now contaminated section will re-enter the urethra thus introducing micro-organisms, presenting a serious infection risk.
1. Catheter straps or sleeves should be used and should be alternated between the left and right leg on alternate days to avoid pressure and flaying of the urethra.
1. The level of the bag should never be raised above the level of the bladder (unless a catheter belly bag is worn) so that reflux of urine into the bladder is prevented and gravitational flow is maintained.
1. The drainage bag and valve should be changed according to manufacturer’s instructions.

Emptying the urine drainage bag

1. Empty urine bag when ¾ full to maintain urine flow and prevent reflux or as directed by medical/nursing staff if urine monitoring in progress. Unnecessary emptying should be avoided as this breaks the closed circuit thus increasing the risk of infection.
1. When emptying the bag, great care should be taken to avoid contamination of the nozzle or tap. AT NO TIME should it come into contact with the floor or other objects. Gloves must always be worn to avoid contamination of the hands with urine.

12. Procedure to empty a drainage system

Equipment

- non-sterile vinyl gloves
- alcohol swab
- urinal or bedpan

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<tr>
<th>ACTION</th>
<th>RATIONALE</th>
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</table>

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1. Decontaminate hands using soap and water or alcohol gel if visibly clean. To prevent cross infection.

2. Wearing non-sterile vinyl gloves empty the drainage bag into a disposable urinal or bedpan, (after observing amount of urine in the drainage bag). Use a separate container for each patient. To prevent cross infection.

3. Close the tap or nozzle. Wipe with alcohol swab. To prevent drips of urine contaminating the floor.

4. Dispose of urinal and urine directly into macerator. To prevent risk of cross infection.

5. Remove and dispose of gloves. Decontaminate hands using soap and water or use alcohol gel if visibly clean. Reduce the risks of cross infection and achieve decontaminated hands.

6. Record urine measurement on patients chart. To maintain fluid balance assessment.

**Leg drainage bags**

7. If a leg drainage bag is worn then a night drainage bag must be attached to the leg bag outlet at night times. To maintain a ‘closed system’ reducing infection risks.

**NB**: Leg bags should be changed every 7 days or as directed by the manufacturer.

### 13. Procedure to remove night drainage bag

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
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</thead>
<tbody>
<tr>
<td>1. Decontaminate hands using soap and water or alcohol gel if visibly clean.</td>
<td>To prevent cross infection.</td>
</tr>
<tr>
<td>2. Wearing non-sterile vinyl gloves close the tap on the leg bag and disconnect the night bag.</td>
<td>To prevent bacterial contamination of the nurses hands and spillage of urine.</td>
</tr>
<tr>
<td>3. Empty bag into toilet or sluice</td>
<td>Proper disposal of human excreta.</td>
</tr>
</tbody>
</table>
4. Discard empty bag into appropriate clinical waste disposal bag.
   Proper disposal of clinical waste.

5. Remove and dispose of gloves. Decontaminate hands using soap and water or use alcohol gel if visibly clean.
   To reduce cross infection.

6. Empty bag in suitable receptacle and if required to record measurement of urine on patients chart.
   To maintain fluid balance assessment.

14. Procedure to change a catheter valve

**Equipment**

- sterile catheter valve
- sterile vinyl gloves
- alcohol swab

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<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
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<tbody>
<tr>
<td>1. Ask patient to empty their bladder prior to commencing procedure.</td>
<td>To reduce infections and reduce dribbles or spillage.</td>
</tr>
<tr>
<td>2. Decontaminate hands using soap and water or alcohol gel if visibly clean.</td>
<td>To prevent cross infection.</td>
</tr>
<tr>
<td>3. Open the packaging of the catheter valve taking care not to touch the valve.</td>
<td>To reduce time and reduce cross infection</td>
</tr>
<tr>
<td>4. Wearing sterile vinyl gloves ensure catheter valve is closed, squeeze the catheter (just above the catheter valve) and disconnect the valve and dispose of as per hospital policy.</td>
<td>To ensure no urine flows.</td>
</tr>
<tr>
<td>5. Clean the end of the catheter using the isopropyl alcohol swab.</td>
<td>To reduce infection.</td>
</tr>
<tr>
<td>6. Connect new sterile catheter valve to catheter ensuring tap is closed.</td>
<td>To reduce infection.</td>
</tr>
<tr>
<td>7. Decontaminate hands using soap and water or alcohol gel if visibly clean.</td>
<td>To prevent cross infection.</td>
</tr>
<tr>
<td>8. Document in patients notes procedure undertaken.</td>
<td>To have a record of when the valve was changed.</td>
</tr>
</tbody>
</table>
15. Obtaining a sterile catheter specimen of urine (CSU)

It is important that catheter specimens of urine are taken in an aseptic manner to ensure that contamination of the urine does not occur. Specimens of urine must be taken only from the sampling port of the urine drainage system.

NEVER send urine from a urine drainage bag.
NEVER disconnect the catheter from the drainage bag in order to obtain a specimen of urine.

Equipment
Clean tray containing:-
1• 1 pair non-sterile vinyl gloves
2• 1 sterile urine sample container
3• 1 alcohol swab
4• Accurately labelled culture bottle and bacteriology request card

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<th>ACTION</th>
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<tr>
<td>2. Decontaminate hands using soap and water or use alcohol gel if visibly clean.</td>
<td>To reduce cross infection.</td>
</tr>
<tr>
<td>3. Wearing gloves directly cleanse the self sealing sleeve on the drainage tube thoroughly, using the isopropyl alcohol swab.</td>
<td>To reduce infection risks by indirect contamination.</td>
</tr>
<tr>
<td>4. Using the urine sample container puncture the sample port and twist to the right. Aspirate a sample of urine.</td>
<td>To prevent bacterial contamination of urine.</td>
</tr>
<tr>
<td>5. Label the urine sample with the patient’s details; check the details match the completed request card and verify details with the patient wherever possible. Send the sample to the laboratory with request card, as soon as possible.</td>
<td>For microbiological assessment.</td>
</tr>
<tr>
<td>6. Ensure the removal of clamp if used. Make patient comfortable. If accidental disconnection of the drainage tube occurs, clean the end of the catheter thoroughly with an alcohol wipe and carefully connect with a new bag, discard the old bag.</td>
<td>To reduce risk of infection.</td>
</tr>
</tbody>
</table>
7. Remove and dispose of gloves. Decontaminate hands using soap and water or use alcohol gel if visibly clean. To reduce risk of infection.

8. Document procedure in patients notes. To have a record of procedure undertaken.

16. Changing the catheter

Catheters must only be changed on the advice of medical/senior nursing staff, if obstructed, if a malfunction occurs or for the routine replacement up to 12 weeks if a long term catheter is used or up to 4 weeks for a medium term catheter. Repeated catheterisation carries serious infection and trauma risks.

17. Removal of Catheter

Removal of a catheter is best performed at 12 midnight before the patient goes to sleep. This promotes natural passage of urine on waking the next morning. Chart all urine passed for the following 24 hours. Advise Doctor of any observed difficulty in micturition.

**Equipment**

1. Non-sterile vinyl gloves
2. Appropriate size sterile syringe
3. Receiver
4. Sterile gauze swabs

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain procedure to patient, ensure privacy and dignity is maintained.</td>
<td>Patient safety and comfort. Patient compliance.</td>
</tr>
<tr>
<td>2. Decontaminate hands using soap and water or use alcohol gel if visibly clean. Don gloves.</td>
<td>Reduction of infection risks.</td>
</tr>
<tr>
<td>3. Using the syringe withdraw the water from catheter balloon <strong>NB.</strong> If the balloon will not deflate or difficulty is encountered when removing the catheter, the nurse in charge should inform medical/urology staff. <strong>Do not cut the catheter.</strong></td>
<td>To enable removal of catheter.</td>
</tr>
<tr>
<td>4. Using swabs around the urethral meatus, gently but firmly withdraw catheter into receiver. Inspect the catheter to ensure all parts have been removed.</td>
<td>To ensure catheter is intact and observe for any debris.</td>
</tr>
</tbody>
</table>
5. Explain to patient urination and pelvic floor exercises. Explain some soreness on micturition for several days may occur. | Reduction of patients stress. Patient’s co-operation. 
---|---
6. Remove gloves, clear away equipment and decontaminate hands using soap and water or use alcohol gel if visibly clean. | Prevention of infection. 
---|---
7. Record urine output and time of catheter removal on fluid balance chart and nursing care plan. | Accurate fluid balance record. 
---|---
8. A specimen of urine for culture and sensitivity should only be taken 48 hours after the removal of the catheter. | Appropriate time for bacteriological assessment. 
---|---

### 18. Trial without catheter

#### Indications for a trial without catheter (TWOC)

- To ascertain if voiding is possible
- To prevent continued catheter usage which may not be needed
- Post operatively to ascertain voiding function
- Post acute urinary retention and ascertain the effectiveness of alpha blockers in men
- Chronic retention to ascertain voiding and to what degree

#### Suitability for a TWOC

- Check medical status (infection history, antibiotic indications, diabetic, cardiac status, nocturnal polyuria indications, cognitive status, mobility and dexterity status, social status). Is medical status improving, stable or deteriorating
- Ability to consent/co-operate
- Falls, poor mobility, dexterity, difficulty in getting to the toilet
- Skin and wound complications

#### How to minimize discomfort during a TWOC

- In removing a catheter at the start of a TWOC, avoid pulling on the syringe as this may create a vacuum and cause the balloon to cuff making removing difficult
- Increasing the fluid intake during a TWOC (this dilutes the urine and reduces pain on voiding due to higher osmolarity)
- If a TWOC fails drain the bladder as soon as possible to prevent anxiety, pain and bladder damage associated with acute retention
Indications to abandon a TWOC

- Patient becomes ill during the TWOC
- Patient withdraws consent
- Bleeding is of concern
- Pain is of concern

If a TWOC fails consider conversion to intermittent self catheterisation if appropriate for the individual patient.

19. References


Appendix A

**Individual Learning Contract**

**Section 1**

**Learning Needs:** What do you need to know and what do you need to be able to do?

**Learning Goals:** Goals should be SMART – specific, measurable, achievable, relevant and time orientated
**Individual Learning Contract**

**Section 2**

**Review**: Provide evidence to demonstrate learning goals have been achieved. Were there any constraints to development?

<table>
<thead>
<tr>
<th>Practitioners signature</th>
<th>Date</th>
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<table>
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<tr>
<th>Mentors signature</th>
<th>Date</th>
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</table>
## COMPETENCY FRAMEWORK – URINARY CATHETERISATION

### COMPETENCY LEVELS:

All practitioners must achieve no less than 1 to 4; Assessors must achieve all of the levels 1 to 5

1. **Observation**: Practitioner has the opportunity to observe and/or be involved in discussions concerning the competence.
2. **Participation**: The practitioner is presented with the opportunities to apply recently acquired knowledge and skills under the guidance and supervision of the clinical assessor.
3. **Application**: The practitioner is confidently able to apply recently acquired knowledge and skills with minimum supervision.
4. **Integration**: The practitioner is fully integrated recently acquired knowledge and skills in his/her practice, requiring no supervision (Competency assessment).
5. **Education**: The practitioner is confident in his/her practice of sharing his/her knowledge and/or teaching others skills learned (Assessors only).

This competency is linked with the National Occupational Standards CC02.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Competency Indicator</th>
<th>Competency Level</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understands scope of own clinical practice and responsibility in the context of catheter management</td>
<td>Verbal discussion with assessor to demonstrate understanding</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Understands the need for and makes accurate, clear and timely records in clinical notes and rationale for explaining clinical decisions.</td>
<td>Verbal discussion with assessor – knowledge of current legislation, information governance and Trust documentation policy</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Able to identify issues of consent in urethral catheter care as Trust guidelines.</td>
<td>Verbal discussion with assessor to demonstrate an understanding of different forms of consent implies/written and informed consent</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Demonstrates accurate and clinically justifiable reasons for undertaking urinary catheterisation</td>
<td>Understands through discussion the causative factors that determine the need for a urethral urinary catheterisation</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
| Undertakes a comprehensive assessment of the risks and benefits to the patient prior to undertaking the procedure | Must demonstrate knowledge of the different risks and health issues that will influence a decision to undertake urinary catheterisation  
• Predisposing health conditions  
• Allergy  
• Previous difficulty in catheter insertion and/or removal  
• Risk of haematuria  
• Multi-resistant infection | 5                |                                                                           |
<p>| Undertake the procedure for urethral catheterisation according to Trust policy | Verbal discussion and observation by assessor which demonstrates sound knowledge of the Trust policy on catheterisation | 1                |                                                                           |
| Show evidence of attendance at catheter study day | Provides written evidence of completion of workbook | 2                |                                                                           |</p>
<table>
<thead>
<tr>
<th>Task</th>
<th>Knowledge and Use of</th>
<th>Verbal Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates effective infection prevention procedures reflected in local Trust and National policy</td>
<td>Selection and use of appropriate protective equipment, correct hand washing techniques, aseptic non-touch technique</td>
<td>Demonstrate knowledge and use of protective equipment, hand washing techniques, aseptic technique. Discuss implications with assessor regarding: the environment, control of cross infection, aseptic technique.</td>
</tr>
<tr>
<td>Evaluates the urinary catheter and discontinues its usage when clinically indicated in an effective and safe manner (TWOC)</td>
<td>Verbal discussion with assessor demonstrating rationale for implementation of trial without catheter, evaluation has taken place as planned and date for future evaluation documented.</td>
<td></td>
</tr>
<tr>
<td>Applies knowledge of anatomy and physiology to voiding dysfunction and appropriately demonstrates how urinary catheters may be used to alleviate these problems</td>
<td>Verbal discussion with assessor to demonstrate application of theoretical knowledge related to the use of urinary catheters with regard to the following: anatomy and physiology of the lower urinary tract, altered physiology, catheter indications/contra-indications.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates the appropriate selection of catheter based products on individual clinical assessment</td>
<td>Verbal discussion with assessor. Knowledge of: different materials, catheter size, charriere size, inflation balloon volume, manufacturers recommended duration of use, catheter lengths.</td>
<td></td>
</tr>
<tr>
<td>Identify special precautions and how to avoid/minimize them</td>
<td>Demonstrates through verbal discussion with assessor knowledge of special precautions needed prior to urinary catheterisation: autonomic dysreflexia, heart defects/artificial valves, immuno suppressed/organ transplant patients, UTI post catheterisation.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates the appropriate selection of a catheter drainage system based on clinical need and individualised need including the maintenance of a</td>
<td>Demonstrates understanding of a broad range of urinary drainage systems, appropriate storage and disposal.</td>
<td></td>
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</table>
Appendix C

**RECORD OF PRACTITIONERS DETAILS**

Name of Practitioner: .................................................................

Job Title/Designation: .................................................................

Department/Directorate ............................................................

Learning Contract negotiated: Yes/No if No why not .................................................................

Dates of theoretical training ...........................................................

**Record of Assessment Sessions**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time started</th>
<th>Time finished</th>
<th>Mentor signature</th>
<th>Practitioners signature</th>
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</table>

Achievement of competence Yes/No Competency level attained ......................

Signature of Mentor ............................................................................

Signature of practitioner ......................................................................
On completion of the competency framework and practical assessments to demonstrate that you are able to catheterise, you will have evidence to show you are matching the following dimensions and levels. This must be revisited periodically in line with Trust requirements to have relevant and up to date evidence of knowledge and skills.

The following dimensions of the NHS Knowledge, Skills and Framework are relative to urethral catheterisation

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Level</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Communication                                  | 3 – A, D, E | Communicates to the patient and explain procedure clearly to be undertaken.  
Communicates to members of multi-disciplinary team.  
Obtains consent for urethral catheterisation.  
Documents procedure in patients' notes.  
Maintain patient confidentiality at all times. |
| Health, Safety and Security                    | 1 – C, D, E | Minimises risks by following correct policy and procedure.  
Competent to catheterise patient.  
Complies with infection prevention measures. |
| Quality                                        | 1 – All | Complies with legislation, policies, procedures in relation to urinary catheterisation and patient care.  
Works within limits of own competence and responsibility and refers issues beyond these limits to relevant people.  
Acts responsibly as a team member and seeks help if necessary.  
Reports problems that arise.  
Use correct consumables e.g. type of catheter, water and Instillagel. |
| Equality and Diversity                         | 1 – B, C, D | Treat patient with privacy and dignity during the procedure.  
Do not discriminate.  
Demonstrate promoting patient dignity before, during and after catheterisation. |
| Assessment and Care Planning To meet Health and Wellbeing Needs (HWB2) | 3 – A, D, F, G | Obtain consent from patient.  
Explain procedure to patient in appropriate terminology.  
Complete catheterisation procedure as outlined in competency framework and after relevant training.  
Record and report back accurately and fully to multi-disciplinary team.  
Recognise and interpret risks and offer multi-disciplinary insight into health and wellbeing needs of patient.  
Recognise and report any changes in patient condition by knowing the above.  
Demonstrate an understanding on when and why to catheterise and when to plan a trial without catheter. |
| Provision of Care to Meet Health and Wellbeing Needs (HWB5) | 3 – C, D, E, G, H | Communicate to patient reason for catheterising as part of their care plan.  
Prepares equipment and demonstrate how to catheterize aseptically using ANTT technique.  
Demonstrate how to promote patient comfort and dignity when carrying out catheterising.  
Provides feedback to the multi disciplinary team.  
Show how to record procedure in notes.  
Recognise any potential risks to patient health and wellbeing.  
Makes accurate records of fluid balance chart if appropriate.  
Demonstrate what action can be taken to address issues and risks such as rapid deterioration of condition.  
Feedback to discipline with overall responsibility of care plan effectiveness of treatment. |

Please not that this provides evidence for part of your knowledge and skills. In order to demonstrate that you are working both effectively and consistently at the required level for KSF you will require further supporting evidence from other work activities.

<table>
<thead>
<tr>
<th>Trainees signature</th>
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Urinary Catheters:
- 100,000 patients develop hospital acquired urinary tract infections (UTIs) in the UK every year.
- 80% of these infections are from a urinary catheter.
- About half of the patients with a urinary catheter do not have a valid indication for placement.
- Each day the urinary catheter remains in place the risk of urinary infection (CAUTI) increases 5% per day.

Guidelines for Indwelling (Foley) Urinary Catheter

Is there a Foley Catheter in place?

- Yes
  - Does the patient meet indications for a Foley?
    - Yes
      - Have you documented reason and consent?
    - No
      - Continue to monitor Foley need on a daily basis
  - No
    - No action necessary. Avoid catheter placement.

Remove Foley

Ensure clear documentation in medical notes re insertion, justification and removal of catheter

Indications for Indwelling Urinary Catheters:
- Urinary Tract Obstruction: blood clots; enlarged prostate; urethral problems, hydronephrosis.
- Retention of urine: inability to pass urine; lower abdominal pain of acute onset; desire to void with evidence of enlarged bladder.
- Excessive skin excoriation (under instruction from tissue viability nurse).
- Palliative Care patient (rare cases).
- Strict output monitoring on critically ill patients.

Indwelling Urinary Catheters are not indicated for:
- Incontinence
- Immobility
- Convenience
- Patient Requests
- Urine Specimen Collection
- Output monitoring on non