## Trust Standard for Assessment and Management of Physical Health Practice

### Guidance Note

### Urethral, Suprapubic and Intermittent Catheterisation – V04

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1 Introduction

A urethral catheter is a hollow tube inserted into the urethra and retained in the urinary bladder for drainage, instillation of treatments or monitoring of urine output. Urethral catheter insertion is an invasive procedure that must only be carried out when essential for individual patient care. The patient’s clinical need for catheterisation must be reviewed regularly and the urinary catheter removed when no longer clinically required.

Indwelling urinary catheters must be used only after alternative methods of management have been considered.

2. Guideline Scope

Urethral catheter insertion is an invasive procedure that should only be carried out when essential for individual patient care and only by a competent qualified practitioner, using an aseptic non-touch technique (ANTT).

3. Aim

The aim of the competency is to ensure all patients receive a consistent and safe standards of care during urinary catheterisation within Cumbria Northumberland Tyne and Wear Trust.

High impact Actions for Nursing and Midwifery (2020) advocated a dramatic reduction in the rate of UTI for patients in NHS provided care and cited that 80% of UTIs occurring in hospitals can be traced to indwelling urinary catheters. The Cost Effective Commissioning for Continence Care (2011) reported that annually there are 224,670 admissions for UTI (HES 2009-2010) and that these hospital admissions are costly, increasing length of stay up to 9 days.

In acute care facilities. The risk of developing bacteriuria increases 5% with each day of catheterisation. Approximately 24% of bacteriuric patients will develop CAUTI, and of these up to 4% develop severe systemic infection (Loveday et al 2013).

Therefore clinical staff must review the patient’s care need of a urinary catheter at least daily and remove promptly when clinically no longer required.

4. Indications for urethral catheterisation

- Acute Urinary retention symptoms (voiding difficulties and renal protection)
- Chronic Urinary Retention.
- Neurological disease for short term use only (symptoms and renal protection)
Facilitate continence and maintain skin integrity when all conservative methods have failed.
End of life care (comfort)

5. Consent

Catheterisation is an invasive procedure with associated serious risks, therefore obtaining verbal valid consent is vital prior to the procedure and this is to be clearly documented in patients RIO. In the patient who is unable to give consent, there must be a clearly stated rationale for using a catheter and it must be clear that this is in the best interests of the patient. There should be MDT involvement in this situation, and also evidence of consultation with appropriate next of Kin.

6 Assessment for the need of urethral catheterisation

During individual assessment, when bladder drainage is deemed necessary, consider the patients suitability for intermittent, suprapubic or urethral catheterisation. (NICEGC171). A trust wide continence assessment tool is available (APPENDIX 1) and should be used for all patients with continence issues.

Factors to consider prior to catheterisation

1. Is there an alternative, less invasive method of management (epic 2013)
2. History of haematuria and or discharge
3. Concomitant infection, potential need for antibiotic prophylaxis, discuss with named consultant
4. History of urethral obstruction or previous difficult catheterisation
5. History of recent surgery or malignancy to the lower urinary tract or previous genital reconstruction surgery, for management of gender dysphoria.
6. Congenital abnormalities affecting the pelvis
7. History of fused labia or labial adhesions, presence of uterovaginal prolapse
8. Trauma to the pelvis or abdomen
9. Inflammation of the genito-urinary tract, cystitis, urethritis, vaginal pain
10. Immunocompromised patients
11. Catheterisation of patients who are agitated and/ cognitively impaired should be carefully considered and risk assessed, due to the possibility of deliberate self-removal of catheter leading to tissue trauma.

12. Spinal cord injured patients with risk of autonomic dysreflexia

If the patient has any of the above concerns advice should be sought from a suitably qualified and experienced practitioner working in the clinical area of urology, urogynaecology

7 Catheter Selection / Equipment

When considering the approach to catheterisation and equipment selection, it is important to recognise that some individuals may have genital anatomy that is different to their gender identity or stated / legal gender. Clinical decision about catheterisation should be based on the anatomy of each person, not their gender. However, a patient wishes regarding gender presentation, use of pronouns etc, should be respected throughout.

Urethral Catheter

Standard packs would be used which include size 12CH, 14CH or 16CH catheters. Latex free catheter to be used for patients with latex allergy. BARD ALL SILICONE FOLEY CATHETERS, Anaesthetic gel is not included in the catheter pack.

Anaesthetic gel

National guidelines are ambivalent as to whether a lubricant gel or an anaesthetic gel should be used prior to catheterisation (RCN 2012). NICE advises an appropriate lubricant should be used in all catheterisations. Anaesthetic gels which contain 2% lidocaine hydrochloride and chlorhexidine gluconate solution 0.25% anesthetises, has antiseptic properties and dilates the urethra thus reducing the risk of trauma and infection. Lubricating gel will only dilate the urethra. CNTW staff will continue to use an anaesthetic gel when indicated.

- At least 11ml (male anatomy) or 6ml (female anatomy) of the gel is instilled directly into the urethra until this volume reaches the sphincter/bladder neck region. The practitioner should wait 5 minutes after instilling the gel, before starting the catheterisation but it is important to follow manufacturer’s guidance.

- Anaesthetic gel must be prescribed.

Do not use an anaesthetic gel if any of the following apply.
• If allergic (hypersensitive) to lidocaine, chlorhexidine, methyl hydroxybenzoate, propyl hydrobenzonate or any of the other ingredients

If the moist lining of the application site is damaged or bleeding Care should be taken when using anaesthetic gel :-

• If patients have heart problems
• If patients are epileptic
• If patients have respiratory impairment If a serious adverse reaction occurs:
  • Inform GP/dial 999
  • Complete documentation and clinical incident as per Trust Policy
  • Complete a Yellow card as detailed in the BNF

Catheters can either be intermittent, short/medium term (4 weeks), long term (12 weeks) or suprapubic See manufactures guidance in all packs

**Catheter size**

Standard pack available in sizes 12ch, 14ch or 16ch, suitable for both Male and Female patients

**Balloon size**

Instruction on the catheter packaging should be followed
Routine 10 ml sterile water pre filled syringe included in pack
Anaesthetic gel (Not included in Pack)
If no risks apparent, slowly instil a lubricating/prescribed anaesthetic gel according to manufacturer’s instructions. If using Instillagel please wait 3-5 minutes for the anaesthetic to take effect.

**Inflating the urinary catheter balloon**

Only inflate the urinary catheter balloon having ensured that the urinary catheter is fully inserted into the urethra and is draining adequately. Slowly inflate the balloon according to manufacturer’s instructions. If the patient experiences pain during inflation of the balloon, stop inflation and reposition the catheter. If pain continues seek medical advice immediately. If the urine cannot be drained or aspirated then remove the catheter and seek immediate expert advice.

8. **Suprapubic Catheterisation**

EAUN (2012) highlights several benefits to having a suprapubic catheter when compared to a urethral catheter. These include

• Greater comfort, particularly for patients who are in a wheelchair.
• There is less risk of ureteral trauma, necrosis, or catheter induced urethritis and urethral strictures.
• Easier access to the cystostomy site for cleaning and catheter changes.
• Reduced risks of catheter contamination with microorganisms that’s are commonly found in the bowel, therefore reducing the risk of urinary tract infections.
• Enables the patient to remain or be sexually active.
• Micturition is still possible if ureteral not surgically closed or obstructed.

To reduce infection in the supra pubic site, always ensure good hand hygiene is performed prior to any intervention, and ensure an aseptic technique is followed during catheter changes.

National guidelines recommend that daily cleansing of the site with soap and water is all that is required as excess cleansing may increase the risk of infection EAUN, (2012)

**Changing a suprapubic**

Following the initial insertion of a suprapubic catheter, the catheter must stay in place for up to 4 to 6 weeks. This allows time for the tract to become established EAUN (2012)

The first change of the catheter must be done in a hospital setting without delay so that the cystostomy is not allowed to close. A subsequent change, when the cystostomy is established, is not so critical but does need to be carried out immediately after the old catheter is removed.

Most uncomplicated catheter changes can take place in the patient’s own home or ward environment.

**Training and experience in changing a suprapubic catheter is essential. Only appropriately trained staff should undertake a suprapubic change.**

On insertion of the catheter, advance the catheter in to the tract 3cm deeper than the removed catheter. If no urine drains, gently apply pressure on the symphysis pubic area. Once urine starts to drain, slowly inflate the catheter balloon according to the manufactures instructions. Withdraw the catheter slightly and attach the drainage bag and secure with the appropriate straps (EAUN 2012)

Dressings are often unnecessary and are best avoided, if is dressing is used to contain discharge from the site, this should be undertaken with strict aseptic technique to protect against infection.

A care plan for bladder management / catheter care should be available and clear written documentation should be maintained. A fluid balance chart should be maintained for all inpatients.
9. **Intermittent self-catheterisation**

Intermittent catheterisation may be a short or long term intervention. It has been identified as the optimal treatment for persons with chronic urinary retention or incomplete emptying of the bladder (RCN, 2019). Ideally patients should be taught CISC once and supervised in undertaking the procedure until the practitioner feels confident. The procedure involves the episodic introduction of a catheter into the bladder to remove urine. Once the bladder is empty the catheter is removed, leaving the patient catheter free between catheterisations. The patient should perform catheterisation as often as necessary to prevent incontinence or prolonged retention of urine. Clean Intermittent Self Catheterisation (CISC) is performed by the individual, Intermittent catheterisation (IC) is performed by a competent Healthcare professional, carer or family member.

10. **Catheter Maintenance**

The most common complications that occur are urinary tract infection (UTI) and catheter blockage, which can affect up to 70% of catheterised patients. Blockage, in turn can lead to leakage, or bypassing of urine and discomfort and embarrassment for the patient.

**Selecting the right solution**

Following diagnosis of the catheter problem the correct solution can be chosen. If the blockage is due to debris, as a first line URO –Tainer NaCl 0.9% can be used. If the blockage is due to encrustation, URO tainer Suby G may be used to reduce/ dissolve the encrustation (Braun 2019)

**Braun Uro-Tainer® NaCl 0.9%**

Indication: This isotonic fluid is used primarily for cleaning the bladder and catheters mechanically, e.g. in the case of debris formation in the bladder. Recommend rinse frequency: 1 to 2 times per day depending on the scope of the problem, unless prescribed differently by the doctor.

**Uro-Tainer® Twin SUBY G**

Twin bag for a superior efficacy in dissolving / reducing encrustations thanks to 2 sequential instillations
Kinder in use due to smaller volumes
Higher patient's quality of life
Suby G to be prescribed by medical staff and can be administered 1-2 times per day.

All catheter bags should be emptied when two thirds full. See Appendix 5 for guidance on how to empty a catheter bag. Change drainage bags when clinically indicated in line with manufacturer’s recommendations and document in the patient’s notes/ Rio

Training available for maintenance of catheter and catheter care.
Collecting a urine sample (CSU)

Following clinical assessment, if a patient has symptoms indicating a urine infection a CSU should be taken to determine the cause of infection. Urine samples must be obtained using an aseptic technique from a catheter sampling port and only if

- Clinical indication of infection is present
- The patient is not responding to antibiotic treatment

See Appendix 4 for guide in how to obtain a CSU.

11. Competence

Inserting a urinary catheter should only be carried out by a registered, qualified healthcare professional who can demonstrate that they have received suitable training or instruction and deemed competent under the NMC Code (NMC, 2016), General Medical Council (GMC, 2006) or the Health Professions Council (HPC London).

Competency for urinary and intermittent catheterisation

- The registered, qualified healthcare professional should not undertake these procedure until they are assessed and deemed competent. Until such time this procedure should be undertaken as part of supervised training with a suitable competent, registered, qualified doctor, nurse or healthcare professional.
- The registered, qualified healthcare professional needs to be familiar with Trust equipment and guidelines.
- Senior supervision should be available if required.

To gain competence the following practice recommendations should be met.

- Gain theoretical knowledge and understanding in aspects of catheterisation.
- Observe model/manikin being catheterised.
- Practice catheterisation on a model/ manikin under supervision until confident using ANTT
- Observe catheterisation performed by others on an actual patient using ANTT
- Undertake supervised catheterisation on an actual patient using ANTT
- Be able to catheterise without direct supervision
- Gain experience and become confident

To maintain competence you must keep up to date with new knowledge and changes to procedures.
Competency assessment documents (Appendix 2 catheterisation and Appendix 6 Intermittent catheterisation) to be completed and signed off by competent practitioner declaring individual competence with approved level of knowledge and skill. There is no minimum or maximum number of times the qualified/registered practitioner should carry out this skill under supervision before deemed competent. This will be based on the judgement of the assessor.

Catheterisation and care of the catheter to be discussed in clinical supervision and reflective practice to be utilised.

12. **Documentation**

A record of the catheterisation must be made in the patient record/Rio care plan. The information must follow the NMC (2020) The Code and include:

- Reason(s) for catheterisation or continued catheterisation
- Date and time of catheterisation
- Type of catheter used, (calibre, length, balloon size, material, batch number and manufacturer)
- Cleansing solution (normal saline) or in the community (soap and water) and lubricant/anaesthetic agent used
- The single use anaesthetic gel must be prescribed by a competent registered nurse/doctor or supplied to the patient by a registered nurse under a Patient Group Direction. This becomes the patient’s own medication which can then be handed to the Nurse/Midwife/Assistant Practitioner for administration to the patient.
- Amount and expiry date of the prescribed anaesthetic gel used
- Problems encountered during procedure
- Presence and amount of immediate urine drainage
- Date, place and personnel for next re-assessment, catheter change or removal
- Type of drainage equipment used and date when it is required to be changed
- Document catheter blockages and any trauma during catheterisation
- Signature of the practitioner who carried out the catheterisation

Catheter History chart (Appendix 3) can be used to support RIO care plan.

13. **Removal of catheter**

A trial without catheter (TWOC) should be considered at the earliest opportunity.

Suitability for TWOC must be taken into account (medical status, infection history, antibiotic indications, and patient’s ability to consent.

Cautions when assessing for TWOC include

- Presence of large urogenital prolapse
• Previous failed TWOC
• Any surgery for stress incontinence
• Medications (anticholinergics)
• Large fibroid uterus

Catheter valve

A catheter valve is like a tap which fits directly into the end of the indwelling catheter. The valve is an alternative to the catheter drainage bag. The valve allows the bladder to continue being used maintaining normal function and is discreet.

The valve should be changed every 5-7 days and catheter bags can be attached at night on continual drainage. These are not recommended for those patients who have over active bladder. Catheter valves are fitted using the same technique as leg bags.

Planned removal of catheter should be discussed with patient, medical staff and if appropriate family / next of kin. A care plan should be developed in partnership with the patient setting out the clear wishes of the patient as well as a documented plan of the removal of catheter looking at suitability and potential risk factors.

Following the removal of the catheter it is best practice that three post void bladder scans are completed to ensure the patient is not in urinary retention. If a bladder scanner is not available strict monitoring of fluid balance should be maintained, to ensure patient is passing urine adequately.

14. Education of patients and their carers:

Patients and carers should be educated and trained in the techniques of hand decontamination and catheter care before being discharged from hospital.

No patient should be discharged or transferred with a short term indwelling urethral catheter without a plan documenting the:

• Reason for the catheter
• Clinical indications for continuing catheterisation
• Date for removal or review by an appropriate clinician overseeing their care

Prior to discharge home all patients who are leaving hospital with a long term catheter should have a referral made to district nursing team and continence aid provider to ensure equipment available on discharge.

15. Monitoring

All patient with catheters and patients who have been diagnosed with Urinary Tract infections (UTI) should be recorded on the Safety thermometer. All UTI’s
should be incident reported and investigated at ward level and discussed as part of medical review.

16. References

- **Braun** 2019 *Catheter Maintenance with URO –Tainer* – Improving Patient Quality of Life. Edition 8, Sheffield, UK
- **British Association of Urological Nurses** (2010) *Clean Intermittent Catheterisation: The Patient Journey*
- **General Medical Council.** 2006 GMC London
- **Health Protection Agency**, English national point prevalence survey on healthcare associated infections and antimicrobial use (2012)
- **Loveday, H.P et al** (2013) Epic 3: *Journal of Hospital Infection* December 2013 86S1:S1-S70
- **NICE** (2012) *Urinary incontinence in Neurological disease: Management of lower urinary tract Dysfunction in neurological disease*
- **RCN** (2019) *Catheter Care RCN guidance for nurses*
- **Royal College of Nursing Catheter Care** RCN Guidance for Nurses (2019)

Skills for Health

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<tr>
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<td>Assess bladder and bowel dysfunction</td>
<td>CC01</td>
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<td>Enable individuals to carry out intermittent catheterisation</td>
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<td>Help Individuals to effectively evacuate their bowels</td>
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