Northamptonshire Healthcare NHS
NHS Foundation Trust

Catheterisation Insertion and Management Protocol
(Whole Healthcare Economy)

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Document Management

Policy Title	Urethral Catheterisation Insertion and Management Protocol
Policy Purpose	The aim of this policy is to provide nursing and care staff with research based evidence to reduce as much as possible the infection risks involved with catheterisation and catheter use.
Status: - review or New	Review
Trust Policy Board Approved	21st June2011
Areas affected by the policy	Trust-wide
Policy originators/authors	Infection Prevention and Control Team
Consultation and Communication with Stakeholders including public and patient group involvement.	Members of the Safer Hospitals and Environment. Comprising of representation from: - Mental Health Services. Learning Disability Services. Sexual Health Services. Drug and Alcohol Services. Medical Representative. Occupational Health Service. Estates & Facilities Services. District Nurses Health Visitors Podiatrists Chairman of Northamptonshire Healthcare NHS Foundation Trust representing the Public.
Archiving Arrangements	A central register will be held by the CGST which will hold archived copies of this policy.
Register of Procedural Documents	A current copy of this policy will be held on a central register, on the Trust intra-net.
Equality Impact Assessment (including Mental Capacity act 2005)	Yes
Training Needs Analysis	As part of the Infection Prevention and Control training.
Monitoring Compliance and Effectiveness	Compliance with this policy will be monitored through the Safer Hospitals and Environment Group.

Meets national criteria with regard to:	
NHSLA	Yes: Standard 1.2.8 & 2.2.8
NICE	Yes - 2003
NSF	N/A
Mental Health Act	N/A
Other	Department of Health, NPSA
Further comments to be considered at the time of ratification for this policy.	Health and Social Act 2008 code of practice for health and social care on the prevention and control of infections and related guidance.
If this policy requires Trust Board ratification please provide specific details of requirements	Trust Policy Board

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1 INTRODUCTION

This protocol provides Registered Practitioners and care staff with research based evidence to reduce the infection risks involved with urinary/urethral catheterisation and catheter use.

Saving Lives (2007) noted that Urinary tract infections (UTI) are the largest single group of healthcare associated infections (HCAI) and account for 23% of all infections.

The presence of a urethral catheter, the duration of its insertion and the quality of care are all contributory factors to the development of a urinary tract infection.

The aim of this policy is to provide nursing and care staff with research based evidence to reduce as much as possible the infection risks involved with catheterisation and catheter use.

Catheterisation increases the risk of acquiring a urinary tract infection, the longer the catheter is in place the greater the danger. The risk of acquiring bacteriuria is approximately 5% for each day of catheterisation. Patients who develop a urine tract infection then have a 1-4% risk of developing bacteraemia and of these, 13-30% die
(Department of Health Epic Project Jan 2001).
Bacteria will flourish in a urine drainage system: a non-return valve is not a sufficient barrier. Good evidence-based practice is essential to prevent ascending infection.

2 ASSESSING THE NEED

Assessment should take account of the possible sexual, physical, social, psychological and environmental impact of catheterisation.

The decision to catheterise should be made following a full holistic continence assessment with consideration given to alternative methods of management where appropriate. Catheterisation to manage incontinence should only be used when all other management strategies have been tried and failed.

Review of the necessity for the catheter should be made at agreed and regular intervals. Further advice can be obtained from the Continence Nurse Specialist.

Host infection risks include immune system compromise, post partum, age and debility.

3 AIMS

The aim of this protocol is:

- To provide a set of measures for indwelling urethral catheterisation to be followed by all Registered Practitioners/care staff.
- To provide guidance to staff on interventions required to reduce the incidence of urethral catheter associated infections.

4 OBJECTIVES

- To standardise practice across the Northamptonshire healthcare economy
- To minimise the potential risk of infections associated with indwelling urethral catheters
- To ensure that all staff have undertaken competency based training for the insertion and care of urethral catheterisation
- To ensure that the appropriate catheterisation and drainage products are used
- To ensure that patients are catheterised appropriately

5 DEFINITION

Urethral catheterisation is the insertion of a special tube into the bladder, using an aseptic technique, for the purpose of evacuating or instilling fluids (Marsden, Manual of Clinical Nursing Procedures 2001)

6 WHO CAN CATHETERISE?

Any Registered Practitioner, male or female can catheterise a patient provided they have received appropriate training in the procedure and have completed the recognised competency/scope of practice.

A Health Care Assistant (HCA) can catheterise an intended female urethral catheterisation provided they have received and been deemed competent in their knowledge and skills and have had appropriate training from a Registered Nurse with a teaching qualification.

7 INDICATIONS/NEED FOR CATHETERISATION

Assessment should take account of the possible sexual, physical, social psychological and environmental impact of urethral catheterisation.

The decision to catheterise should be made following a full holistic continence assessment with consideration given to alternative methods of management where appropriate.

Urethral catheterisation would be carried out for the following reasons:

- To relieve retention of urine
- To determine residual urine
- To measure urine output accurately
- To allow irrigation of the bladder
- To instil medication into the bladder
- To allow bladder function tests to be carried out
- To relieve incontinence when no other means is practicable

Review of the necessity for the catheter should be made at agreed and regular intervals.

8 CONSENT

Informed consent must always be obtained in accordance with the national guidelines for consent including any issues relating to the patients capacity to consent. This should be documented in the patients' medical notes.

9 CATHETER SELECTION

- The choice of catheter material is determined by the expected maximum duration that the catheter is to be in situ. Catheters are generally categorised as being for short-term (maximum of 28 days duration) or long-term (maximum of 12 weeks duration).
- If the catheter is regularly requiring changing after less than 4 weeks, discuss with the Continence Nurse Specialist.
- For urethral drainage select the smallest gauge catheter possible usually 10-12Ch for a female, or 12-14Ch for a male, with a 10ml balloon. Occasionally patients with urological conditions may require a larger gauge catheter and balloon. Smaller gauge catheters minimise the risk of urethral trauma and residual urine volumes, which pre-dispose to UTIs. Larger sizes may cause pain and discomfort, pressure ulceration, blockage of the para urethral ducts and abscess formation.
- Three lengths of catheter are available to meet the needs of different patients and individual patient assessment is paramount
- Single use self lubricating hydrophilic catheters are the recommended choice for intermittent self-catheterisation.
- Check if patients have a latex allergy.

Female only catheters (20-26cm) can cause severe trauma and haemorrhage if used in males

http://www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/female-urinary-catheters/

Standard catheters (40 to 45cms) can be used for males and females.

Shorter catheters (20 to 26cms) are for females only

10 CATHETER INSERTION

- Catheter insertion should only be undertaken by a practitioner who has received training in the procedure and is deemed to be competent.
- Catheterisation is an **aseptic procedure and, therefore, an aseptic technique must be used**.
- The perineum will require cleansing with soap and water before commencing aseptic technique.
- To minimise introduction of bacteria on catheterisation the urethral meatus should be cleaned prior to catheter insertion using sterile normal saline.
- For both male and female patients, a lubricant and anaesthetic gel from a single use container must be used and inserted directly into the urethra and left for the recommended time.
- Intermittent self catheterisation is always an aseptic technique when undertaken by a health care practitioner. When undertaken by the patient, it is a clean technique where gloves are not required, but strict hand hygiene should be used.
- An audit should be undertaken by managers to monitor compliance and to ensure an aseptic technique is used.
- A record of staff training and audit should be available.

11 DOCUMENTATION

The following details should be documented in the patient's notes (use adhesive label if provided by manufacturer).

- Amount of urine drained.
- Any problems or patient discomfort.
- Reason for catheterisation.
- Date of insertion.
- Catheter size, type, length.
- Balloon size, batch no. expiry date.
- Lubricant used; lot number and expiry date.
- Type of cleansing lotion used.
- Date catheter change is due
- Signature.

12 DRAINAGE BAGS

- Drainage bags may be body-worn, i.e. leg bag, or free standing. There should be effective fixation of the catheter and drainage bag to prevent trauma.
- Maintenance of a closed system is essential to prevent infection.
- Two litre drainage bags should be added for overnight drainage in patients with body worn (leg bag) systems using a no touch Clean Technique.
- Body worn (leg bag) systems should be changed weekly (or in line with manufacture's instructions).

13 CATHETER CARE

- The catheter closed drainage system should only be opened for the connection of a new bag every 7 days as per manufacturer's instructions. More frequent changes always increase the risk of infection.
- When opening the closed system to fit a new bag, a rigorous no touch clean technique is essential. The tip of the new drainage tube must not be touched before inserting into the catheter.
- Catheter valves are sometimes used for patients with urological conditions as an alternative to a leg bag. They need to be changed every 5-7 days as per manufacturer's instructions using a rigorous no touch clean technique.
- Position the urine drainage bag below the level of the bladder to allow good drainage, incorrect positioning even for a short time is linked to higher rates of infection. The bag must be kept off the floor.
- For mobile patients a leg bag should always be used, held in place with a strap to minimise trauma to the bladder neck. The leg bag needs to be the correct size to allow emptying when 2/3 full, and the inlet tube needs to be the correct length to prevent kinking and/or pressure on the bladder neck.
- Overnight drainage bags connected to a leg bag should be single use. The washing out/reuse of bags is **unacceptable** practice. Night bags should be used once and thrown away.
- There is no research-based evidence to substantiate the use of antiseptic or antibacterial solutions for cleaning urine drainage bags.
- Do not change catheters unnecessarily, but if the catheter is frequently blocking, bypassing, etc., refer to local policy or discuss with the Continence Nurse Specialist.
- Routine personal hygiene is all that is needed to maintain meatal cleanliness, i.e. a daily bath or shower. For patients who are unable to bath or shower daily, staff should wash the urethral meatus at least twice daily with soap and water and following a bowel movement.
- Hand washing and wearing non-sterile gloves when performing catheter care is always essential by nurses/carers.

14 BAG EMPTYING

- Research suggests that this procedure carries a risk of healthcare associated infection.
- Where possible educate and encourage the patient to empty their own drainage bag.
- A rigorous no touch clean technique is required for this procedure.
- Staff should wear a disposable apron.
- Good hand washing and wearing a pair of non-sterile latex or vinyl gloves is essential prior to emptying or changing the drainage bag; this procedure always carries a high risk to the patient. Hands must always be washed before and after the procedure.
- The bag should be emptied when 2/3 full.

- The outlet port should be swabbed with a 70% isopropyl alcohol wipe before and after opening. In any healthcare setting, a separate single use clean container should be used for each patient to empty the urine into and then emptied and disposed of appropriately, e.g. macerater or clinical waste.
- In the patient's own home a designated container can be reused to empty the urine into. This must be washed thoroughly after use with detergent and hot water and dried.
- Always avoid contact between the urine drainage bag tap and the container.

15 CATHETER MAINTENANCE SOLUTIONS

The use of catheter maintenance solutions may be indicated as part of an **individualised care plan** to prolong the catheter life, remove debris and encrustation in identified patients, and for recurrent catheter blockage. The decision to use a catheter maintenance solution must be made following a risk assessment and advice should be sought from the Continence Nurse Specialist. Evidence of encrustation should always be seen prior to deciding to use a catheter maintenance solution. Long term use of such solutions is not recommended and their use and effectiveness should be reviewed on a regular basis.

- Bladder/catheter irrigation, installation and washouts do not prevent catheter-associated infections. They actually increase the risk of infection.
- The use of antiseptic solutions such as chlorhexidine is not recommended and may contribute to bacterial resistance.
- If a catheter is blocked/not draining a catheter maintenance solution could be considered or remove the catheter and re-catheterise.

16 SUPRAPUBIC CATHETERS

The insertion of a self-retaining catheter directly into the bladder via the anterior abdominal wall under aseptic conditions.

Indications for Suprapubic Catheterisation	**Short-term**: following urological, gynaecological, or other types of surgery **Long term**: as an alternative to urethral drainage: • in sexually active adults • in those for whom a urethral catheter has proved problematic or intolerable • in some wheelchair bound people • in those patients for whom urethral route is not possible.

Catheter selection	For long-term drainage the catheter used is: • Hydrogel coated latex 16-18Ch 10ml balloon • standard length • for patients with a latex allergy - all silicone catheter.
Catheter Management The main principles of of care and management of the suprapubic catheter are similar to those for urethral catheters. Prevention of Infection is the primary aim with adherence to aseptic technique.	• A dry dressing may be required for the first 24/48 hours after initial insertion. • The catheter, as it emerges, must be supported at right angles to the abdomen. Clothing must therefore not be too tight. • If a dressing is used as part of routine care, it should be sterile. Dressings are not usually required unless there is a discharge.
First and Subsequent Routine Catheter Change	• Within 6 weeks the supra pubic tract should be established. • Catheter changes for long term catheters can be undertaken 12 weekly by a practitioner who has received training and has been assessed as competent • Drainage system As for urethral catheter, although a holster appliance may be more comfortable.

17 CATHETER TROUBLESHOOTING

17.1 Bleeding/Haematuria

A few specks of blood may indicate trauma to the urethra on catheterisation. Haematuria may also be caused by trauma due to traction on the catheter, infection or renal/bladder pathology. Consider the use of a catheter retaining device and ensure that the catheter bag is properly supported. If it is severe medical referral should be made immediately and the patient monitored for signs of clot formation and catheter blockage. The patient may require further medical investigation eg: cystoscopy.

17.2 Infection

Symptoms of infection include cloudy offensive smelling urine, burning pain and elevated temperature. Obtain a specimen of urine and dipstick the urine. If positive to nitrates, leucocytes, protein, blood, send fresh urine sample for microscopy, culture and sensitivity and inform the patient's medical team.

17.3 No Urine Drainage

This may be due to:

- Kinked tubing
- Constipation
- Drainage bag positioned above waist level
- General condition - is patient dehydrated or in renal failure
- Catheter not in urethra
- Catheter not the correct length (obese female patients may require a standard length catheter as a female length may to too short)
- Encrustation and blockage - see below

Perform a bladder scan to see if urine is present in the bladder.

17.4 Catheter Bypassing

Catheters bypass for the following reasons and it is important to ascertain what the cause of the problem is as each will be dealt with in a different way:

- Encrustation and blockage - see below
- Twisted tubing - change position of tubing. If using a leg bag, is a shorter length tube required?
- Constipation - relieve constipation, give fluid and dietary advice.
- Bladder spasm - common within the first 24 - 48 hours after catheterisation, if it persists consider if the patient still needs to be catheterised, check size and balloon size of catheter as reducing the size of these may help, consider anticholinergic medication if the problem persists as it may be due to bladder spasm.
- Bladder calculi - is possible in patients who have a long-term catheter. This will need to be confirmed by x-ray.

17.5 Catheter Blockage

Change catheter and inspect catheter tip for signs of debris or encrustation and document in patient records. If an in-patient was catheterised prior to admission contact the District Nurse and enquire about management. Maintain a record of catheter changes to see if a pattern emerges. Consider pre-empting blockage and changing the catheter prior to blockage if a pattern of catheter life is clear.

17.6 Urethral Discomfort

This can be caused by the distension of the urethra by a catheter which is too large or occlusion of the par urethral glands leading to infection, urethritis and offensive discharge around the catheter. Refer to Medical Practitioner if there is offensive urethral discharge. Consider removing the catheter or changing to a smaller size catheter.

17.7 Unable to Tolerate the Catheter

Psychological trauma, overactive bladder or radiation cystitis. Consider alternatives to catheterisation.

17.8 Paraphimosis

This can occur if the foreskin is not replaced following catheterisation or hygiene procedures. If the foreskin cannot be replaced into its normal position refer for medical advice.

18 REFERENCES

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National Institute for Clinical Excellence (2003) Prevention of Healthcare Associated Infection in primary and Community Care. NICE London

Appendix 1 - Protocol for Female Catheterisation

Equipment required:

- Hand sanitizer
- Disposable apron
- Sterile catheter dressing pack
- Catheter of appropriate length, size and type
- Sodium Chloride 0.9%
- Instillagel 6ml syringe (lubricant/surface anaesthesia)
- 10ml sterile water to fill catheter balloon unless using prefilled catheter
- Syringe and blue 23G needle if not needle free system (sharps box to ensure safe disposal of sharp)
- Sterile disposable gloves
- Appropriate drainage system
- Urine specimen container for MCS (if necessary)
- Catheter Holder/ straps
- Disinfectant Wipe (eg sanicloth to clean neck of ampoule

Before starting the procedure:
Obtain consent of patient
Cleanse the genital area with soap and water. Check that the patient is not allergic to any of the products used in the catheterisation procedure (eg: latex). If latex allergic, use a 100% silicone catheter and non-latex gloves.

Action	Rationale
Explain and discuss the procedure with the patient verbally and obtain consent	To ensure that the patient understands the procedure • check patient's identity • and check any allergies • and check valid consent
a) Assist the patient to get into the supine position with bent knees, hips flexed and feet resting about 60cm apart. b) Do not expose the patient at this stage of the procedure	To enable genital area to be seen To maintain the patient's dignity and comfort
Ensure that a good light source is available.	To enable genital area to be seen clearly
Decontaminate hands with either soap and water or using hand sanitizer	To reduce the risk of cross infection
Put on disposable apron	To reduce the risk of cross infection from micro-organisms on clothes

Action	Rationale
Clean and prepare the trolley, placing all equipment on the bottom shelf. Take the trolley to the patient's bed/bedside. In community setting prepare a clear area.	To reserve top shelf for clean working spaces
Clean hands Open the outer cover of the catheterisation pack and slide the pack onto the top shelf of the trolley	To prepare equipment
Using an aseptic technique, open supplementary packs	To reduce risk of introducing infection into the urinary tract
Clean neck of ampoule with sodium chloride 0.9% solution prior to drawing up sterile water	To reduce cross infection
Remove cover that is maintaining the patient's privacy and position a disposable pad under the patient's buttocks	To ensure urine does not leak onto bedclothes
Decontaminate hands with either soap and water or using hand sanitizer	Hands may become contaminated by handling outer packaging
Put on sterile gloves	To reduce the risk of cross infection
Place sterile towels under patient's buttocks	To create a sterile field
Using gauze swabs, separate the labia minora so that the urethral meatus is seen (one hand should be used to maintain labial separation until catheterisation is completed)	This manoeuvre provides better access to the urethral orifice and helps to prevent labial contamination of the catheter
Clean around the urethral orifice with 0.9% sodium chloride using single downward strokes	Inadequate preparation of the urethral orifice is a major cause of infection following catheterisation. To reduce the risk of cross infection.
Insert the nozzle of the Instillagel into the urethra. Squeeze the gel into the urethra, remove the nozzle and discard the tube.	Adequate lubrication helps to prevent urethral trauma. Use of local anaesthetic minimises the patient's discomfort.
Place the catheter, in the receiver, between the patient's legs	To provide a temporary container for urine as it drains
Remove soiled gloves, decontaminate hands prior to donning sterile gloves	To reduce cross infection
Introduce the tip of the catheter into urethral orifice in an upward and backward direction. Advance the catheter until 5-6cm has been inserted	The direction of insertion and the length of catheter inserted should bear relation to the anatomical structure of the area

Action	Rationale
a. Advance the catheter 6-8 cm. b. Inflate the balloon according to the **manufacturer's directions**, having ensured that the catheter is draining adequately. c. Withdraw the catheter slightly and allow urine to flow before connecting the drainage system. d. Support the catheter. Ensure it does not become taut when the patient is mobilising.	This prevents the balloon from becoming trapped in the urethra. Inadvertent inflation of the balloon within the urethra is painful and causes urethral trauma. To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma.
Make the patient comfortable and ensure the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur.
Measure the amount of urine	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance.
Send a urine specimen for laboratory examination if required	To detect presence of bacteria
Dispose of equipment in appropriate waste bag/double bag and seal before moving the trolley for cleaning	To prevent environmental contamination
Decontaminate hands with either soap and water or hand sanitizer	Reduce the risk of cross infection
Document procedure/catheter type and size. Volume of water in balloon, lot number and expiry date in medical notes.	To provide a point of reference or comparison in the event of later queries.

Appendix 2 - Protocol for Male Catheterisation

Equipment required:

- Hand sanitizer
- Disposable apron
- Sterile catheter dressing pack
- Catheter of appropriate length, size and type
- Sodium Chloride 0.9%
- Instillagel 11ml syringe (lubricant/surface anaesthesia)
- 10ml sterile water to fill catheter balloon unless using prefilled catheter
- Syringe and blue 23G needle if not needle free system
- Sterile disposable gloves
- Appropriate drainage system
- Urine specimen container (if necessary)
- Catheter holder or leg straps
- Disinfectant Wipe (eg sanicloth to clean neck of ampoule

Before starting the procedure:
Cleanse the genital area with soap and water. Check that the patient is not allergic to any of the products used in the catheterisation procedure (eg: latex). If latex allergic, use a 100% silicone catheter and non-latex gloves.

Action	Rationale
Explain and discuss the procedure with the patient verbally and obtain consent.	To ensure that the patient understands the procedure • check patient's identity • And check any allergies • and check valid consent.
Assist the patient to get into the supine position with the legs extended. Do not expose the patient at this stage of the procedure.	To ensure patient's privacy.
Decontaminate hands with either soap and water or hand sanitizer.	To reduce the risk of cross infection.
Put on disposable plastic apron	To reduce the risk of cross infection
Clean and prepare the trolley, placing all equipment required on the bottom shelf. Take the trolley to the patients bedside. In community setting prepare a clear area.	The top shelf acts as a clean working surface.
Open the outer cover of the catheterisation pack and slide the pack onto the top shelf of the trolley, in community setting a clear area.	To prepare equipment.

Action	Rationale
Clean neck of ampoule with sodium chloride 0.9% solution prior to drawing up sterile water	To reduce cross infection
Using an aseptic technique, open the supplementary packs.	To reduce the risk of introducing infection into the bladder.
Remove cover that is maintaining the patient's privacy and position a disposable pad under the patient's buttocks and thighs.	To ensure urine does not leak onto the bedclothes.
Decontaminate hands with soap and water or hand sanitizer.	Hands may have become contaminated by handling the outer packaging.
Put on sterile gloves	To reduce the risk of cross infection
Place sterile towels under patient's buttocks.	To create a sterile field.
Wrap a sterile swab around the penis. Retract the foreskin, if necessary and clean the glans penis with 0.9% sodium chloride.	To reduce the risk of introducing infection to the urinary tract during catheterisation.
Insert the nozzle of the Instillagel into the urethra. Squeeze the gel into the urethra, remove the nozzle and discard the tube. Massage the gel along the urethra.	Adequate lubrication helps to prevent urethral trauma
Squeeze the penis **and wait approximately 5 minutes.**	To prevent anaesthetic gel from escaping and allow it to take effect.
Remove soiled gloves, decontaminate hands prior to donning sterile gloves to insert sterile catheter	To reduce cross infection
Grasp the penis behind the glans, raising it until it is almost totally extended. Maintain grasp of penis until the procedure is finished.	This manoeuvre straightens the penile urethra and facilitates catheterisation. Maintaining a grasp of the penis prevent contamination and retraction of the penis.
Place the receiver containing the catheter between the patient's legs. Insert the catheter for 15-25cms until the urine flows. Do not inflate balloon until urine flow is seen in tubing	The male urethra is approximately 18 cm long. Ensuring correct placement will prevent trauma of urethra and allow patency of the catheter.
If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to strain gently as if passing urine.	Some resistance may be due to spasm of the external sphincter. Straining gently helps to relax the external sphincter.

Appendix 2 - Protocol for Male Catheterisation (continued)

Action	Rationale
a. When urine begins to flow advance the catheter almost to its bifurcation. b. Gently inflate the balloon according to the manufacturer's directions c. Withdraw the catheter slightly and attach it to the drainage system. d. Support the catheter. Ensure that the catheter does not become taut when patient is mobilising or when the penis becomes erect. Ensure that the catheter lumen is not occluded by the fixation device or tape. e. If catheter cannot be advanced - Stop procedure and seek further medical advice immediately	Advancing the catheter ensures that it is correctly positioned in the bladder. Inadvertent inflation of the balloon in the urethra causes pain and urethral trauma. To maintain patient comfort and to reduce the risk of urethral and bladder neck trauma. To prevent further trauma and injury
Ensure that the glans penis is clean and then reduce or reposition the foreskin.	Retraction and constriction of the foreskin behind the glans penis (paraphimosis) may occur if this is not done.
Make the patient comfortable. Ensure the area is dry.	If the area is left wet or moist, secondary infection and skin irritation may occur.
Measure the amount of urine	To be aware of bladder capacity for patients who have presented with urinary retention. To monitor renal function and fluid balance.
Take a urine specimen for laboratory examination if required.	
Dispose of equipment in appropriate waste bag and seal before moving the trolley.	To prevent environmental contamination.
Perform hand hygiene	Reduce the risk of cross infection
Document procedure/catheter type and size. Volume of water in balloon, lot number and expiry date in notes.	To provide a point of reference or comparison in the event of later queries

Appendix 3 - Protocol for Removing a Catheter

Equipment required:

- Hand sanitizer
- Sodium Chloride 0.9%
- Disposable apron
- Sterile dressing pack
- Disposable gloves
- Needle and syringe (if urine specimen is required)
- Sharps disposal unit
- Syringe for deflating balloon
- Waste bag

(NB Catheters should be removed early in the morning so that any retention problems can be dealt with during the day).

Action	Rationale
Explain the procedure to the patient and inform him/her of potential post catheter symptoms (e.g. urgency, frequency and discomfort which are often caused by irritation of the urethra by the catheter). Decontaminate hands with either soap and water or using hand sanitizer. Put on disposable plastic apron and gloves.	To ensure that the patient understands the procedure • check patient's identity • and check any allergies • and check valid consent.
Clamp below the sampling port until sufficient urine collects; take a catheter specimen of urine using the sampling port if clinically indicated.	To obtain an adequate urine sample and to assess whether post catheter antibiotic therapy is needed. For easy removal of catheter
Remove gloves and decontaminate hands with either soap and water or using hand sanitizer	To reduce the risk of cross infection
Put on gloves then use the sodium chloride 0.9% solution to clean the meatus and catheter, always swabbing away from the urethral opening. In women, never clean from the perineum/vagina towards the urethra.	To reduce the risk of infection
Release leg support	For easy removal of catheter
Having checked the volume of water in the balloon, use syringe to deflate balloon. **Do not cut catheter**. If balloon will not deflate do not add anything to current volume in balloon - seek help.	To confirm how much water is in the balloon. To ensure the balloon is completely deflated before removing catheter.

Ask patient to breathe in and then out: as patient exhales gently – but quickly- remove catheter. Male patients should be warned of discomfort as the deflated balloon passes the prostate gland.	To relax pelvic floor muscles
Clean meatus. Place all used equipment in an appropriate coloured waste bag. Make patient comfortable.	
Remove gloves and apron and decontaminate hands	Hands should always be washed after removal of gloves to reduce risk of cross infection
Complete documentation as per local policy	For audit purposes

Appendix 4 - Protocol for emptying a Catheter Bag

Equipment required:

- Disposable apron
- Non-sterile gloves
- Swab (70% isopropyl alcohol + 2% chlorhexidine impregnated)
- Disposable clean receptacle

Action	Rationale
Explain the procedure to the patient	To ensure that patient's identity and understanding of the procedure and give consent
Wash hands or use hand sanitizer prior to putting on disposable gloves and apron.	To reduce the risk of cross infection
Clean the outlet valve with a swab saturated with 70 % isopropyl alcohol and 2% CHG impregnated wipe. Allow to dry.	To reduce the risk of infection
Open and allow the urine to drain into the clean receptacle (do not allow tap to touch sides of container).	To empty drainage bag and accurately measure volume of contents
Close the outlet valve and clean it again with a new alcohol impregnated swab. Allow to dry.	To reduce the risk of cross infection
Check the tap is not in contact with the floor and that drainage is not obstructed	Bacteria can ascend up the tubing into the bladder causing infection
If required, measure amount of urine and then dispose of urine	To comply with waste policy
Dispose of receptacle.	Bacterial can thrive in dirty, wet containers
Remove gloves and apron and dispose of appropriately	To comply with waste policy
Decontaminate hands with either soap and water or hand sanitizer	Hands should always be washed after removal of gloves to reduce the risk of cross infection
Complete records	To provide evidence of activity

Appendix 5 - Protocol for collection of a Catheter Specimen of Urine (CSU)

Samples should only be taken from catheters for valid reasons such as suspected infection and should never be taken from the catheter but instead from the sample ports on the bag's draining tubing.

Equipment required:

- Sterile 5 ml syringe
- (if not a needle less port – a blue 23G needle is also needed)
- Disposable gloves/apron
- Sterile urine specimen container
- 70% isopropyl alcohol and 2% CHG impregnated wipes
- Laboratory request form
- Clamp if necessary
- Sharps box if necessary

Action	Rationale
If there is no urine in the tubing, clamp the tubing a few centimetres below the sampling port until sufficient urine collects	To obtain adequate sample of urine
Decontaminate hands with either soap and water or hand sanitizer. Put on disposable apron and gloves	To reduce the risk of cross infection
Clean the sample port with a 70% isopropyl alcohol wipe and 2% CHG impregnated wipes eg Sanicloth. Allow to dry for 20 seconds.	To reduce the risk cross infection

Then either

If needle less collection port system:

Action	Rationale
Insert the sterile syringe into the port and aspirate urine and remove syringe	To obtain specimen of urine

If syringe collection port system:

Action	Rationale
Attach needle to syringe and insert into port at 45°angle, aspirate urine and remove needle from port. Remove needle from syringe using aperture on sharps box	To Obtain specimen of urine
Place urine into specimen container and dispose of syringe in sharps box	To reduce the risk of infection
Swab the sample port again and remove any clamp used	To reduce infection

Action	Rationale
Label specimen container and seal securely in specimen bag	To confirm patients details and for safe transportation
Remove and dispose of gloves and perform hand hygiene	To reduce the risk of cross infection
Complete records	To provide a point of reference or comparison in the event of later queries

If specimen has to be kept overnight, this should be stored in a specimen fridge and sent to the laboratory immediately next day.

Appendix 6 - Protocol for the Care and Management of Indwelling Catheter

Action	Rationale
Wash hands thoroughly before and after any manipulation of the catheter. Wear a new pair of clean, non-sterile gloves and an apron. Use a disposable container to drain the urine	To reduce the risk of cross infection when emptying catheter bags.
Maintain closed system Only empty the urinary drainage bag or take a urine sample when necessary	Maintaining a sterile continuously closed urinary drainage system is central to the prevention of Catheter Associated Urinary Tract Infections (CAUTI). Unnecessary emptying of the drainage bag or taking a urine sample will increase the risk of catheter-related infection and should be avoided
Ensure catheter is positioned below waist level to assist drainage. Use a stand and do not let the catheter bag drag on the floor. Secure catheter to prevent any trauma.	Reflux of urine is associated with infection and therefore drainage bags should be positioned in a way that prevents backflow of urine. Emptying the drainage bag when necessary will maintain urine flow and prevent reflux.
Change the catheter bag every seven days including leg bag or in accordance to either the manufacturers' recommendations or the patient's clinical need.	Catheter acquired urinary tract infections are less likely to occur when catheter bags are changed less frequently.
Maintain catheter care at least twice daily, using only soap and water. The area should be thoroughly cleansed after all bowel movements. If self-caring incorporate into daily personal hygiene.	Meatal cleansing with antiseptic solutions is not recommended, as they have not been shown to actually reduce infections.
Observe for changes in colour, consistency and odour of urine. Obtain CSU as appropriate and document. Obtain urine from a sampling port using aseptic technique.	A urine sample should not be taken from the catheter bag. Specimens collected from the drainage bag may give false results due to organisms growing there.
Educate patient regarding fluid intake. Preferably two and a half litres a day, unless on fluid restriction. Maintain fluid balance chart.	Ensure adequate fluid intake and record urine output is satisfactory.

Action	Rationale
Bladder washouts must be prescribed and documented.	Irrigation, instillation and washout do not prevent infection.
Catheters must not be changed unnecessarily or as part of routine practice except where necessary to adhere to the manufacturers guidelines.	The commonest complication associated with urinary catheter insertion is infection. Co-existing factors may include trauma to the urethra, or a poor aseptic technique during catheter insertion.
Document all catheter management procedures	To provide a point of reference or comparison in the event of later queries

Name: ..... Job Title: ..... Band: .....

Work Place: ..... Date Assessed: .....

Date of attending theoretical session: .....

Appendix 7 - Competency Assessment Tool for a Catheterisation

	YES	NO	EVIDENCE PROVIDED
Materials and Equipment			
A working knowledge of the types of catheters, urinary drainage bags, link systems, catheter valves and support methods including garments, straps and stands that can be used with the appropriate selection to meet the individuals specific needs			
A working knowledge of the types and use of lubrication gels			
A working knowledge of the solution used to fill balloons			
Anatomy and Physiology			
An in-depth understanding of the anatomy and physiology of the male and female lower urinary tract in relation to lower urinary tract function and continence status including:-			
• Urine production and what influences this			
• Normal micturition			
• The nervous system including autonomic dysreflexia			
• Sexual function and links to catheter usage			
• The prostate gland, urethral sphincters and the urethra			
• Applied anatomy and physiology to voiding dysfunction and how a urethral urinary catheter could be used to relieve this			
• Anatomy and physiology links of how common catheter related complications occur			

	YES	NO	EVIDENCE PROVIDED
A working knowledge of how to advise individuals in the use of catheters in relation to their anatomy, its function and sensation			
Urethral Catheterisation			
A working knowledge of the causative factors which determine the need for a urethral urinary catheter			
A working knowledge of the reasons why individuals have planned catheter changes and how to initiate unplanned catheter changes because of blockage or other complications			
An in-depth understanding of the adverse effects and complications during urethral catheterisation and the appropriate actions to take			
An in-depth understanding of how to advise individuals using catheters in relation to lifestyle advice, maintaining catheter function, reducing infection, what to do in the event of problems with equipment and how to deal with common complications			
An in-depth understanding of the short and long term risks and health implications associated with urethral urinary catheterisation			
An in-depth understanding of why a risk assessment prior to the decision to catheterise is important and what contributes to this assessment			
Infection Control Related to Catheter Care			
A working knowledge of the causes of urinary tract invasion from bacteria and how to minimise this in all care settings			
A working knowledge of the importance of applying standard precautions for infection control and the potential serious life threatening consequences of poor practice			
A working knowledge of how to meet standards of environmental cleanliness in the area where catheterisation is to take place to minimize the infection risk			
A working knowledge of when to undertake urinalysis and obtain a catheter specimen of urine			

	YES	NO	EVIDENCE PROVIDED
Drugs and Medication			
An in-depth understanding of the indications, mode of action, side-effects, cautions, contraindications and potential interactions of medication, antibiotics, anaesthetic agents and associated solutions used for individuals urethral catheterisation			
Care and Support of the Individual			
A working knowledge of how to obtain valid consent and how to confirm that sufficient information has been provided on which to base this judgment			
A working knowledge of the importance of respecting an individuals' privacy, dignity, wishes and beliefs'			

The healthcare worker will only be assessed as competent at catheterisation if ALL elements are completed. If any one element is failed the healthcare worker must be assessed again.

Assessed by competent by (Assessors name):

Signature: ..... Print Name: .....

Job Title: ..... Work Place: .....

Band: .....

Equality Impact Assessment (EqIA)

Title of document or Function	Catheterisation Insertion and Management Protocol		**Policy/document Ref:** ICP 013
Name of persons completing this EqIA: Jenny Boyce **Lead:** Lead Nurse Infection Prevention and Control		**Directorate:** Nursing	**Date: 1st July 2011**

1	**What are the aims, purpose, activities and outcomes of the policy/service/function?** The aim of this policy is to provide nursing and care staff with research based evidence to reduce as much as possible the infection risks involved with catheterisation and catheter use
2	**How does it fit with the wider aims of the Trust? (e.g. business objectives, priority)** The Policy is compliant with the Health and Social Act 2008 (10): Code of Practice for the prevention and control of health care associated infections and related guidance. *Cleanyourhands* Campaign, National Patient Safety Agency, launched 2003 Essential Steps to Safe Clean Care 2006 Nice Guidelines, 2003 Winning Ways, 2003
3	**Who will be affected by and / or benefit from this policy/service/function?** All Service Users and Staff working within the Trust.
4	**Who has been involved in the development of this policy/service/function?** Lead Nurse - Infection Prevention and Control **Who have you consulted with and when?** Members of the Safer Hospital and Environment Group
5	**What does the available data/research/reports/audits/complaints/ feedback /surveys and results of consultations say about the policy/service/function under review/development?** The Department of Health (2008) requires NHS organisations to have policies and protocols for the prevention and control of healthcare associated infections).

6	**Who else do you need to consult? Is there any other information you need? (If yes, what is needed and how will this be carried out?)** No
7	In relation to **SERVICE USERS (and potential service users),** could the policy/service/function have an adverse or negative impact on the target Equality and Diversity strands below? Or does it have a positive impact? (Promoting equality, eliminating discrimination, achieving equal opportunities, improving relations?)

Equality Strand	**Impact**		**Reason**	**Comments Action to minimise any negative/adverse impact**
	positive	**Adverse/ negative**		
Race, culture or ethnicity	X			
Religion/faith/belief	X			
Disability (mental health, cognitive/learning disability, hearing and visual impairment, mobility)	X			
Gender	X			
Sexual orientation	X			
Age	X			

8	In relation to **STAFF (and/or potential employees and volunteers)** could the policy/service/function have an adverse or negative impact on the target Equality and Diversity strands below? Or does it have a positive impact (e.g. promoting equality, eliminating discrimination, achieving equal opportunities, improving relations?)

Equality Strand	**Impact**		**Reason**	**Comments Action to minimise any negative/adverse impact**
	Positive	**Adverse/ negative**		
Race, culture or ethnicity	X			
Religion/faith/belief	X			
Disability (mental health cognitive/learning disability, hearing and visual impairment, mobility)	X			
Gender	X			
Sexual orientation	X			
Age	X			

9 Are there concerns that the policy/service could have a negative impact in terms of the following human rights principles:				
Equality Strand	**Impact**		**Reason**	**Comments Action to minimise any negative/adverse impact**
	Positive	**Adverse/ negative**		
Fairness	X			
Respect	X			
Equality	X			
Dignity	X			
Autonomy	X			
If you have indicated there are any negative/adverse impact: Is the impact lawful? Yes / No Intended? Yes / No			(If you answer “yes” please state what actions you will now take to minimise any adverse impact)	

10 Mental Capacity Act and Mental Health Act 1983				
Equality Strand	**Impact**		**Reason**	**Comments** **Action to minimise any negative/adverse impact**
	Positive	**Adverse/ negative**		
Have you considered the implementation of the MCA and MHA in relation to this function/policy?				
If it is relevant: a) Please comment on how you have ensured compliance with these Acts? b) Is this the least restrictive practice?	X X			

SUMMARY	
Summarise the findings and give an overview on whether it will promote equality and diversity?	It is essential that all staff working within the trust are sensitive to persons of different age, ethnicity, gender, disability, religion / belief and sexual orientation.
What is the priority for this EqIA for NHFT?	It is the Trust priority to prevent the spread of infections within it's services and where an infection occurs to treat it safely, promptly and follow best practice guidance.
Are there any risks to the Trust? **Identify Risk Rating** **Who else needs to know about this EqIA?**	No

ACTION PLAN					
Equality strand	**Desired outcome**	**Action**	**When**	**Who will monitor?**	**Evidence of completion**
Race/ethnicity					
Religion/belief/faith					
Disability					
Gender					
Sexual orientation					
Age					

Name of Person Completing EqIA **Jenny Boyce** **Signature:** ..... **Date:** **16th June 2011**

Equality and Diversity Manager: **Signature:** ..... **Date:**

Returned to (e.g. Clinical Governance): ..... **Date:**

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