1. **Policy Objectives**

This policy aims to:

- Reduce the incidence of urinary tract infections related to indwelling urinary catheters
- Standardise the care of urinary catheters, using evidence based guidelines, to ensure best practice across the healthcare communities served by Torbay and South Devon NHS Foundation Trusts. (TSDFT)

2. **Introduction: Catheter Associated Urinary Tract Infections (CAUTI)**

Urinary tract infections (UTI) are the commonest healthcare associated infections (HCAI), accounting for ~20% of all cases. Although UTIs are generally minor and asymptomatic, bacteriuria is an independent predictor of mortality among hospitalised patients, and as many as 15%-17% of nosocomial bloodstream infections are secondary to UTIs.

The presence of a urinary catheter and the duration of insertion are significant risk factors for the development of a UTI. Approximately 80% of healthcare associated urinary tract infections are related to the presence of catheters.

Improving the management of urinary catheters will reduce the incidence of catheter-associated UTIs (CAUTI) and the burden of HCAIs in general:

- Biofilms develops on the surface of a catheter 1-3 days after catheterization and there is evidence from one clinical trial that changing or removing catheters that have been in place for over seven days, before treatment with antibiotics, improves the chance of cure as infected biofilms are no longer present. *(Raz et al, 2000 cited in NICE NQS 90, 2015)*
- The recommendations from NICE about when to change catheters are based on expert opinion and in hospital settings it should be comparatively easy to change catheters before antibiotic treatment begins, however in the community setting, this may not be possible.
- Community/District Nurses are advised in training that urinary catheters should be changed after the first dose of antibiotics or as soon as possible, and that they should ask their patients or carers to contact them if a CAUTI has been diagnosed and the patient put on antibiotics.
- The current antibiotic treatment for CAUTI’s is Trimethroprim 200mg twice daily (BD) *(NICE Guidance NQS 09 2015)*

This policy is to be used in conjunction with ‘Saving Lives: a delivery programme to reduce Healthcare Associated Infection’.

3. **Assessing The Need For Catheterisation**

- Assess patient on admission and regularly thereafter as their condition and needs change. **Avoid catheterisation if at all possible.** *(see appendix 1)*
- Consider indications and contraindications to insertion of a urinary catheter. *(See appendix 2)*
- Only use indwelling urethral catheters after considering alternative methods of management. If necessary seek advice from Continence Adviser telephone 01626 357258, the Urology Nurse Practitioners ext 55009 #6294 or bleep 307. Out of hours ring Cromie Ward ext 55505/55917
- Decide on the most appropriate mode: urethral, suprapubic or intermittent catheterisation.
• Assess whether antimicrobial prophylaxis is required (Appendix 3).

• All Acute Trust patients who have a urinary catheter inserted should commence a Urinary Catheter Care Plan, (Appendix 8) and receive a patient information leaflet.

• For recently catheterized in-patients review daily the patient’s clinical need for continuing urinary catheterisation and remove catheter as soon as possible. For patients already designated for long term catheters review the same as patient’s condition changes.

• The Bladder & Bowel Care Service are able to provide patients with ‘Hospital to Home’ packs on discharge, catheter care leaflets, and ordering advice for equipment in the community.

• Home care packs will also be supplied on discharge from Torbay Hospital.

ALL PATIENTS MUST HAVE THEIR ALLERGY STATUS CHECKED FOR LATEX, ANAESTHETIC LUBRICATING GEL, OR CHLORHEXIDINE PRIOR TO CATHETERISATION

• There are clear contraindications/cautions for use of Instiligel™, on the manufacturers website: www.clinimed.co.uk/urology due to the gel contents, and for patients who have trauma, abrasions, or lesions on the penis or urethral orifice, which may increase absorption of lidocaine systemically, leading to symptoms of cardiac shock/anaphylaxis. This is supported by the Royal Marsden (p.208) which cites research from the BNF (2011) regarding using lidocaine gels in the elderly, and for patients with dysrhythmias due to increased risk of lidocaine absorption during the catheterisation procedure.

4. Selection of Catheter Type

• For urethral catheters select the smallest gauge catheter that will allow free urinary flow. The recommended size is 12 –14 ch (Charrière) with a 10ml balloon for adults. Urological patients may require larger gauge sizes and balloons, (e.g. those with catheter encrustation and frequent catheter blockages as a result). Only use sterile water to fill balloons and fill to the appropriate volume. For supra-public catheters patients are usually fitted with size 16 Ch catheter initially, and maintained on size 18-20 Ch for the long term.

• Urethral catheters used after urological procedures such as prostate or bladder tumour resection (TURP and TURBT) are often larger (18-22 Ch) and are 3 way (the third channel is used for the irrigating fluid). The same catheters are often needed for patients presenting in clot retention. The catheter balloons are often inflated to 20-30 ml. These catheters are used for a short period (usually few days), and should not be used for long term. If patients need to have a catheter on discharge, then these catheters must be changed to a suitable long term ones.

• Female, (short length 23 – 26cm) catheters must only be used in TSDFT hospitals within specified areas such as Stroke Wards George Earl (Acute), Teign Ward (community) and Women’s Health.

• Only Male length (standard 40 – 44cm) catheters should be used unless a client specific need for a short length (female 23 – 26cm) has been identified, with a clear rationale, documented by a qualified practitioner.

• Intermittent catheterisation should be used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient. This should only take place after careful consideration by a qualified person.
• Consideration should be given to the most appropriate type of catheter. Certain catheters are better suited to specific situations. All silicone catheters are preferred for patients with latex sensitivity. Non-retained single use catheters are preferred for intermittent self-catheterisation, catheters with low allogenecity are preferred for long-term use and for the initial insertion of suprapubic catheter.

• All silicone X-Flow, DUFOUR type, can stay insitu for 12 weeks. This type of catheter is used for patients with problematic urethras as well as for clot retention and different to post-operative Simplastic in duration of use.

• N.B: 100% silicone catheters have a wider lumen, but are more prone to cuffing on deflation. Silicone also permits gas diffusion which may cause the catheter to deflate, and fall out prematurely: Although 100% silicone catheters are still recommended for suprapubic catheterisation, caution should be taken when considering their use.

• Patients with suprapubic catheters are more prone to developing bladder stones, and blocking due to debris, therefore, the average time span between changes for suprapubic catheters is often 6 - 8 weeks.

• Trials of silver alloy and Nitrofurazone-impregnated catheters to prevent CAUTI have been small and more research is needed to identify their effectiveness, however they may be prescribed on a patient specific basis following urology review.

5. Catheter Insertion

• All catheterisations carried out by healthcare workers should be aseptic procedures.
• All staff must be trained and assessed as competent before carrying out this procedure.
• Those patients who perform intermittent self- catheterisation will follow a clean procedure rather than an aseptic procedure. For guidance on how to perform an aseptic catheter insertion see appendix 4.

6. Documentation Of Catheter Insertion

• Document all of the following in the patient care plan: Appendix 8 Acute Trust/Appendix 9 Community
  a. Indication for catheterisation
  b. Date of catheterisation
  c. Make and type of catheter
  d. Size of catheter and balloon, lot number and batch number of catheter – best done by placing catheter pack information sticker in patient notes
  e. Residual volume and type of urine post catheter insertion
  f. Daily care/evaluation of urethral/supra pubic catheter and catheter management care plan

7. Education of Patients, Carers and Healthcare Workers

• All patients who have a urinary catheter inserted will receive a patient information leaflet available via http://www.baus.org.uk/patients/patient-information/bladder

• Patients and carers of those who have urinary catheters inserted should be educated and trained in techniques of hand decontamination, insertion of intermittent catheters where applicable and catheter management before discharge from hospital.
• Community and primary healthcare workers must be trained in catheter insertion, including suprapubic catheter replacement and catheter maintenance.

• A minimum of 2 assessments in practice, supervised by an experienced Registered Professional, must be undertaken, using valid competency assessment documentation provided in training, to ensure competency is achieved.

• Follow up training and on-going support of patients and carers should be available for the duration of long-term catheterisation.

• Registered Nurses (RN’s) and Skilled Not Registered Nurses (SNR’s) undertaking any clinical skill are required to prove through reflection or discussion with their manager that they have reviewed current guidelines and policies related to the clinical skills they use in practice annually. This can be via on-line modules, Hiblio, BUZZ, or attending practical skills training with manikins.

8. Catheter Maintenance

• Routine daily personal hygiene is all that is needed to maintain meatal hygiene including the daily routine of bathing or showering.

• Hands should be decontaminated according to Trust Hand Hygiene Policy 0239 and a new pair of clean, non-sterile gloves and disposable plastic apron put on before any catheter manipulation.

• Patients managing their own catheters, and their carers’, must be educated about the need for hand decontamination before and after catheter manipulation and be advised on the appropriate use of standard precautions.

• Connect indwelling urethral catheters to a sterile closed urinary drainage system, BARD™ complete catheter packs, used in the community, already have the bags attached. Catheter valves may be more suitable for certain patients and further advice is available from the Urology Nurses, (Cromie Ward ext 55505/55917) or Urology Nurse Practitioners #6294 and bleep 307.

• A link system should be used to facilitate overnight drainage to keep the original system intact.

• Ensure that the connection between the catheter and the urinary drainage system is only broken for appropriate clinical reasons, such as changing the bag, in line with the manufacturer’s recommendations. Document the date of connection on the bag.

• Urine samples should only be obtained from the needle-less sampling port using Aseptic None Touch Technique. (ANTT)

• Position urinary drainage bags below the level of the bladder on a stand or in a bowl that will prevent both contact with the floor and reflux. In Hospital if such drainage cannot be maintained (e.g. when the patient is mobilising in the bed) clamp the urinary drainage bag tube (never the catheter) and remove the clamp as soon as dependent drainage can be resumed.

• BARD™ complete catheter packs, used in the community, do not contain catheter bags with clamps, but clamps can be ordered through procurement or from the manufacturer.

• Empty the urinary drainage bag frequently enough to maintain urine flow and prevent reflux. Drain the contents of the catheter bag into a single-use container. Avoid contact between the urinary drainage tap and container. After measuring volume drained (if appropriate), dispose
of the urine in the sluice-hopper. Single-use containers should be disposed of in a macerator. Areas without macerators should contact Infection Control for advice.

- In a patient’s home, the contents of the bag should be emptied into the toilet, and the bag disposed of as per Trust waste management guidelines. Patients with long-term catheters should be provided with clinical waste bags.

- After removing gloves and apron, dispose of into a yellow clinical waste bag and wash hands with soap and water.

- Catheter bags should be changed every 5-7 days maximum, or earlier if indicated (e.g. if they become blocked). Two-litre bags should be changed after 48-72 hours or earlier depending on the condition of the bag.

- Antiseptic or antimicrobial solutions should not be added to urinary drainage bags.

- Use of catheter maintenance solutions (Appendix 6)

- Bladder washouts should not be performed for the routine clearing of blockages (see Appendix 5). Further advice regarding bladder washouts can be obtained from the Urology Nurses bleep #6294, (Cromie Ward ext 55505/55917). All bladder washouts performed must be documented in the patient’s notes.

- Specialist Urology advice should be obtained for patients who have had recent Urology surgery or procedures.

- Men with possible Upper Urinary Tract Infections, presenting with signs and symptoms suggestive of Pyelonephritis should be advised to see their GP as soon as possible. NICE Guideline NQS 90 (2015)

9. **Catheter Removal**

- Hands should be decontaminated according to the Hand Hygiene Policy and a new pair of clean, non-sterile gloves and disposable plastic apron put on before any catheter manipulation.

- Drain the contents of the catheter bag into a single-use container. After measuring volume drained (if appropriate), dispose of the urine in the sluice-hopper. Single-use containers should be disposed of in a macerator. Areas without macerators should contact Infection Control for advice.

- Deflate the balloon using a sterile 10-ml syringe. Do not use increased pressure to deflate the balloon as this may cause ridges to form in the balloon space.

- Withdraw the catheter and inspect the end to ensure it has been completely removed.

- Dispose of the entire catheter system in a yellow clinical waste bag.

- In the community, urine should be disposed of into the toilet. Urinary drainage systems can be safely disposed of as domestic waste (unless there is a suspected UTI, in which case all parts of the system should be disposed of as clinical waste). The urinary drainage system should be wrapped in paper to

- absorb excess urine and placed in a sturdy plastic bin liner inside a sealed bin. Patients with long-term catheters will be provided with clinical waste bags.
10. **Storage Of Equipment**

Urinary catheters

- Store in a dry, well-ventilated area away from sunlight as per manufacturers guidance.
- Store in manufacturer’s protective boxes.
- Use stock control methods to ensure compliance with expiry dates.
- Elastic bands should not be used to hold catheters together in sizes, as this may damage packing and catheters.

Urinary drainage bags

- Store in a similar fashion as urinary catheters.

Urinary penile sheaths/catheters

- As for urinary catheters.

11. **Audit Of Clinical Care**

Audit tools developed for ‘Saving Lives: a delivery programme to reduce Healthcare Associated Infections’ are available from the Infection Control Team, Infection Control link nurse or ward manager. A continuous audit programme reviewing three patients per ward area will be conducted on a monthly basis to access compliance with the Saving Lives Delivery Programme.

12. **Review**

The Urinary Catheter Standard will be reviewed and updated no later that every two years or depending on change or developments in legislation or regulations.

The Head of Patient Safety will be responsible for nominating a suitable individual to carry out reviews of this policy.

Any revision activity will be recorded in the Version Control Table as part of the document control process.

13. **Equality and Diversity**

This document complies with the Torbay and South Devon NHS Foundation Trust Equality and Diversity statement.
Thinking of inserting a urinary catheter?

Have alternatives been considered?

Is the indication clear and appropriate? (see appendix 1)

Consider
- Continence care plan
- Convene
- In/out catheter
- Intermittent self catheterisation

Reconsider alternatives
Discuss with medical team
Clarity indication

Review whether antibiotic prophylaxis is required (appendix 3)

Insertion of catheter using aseptic technique

Remove within 24 hours

Complete catheter sticker and place in notes

Ensure catheter care plan completed

Daily review
Is catheter still required?

Liaise with medical team, if necessary, and remove
Appendix 2

Indications and contraindications to insertion of urinary catheter

INDICATIONS

- Acute painful retention
- Chronic retention with renal impairment / high tension chronic retention
- To protect the upper urinary tract from high intravesical pressure, e.g. some neuropathic bladders, detrusor-sphincter dyssynergia, etc
- Surgery on the lower urinary tract
- Pelvic surgery, e.g. rectal and gynaecological surgery; and major surgical interventions with a high probability of acute urinary retention postoperatively
- Monitoring of hourly urinary output in critically ill patients e.g. acute renal failure, large blood loss, hypotension from sepsis, cardiogenic shock
- Severe and extensive excoriation or deteriorating pressure ulcers, (while considering the patients general health, level of consciousness and pain)
- Palliation of the terminally ill
- Last resort for urinary incontinence (see below)

CONTRA-INDICATIONS

- Mild to moderate excoriation from urinary incontinence - should be managed by regular toileting and intensive skin care (the patient’s general condition must be taken into account). A urinary catheter may reduce mobility and increase the risk of pressure sores.
- Stroke- early catheterisation should be avoided if possible
- Confusion- avoid catheters where possible
- Incontinence- fully assess first, only use catheter if other methods fail

Advice and guidance gratefully received from:
- Magdi Kirollos, consultant urologist
- Helen Orchard, Tissue Viability Nurse Specialist
- Michael Swart, director of Intensive Care Unit
Antimicrobial prophylaxis for urinary catheter manipulation.

Background

Instrumentation of the urinary tract is a major risk factor for urinary tract infection and can precipitate bacteraemia.

Indications

Unless clinical indications exist (e.g., in patients with bacteriuria upon catheter removal post urologic surgery), do not use systemic antimicrobials routinely as prophylaxis for UTI in patients requiring either short or long-term catheterization. (Evidence category IB)

Patients with clinical evidence of a UTI (dysuria, frequency, supra-pubic pain AND a significant urine culture result) should be treated with appropriate antibiotics before or at the same time as catheter insertion or removal.

Antibiotic prophylaxis at catheter manipulation is only indicated in:

1. Patients with a history of catheter-associated sepsis, following catheter manipulation.
2. Patients who have been catheterised following urinary tract manipulation or instrumentation (e.g. transurethral resection of prostate).
3. Neutropenic patients (< 0.5 x 10^9/l or with a rapidly falling higher count).

Any benefit gained from prophylaxis in other patient groups is likely to be outweighed by the hazards of antibiotics, and is therefore not recommended.

Antibiotics

Gentamicin IV 3mg/kg (up to a maximum of 240 mg) just before procedure. This will be appropriate for most but microbiological isolates from urine specimens should be taken into consideration and prophylaxis adjusted accordingly.

For community patients where intra venous injection is not possible; Ciprofloxacin 500mg to be administered 30 minutes prior to procedure. Do not use ciprofloxacin if the patient has diarrhoea at present or if the patient has a history of Clostridium difficile associated diarrhoea.

For known ESBL or for further advice please contact the On Call Microbiologist.

All nurses should refer to the CAUTI CARE PLAN: High Impact Intervention No 6 Urinary Catheter Care Bundle at Appendix 7.
## Aseptic Catheter Insertion

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collect all the required equipment (catheterisation pack, gloves, sterile swabs, drainage bag, sterile lubricating anaesthetic gel 10ml syringe, 10ml sterile water, disposable pads, disposable apron etc). BARD Complete Catheter Packs containing the correct sized catheter should be used in the community, plus anaesthetic gel, and extra sterile gloves if required. It is also advised to have a spare catheter available.</td>
<td>Ensure all equipment to hand, prevent interruptions to procedure and promote adherence to aseptic technique. These sterile packs contain everything required for catheterisation, but only have a lubricating gel. The bag is already connected to the catheter. In case the one in the pack becomes contaminated.</td>
</tr>
<tr>
<td>2. Ensure dressing trolley is cleaned appropriately. Set up trolley utilising bottom shelf. In patient’s homes, ensure you prepare a private, clean area/surface.</td>
<td>To prevent interruptions to procedure and promote adherence to aseptic technique.</td>
</tr>
<tr>
<td>3. Select the correct catheter type, size and length for the patient &amp; include on trolley. Select correct catheter size BARD pack (See notes above for selection).</td>
<td>To ensure clinical need is met.</td>
</tr>
<tr>
<td>4. Confirm the patient’s identity and provide explanation of the procedure. Answer questions. Gain valid consent where possible.</td>
<td>To reduce anxiety and understand previous catheterisation history.</td>
</tr>
<tr>
<td>5. Screen bed, position patient and select appropriate site. Ensure adequate light and privacy.</td>
<td>Maintain privacy, dignity, comfort and safety.</td>
</tr>
<tr>
<td>6. Set up trolley/area with catheterisation pack and create a sterile field. Prepare equipment and catheter on sterile field, checking for faults or damage. Open packs maintaining sterile technique.</td>
<td>Prevent introduction of infection into the bladder.</td>
</tr>
<tr>
<td>7. Place disposable pad under patient, don disposable apron and gloves.</td>
<td>Prevent leaking of fluids onto bedclothes, or uniform.</td>
</tr>
<tr>
<td>8. Remove old catheter if in situ, by deflating balloon using a 10ml catheter tipped syringe.</td>
<td>Prepare area prior to aseptic catheter insertion.</td>
</tr>
<tr>
<td>9. Gently remove old suprapubic catheter rotating as withdrawing</td>
<td>To prevent trauma to the suprapubic tract.</td>
</tr>
<tr>
<td>10. The urinary meatus/ suprapubic site may be cleaned with soap and water at this point.</td>
<td>Prepare area prior to aseptic catheter insertion.</td>
</tr>
<tr>
<td>11. Remove gloves, and wash hands with soap and water according to Hand Hygiene policy. If there are no hand-washing facilities, clean hands using alcohol hand rub.</td>
<td>To maintain asepsis.</td>
</tr>
<tr>
<td>13. Attach the bag to the catheter</td>
<td>To maintain a closed system for insertion.</td>
</tr>
</tbody>
</table>
14. For a male, hold penis with a sterile gauze swab. For a female, hold the labia open with a sterile gauze swab. **Reduce risk of cross-contamination.**

15. Use sterile normal saline to clean urethral meatus or suprapubic site. **Reduce risk of cross-contamination.**

16. Apply sterile local anaesthetic and/or lubricating jelly into the urethra of both male and female patients. Wait for 4-5 minutes. **Prevent trauma and pain, lubricate and relax the urethra and minimise subsequent infection risk.**

17. Apply sterile lubricating jelly into the suprapubic catheter tract, or onto the new suprapubic catheter: Insert immediately. **Prevent trauma, and lubricate and relax the tract to minimise subsequent infection risk. To prevent the tract closing which could result in the need for emergency intervention**

18. Insert the catheter until urine flows. **Ensure catheter is correctly sited in the bladder and is draining urine.**

19. Place 10ml sterile water into catheter retention balloon. **To keep catheter in place.**

20. Secure the tubing and bag into position below the patient’s bladder, using leg straps or adhesive device. **To ensure drainage of urine, and prevent reflux and displacement of the catheter.**

21. Clean the urethral meatus or suprapubic site with gauze and sterile normal saline. Replace foreskin on males. **To remove leaked alcohol gel, and reduce the risk of infection To prevent paraphymosis**

22. Dispose of clinical waste, remove gloves and apron, and wash hands. **Reduce the risk of cross-contamination**

23. Document in patient notes using a catheterisation record sticker and catheter pack information sticker. **For professional accountability and information for colleagues.**

24. Complete patient’s catheter Care Plan. **Ensure continuity of catheter management in accordance with best practice**
Appendix 5

Failure of urine to drain

Urine may fail to drain for a number of reasons. Simple mechanical causes such as kinking of drainage tubing and equipment should be excluded first. Physical causes such as constipation and bladder spasm are also a common cause along with catheter encrustation. Debris is a common cause for catheter blockage in patients with long term catheters particularly when fluid intake is inadequate. Heavy bleeding/clots is another cause of catheter blockage in surgical cases, and that is usually obvious. It is common sense to address constipation if present, but that does not have any bearing to catheter drainage. Increasing fluid intake though is important in managing blocked catheters due to debris, etc.

Urine does not drain

Catheter previously draining
- Is there mechanical obstruction?
- Is the tube kinked?
- Is the bag valve occluded?
- Is the drainage bag below level of bladder?
- Does the drainage bag need to be emptied?

Newly inserted catheter does not drain urine
- Is the catheter correctly positioned in the bladder?
- Is the catheter selected the appropriate length?

Are catheter eyes blocked by:
- Anaesthetic gel?
- Bladder Mucosa?
Gently instil 20-30ml sterile water/saline to clear eyes.

Bladder Spasm
- This is the spasmodic contraction of the bladder (detrusor) muscle due to the presence of a foreign body. It usually stops after 24-48 hours, but may persist in some patients. It may occur secondary to blockage, large Charriere (Ch) size and large volume balloons. Management is based on addressing the cause. Large catheters and balloon should be replaced with smaller sizes and the catheter checked for blockage. Anti-cholinergic therapy may be useful if other treatments prove unsuccessful.

Remove and/or change catheter and inspect for ENCRUSTATION
Appendix 6

CATHETER MAINTENANCE SOLUTIONS

- Catheter maintenance solutions should be prescribed and authorised, and discontinued if not successful.
- All catheter maintenance solutions should be given aseptically, following individual assessment of need and as per attached instructions.
- They should only be considered after monitoring the catheter history and accurate assessment and documentation:
- Catheter maintenance solutions should only be used as part of a continuing care regime, and not as a one-off measure.
- Use a Suby G solution: UroTainer (Braun) or Optiflow (Bard).

Catheter maintenance solutions should only be used:

- If catheters are blocking more than once a week
- Where sediment is visibly present in catheter tubing.
- Increased fluid intake has proved ineffective.
- Where frequent catheter changes are painful /traumatic to patient.
- Constipation if present has been resolved with no benefit to catheter problem.

When instilling a catheter maintenance solution:-

- Warm it to body temperature (37°C) prior in instillation. Place the container in a jug of luke-warm water.
- Recommended catheter maintenance solutions to be used as per manufacturers guidelines.
- Use no more than three times a week and leave a break of a day. Work out individual regime using 20-30ml of solution depending on severity of case.
- NB This solution should not be used on augmented bladders as their effect on bowel is unknown and they may be absorbed, therefore use only saline to remove mucus.
- Use UroTainer (B/Braun Medical Ltd) or Optiflow (Bard).
- Instil as per attached guidelines.
- The contents should drain into the bladder under gravity only, not with any force.
- Leave solution in the bladder for approximately 5 minutes.
- Document frequency and type of catheter maintenance solutions plus batch number in nursing records.
- 60ml bladder-tip syringes should not be used for bladder irrigation.
- Do not use chlorhexidine.
- Do not use saline (except if patient has had bladder augmentation).
- Do not use Mandelic Acid
- Do not use solution R except under specific circumstances and with the involvement of the bladder and bowel Care Services.


Appendix 7

Trial without Catheter (TWOC)

For Post-operative patients there should be an aim to remove urinary catheters at about 24 hours post-op. Clinicians should be asked to review the necessity of a urinary catheter after this time.

All other patients ought to have their requirement for a catheter reviewed daily because by doing this; urinary catheter associated infections can be reduced by up to a half.

Trial without catheter in the community, should be undertaken in the morning, not out of hours, to ensure help/advice will be accessible.
**Urinary Catheter Record Sheet**

**This form Must be completed for Every catheter insertion**

**Aim:** To reduce the incidence of urinary tract infections related to indwelling urethral catheters (DH 2007)

**Insertion reason:**
- Acute retention: □
- Post operation: □
- Chronic retention: □
- Monitor output: □
- Trauma: □
- Replacement: □

**Name:**

**Medical Records number:**

**Date of Birth:**

**Ward:**

**Date of insertion:** / /20

**Type of catheter:** short / long term (circle)

**Size of catheter:** .............. ch

**Residual volume:** .............. mls

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**Urinary Catheter Record Sheet : Daily Assessment**

This Care Record must be completed once every 24 hours

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Catheter Care given – Print Name</th>
<th>Can the Catheter be Removed</th>
<th>If Yes date removed</th>
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<tbody>
<tr>
<td>Day 1</td>
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<td>Yes / No</td>
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<td>Day 2</td>
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<td>Day 21</td>
<td></td>
<td>Yes / No</td>
<td></td>
</tr>
</tbody>
</table>

**Increasing Risk of Catheter - associated UTI**

**At day 7:** If catheter is still in-situ, discuss clinical reason with medical staff and document plan for removal.

**Nurse / Doctor signature:**

**Print Name:**

**Date:**

**Reason for continued need :**

**Removed on:**

**Does the patient have signs of a catheter-associated UTI?**

CA-UTI must be at least two of the following criteria

- Pyrexia > 38°C or chills
- New flank or Suprapubic pain or tenderness
- Change in character of urine
- Worsening of mental or functional status
- If so, “Action Box” on reverse
**CA-UTI Action Plan:**

1. Perform urinalysis (from sample port) using ANTT technique
2. Send catheter specimen of urine to microbiology, stating the UTI clinical symptoms (e.g., pyrexia, burning pain etc)
3. Inform Doctor so that antibiotics can be prescribed (make sure you take the sample prior to commencement of antibiotics)
4. Remove catheter if no longer clinically required. If catheter is due to change then the replacement will require antibiotic therapy cover.
5. Explain to patient and or next of kin your findings and proposed treatment.

---

### Insertion Actions

<table>
<thead>
<tr>
<th>Catheter needed? Avoid if possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explain and discuss procedure with patients</td>
</tr>
<tr>
<td>• Obtain verbal consent and document</td>
</tr>
</tbody>
</table>

**Catheter selection:** All catheters must be standard length unless shorter is patient specific

- Female 10-12ch and Male 12-14ch
- Suprapubic 16 – 20ch. All new from 2016 will be 20ch
- Short-term catheters : Latex (PTFE) catheters last up to 28 days
- Long-term catheters : Silicone-coated catheters last up to 12 weeks

### Ongoing Care

**Personal protective equipment**

- Gloves and aprons are single-use items and should be removed and discarded immediately after the care activity.
- Eye/face protection is indicated if there is a risk of splashing with blood or body fluids.

**Hand hygiene**

- Decontaminate hands before and after each patient contact
- Use correct hand hygiene procedure

**Hand hygiene**

- Decontaminated hands before and after each patient contact
- Use correct hand hygiene procedure

**Clean the urethral meatus**

- Prior to insertion of catheter
- With sterile normal saline
- Use sterile anaesthetic lubricating jelly

**Aseptic technique**

- Apron, gloves and sterile dressing pack should be used for insertion of invasive devices

**Select and maintain a sterile, closed drainage system**

- Consider leg bag (plus night bag) combination to optimise patient mobility
- Consider flip-flo catheter valve to mimic normal bladder filling/emptying cycle, unless medically contra-indicated

**Patient education**

- Educate patient / carers re catheter care ; ensure they know why they have been catheterised
- Encourage adequate fluid intake unless medically contra-indicated

---

**Drainage bag position**

- To prevent contamination, the drainage bag should be above floor level with the tap tucked up
- To prevent reflux, the drainage bag should be below the level of the bladder and emptied when half full

**Catheter manipulation**

- Examination gloves should be worn to manipulate a catheter, and manipulation should be preceded and followed by hand decontamination

**Catheter needed?**

- Discuss plan for continued use of catheter with medical team
- Agree criteria for its removal and remove as soon as possible
# CATHETER CARE PLAN

## Name:
Or Insert label

## Team:

## NHS No:

## Date of Birth:

### Does the individual have capacity to give informed consent?  
Yes [ ] No [ ]

### If NO, has a best interest decision been made through MDT?  
Yes [ ] No [ ]

### Is a Mental Capacity Assessment required?
Yes [ ] No [ ]

## CURRENT PROBLEM / NEED

### Reason for catheter insertion:

### Date of first/ original insertion:

### Type of insertion:  
urethral / supra-pubic (circle appropriate)

### Type inserted:

### Length:  
Standard / female / paediatric (circle appropriate)

### Charrière:  
12 / 14 / 16 / 18 / 20 / 22 (circle appropriate)

### Catheter life expectancy in weeks:

## OBJECTIVE/ AIM

- Promote self-care strategies
- Ensure catheter is the most effective method for continence
- Reduce risk of healthcare associated infections (HCAI)
- Change catheter proactively and maintain patency

## ACTION PLAN TO MEET INDIVIDUAL NEEDS, TO INCLUDE REVIEW DATES

1. **Supply patient information leaflet**
   - Yes / No

2. **Assessed need for re-catheterisation**
   - Yes / No

3. **Can you discontinue catheterisation?**
   - Yes / No

    **If YES, what further action is required?**
    - [ ]

    **If NO, why not?**
    - [ ]

4. **Reduce risk of Health Care Associated Infections**
   - **Hand Hygiene** – decontaminate hands before and after each patient contact and use correct hand hygiene products
   - **Personal Protective equipment** – wear single use examination gloves, disposable apron and goggles if appropriate
   - **Aseptic technique must be performed**
   - **Meatal cleansing, soap and water / sterile saline**
   - **Safe disposal of sharps**

   NICE 2014

   EU Guidance 2013
4. **Change catheter proactively**

   Catheter changes are needed every:  
   Number of weeks

   Does this person need catheter instillation?  
   Yes / No

   Reason for catheter instillation and type of instillation  
   

   Name:

   NHS No:

   Date of Birth:

---

**RECATHETERISATION / CATHETER INSTILLATION RECORD**

- Reassessed need for recatheterisation (goal 1, 2,) Yes / No
- Reassessed need for catheter instillation (goal 4) Yes / No
- Informed Consent obtained (if no do not proceed) (goal 2) Yes / No

<table>
<thead>
<tr>
<th>Catheter size (Ch)</th>
<th>Instillation volume</th>
</tr>
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<tbody>
<tr>
<td>Catheter type</td>
<td>Type of instillation</td>
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<tr>
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<td>Lot no.</td>
<td>Expiry Date</td>
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<tr>
<td>Length</td>
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</table>

Procedure performed according to local guidelines for catheterisation, and in accordance with the aseptic technique, gloves and aprons worn, sharps disposed of safely  
Yes / No  
(If No, state reason below)

- Any unexpected occurrence during procedure (please state)

- Description of urine, and drainage amount (please state)

- Which drainage system used, and size of the leg/night bags (please state)

**THIS CARE PLAN IS SUPERCEDED BY CARE PLAN No:**

- Care Plan discussed with patient and consent gained Yes ☐ No ☐
- If No, consent has been gained for alternative agreed treatment Yes ☐ No ☐
- If No, document clearly on evaluation page and explain potential consequences to patient and document appropriate action taken.

**SIGNATURE:**

**DATE:**

**ROLE:**

**TIME:**
### Purpose of document:
Reduce the incidence of urinary tract infections related to indwelling urinary catheters
Standardise the care of urinary catheters, using evidence based guidelines, to ensure best practice across the healthcare communities served by Torbay and South Devon NHS Foundation Trusts. (TSDFT)

### Date of issue:
20 January 2017

### Next review date:
20 January 2019

### Version:
7

### Last review date:
28 April 2016

### Author:
Urology Specialist Nurses

### Directorate:
Organisation Wide

### Equality Impact:
The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief

### Committee(s) approving the document:
- Care and Clinical Policies Group
- Chief Nurse
- Medical Director
- Clinical Director of Pharmacy

### Date approved:
16 January 2017

### Links or overlaps with other policies:
All TSDFT Trust Strategies, policies and procedure documents: 0239 Hand Hygiene Policy

---

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| Does this document have implications regarding the Care Act? If yes please state: |
|------------------------------------------------------------------------------|-----|----|
|                                                                               |     |    |

| Does this document have training implications? If yes please state: |
|---------------------------------------------------------------------|-----|----|
|                                                                     |     |    |

| Does this document have financial implications? If yes please state: |
|---------------------------------------------------------------------|-----|----|
|                                                                     |     |    |

| Is this document a direct replacement for another? If yes please state which documents are being replaced: |
|--------------------------------------------------------------------------------------------------------|-----|----|
|                                                                                                       |     |    |
Document Amendment History

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<td>Director of Nursing and Professional Practice</td>
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<td>5</td>
<td>2 October 2015</td>
<td>Revised due to change in NICE Guidance 2015</td>
<td>Urology Nurse Specialist as advised by Director of Infection Prevention and Control</td>
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<td>6</td>
<td>28 April 2016</td>
<td>Revised due to change in NICE Guidance 2015</td>
<td>Urology Nurse Specialist as advised by Director of Infection Prevention and Control, and Deputy Director of Nursing, Professional Practice in the Community</td>
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</tbody>
</table>
The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions.

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person’s ability to make a decision due to ‘an impairment of or disturbance in the functioning of the mind or brain’ the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual’s right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.
### Quality Impact Assessment (QIA)

<table>
<thead>
<tr>
<th>Who may be affected by this document?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient / Service Users ☒</td>
<td>Visitors / Relatives ☒</td>
<td></td>
</tr>
<tr>
<td>General Public ☐</td>
<td>Voluntary / Community Groups ☐</td>
<td></td>
</tr>
<tr>
<td>Trade Unions ☐</td>
<td>GPs ☐</td>
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</tr>
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<td>NHS Organisations ☒</td>
<td>Police ☐</td>
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<td>Councils ☐</td>
<td>Carers ☒</td>
<td></td>
</tr>
<tr>
<td>Staff ☒</td>
<td>Other Statutory Agencies ☐</td>
<td></td>
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<tr>
<td>Others (please state):</td>
<td></td>
<td></td>
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</tbody>
</table>

**Does this document require a service redesign, or substantial amendments to an existing process?** No

*If you answer yes to this question, please complete a full Quality Impact Assessment.*

<table>
<thead>
<tr>
<th>Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Age ☐</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Gender re-assignment ☐</td>
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<tr>
<td>Pregnancy and maternity ☐</td>
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<tr>
<td>Religion or Belief ☐</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation ☐</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*If you answer yes to any of these strands, please complete a full Quality Impact Assessment.*

### If applicable, what action has been taken to mitigate any concerns?

**Who have you consulted with in the creation of this document?**

*Note - It may not be sufficient to just speak to other health & social care professionals.*

<table>
<thead>
<tr>
<th>Patients / Service Users ☐</th>
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<tr>
<td>Details (please state):</td>
<td>National Guidelines</td>
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</table>
Rapid Equality Impact Assessment (for use when writing policies and procedures)

<table>
<thead>
<tr>
<th>Policy Title (and number)</th>
<th>Urinary Catheter Standards of Care Ref:1020</th>
<th>Version and Date</th>
<th>6 19/10/2016</th>
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<tbody>
<tr>
<td>Policy Author</td>
<td>Urology Specialist Nurses</td>
<td></td>
<td></td>
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</table>

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

**EQUALITY ANALYSIS:** How well do people from protected groups fare in relation to the general population?

**PLEASE NOTE:** Any ‘Yes’ answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

<table>
<thead>
<tr>
<th>Age</th>
<th>Disability</th>
<th>Sexual Orientation</th>
<th>Race</th>
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</table>

Is it likely that the policy/procedure could affect particular ‘Inclusion Health’ groups less favorably than the general population? (substance misuse; teenage mums; carers; travellers; homeless; convictions; social isolation; refugees)

Yes ☐ No ☒

Please provide details for each protected group where you have indicated ‘Yes’.

**VISION AND VALUES:** Policies must aim to remove unintentional barriers and promote inclusion

<table>
<thead>
<tr>
<th>Is inclusive language used throughout?</th>
<th>Are the services outlined in the policy/procedure fully accessible?</th>
<th>Does the policy/procedure encourage individualised and person-centered care?</th>
<th>Could there be an adverse impact on an individual’s independence or autonomy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</table>

If ‘Yes’, how will you mitigate this risk to ensure fair and equal access?

**EXTERNAL FACTORS**

Is the policy/procedure a result of national legislation which cannot be modified in any way? ☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?) 2 Yearly review out of date

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Original Catheter Care Standards Group, Urology Nurses, Deputy Director of Nursing - Professional Practice

**ACTION PLAN:** Please list all actions identified to address any impacts

<table>
<thead>
<tr>
<th>Action</th>
<th>Person responsible</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated with new legislation and references</td>
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**AUTHORISATION:**

By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

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<tr>
<th>Name of person completing the form</th>
<th>Validated by (line manager)</th>
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<tbody>
<tr>
<td>Urology Nurse Specialist</td>
<td>Matron</td>
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<tr>
<td></td>
<td>Deputy Director of Nursing and Professional Practice</td>
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