POLICY FOR CATHETER MANAGEMENT

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1. INTRODUCTION

Urinary catheterisation is the insertion of a specially designed tube into the bladder, using an aseptic technique. It is an invasive procedure and should not be undertaken without full consideration of the benefits and risks. The presence of a catheter can be a traumatic experience for patients and have huge implications for body image, mobility, pain, and discomfort (The Royal Marsden Hospital 2024).

There is consistent evidence available to show that infection is a significant risk associated with urinary catheterisation. NICE (2014) suggests that catheter-associated urinary tract infections comprise a large proportion of healthcare associated infections and can occur whether a person has a long- or short-term catheter. There is a strong association between the duration of urinary catheterisation and the risk of infection, and catheters are sometimes inserted inappropriately or there is delay in removing them. This risk is greatly reduced by complying with all parts of the process for safe catheter insertion, maintenance, and removal as soon as it is no longer needed. This is important in terms of both infection prevention and patient comfort and experience.

Nurses are primarily responsible for the insertion and management of urinary catheters, and therefore it is essential that they have the appropriate knowledge and skills to undertake the role safely. Male catheter insertion can be carried out by a suitably trained practitioner, if safe to do so. A catheter for end-of-life care or continence management can be inserted after an assessment by a nurse or paramedic.

When inserting a catheter for urinary retention, additional advice and assessment should be sought; this could be from the GP, and Advanced Clinical Practitioner (ACP) or the local urology team. Urinary retention is complex and may be present in various ways for different pathological processes. Urinary retention may be chronic, acute or acute on chronic. In about 10% of cases diuresis is excessive, patient could become acutely unwell and requires careful fluid replacement. Advice has been sought from Mr Gupta, Consultant Urologist JPUH in November 2024, he has reviewed literature and although he has found it does not mention any volume as contraindication for catheterisation in the community a patient with a residual of over 1000ml requires hospital admission. Most guidelines emphasise that urinary output should be monitored and if it is excessive, then it needs to be replaced appropriately. The risks of excessive diuresis are obviously higher with bigger volume but there is no specific cut off point above which catheterisation in community is contraindicated. The nurse or paramedic should carefully record urine drained for 15 minutes after catheterisation to establish the true residual. Fluid output should then be monitored to assess diuresis. The patient or carer should be asked to monitor their output and if it is excessive (over 2.5L in one hour), consideration for hospital admission should be made. Ongoing medical assessment, treatment and referral is required for this group of patients.

While it is the nurses' responsibility to maintain and improve their professional knowledge and competence, these guidelines have been written to aid nurses and Assistant Practitioners (AP) within East Coast Community Healthcare CIC (ECCH) and standardise practice when inserting urethral catheters and changing supra

pubic catheters. Make the care of people your first concern, treating them as individuals and respect their dignity (Nursing and Midwifery Council 2011).

The policy standards here are related to catheter management for patients in their own homes, Community Hospitals and ECCH premises, which will ensure best practice.

2. PURPOSE

The purpose of this policy and procedure is to ensure that relevant staff have been trained and are competent to carry out the procedure.

3. SCOPE

This policy and procedure relates to ECCH Community Hospital and Community based staff.

4. DEFINITIONS

The following definitions are intended to provide a brief explanation of the various terms used within this policy.

Term	Definition
Policy	A policy is a formal written statement detailing an enforceable set of principles or rules. Policies set the boundaries within which we operate. They also reflect the philosophy of our organisation.

5. RESPONSIBILITIES

- **ECCH Employees** – Are responsible for the implementation of this policy and following the requirements of the policy, ensuring best practice.
- **Chief Executive of ECCH** – Overall responsibility for the enforcement of this policy lies with the Chief Executive of ECCH

6. POLICY STATEMENT

This policy will be implemented to ensure safe practice and every effort is undertaken to keep the patient as free from micro-organisms as possible.

7. REASONS FOR CATHETERISATION

- Monitoring urine output when a person is critically unwell
- Acute urinary retention
- Chronic urinary retention; only if symptomatic and/or with renal compromise
- During and after certain surgical procedures
- To enable bladder irrigation
- To enable medications to be administered directly
- To bypass an obstruction;
- To enable bladder function tests
- As a last resort treatment for urinary incontinence when all other conservative treatment methods have failed
- To obtain a sterile specimen of urine

Urinary catheterisation is an invasive procedure and should not be undertaken without full consideration of the benefits and risks. The presence of a catheter can be a traumatic experience for patients and have huge implications for body image, mobility and discomfort. Patient needs should be assessed and only considered for catheterisation as a last resort, or if it is considered the best option available (NICE 2012). Routine catheterisation must not be routinely supported by nurses, particularly in specific patient groups such as fracture neck of femur.

The Nursing and Midwifery Council (NMC 2018) published Standards of Proficiency for Registered Nurses. They stated that Registered nurses play a vital role in providing, leading and coordinating care that is compassionate, evidence-based, and person-centred. They are accountable for their own actions and must be able to work autonomously, or as an equal partner with a range of other professionals, and in interdisciplinary teams. In 2008 the NMC states that nurses performing urinary catheterisation should have:

A good knowledge of the urinary tract anatomy and physiology

- A sound knowledge of the principles of aseptic technique
- A knowledge of equipment and devices available
- Awareness of infection control practice and legislation
- Practice within the limits of competence and be able to recognise when they need to seek help from more experienced staff
- Understanding of the issues of informed consent and a knowledge of the Mental Capacity Act
- The ability to deliver care based on the best available evidence or best practice.

It is the responsibility of the assessing nurse to ensure that the patient/carer is aware of all the potential problems before the decision to catheterise is being made. The nurse must be sure, in consultation with the doctor, patient and/or carer, that the decision to catheterise is made for the right reasons and not for the convenience of the carers.

The reason for continued use of a urinary catheter **must** be reviewed at every change. The nurse should consider alternative methods of treatment or management. This may include:

- Voiding techniques.
- Penile sheath.
- Male/Female urinals.
- Disposable or re-usable incontinence products.

8. CATHETER SELECTION

A wide range of urinary catheters are available, made from a variety of materials and with different design features. Careful assessment of the most appropriate material, size and balloon capacity will ensure that the catheter selection is as effective as possible for the intended purpose, that complications are minimised, and that patient comfort and quality of life are promoted. Catheters should be used in line with the manufacturer's recommendations, in order to avoid product liability (Royal Marsden 2024).

Material and length of use

The key criterion in selecting the appropriate material is the length of time the catheter is expected to remain in place.

Intermittent

- Polyvinyl chloride (PVC) non-coated: are quite rigid and require lubrication prior to insertion.
- Hydrophilic coated catheters: impregnated with a coating, which lubricates the catheter throughout the entire catheterisation process. Hydrophilic catheters may require activation with water. Good quality drinking water or from a pre-filled sachet provided can be used.

Short to mid term (up to 28 days)

- Latex: Latex is a purified form of rubber and is the softest of the catheter materials. It's surface is smooth and has a tendency to form a crust. Latex absorbs water and swells, reducing the size of the lumen. It can also cause urethral irritation and should only be used short term up to 7 days. Patients should always be asked whether they have had an adverse reaction to rubber products before catheters containing latex are utilised (Royal Marsden 2024).
- Polytetrafluoroethylene (PTFE): The coating is applied to a latex catheter to render the latex inert and reduce irritation. These catheters are normally for short to mid term, check the manufacturer's recommendations.

Long term (up to 12 weeks)

- Hydrogel coated latex: a latex core catheter, coated with a hydrophilic polymer coating provides very smooth internal and external surfaces, which are resistant to encrustation. They are also inert and well tolerated by the urethral mucosa.

- All silicone: these are made by an extrusion process, which makes a thin-walled catheter, which has a large D shaped lumen. Due to the inert nature of silicone, they can reduce irritation and are suitable for those with a latex allergy. However, they are relatively stiff, and some patients find them uncomfortable. Because silicone permits gas diffusion, balloons may deflate and allow the catheter to fall out prematurely.

Other materials

Research into new types of catheter materials is ongoing, particularly examining materials that resist biofilms and urinary tract infection. All catheterised bladders show an increase in bacteria in the urine, no matter what material or coating is used, although some materials are more resistant than others. However, after 30 days these differences disappear and all patients have bacteriuria (Leaver 2017).

Catheter length

The three lengths available are:-

- **Paediatric -** length 30cms
- **Female -** length 26cms; the shorter female length is often more discreet and less likely to cause trauma or infections because movement in and out of the urethra is reduced. Infections may also be caused from a longer catheter looping or kinking. In obese women, or those bed-bound or wheelchair bound, the inflation valve of the shorter catheter may cause soreness by rubbing on the inner thigh and pulling on the bladder neck, therefore a standard length should be used. Be aware that some manufacturers use a longer length 33cm female catheter, extra care should be taken not to insert these into male urethras.
- **Standard -** length 40cms (must be used for all male urethral catheterisations but can also be used for some female urethral catheterisation after assessment)

Balloon size

- **3 to 5ml -** Paediatric balloon.
- **5 to 10ml -** balloon for adults.
- **20-30ml -** balloon should only be used in specific circumstances such as post prostatic surgery, but their use should always be questioned. The heavier weight and larger balloon may cause bladder spasm, damage the bladder neck and irritation of the trigone.

Catheter balloons should be filled as specified by the manufacturer. They should never be over or under filled, as this can lead to a misshaping of the balloon that could interfere with urine drainage.

The balloon should always be filled with sterile water or specially filled syringe of glycerine which resists unwanted deflation.

Some manufacturers have produced pre-filled catheters. A reservoir of water is included in the catheter packaging and simply needs to be released once the catheter has been inserted.

The catheter balloon should only be inflated once; deflation/re-inflation or topping up are not recommended by the manufacturers, as distortion of the balloon may occur (Royal Marsden 2024).

Catheter size

The external diameter of the catheter is measured in charriere (Ch). One Ch equals 1/3 of an mm, therefore 12 Ch=4mm.

The smallest size should be chosen to provide adequate drainage. Larger sizes can cause irritation and bypassing of urine around the catheter. The larger sizes are usually reserved for clot drainage and stricture dilation. In any other situation their use should be questioned.

Supra pubic catheters should be replaced with the same size as removed unless there are specific instructions to change the size. Often larger size catheters are used (size 16ch and above). If a smaller catheter is inserted the supra pubic site will quickly contract and a larger size will no longer be able to be inserted without surgical intervention.

Catheter Tip

Urinary catheters have been developed with different tips to aid insertion and drainage. Most catheter are round tipped and aid easy insertion. Tiemann or Coude tipped catheters have curved tips. Most of the time, this catheter type is used by patients who have a narrow urethral path or prostatic obstruction. The catheter should be inserted with the tip facing up. Open ended tipped catheters provide excellent drainage and can be used in patients whose catheters frequently block.

Catheter material, length, balloon volume, tip and size must be specified on the prescription and in the patient notes.

9. INFECTION CONTROL

Catheter associated urinary tract infection (CAUTI).

Urinary tract infection is the most common Healthcare Associated Infection accounting for 19% of all such infections, between 43%–56% of which is catheter-associated, highlighting an additional need to prevent CAUTI to help reduce antimicrobial resistance. Preventing CAUTI requires the avoidance of insertion, unless there is clear justification, and removal of the catheter as soon as it is no longer needed, in addition to adopting best practice techniques of catheterisation (Broom et al 2022).

Bladder irrigation, instillation and washouts must not be used to prevent catheter associated infection (Jordan 2022).

Select the most appropriate type of catheter and drainage system to be used.

All catheterisations carried out by Healthcare workers should be aseptic procedures (NICE 2017). A urinary tract infection may be introduced during catheterisation because of faulty Aseptic Non Touch Technique (NTAT), inadequate urethral cleaning,

or contamination of the catheter tip. Infection can also be introduced via the drainage system because of faulty handling of equipment, breaking the closed system or raising the drainage bag above bladder level causing urine reflux.

If a Urinary tract Infection (UTI) is suspected (See eastern pathology Alliance EPA guidelines appendix1) a specimen of urine must be sent for analysis.

The maintenance of a closed drainage system is central in reducing the risk of catheter associated infection. It is thought that micro-organisms reach the bladder by two possible routes: from the urine in the drainage bag, or via the space between the catheter and the urethral mucosa. To reduce the risk of infection, it is important to keep manipulation of the closed system to a minimum, this includes, changing the drainage bag, unnecessary emptying, or taking samples.

Before handling catheter drainage systems, hands must be decontaminated, and a pair of clean non-sterile gloves and disposable apron should be worn. (ECCH Standard Precaution Policy 2022). Urine samples should be obtained aseptically via specially designed sampling ports, or in the case of a catheter valve, directly from the valve. Samples should not be taken from the catheter bag as the sample may be contaminated (Shepherd 2017).

Education

Patients and carers should be educated about and trained in techniques of hand decontamination, insertion of intermittent catheters where applicable, and catheter management before discharge from hospital. Additional support may be required by community staff.

Community and primary healthcare employees must be trained in catheter insertion, including suprapubic catheter replacement and catheter maintenance.

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

Catheter insertion

All catheterisations carried out by healthcare employees should be NTAT. After training, healthcare employees should be assessed for their competence to carry out these types of procedures by supervision and complete yearly Essential steps to safe clean care and 3 yearly catheter update training available on ESR.

Intermittent self-catheterisation is a clean procedure. A lubricant for single-patient use is required for non-lubricated catheters.

An appropriate lubricant from a single use container should be used during catheter insertion to minimise urethral trauma and infection.

Routinely document the date of insertion and date of removal of the catheter in the clinical records (RCN 2013).

Routine catheter changes

As part of good practice, as recommended by the ECCH/JPUH Consultant Microbiologist, Harish Reddy (update October 2024) patients who are MRSA positive and require a routine catheter change should have Octenisan body washes for 2 days prior to re-catheterisation and for 2 days after, including a daily bed linen change. If a catheter requires an unplanned change, the health professional should wash patient with Octenisan at the time of insertion of catheter, the patient should then use Octenisan body wash for two days post insertion. The clinician should the patients record to establish if they are MRSA positive, an alert will have been recorded on the notes by IPAC.

Catheter passport

All patients who have an indwelling catheter should be issued with a 'Catheter passport'. This should be with the patient to all healthcare appointments and admissions. This must be completed by the Healthcare professional on every catheter change. See appendix 2.

10. EDUCATIONAL REQUIREMENTS FOR CLINICAL PRACTICE

The Code (NMC 2024) states that nurses and nurse associates should make patient care and safety their main concern. They should make sure that patient's dignity is preserved and their needs are recognised. Nurses and nurse associates work within the limits of their competence.

The registered nurse is accountable for ensuring that the delegation of any task is appropriate and in the best interest of the patient (RCN 2011)

Assistant practitioners may undertake scheduled catheter changes only, following a patient assessment by a registered nurse if:

The AP has been deemed competent in the safe removal and insertion of catheters by completing theory and practice training provided by ECCH

The registered nurse agrees that it is appropriate to delegate the catheter task to the particular AP. This change should be routine and not complex. For example: the catheter may potentially be difficult to insert or remove, there has been bleeding on previous catheterisations, patient has autonomic dysreflexia or has an abnormal anatomy such as phimosis or hypospadias.

The patient consents to the AP carrying out the procedure.

The AP must be assessed catheterising patients before being deemed competent to undertake the procedure.

AP's have an individual responsibility to ensure they are confident and competent in knowledge and practice skills.

A relative or carer may in some circumstances, carry out re-catheterisation (urethral/intermittent/ supra-pubic). In these circumstances, the Nurse/Health professional has the responsibility of ensuring that the carer has the necessary

knowledge and competence to both carry out the procedure and manage the catheter/drainage system to a high standard.

Below is a table that guides ECCH staff on the minimum requirements of supervised and observed practice. It is recognised that some individuals may require more supervised and observational practice and it is the responsibility of the individual practitioner to decide when competence has been achieved. Updating of skills and knowledge is essential for good practice and individual practitioners will be responsible for availing themselves of the published literature and research evidence on aspects of catheterisation. The Continence Team holds a variety of information.

All ECCH staff that care for or insert catheters should complete theory session delivered by the continence team, be assessed as competent, the yearly Essential Steps framework that can be located on QUEST and 3 yearly ESR update.

Observation/supervised practice guideline (minimum requirements)

Type of Catheterisation	Observation in Clinical Area	Supervision in Clinical Area	Catheterisation carried out by
Female Urethral	Two	Two	Registered Nurse Paramedic who has attended additional ECCH training workshop Assistant Practitioner Nurse associate Trainee Nurse associate with supervision Carers in some circumstances with appropriate training. Student Nurse with supervision.
Male Urethral	Two	Three	Registered Nurse who has attended additional ECCH training workshop. Paramedic who has attended additional ECCH training workshop Assistant Practitioner who has attended additional ECCH training workshop Nurse associate who has attended additional ECCH training workshop.

			Carer in some circumstances with appropriate training. Trainee Nurse associate or Student Nurse if received additional training and under supervision.
Female Intermittent	One	One	Patient themselves or Carer in some circumstances with training. Registered Nurse. Paramedic who has attended additional ECCH training workshop Nurse associate Student Nurse with supervision.
Male Intermittent	One	One	Registered Nurse who has attended additional ECCH training workshop. Paramedic who has attended additional ECCH training workshop Assistant Practitioner who has attended additional ECCH training workshop Nurse associate who has attended additional ECCH training workshop Carer in some circumstances with appropriate training. Trainee Nurse associate or Student Nurse if received additional training and under supervision.

Supra-pubic	Two	Two	1st change by GP or Hospital Consultant 1st change after 4 weeks in situ and subsequent changes by: Registered Nurse who has attended an additional ECCH workshop. Assistant Practitioner who has attended additional ECCH training workshop Nurse associate who has attended additional ECCH training workshop Paramedic who has attended additional ECCH workshop Carers in some circumstances with appropriate training. Trainee Nurse associate or Student Nurse if received additional training and under supervision.

11. CATHETER REMOVAL

Catheters should be changed only when clinically necessary or according to the manufacturer's current recommendations (NICE 2012).

Removal of male and female urethral catheters for the purpose of a trial without catheter (TWOC) can be undertaken by a competent Registered Nurse or Assistant Practitioner.

Commented [KW1]: Should that include AP/NA?

All indwelling catheters (Whether urethral or supra-pubic) must have the balloon deflated prior to removal.

The water is removed from the balloon using a syringe fitted into the inflation/deflation valve. (Care needs to be taken to avoid violent suction, which will collapse the inflation channel making deflation of the balloon difficult).

If deflation is not achieved through this means:

DO	DO NOT
▪ Try a different syringe. ▪ Leave the syringe attached for 20 minutes. ▪ Check if the patient is constipated. "Milk" the catheter along its length between thumb and finger to unblock or remove obstructions caused by debris or encrustation. ▪ Insert a 2 mls of air and then draw back on the syringe- this creates a vacuum which may precede deflation. ▪ Insert a 2 mls of sterile water which may help clear a blockage. ▪ If all else fails, attach an orange needle to the syringe and pierce the catheter below the valve, inserting the needle into the inflation chamber, then draw back. This method will bypass a faulty valve. ▪ If the balloon still does not inflate, then seek medical assistance.	▪ **NEVER** attempt to burst the balloon by over inflating it. ▪ **NEVER** cut the catheter or the inflation arm. Any complications created by either of these methods will be the responsibility of the person performing them. ▪ **NEVER** leave the catheter in situ for longer than the recommended time. The nurse is professionally accountable for using products according to manufacturer's instructions. **ACA (2007).**

Ask the patient to breathe in and out: as the patient exhales (gently but firmly with continuous traction) remove the catheter. Clean the meatus (Royal Marsden 2024).

Document type of catheter, date of insertion/removal, batch number and expiry date as well as any problems encountered on removal. Faulty catheters, bags and valves must be reported immediately for action to be taken.

12. DRAINAGE SYSTEMS

A wide variety of drainage bags and systems are available. Selecting a system involves consideration of the reasons for catheterisation, intended duration, the wishes of the patient and infection control issues.

Healthcare professionals should ensure that the connection between the catheter and the urinary drainage system is not broken except for good clinical reasons (NICE 2012).

Leg bags, catheter valves or freestanding drainage bags will normally remain connected to the catheter for 5-7days. More frequent disconnections will break the closed system and increase the risk of infection.

Leg bags, bed bags and night bags

Some patients will prefer to use a leg bag. These are available in 350, 500 and 750ml volumes, with short, medium or long tubing. There are also some specialist bags like belly bags and pocket bags that may be suitable for some individuals.

Most catheter bags are fitted with an anti-reflux valve to prevent backflow of urine into the bladder. It is important to ensure the bag is below the level of the bladder to maintain drainage. However, the catheter bag should not hang too low (more than 30cm) below the level of the bladder, as this will cause negative pressure resulting in bladder mucosa being sucked into the eyes of the catheter leading to bypassing or blockage. The bag should not be in contact with the floor (NICE 2012).

Patients who require a leg bag by day and a higher capacity bed bag by night should use the “link system”. The leg bag is not disconnected from the catheter, but rather the night bag is connected to the drainage tap of the leg bag.

The urinary drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux (NICE 2012).

A single use non drainable night bag should be used for all patients. Never reuse, wash urine bags or reconnect them in any care setting (RCN 2021). Where a patient is on bed care and does not use a leg bag a drainable night bag can be used and changed every 5-7 days.

Patients should be encouraged to empty their own catheter bags whenever possible to promote independence and dignity. Hands should be washed before and after the procedure, if the bag is being emptied by a nurse or professional carer, gloves and apron should be worn.

Leg bags should be secured with leg straps or a leg sleeve. The use of thigh straps and other fixation devices help to immobilise the catheter and thus reduce the trauma potential to the bladder neck and urethra. It is recommended that all catheter uses secure their catheter in this way (Royal Marsden 2024). Urine bags should be hung on a suitable stand to avoid contact with the floor. Stabilisation devices can be loosened or removed at night for comfort, but can also stay in place to stabilise the catheter.

Catheter valves

Catheter valves were first introduced to the UK in 1986 and have since been shown to be suitable for both male and female patients with indwelling or supra-pubic catheters. Catheter valves are small devices attached directly to the catheter, allowing control of bladder emptying. The introduction of the catheter valve has widened the choice of therapeutic interventions that are available to the catheterised patient, with the potential for significant clinical benefits.

The Benefits of Valves include providing independence from cumbersome drainage bags and encourages normal bladder function, maintaining detrusor muscle tone and bladder capacity.

Some patients may not be suitable to use a catheter valve. All patients require individual assessment prior to the use of a valve. Patients and carers should

understand the rationale behind the use of a valve and have the mental capacity to remember to release the valve at regular intervals if their bladder sensation is compromised. Valves may be inappropriate if bladder capacity is very limited. This might be the cause if the patient has been on free drainage for many years. However, capacity can be increased if a regime for the frequency of opening/closing the valve is planned carefully, decreased gradually and support is given to both patient and carer. The use of catheter valves is individualised. Some patients may leave their valve closed overnight if a full bladder wakes them, others may attach to free drainage with a night bag. Catheter valves may be inappropriate for patients with uncontrolled overactive bladder, ureteric reflux or renal impairment (Royal Marsden 2024).

13. APPROPRIATE USE OF BLADDER SOLUTIONS

It has been identified that there are a group of patients with indwelling catheters whose catheters block on a regular basis regardless of what has been done to try to prevent the blockage. It has been suggested that for this group, regular catheter changes is best management and by identifying these “blockers” it allows for planned catheter management. It is suggested that keeping a catheter calendar, encourages proactive catheter care, identifying the potential problem before it becomes a real problem ensuring the catheter remains patent (ACA 2007). Changes should be planned regularly according to the pattern of an individual catheter life (Holtom 2004).

Recurrent catheter encrustation leading to blockage occurs in up to half of patients who are catheterised long-term. Bacteria in the urine, most commonly Proteus, produce an enzyme called urease, which splits urinary urea into ammonia and carbon dioxide. This results in an increase in alkalinity, conditions for the development of crystals e.g. Struvite and Calcium Phosphate. The crystals develop around the eyelets, balloon and internal lumen of the catheter (ACA (2007)). Catheter washouts are designed to dissolve the encrustation or reduce growth of the alkaline bacteria.

There is much debate surrounding the use and effectiveness of bladder irrigation solutions. Only a small amount of solution is required to bathe the tip. The registered nurse must first perform a full, holistic nursing assessment to establish rationale for catheter blockage and rule out any obvious issues (Jordan 2022). This is further supported by Thomas (2020) who suggests that these solutions should not enter the bladder. Their primary purpose is to clear any build-up within the catheter. Citric acid solutions ‘G’ and ‘R’ have been found to potentially dissolve encrustation but have also been identified that they should be used with caution, as benefits may be outweighed by inflammatory tissue reactions.

Bladder washouts should never be routinely administered to catheterised patients without a therapeutic intervention and should not be used as a substitute for re-catheterisation if this is what is required (Addison 2000).

Bladder instillations or washouts must not be used to prevent catheter-associated infection (NICE 2012). Smaller volumes of washout (50ml) are as effective as the standard 100ml and two sequential washouts with 50ml are more effective than a single washout (Holtom 2004).

Catheter maintenance solutions are prescription only medication (POM) and should be treated in the same way as any POM medication. The solution should be prescribed

for each individual patient as per ECCH prescribing formulary. At present all of the catheter maintenance solutions are available in the Nurse Prescribing formulary. They can therefore be prescribed by nurses who hold a Nurse Prescribing qualification (ACA 2007).

A Healthcare assistant (HCA) may carry out the administration of a catheter solution once they have been assessed as competent to carry out the procedure. The HCA may carry out a washout on patients who have been assessed by a trained nurse as requiring a prescribed regime of washouts to maintain their indwelling catheter. The use of the washout should be identified in the patient's plan of care. The HCA should not be the sole provider for this aspect of care; it is recommended that the HCA should not carry out more than 2 consecutive washouts before the trained nurse assesses the patient. The HCA should only carry out the washout as part of a plan of care. They should not perform the procedure in cases of acute catheter blockage, as this situation would require assessment by a trained nurse. See Appendix 3 Catheter process chart which will advise what to do in the event of frequent blocking of catheters.

14. PATIENT INFORMATION

The catheter passport is a patient held document that provides detailed information about their catheterisation (Wamburu et al 2024). This includes the type of catheter used, the date of insertion, and any specific care instructions. The passport aims to improve communication between healthcare providers and patients, ensuring consistent and accurate care. Further patient information leaflets are available from the ECCH Continence Team or from ECCHO.

15. CATHETER ASSOCIATED URINARY TRACT INFECTION

If the patient is assessed as having a suspected or proven catheter associated urinary tract infection (CAUTI) the Eastern Pathology Alliance algorithm should be followed (Appendix 1 & 2) Symptoms indicative of a CAUTI include loin pain or temperature of less than 36 0C or more than 38.3 0C or clinical sepsis and no other source of infection evident. The algorithm states that patients should be treated with empirical antibiotics following local guidelines and if clinically septic consider need for hospital review. The catheter should be removed or changed after the first dose of antibiotic.

16. MONITORING AND REVIEW

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to best practice. Yearly audits using Essential Steps to Clean Safe Care will be completed by staff carrying out catheterisation and 3 yearly update on ESR will be completed. This document will be reviewed by the Continence Team every two years, or sooner if changes in legislation occur or new best practice evidence becomes available.

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18. ASSOCIATED POLICIES & PROCEDURES *(To include but not limited to)*

- East Coast Community Healthcare (2022) Standard Precautions Policy.

19. AUTHOR

Helen Notley and Karen Dewbery - Continence Team – July 2025

20. APPENDICES

Appendix 1 - Female Catheterisation SOP
Appendix 2 - Male Catheterisation SOP
Appendix 3 - Suprapubic Catheterisation SOP
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Appendix 1 – Female Urethral Catheterisation

Standard operating procedure (SOP) - Female Urethral Catheterisation

Purpose

To ensure that female urethral catheterisation complies with national guidance and standards for practice and risks associated with insertion of urinary catheters are managed effectively.

Scope

This SOP sets standards for all staff undertaking female urethral catheterisation.

Unregistered staff, providing planned care to female patients requiring urethral catheterisation will be signed off with competent to conduct this intervention.

Unregistered staff must undertake 3 yearly on-line catheter e-learning and are assessed yearly by a competent Registered Nurse as competent in both catheterisation and Aseptic Non-Touch Technique (ANTT).

The patient should be seen by a Registered Nurse for a full holistic assessment and treatment plan before this intervention is delegated to unregistered staff and for review at least annually.

This SOP does NOT apply to suprapubic catheters.

Staff are expected to ensure that the risks to patients with neurological conditions are understood and managed appropriately.

Known risks

- infection
- trauma
- encrustation
- medication i.e. Warfarin
- sensitivities
- bleeding
- autonomic dysreflexia

Equipment required to conduct the procedure

- Urinary Catheter Insertion Pack (or wound care pack if not available)
- Additional pair of sterile gloves
- One pair of non-sterile gloves
- Sterile prefilled Catheter
- Sterile lubricating gel
- Alcohol hand rub
- Sterile saline – for labial cleansing
- Stabilisation device
- Syringe x 2 (if not included with catheter)
- Catheter valve or leg drainage bag
- Drainage system

Urethral Catheter Selection

The formulary is available on ECCHO

Catheter Length

The three lengths available are:

- Paediatric 30cm (only direct from manufacturer)
- Female 26cm for ambulatory female patients
- Standard 40cm used for male patients and female non-ambulatory or high BMI patients or where this is patient preference.

Balloon Size

- 10 ml balloon for routine drainage (**ALL** community patients). 5 ml can be used on appropriate patients after clinical assessment, with suitable catheter as per manufacturers guidelines.
- 30ml balloon **only** for hospital, urological post-operative use and as a haemostat. N.B. 30 ml balloons are NOT suitable for Community use as the weight of water in 30 ml balloons may lead to dragging/pulling of the catheter on the bladder neck. They may also cause bladder spasm and discomfort due to pressure against the trigone of the bladder.
- Balloons must **only** be filled with sterile water.
- The volume of water specified by the manufacturer will be inserted.
- Over inflation will **not** prevent a catheter from being expelled.
- Under inflation will result in catheter tip deflection which may increase bladder spasm and /or necrosis.

Charriere size

- Choose a catheter with the smallest possible diameter that will allow adequate drainage. This should be decided on individual patient assessment. Larger diameter catheters are associated with increased bladder irritability resulting in painful spasms and leakage. Guidelines suggest Female 12/14ch.
- Larger catheters can cause urethral irritation and bypassing around the catheter. Larger charriere sizes (i.e. 18 or above) will only be used if clots or debris are present, post operatively or for supra-pubic catheterisation, (if size 16 is not appropriate).

Designed locally, endorsed by ANTT

ANTT®
Aseptic non touch technique

Community Indwelling Urinary Catheterisation (Standard ANTT)

for the ANTT practice principles see: www.antt.org.uk

Cv01

When entering the patient's home clean hands

1

Gather equipment

2

Open pack
Manage as a general aseptic field using NTT

3

Apply disposable apron

4

Clean hands
with alcohol hand rub or soap & water

5

Apply sterile gloves

6

Prepare equipment
using non-touch technique (NTT)

7

Apply aseptic field drapes
over genitals & between legs

8

Clean urethral orifice with normal saline & gauze

9

Insert lubricating gel

10

Dispose of gloves
Clean hands
Apply sterilie gloves

11

Insert catheter
Using NTT by only touching the plastic wrapping

12

Ensure drainage of urine observed
Inflate balloon
using NTT

13

Attach collection bag
using NTT

14

Dispose of waste,apron & gloves

15

Clean hands
with soap & water or alcogelimmediately after glove removal

When leaving the patient's home clean hands

Pre-procedure

- Explain procedure and gain informed consent. Consent is a patient's agreement for a health professional to provide care. Before health care professionals examine, treat or care for any person they must obtain their valid consent in line with ECCH's Consent to Examination and Treatment Policy and the Mental Capacity Act Policy. There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.
- If the health professional feels that the patient has the capacity to give consent, their decision will be accepted and the wishes of the patient will continue to be respected, even if they lose capacity at a later stage.
- If the health professional feels the patient does not currently have the capacity to consent, and the patient has not made an advance decision or formally appointed anyone to make decisions for them then the professional needs to consider what is in the best interests of the patient before making a decision. This must be documented in the patient's healthcare record.
- If the patient has Learning Disabilities and / or Dementia, more pre procedure work may be required such as desensitisation / social story / reasonable adjustments to ensure that the person feels safe. Consult with LD services or Dementia Services for advice where needed.
- Clarify if the patient requires a chaperone; following ECCH Chaperone Policy.
- Check patient identity with the patient (following Patient Identification Policy).
- Patients must have a spare catheter at home, so that replacement can occur as quickly as possible should any difficulty with drainage occur.
- Review Catheter Passport and Care Plan.
- Perform physiological observations where the patient has a neurological condition and therefore may be at risk of Autonomic Dysreflexia, where indicated in the patient's care plan.
- Ensure patient privacy and dignity
- Remove patient's underwear, maintaining their privacy and dignity. Assess the need to wash the patient with soap and water prior to the procedure. Do not leave the patient exposed at this stage of the procedure.
- Assist the patient to get into an appropriate and comfortable position.
- Ensure that a good light source is available.
- Decontaminate hands.
- Put on a disposable apron and non-sterile gloves.

Procedure

- Throughout the procedure observe for signs of Autonomic Dysreflexia in spinal cord injured patients. If at any time the heart rate drops, rhythm changes or signs of Autonomic Dysreflexia. STOP the procedure immediately and escalate.

- The removal of an existing catheter is performed as a clean technique, in advance of setting up for aseptic reinsertion.
- Once removed the urinary catheter should be inspected for encrustation; crystals in catheter lumen, this will inform the rationale for frequency of future catheter changes (record in patient healthcare record and within the patient's catheter passport).
- Remove PPE and decontaminate hands
- Prepare work area and gather all equipment that is required for procedure.
- Check the expiry date of all equipment including the catheter.
- Prepare the equipment using an aseptic technique.
- Apply apron and decontaminate hands and put on sterile gloves.
- At this point clinicians may wish to connect the sterile catheter drainage system to catheter prior to insertion to maintain closed drainage system ensuring that aseptic technique is maintained, or this may be done after insertion of catheter and insertion of balloon.
- Place sterile towels across the patient's thighs.
- 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.
- The urethral meatus is cleaned with sterile saline from front to back.
- Insert the nozzle of the lubricating gel into the urethra. Squeeze the gel into the urethra, remove the nozzle from the urethra and discard the tube. Where anaesthetic gel is used, allow a minimum of 5 minutes for the gel's anaesthetic effects to occur.
- Remove and dispose of gloves. Decontaminate hands and put on sterile gloves.
- Introduce the tip of the catheter into the urethral orifice in an upward and backward direction.
- Advance the catheter until urine flows and then continue for a further 5 – 6 cm.
- Inflate the balloon according to the manufacturer's directions, having ensured that the catheter is draining adequately.
- Withdraw the catheter slightly, until resistance is felt.
- Support the catheter by using a specially designed supportive system (G-strap or similar). Ensure that the catheter does not become taut when patient is mobilizing. If the patient is not mobile ensure the support system is on the upper thigh surface and facing downwards to allow drainage. Ensure that the catheter lumen is not occluded by the fixation device.
- Ensure the closed catheter drainage system is below the level of the bladder, and well supported, using the drainage system appropriate to the individual's needs.
- Remove and dispose of gloves. Decontaminate hands.

Post procedure

- Make the patient comfortable and dry.
- Replace clothing.
- Measure the amount of urine.
- Collect a urine sample if needed.
- Dispose of clinical waste as per ECCH Waste Management Policy and Community Waste Policy.
- Record information in relevant documents (including the catheter care plan and Patient's Catheter Care Passport). This should include:
    - reasons for catheterisation;
    - date and time of catheterisation;
    - catheter type, manufacturer, lot number, expiry date, length and size;
    - drainage system;
    - amount of sterile water instilled into the balloon;
    - a description of the urine (e.g. if there is haematuria, cloudy or containing debris), residual urine volume (if appropriate)
    - batch number and expiry date of lubricating gel;
    - any problems negotiated during the procedure;
    - observations of the catheter such as encrustation or crystals in catheter lumen;
    - physiological observations if indicated (for patients with neurological conditions);
    - date of catheter drainage device change due and who will conduct the change of drainage device (i.e. patient / carer / relative). Catheter bags should be changed in line with the manufacturer's recommendation.
    - a date to be reviewed by a Registered Nurse to assess the need for continued catheterisation or date of change of catheter.
- If the patient is unwell complete a full set of observations.
- Unregistered staff to seek advice from a Registered Nurse if:
    - Has signs of urinary tract infection
    - If fresh blood is seen before or after the procedure
- Discuss with patient / carers advice for caring for themselves and their catheter – see Catheter Care Passport.

Training and Competency

Nurse Associates and Registered Nurses are expected to have achieved training in the methodology for providing care to patients with urethral catheters as part of their pre-registration training.

All Registered Nurses and Nurse Associates will complete 3 yearly catheterisation update available on ESR. It covers basic catheter principles.

All staff will complete yearly observed practice by a registered nurse using the Essential Steps Framework. Registered Nurses code of professional conduct requires that they practice within their competency and that competency is maintained. Competency will be reviewed, recorded and monitored as part of the annual Personal Development Planning (PDP) process.

Unregistered staff providing care to patients with urethral catheters will be signed off competent to conduct this intervention by their supervisor / registered practitioner against the standards set out in this SOP. This will be recorded using competency documentation.

Training on IPAC Standard Precautions is provided at induction and annually via mandatory training.

Registered and unregistered nursing staff conducting urinary catheter care must have an awareness of ANTT principles for catheter care.

Reference and further information

- ECCH Urinary Catheterisation Policy
- ECCH IPAC policies
- European Association of Urology Nurses (2012) Evidence Based Guidelines for Best Practice in Urological Healthcare: Catheterisation indwelling catheters in adults urethral and suprapubic.
- NICE (2012) Evidence-based Guidelines for Best Practice in Urological Health Care
- Catheterisation Indwelling catheters in adults Urethral and Suprapubic.
- Royal College of Nursing (2021): Catheter Care Guidance for Healthcare Professionals https://www.rcn.org.uk/professional-development/publications/catheter-care-guidance-for-health-care-professionals-uk-pub-009-915
- NHS England (2020) My Urinary Catheter Passport https://www.england.nhs.uk/wp-content/uploads/2020/08/Catheter_passport_clinical_v3.pdf

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Acknowledgement NCHC SOP initial author's – joint work in N&W

SOP reference	**NCHC-05**	**Author** (name and job title)	Rosy Watson – Clinical Lead & Student District Nurse; Elizabeth Wilkin – Link Nurse & Student District Nurse;

			Karen Clark – Clinical Improvement and Effectiveness Manager Ruth Broom – Continence Service Lead.

Appendix 2 - Planned Male Urethral Catheterisation

Standard operating procedure (SOP) - Planned Male Urethral Catheterisation

Purpose

To ensure that male urethral catheterisation complies with national guidance and standards for practice and risks associated with insertion of urinary catheters are managed effectively.

Scope

This SOP sets standards for all staff undertaking planned male urethral catheterisation.

Registered Nurses, Nursing Associates and Unregistered Nurses providing planned care to male patients with urethral catheters will be signed off as competent.

Unregistered Nurses must undertake 3 yearly on-line ESR catheter training and are assessed yearly by a competent Registered Nurse as competent in both catheterisation and Aseptic Non-Touch Technique (ANTT).

The patient should be seen by a Registered Nurse for a full holistic assessment and treatment plan, before this intervention is delegated to unregistered staff and for review at least annually.

This SOP does NOT apply to suprapubic catheters.

Known risks

- infection
- trauma
- creation of false passage
- prostatic enlargement
- encrustation
- medication i.e. Warfarin
- sensitivities
- bleeding
- Paraphimosis in uncircumcised men
- Autonomic dysreflexia.
- Hypospadias/epispadias may be seen – a congenital abnormality where the urethra opens on the under or upper side of the penis, if present liaise with medical staff.

Equipment required to conduct the procedure

- Urinary Catheter Insertion Pack (or wound care pack if not available)
- Additional pair of sterile gloves
- One pair of non-sterile gloves
- Sterile prefilled Catheter

- Sterile lubricating gel
- Alcohol hand rub
- Sterile saline – for meatal cleansing
- Specially designed supportive system to anchor catheter
- Syringe x 2 (if not included with catheter)
- Catheter valve or leg drainage bag
- Drainage system

Urethral Catheter Selection

The formulary is available on ECCHO

Catheter Length

The three lengths available are:

- Paediatric 30cm (only direct from manufacturer)
- Female 26cm for ambulatory female patients
- Standard 40cm used for male patients and non-ambulatory female patients.

Balloon Size

- 10 ml balloon for routine drainage (**ALL** community patients). 5 ml can be used on appropriate patients after clinical assessment, with suitable catheter as per manufacturers guidelines.
- 30ml balloon **only** for hospital, urological post-operative use and as a haemostat. N.B. 30 ml balloons are NOT suitable for Community use as the weight of water in 30 ml balloons may lead to dragging/pulling of the catheter on the bladder neck. They may also cause bladder spasm and discomfort due to pressure against the trigone of the bladder.
- Balloons must **only** be filled with sterile water.
- The volume of water specified by the manufacturer will be inserted.
- Over inflation will **not** prevent a catheter from being expelled.
- Under inflation will result in catheter tip deflection which may increase bladder spasm and /or necrosis.

Charriere size

- Choose a catheter with the smallest possible diameter that will allow adequate drainage. This should be decided on individual patient assessment. Larger diameter catheters are associated with increased bladder irritability resulting in painful spasms and leakage. Guidelines suggest Male 14/16ch (12 may be appropriate).
- Larger catheters can cause urethral irritation and bypassing around the catheter. Larger charriere sizes (i.e. 18 or above) will only be used if clots or debris are present, post operatively or for supra-pubic catheterisation, (if size 16 is not appropriate).

Flowchart summary of procedure

Pre-procedure

- Explain procedure and gain informed consent. Consent is a patient's agreement for a health professional to provide care. Before health care professionals examine, treat or care for any person they must obtain their valid consent in line with ECCH's Consent to Examination and Treatment Policy and Mental Capacity Act Policy. There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.
- If the health professional feels that the patient has the capacity to give consent, their decision will be accepted and the wishes of the patient will continue to be respected, even if they lose capacity at a later stage.
- If the health professional feels the patient does not currently have the capacity to consent, and the patient has not made an advance decision or formally appointed anyone to make decisions for them then the professional needs to consider what is in the best interests of the patient before making a decision. This must be documented in the patient's healthcare record.
- If the patient has Learning Disabilities and / or Dementia, more pre procedure work may be required such as desensitisation / social story / reasonable adjustments to ensure that the person feels safe. Consult with LD services or Dementia Service for advice where needed.
- Clarify if the patient requires a chaperone; following ECCH Chaperone Policy.
- Check patient identity with the patient the Patient Identification Policy.
- Patients must have a spare catheter at home, so that replacement can occur as quickly as possible should any difficulty with drainage occur.
- Review Catheter Passport and Care Plan.
- Perform physiological observations where the patient has a neurological condition and therefore may be at risk of Autonomic Dysreflexia, where indicated in the patient's care plan.
- Ensure patient privacy and dignity
- Remove patient's underwear, maintaining their privacy and dignity. Assess the need to wash the patient with soap and water prior to the procedure. Do not leave the patient exposed at this stage of the procedure.
- Assist the patient to get into an appropriate and comfortable position.
- Ensure that a good light source is available.
- Decontaminate hands.
- Put on a disposable apron and non-sterile gloves.

Procedure

- **Throughout the procedure observe for signs of Autonomic Dysreflexia in spinal cord injured patients. If at any time the heart rate drops, rhythm changes or signs of Autonomic Dysreflexia. STOP the procedure immediately and escalate in line with ECCH policy for responding appropriately to patients in deterioration.**

- The removal of an existing catheter is performed as a clean technique, in advance of setting up for aseptic reinsertion.
- Once removed the urinary catheter should be inspected for encrustation; crystals in catheter lumen, blood clots, etc. this will inform the rationale for frequency of future catheter changes (record in patient healthcare record and within the patient's catheter passport).
- Remove PPE and decontaminate hands.
- Prepare work area and gather all equipment that is required for procedure.
- Check the expiry date of all equipment including the catheter.
- Prepare the equipment using an aseptic non-touch technique.
- Apply apron and decontaminate hands and put on sterile gloves.
- At this point clinicians may wish to connect the sterile catheter drainage system to catheter prior to insertion to maintain closed drainage system ensuring that aseptic technique is maintained, or this may be done after insertion of catheter and insertion of balloon.
- Place sterile towels across the patient's thighs and around the pubic area ensuring the whole area is covered except for the penis.
- Wrap a sterile low linting swab around the penis. Retract the foreskin, if necessary, and clean the glans penis with sterile saline and dry.
- Instill approximately 1mL of local anaesthetic gel around meatus and insert nozzle into the urethral meatus. After instilling gel, remove the nozzle from the urethra. Hold the glans penis firmly to prevent the gel from being released.
- Whilst continuing to hold (for 3-5 minutes for the anaesthetic to take effect), wipe the underside of the penile shaft in a downward direction several times with a dry swab to move the gel towards the prostatic urethra.
- Remove gloves and decontaminate hands. Apply a new pair of sterile gloves.
- Holding the penis in an upright and extended position. This straightens the first curve of the urethra and facilitates catheterization. Gently pass the catheter into the urethral meatus. Continue to pass the catheter slowly and smoothly through the urethra and into the bladder.
- If at any stage there is difficulty passing the catheter, if bleeding occurs or if the patient complains of undue pain, stop and seek advice.
- If resistance is felt at the prostatic urethra/sphincter region, ask the patient to relax the muscles as if he were passing urine, or to cough, at the same time as gently passing the catheter into the bladder. If there is still resistance or the patient has bleeding or discomfort other than that associated with minor trauma, stop and seek advice. No more then 2 attempts should be made before seeking advice from GP, detailing the reason for catheterisation and the difficulty encountered, requesting escalation to acute for re-catheterisation.
- Insert the catheter until urine begins to flow into the drainage bag, then advance it almost to its bifurcation. Inflate the balloon according to the manufacturer's instructions, having ensured that the catheter is draining properly beforehand.

Reposition the foreskin to prevent paraphimosis. Withdraw the catheter slightly, until resistance is felt.

- Support the catheter by using a specially designed supportive system (G-strap or similar). Ensure that the catheter does not become taut when patient is mobilizing or when the penis becomes erect. If the patient is not mobile ensure the support system is on the upper thigh surface and facing downwards to allow drainage. Ensure that the catheter lumen is not occluded by the fixation device.
- Ensure the closed catheter drainage system is below the level of the bladder, and well supported, using the drainage system appropriate to the individual's needs.
- Remove and dispose of gloves. Decontaminate hands.

Post procedure

- Make the patient comfortable and dry.
- Ensure that the glans penis is clean and then reduce or reposition the foreskin in non-circumcised patients.
- Replace clothing.
- Measure the amount of urine.
- Collect a sample of urine if needed.
- Dispose of clinical waste as per ECCH Waste Management Policy.
- Record information in relevant documents (including the catheter care plan and Patient's Catheter Care Passport). This should include:
    - reasons for catheterisation
    - date and time of catheterisation;
    - catheter type, manufacturer, lot number, expiry date, length and size
    - drainage system
    - amount of sterile water instilled into the balloon
    - a description of the urine (e.g., if there is haematuria, cloudy or containing debris), residual urine volume (if appropriate)
    - batch number and expiry date of anaesthetic lubricating gel
    - any problems negotiated during the procedure
    - observations of the removed catheter such as encrustation or crystals in catheter lumen
    - physiological observations if indicated (for patients with neurological conditions)
    - date of catheter drainage device change due and who will conduct the change of drainage device (i.e., patient / carer / relative). Catheter bags should be changed in line with the manufacturer's recommendation
    - a date to be reviewed by a Registered Nurse to assess the need for continued catheterisation or date of change of catheter.
- If the patient is unwell complete a full set of observations.
- Unregistered staff to seek advice from a Registered Nurse if:
    - Has signs of urinary tract infection

- If fresh blood is seen before or after the procedure

- Discuss with patient / carers advice for caring for themselves and their catheter – see page 4 Catheter Care Passport.

Training and Competency

Nurse Associates and Registered Nurses are expected to have achieved training in the methodology for providing care to patients with urethral catheters as part of their pre-registration training.

All Registered Nurses and Nurse Associates will complete the 3 yearly catheterisation training available on ESR, it covers catheter principles.

All staff will complete yearly observed practice by a registered nurse. Registered Nurses code of professional conduct requires that they practice within their competency and that competency is maintained using the essential steps framework. Competency will be reviewed, recorded and monitored as part of the annual Personal Development Planning (PDP) process.

Unregistered staff providing care to patients with urethral catheters will be signed off competent to conduct this intervention by their supervisor / registered practitioner against the standards set out in this SOP. This will be recorded using the Competency documentation.

Training on IPAC Standard Precautions is provided at induction and annually via mandatory training.

Registered and unregistered nursing staff conducting urinary catheter care must have an awareness of ANTT principles for catheter care.

11. Reference and further information

- ECCH Urinary Catheterisation Policy
- ECCH IPAC policies
- European Association of Urology Nurses (2012) Evidence Based Guidelines for Best Practice in Urological Healthcare: Catheterisation indwelling catheters in adults urethral and suprapubic.
- NICE (2012) Evidence-based Guidelines for Best Practice in Urological Health Care
- Catheterisation Indwelling catheters in adults Urethral and Suprapubic.
- Royal College of Nursing (2021): Catheter Care Guidance for Healthcare Professionals https://www.rcn.org.uk/professional-development/publications/catheter-care-guidance-for-health-care-professionals-uk-pub-009-915
- NHS England (2020) My Urinary Catheter Passport https://www.england.nhs.uk/wp-content/uploads/2020/08/Catheter_passport_clinical_v3.pdf

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Acknowledgement NCHC SOP initial author's – joint work in N&W

SOP reference	**NCHC-05**	**Author** (name and job title)	Rosy Watson – Clinical Lead & Student District Nurse; Elizabeth Wilkin – Link Nurse & Student District Nurse; Karen Clark – Clinical Improvement and Effectiveness Manager Ruth Broom – Continence Service

Appendix 3 - Planned Suprapubic Catheter: First, Routine and Unplanned Changes

Standard operating procedure (SOP) - Planned Suprapubic Catheter: First, Routine and Unplanned Changes

Purpose

To ensure that the changes of suprapubic catheters (SPC) in the community (including first and unplanned changes) complies with national guidance and standards for practice and to manage the risks associated with first and subsequent changes.

The National Patient Safety Agency publication NPSA RRR005 states that "Patients should be referred to the urology team who should carry out the first change of catheter". However, the NPSA issued further guidance during 2009 stating "the advice contained in this Rapid Response Report (RRR) relates to the initial insertion of a suprapubic catheter. All but one of the serious incidents referred to in the RRR were related to the initial insertion."

The Association of Continence Advisors state that "The first change can be done in the community, in the patient's own home or community clinics. There is no rationale for it being done in a hospital setting, but it is dependent on local policy."

ECCH have a local agreement with the CCGs and the James Paget hospital that community nurses may conduct the first change for patients who meet the following criteria:

- The patient's catheter is 4 weeks old and that the first change is considered suitable within the community. Documentation is completed on SystmOne that confirms that the first change is considered suitable within the community.
- The nurse is competent.

Scope

ECCH provide catheter changes to patients with SPC who are not able to self-manage.

All registered staff providing adult male and female patients with care of a SPC will be competent against this SOP.

For routine and unplanned changes of SPC registered staff must be competent in SPC changes.

It is recommended by British Association of Urological Surgeons (2020) that all failed changes, or expelled suprapubic catheters are admitted to the acute for assessment and re-catheterisation.

This SOP does not cover the <u>initial insertion</u> of suprapubic catheter as this is performed as a surgical procedure within an acute setting by a Urology clinician.

Staff are expected to read the ECCH Urinary Catheterisation Policy prior to undertaking catheter care to ensure that the risks to patients from autonomic dysreflexia are understood and managed appropriately.

Responsibility

It is the responsibility of the Locality Team Leader to ensure that this SOP is shared with all the pertinent staff and to ensure that staff complete training and annual competency review.

Individual staff are responsible for their own practice, ensuring competency to practice and completing the required training.

Allocation – it is the responsibility of the allocator to ensure that the Registered Nurse is identified on the Electronic Staff Record as signed-off as competent.

It is the responsibility of the Registered Nurse to only accept allocated work within their scope of signed-off competency.

Known risks

- urine infection
- trauma
- infection of surface wound and tract
- encrustation around the balloon
- over granulation of skin tissue around the site
- medication status i.e. Warfarin
- allergy status
- bleeding
- inflation of balloon in abdominal cavity or urethra
- autonomic dysreflexia

Equipment

- Urinary Catheter Insertion Pack (this comes with small, medium or large sterile gloves) or wound care pack if not available
- Additional pair of sterile gloves
- One pair of non-sterile gloves and apron
- Sterile Catheter
- Sterile anaesthetic lubricating gel or sterile lubricating gel
- Alcohol hand rub
- Specially designed supportive system to anchor catheter
- Sterile water – for inflating the balloon
- Sterile saline – for cleaning the cystostomy site
- Syringe x2 (if not included with catheter)
- Catheter valve (if appropriately assessed for this), belly drainage bag (preferably) or leg drainage bag
- Stabilisation device
- Drainage system
- Dressing pack in case of any trauma to the cystostomy site.

Pre-procedure

- Once the abdominal channel has been established (about 4 weeks) a SPC can be changed routinely by a competent practitioner. It is recommended that the patient is assessed at 10 weeks for their first change, which will take place at no later than 12 weeks. However, if the patient is having problems the catheter

may be changed between 4 and 10 weeks in the community by a competent practitioner (see above section 2).

- A risk assessment is conducted by the nurse who is to perform the first change and it must confirm that the first change is considered suitable within the community.
- Subsequent changes of suprapubic catheters should be individually assessed depending on the catheter history documented in the catheter passport and SystmOne care plan and should be conducted no later than 12 weekly unless manufacturers' instructions recommend otherwise. If problems arise the catheter can be changed at any time.
- Clinical indications for insertion, maintenance and removal of an SPC must be documented in patient health care records and catheter passport.
- Community Nurses will aim for planned catheter care rather than crisis management by monitoring 'catheter life'. Effective assessment can often establish a pattern of recurrent catheter encrustation and blockage in susceptible patients. Each patient should have an individual care plan designed to minimise the problem of blockage and encrustation by scheduling catheter changes according to assessed need. Use of a catheter passport will help ascertain a pattern of catheter blockages so changes can be planned accordingly.
- The patient will be provided with drainage systems for the first week following discharge by the referrer. The EDL provided to the patient's GP will dictate the catheter size and type for the first change and is detailed in the patient's catheter passport. Catheters for suprapubic insertion may be larger than those used for urethral catheterisation (usually a size 16 charriere).
- The practitioner will conduct an assessment of the patient and will replace the catheter like for like unless their assessment indicates that a different type would better meet the patient's needs. For example if there is:
    - poor drainage
    - difficulty removing or inserting the catheter
    - if it will improve ease of subsequent catheter management.
- A standard-length catheter is used.
- Patients must have a spare catheter at home, so that replacement can occur as quickly as possible should any difficulty with drainage occur. The nurse must ensure that the patient is able to organise this via prescription.
- The choice of drainage equipment is particularly important for the promotion of patient independence and self-management. It is the responsibility of the nurse to match choice with the individual patient's preference and life-style. Where possible the patient should have the opportunity to try out different drainage bags in order to allow them to decide which is most suitable. See ECCHO.
- Assessment to determine whether the suprapubic catheter should be connected to a sterile closed drainage system or to a catheter valve will be done initially by the urology department/ referrer. The assessment for use of a catheter valve

will include the patient /carers' ability to manage regular emptying and manipulation of the value. Catheter valves should be used with caution for clients with:

  - spinal injuries
  - renal impairment
  - high pressure bladder
  - limited bladder capacity
  - unstable bladder (Detrusor instability).

- A link system is used to facilitate overnight drainage, to keep the original system intact.
- Explain procedure and gain informed consent. Consent is a patient's agreement for a health professional to provide care. Before health care professionals examine, treat or care for any person they must obtain their valid consent in line with ECCH's Consent to Examination and Treatment Policy and Mental Capacity Act Policy. There is a basic assumption that every adult has the capacity to decide whether to consent to, or refuse, proposed medical intervention, unless it is shown that they cannot understand information presented in a clear way.
- If the health professional feels that the patient has the capacity to give consent, their decision will be accepted and the wishes of the patient will continue to be respected, even if they lose capacity at a later stage.
- If the health professional feels the patient does not currently have the capacity to consent, and the patient has not made an advance decision or formally appointed anyone to make decisions for them then the professional needs to consider what is in the best interests of the patient before making a decision. This must be documented in the patient's healthcare record.
- If the patient has Learning Disabilities and / or Dementia, more pre procedure work may be required such as desensitisation / social story / reasonable adjustments to ensure that the person feels safe. Consult with LD services or Dementia Lead for advice where needed.
- Clarify if the patient requires a chaperone; following ECCH Chaperone Policy.
- Check patient identity with the patient (following ECCH Patient Identification Policy).
- Perform physiological observations where the patient has a neurological condition and therefore may be at risk of Autonomic Dysreflexia, where indicated in the patient's care plan.
- Apply standard precautions for infection control (Personal Protective Equipment) and take other appropriate health and safety measures.
- At each step in the procedure explain to the patient what you are doing and why and allow time for questions.
- Decontaminate hands, put on apron and non-sterile gloves.

- Prepare patient ensuring comfort and maintaining privacy and dignity. Position the patient lying down and expose the catheter site, loosening the bag from the leg or holster. Assess the cystotomy site and clean with water where needed.
- Take off gloves, decontaminate hands.
- Prepare work area and equipment for aseptic non-touch procedure, check the expiry date on all equipment including the catheter.
- Open outer cover of the catheter pack, using a clean technique open supplementary packs

Procedure

- **Throughout the procedure observe for signs of Autonomic Dysreflexia in spinal cord injured patients. If at any time the heart rate drops, rhythm changes or signs of Autonomic Dysreflexia. STOP the procedure immediately and escalate.**
- Decontaminate hands and put on non-sterile gloves.
- Attach 10ml syringe to existing catheter using the outlet port. Allow the syringe to deflate balloon by gently drawing back on syringe ensuring deflation is complete.
- Grip the existing catheter near to the skin surface and place a finger either side of the catheter.
- Withdraw the catheter from the tract, you may need to twist it a little and there may be a gush of urine as you withdraw it, have some gauze ready. Note the angle that it comes out at.
- Once removed judge the depth the catheter was inserted. Put the catheter to one side (outside of the sterile field) so that it can be examined later.
- Note: When conducting a first change of SPC there should be as little delay as possible between removal and reinsertion (20 minutes maximum). If a delay were to occur the cytostomy (insertion) site is at risk of closure. This is particularly relevant for those that experience bladder or abdominal spasm.
- Remove gloves and decontaminate hands.
- Open inner catheter pack and put on sterile gloves.
- Place sterile drapes over the patients' abdomen above and below the catheter. Clean the cystostomy site using sterile normal saline.
- Aseptic technique is maintained when connecting the indwelling urinary catheter to a sterile closed drainage system. Closed system catheter packs are available, but if this is not used, connect the sterile catheter drainage system to the catheter prior to insertion to maintain a closed drainage system.
- Lubricate the new catheter being careful not to block the drainage eyelets. Insert it into the cystostomy tract advancing to the depth of the previously removed catheter and an additional 3 cms ensuring that the catheter has not been inserted too far and is in the urethra, urine should drain (this indicates correct positioning). If the catheter is not far enough into the bladder, resistance will be

felt when attempting to fill the balloon, and the patient will feel pain. If this happens, deflate the balloon and advance or withdraw as appropriate.

- Inflate the balloon with 10 ml of sterile water (according to manufacturer's instructions) and pull back the newly inserted catheter gently until you feel resistance.
- Observe for urine drainage, which may not be immediate and might be a little blood stained. There may not be any urine drained straight away, but you should ensure that free drainage is achieved before leaving the patient.
- A failed catheter change will be escalated to the acute setting as per recommendation by British Association of Urological Surgeons (2020) for assessment and re-catheterisation.
- Examine the old catheter for signs of encrustation to inform the subsequent catheter care plan, this should be recorded within the patient's healthcare record and catheter passport.
- Measure and record amount, colour and clarity of urine collected immediately after insertion.
- Dress site with a dry dressing if necessary.

Post procedure

- Ensure patient is comfortable and the catheter is secured at 90 degrees and that drainage bag is well supported and the bag is below the level of the bladder.
- Clear away equipment and PPE and dispose of as per ECCH Waste Management Policy.
- Decontaminate hands.
- Document procedure using patient's healthcare record / catheter passport and include:
    - Patients consent and understanding
    - Allergy status
    - Reason for catheterisation
    - Date and time of catheterisation
    - catheter type, manufacturer, lot number, expiry date, length and size
    - drainage system
    - amount of sterile water instilled into the balloon
    - a description of the urine (e.g. if there is haematuria, cloudy or containing debris), residual urine volume (if appropriate);
    - batch number and expiry date of lubricant used
    - Difficulties experienced during procedure
    - date of catheter drainage device change due and who will conduct the change of drainage device (i.e. patient / carer / relative). Catheter bags should be changed in line with the manufacturer's recommendation.
    - Management plan, inc. predicted date of change / removal

- Risk assessment for first change.

- Educate the patient and / or carer on the care of the catheter and attachments to meet infection prevention and control standards, and check understanding at each stage.
- Discuss with patient / carers advise for caring for themselves and their catheter – see page 4 Catheter Care Passport.
- Ensure the patient is dressed and comfortable before leaving.

Training and Competency

Nurse Associates and Registered Nurses are expected to have achieved training in the methodology for providing care to patients with urethral catheters as part of their pre-registration training.

For routine and unplanned changes of SPC registered staff must be competent in SPC changes. **For first and unplanned changes of SPC** registered staff must be competent in SPC changes and thus will be able to adapt their knowledge and skills to accommodate special or novel situations. Staff are signed-off as competent using the Competency documentation.

All Registered Nurses and Nurse Associates will complete the 3 yearly Catheterisation training available on ESR it covers catheter principles.

All staff will complete yearly observed practice by a registered nurse signed off as competent using the Essential Step Framework. Registered Nurses code of professional conduct requires that they practice within their competency and that competency is maintained. Competency will be reviewed, recorded and monitored as part of the annual Personal Development Planning (PDP) process.

Training on IPAC Standard Precautions is provided at induction and annually via mandatory training.

Registered and unregistered nursing staff conducting urinary catheter care must have an awareness of ANTT principles for catheter care.

10. Reference and further information

- ECCH Urinary Catheterisation Policy
- ECCH IPAC policies
- European Association of Urology Nurses (2012) Evidence Based Guidelines for Best Practice in Urological Healthcare: Catheterisation indwelling catheters in adults urethral and suprapubic.
- NICE (2012) Evidence-based Guidelines for Best Practice in Urological Health Care
- Catheterisation Indwelling catheters in adults Urethral and Suprapubic.
- British Association of Urological Surgeons suprapubic catheter practice guidelines – revised Susan Jane Hall, Simon Harrison, Chris Harding, Sheilagh Reid, Richard Parkinson BJU International Volume 126, Issue 4 First published: 28 May 2020

ECCH version

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Acknowledgement NCHC SOP initial author's – joint work in N&W

SOP reference	**NCHC-05**	**Author** (name and job title)	Rosy Watson – Clinical Lead & Student District Nurse; Elizabeth Wilkin – Link Nurse & Student District Nurse; Karen Clark – Clinical Improvement and Effectiveness Manager Ruth Broom – Continence Service Lead.

Appendix 4 - Intermittent Urethral Catheterisation

Standard operating procedure (SOP) - Intermittent Urethral Catheterisation

Objective:

To ensure that intermittent catheterisation complies with national guidance and standards for practice and risks associated with insertion of urinary catheters e.g. Catheter Acquired Urinary Tract Infection (CAUTI) are managed effectively.

Scope:

This SOP sets standards for all staff undertaking intermittent catheterisation using an aseptic non-touch technique. It does not cover training patients to conduct Clean Intermittent Self Catheterisation which is not an ANTT technique.

Staff are expected to read the ECCH Urinary Catheterisation Policy prior to undertaking catheter care to ensure that the risks to patients with neurological conditions are understood and managed appropriately.

Known risks

- infection
- trauma
- medication i.e. Warfarin
- sensitivities
- bleeding
- autonomic Dysreflexia
- Hypospadias/epispadias may be seen – a congenital abnormality where the urethra opens on the under or upper side of the penis, if present liaise with medical staff.
- Paraphimosis in uncircumcised men

Equipment required to conduct the procedure

- Dressing Pack and an additional pair of sterile gloves
- Appropriate receptacle to collect urine
- Disposable apron
- Non-sterile gloves
- intermittent single use catheter
- Alcohol hand rub
- Sterile saline

Pre-procedure

- Explain procedure and gain informed consent. Consent is a patient's agreement for a health professional to provide care. Before health care professionals examine, treat or care for any person they must obtain their valid consent in line

with ECCH Consent to Examination or Treatment Policy and ECCH Mental Capacity Act Policy

- Perform physiological observations (in line with ECCH deteriorating patient policy) where the patient has a neurological condition and therefore may be at risk of Autonomic Dysreflexia.
- Ensure Patient privacy and dignity.
- Remove patient's underwear, maintaining their privacy and dignity. Assess the need to wash the patient with soap and water prior to the procedure. Do not leave the patient exposed at this stage of the procedure.
- Assist the patient to get into an appropriate and comfortable position.
- Ensure that a good light source is available.
- Decontaminate hands.
- Put on a disposable apron and non-sterile gloves.

Procedure

- **Throughout the procedure observe for signs of Autonomic Dysreflexia in spinal cord injured patients. If at any time the heart rate drops, rhythm changes or signs of Autonomic Dysreflexia. STOP the procedure immediately and escalate in line with ECCH Deteriorating Patient Policy.**
- Prepare work area and gather all equipment that is required for procedure.
- Prepare equipment as per manufacturer's instructions.
- Check the expiry date of all equipment including the catheter.
- Open the dressing pack onto a clean surface.
- Using a clean technique open supplementary packs.
- Decontaminate hands and put on sterile gloves.
- Place sterile towels across the patient's thighs.

Female

- Using gauze swabs, separate the labia minora so that the urethral meatus is seen.
- The urethral meatus is cleaned with sterile saline from front to back.
- Remove and dispose of gloves. Clean hands with alcohol hand rub and put on sterile gloves.
- Introduce the tip of the catheter into the urethral orifice in an upward and backward direction.
- Advance the catheter until urine flows and then continue for a further 5 – 6 cm.

Male

- Wrap a sterile low linting swab around the penis.

- Retract the foreskin, if necessary, and clean the glans penis with sterile saline and dry.
- Insert the nozzle of the lubricating gel into the urethra, **if required.** Squeeze the gel into the urethra, remove the nozzle from the urethra and discard the tube. Massage the gel along the urethra.
- Hold the penis upright for approximately 5 minutes to allow the anaesthetic lubricating gel to take effect.
- Remove and dispose of gloves. Clean hands with alcohol hand rub and put on sterile gloves.
- Hold the penis behind the glans, raising it until it is almost totally extended. Maintain grasp of penis until the procedure is finished. Insert the intermittent catheter for 15–25 cm until urine flows. If resistance is felt at the external sphincter, increase the traction on the penis slightly and apply steady, gentle pressure on the intermittent catheter. Ask the patient to strain gently as if passing urine.
- Allow urine to drain into receptacle (use sample pot if pathology testing is required). Observe and record quantity, colour, odour, consistency, etc.
- When urine stops flowing, slowly withdraw the intermittent catheter and dispose of catheter and urine appropriately in line with ECCH Waste infection control Policy.
- Reposition foreskin.
- Remove and dispose of gloves. Clean hands.

Post procedure.

- Make the patient comfortable and dry.
- Replace clothing.
- Record information in relevant documents. This should include:
    - reasons for intermittent catheterisation.
    - date and time of intermittent catheterisation.
    - intermittent catheter type, manufacturer, lot number,
    - expiry date, length and size.
    - any problems during the procedure.
    - a date to be reviewed.

Training and Competency

Nurse Associates and Registered Nurses are expected to have achieved training in the methodology for providing care to patients with urethral catheters as part of their pre-registration training.

All Registered Nurses, Assistant practitioners and Nurse Associates will complete the face-to-face training with the continence team and then will 3 yearly theory updates by completing the Catheterisation E-learning module available on ESR.

All staff will complete yearly observed practice by a registered nurse. Registered Nurses code of professional conduct requires that they practice within their competency and that competency is maintained.

Competency will be reviewed, recorded and monitored as part of the annual Personal Development Planning (PDP) process.

Unregistered staff (APs) providing care to patients with urethral catheters will be signed off competent to conduct this intervention by their supervisor / registered practitioner against the standards set out in this SOP. This will be recorded using the Testimonial of Competency.

Training on IPAC Standard Precautions is provided at induction and annually via mandatory training.

Registered and unregistered nursing staff conducting urinary catheter care must have an awareness of ANTT principles for catheter care.

Reference and further information

- ECCH Urinary Catheterisation Policy
- ECCH IPAC policies
- Royal College of Nursing (2021): Catheter Care Guidance for Healthcare Professionals https://www.rcn.org.uk/professional-development/publications/catheter-care-guidance-for-health-care-professionals-uk-pub-009-915
- NHS England (2020) My Urinary Catheter Passport https://www.england.nhs.uk/wp-content/uploads/2020/08/Catheter_passport_clinical_v3.pdf
- ECCH Delegation of Procedures Non-Registered Health Care Workers Policy

ECCH version

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Appendix 5 - Nurse Led 'Trial without Catheter' (TWOC) in the Community For Uncomplicated Removal of Urethral Catheters

Standard operating procedure (SOP) Nurse Led'Trial without Catheter' (TWOC) in the Community For Uncomplicated Removal of Urethral Catheters

Introduction

Trial Without Catheter (TWOC) is the term used when a catheter, which has been inserted via the urethra into the bladder for drainage purposes, is removed for a trial period to determine whether the patient is able to pass urine safely and spontaneously without the need for further catheterisation. A TWOC is used to test a patient's voiding function and to ensure bladder function has returned to the person's normal habit. Urinary catheters should be removed as soon as the catheter is no longer indicated. (Place 2022)

The aim of this document is to enable uncomplicated removal of urethral catheters to be undertaken safely in the community by competent nurses in patients own homes, residential and nursing homes or other community settings without the need for medical review. TWOC should only be undertaken by qualified nursing staff competent in this area of practice.

If a Health Care Professional (HCP) considers a patient no longer needs a catheter, it is important to perform a TWOC. If the TWOC is unsuccessful, a new catheter merely needs reinserting, or the patient can perform Intermittent Self Catheterisation (ISC) – removing the catheter will not harm the patient. (Urinary catheterisation Best Practice Statement 2022).

The benefits of TWOC, being undertaken in the community setting include:

- Timely removal of urethral catheters can reduce complications such as catheter associated urinary tract infection, psychological and physical pain, bladder spasm and leakages
- Improved patient outcomes as the patient will lose less muscle tone the sooner the catheter is removed
- Improved patient outcomes as the intervention will be completed in their home environment
- Reduced risk of acquiring infection as patients remain in their own home environment
- Freeing of acute hospital beds by reducing unplanned admissions thus preventing cancellation of operations
- Addressing the difficulty of bed space which potentially results in catheters being left in situ longer than necessary, again increasing the risk of urinary tract infection
- Preventing unnecessary admission of patients who are elderly with mobility problems who may require hospital transport to attend to hospital (RCN 2019).

Purpose

To assess patients prior to undertaking TWOC in the community, in order to promote success of the procedure and patient safety.

Scope

All eligible patients referred that meet the criteria under the indications section for a nurse led TWOC in the community.

Core Requirements

On receipt of referral or when considering TWOC, review the patient's records to assess their suitability for TWOC against the following indications and contraindications:

Indications for Nurse Led TWOC in the community

The following conditions/situations are suitable for nurse led TWOC in the community:

- **Catheterised as part of clinical pathway to monitor input/output, surgical procedure (excluding urology/gynaecology/neuro) and removal date for catheter was recorded in patient notes and/or discharge letter.**
- **Catheterisation for co-morbidities**
- **Requested by GP for uncomplicated TWOC**
- **Clear instructions for a nurse led TWOC documented in patient notes**

Contraindications for Nurse Led TWOC in the community

The following conditions/situations are NOT suitable for nurse led TWOC in the community:

- Post radical prostatectomy for Ca prostate
- High pressure urinary retention awaiting bladder outflow surgery
- Patients needing to be taught clean intermittent self-catheterisation (CISC) or intermittent self-dilatation (ISD) - catheters will be removed at the time of their clinic appointment for teaching
- Patients who had a complex catheter insertion with a secondary or tertiary centre (requiring direct visualisation with a flexible cystoscopy / guidewires) - these will need to be within a clinic setting in the event they fail their TWOC and need a new catheter reinserting
- Any documented reason that a monitored trial without catheter (TWOC) is to be undertaken within a Urology Trial of Voiding (UTOV) clinic - this could be due to multiple failed TWOCs
- Bladder neck incision within the last eight weeks
- Optical urethrotomy within the last eight weeks
- Urethral stricture
- Undiagnosed haematuria
- Clot retention
- Systemically unwell
- Patients who are constipated - with no bowel movement for 3 days or more
- Confirmed urinary tract infection or recurrent urinary tract infections
- Hydronephrosis

- Known lower urinary tract cancer deemed not suitable for TWOC by a Urologist
- Patients who are not alert, orientated or have poor cognitive function and are unable to concord with treatment regime.
- Patients who withhold consent. If the patient lacks capacity, then TWOC can be carried out in 'Best Interests' using the Mental Capacity Act. This must be fully documented (Nazarko 2020)
- Patients, families, or carers who are unable to alert the community nurse of any difficulties when undergoing a TWOC

If assessed as suitable for TWOC, contact patient, explain procedure, and plan date for TWOC.

TWOC Procedure

Purpose

To enable TWOC to be carried out safely and successfully.

Scope

Registered Nurses who are competent in undertaking TWOC.

Core Requirements

- Check again that there are no contraindications for Nurse led TWOC in the Community. If the patient appears unwell, the TWOC should be deferred.
- To ensure that the patient understands the procedure and gives their valid consent, explain to the patient that should the TWOC be unsuccessful then they will need to be re-catheterised, or could try intermittent self-catheterisation
- Explain procedure and give patient TWOC information leaflet
- Discuss potential risks with the patient.
- Check when the patient last opened their bowels. Advise the patient that if constipated the TWOC will be deferred. The patient would ideally have opened his/her bowels within the 24 hours before the TWOC (Colemeadow 2018).
- Check patient's medication to ensure that those on diuretics are aware of the need to take medication on the morning of the procedure.
- Explain to the patient how to monitor fluid intake and urine output and complete charts.
- Encourage the patient to drink normally (1.5 to 2 litres during the day) the day prior to TWOC, as over consumption of fluids may compromise bladder function (RCN 2019).
- TWOC should be undertaken on a weekday morning.
- Health care professionals conducting TWOC or re-insertion of a catheter must have awareness of ANTT principles of catheter care. (RCN 2021)
- Prior to the visit, assemble all necessary equipment

Equipment required:

- Single use disposable gloves and apron

- Syringe for deflating balloon
- Specimen container if CSU required
- Bladder Scanner
- Stock for replacing catheter
- Supplies
- Appropriate documentation
- Obtain verbal consent and offer a chaperone, document response.
- Attach care plan to SystmOne record.
- To prevent cross infection, ensure patient has washed perineum prior to catheter removal (assist with this if necessary).
- Remove catheter early morning
- Advise patient regarding fluid intake. Ask the patient to drink 200ml of fluid each hour or 1litre by 1pm (4 hours later) and to record fluid intake and output on a fluid balance chart. This level of fluid intake will enable the bladder to sufficiently fill before voiding so that trial without catheter can be monitored within a reasonable period (Nazarko 2020).
- Advise the patient to take meals as normal.
- Explain to the patient that the first void may sting, and they may see a little blood, due to trauma of removing the catheter.
- Inform patient of possible symptoms, such as urinary urgency, frequency, and discomfort (caused by inflammation of the urethra following prolonged catheterisation). Knowing what to expect will enable the patient to plan daily activities.
- Give patient contact numbers in case of any problems and explain follow up procedure for that day.
- Contact patient after 4 hours (maximum) to monitor progress and check fluid intake (where appropriate this may be by telephone). If the patient is unable to void and is uncomfortable arrange to perform a bladder scan.
- Remind patient of timing for next visit.

Monitoring Success of TWOC

Purpose

To monitor success of TWOC approximately 8 hours post removal of the catheter.

Scope

Registered Nurses who are competent in undertaking nurse led TWOC.

Core Requirements

This visit should be undertaken approximately 8 hours post removal of the catheter
Review fluid balance chart to check passing urine of at least 100mls at each void.
If not, assess the need to perform a bladder scan or reinsert catheter to check residual volume.

TWOC is successful if:

- The patient is passing urine
- The residual volume is 400mls or less
- The patient is comfortable

TWOC is unsuccessful if:

- The residual volume is more than 400ml
- The patient is uncomfortable

If TWOC unsuccessful, re-catheterise with a Foley catheter size 12ch – 14ch using aseptic technique. If unable to re-catheterise liaise with the On-Call urology team at JPUH to arrange reinsertion, send patient with their Catheter Passport.

Ensure that the patient knows to contact ECCA if any problems are experienced or NHS 111

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- accessed 23.01.23

ECCH version

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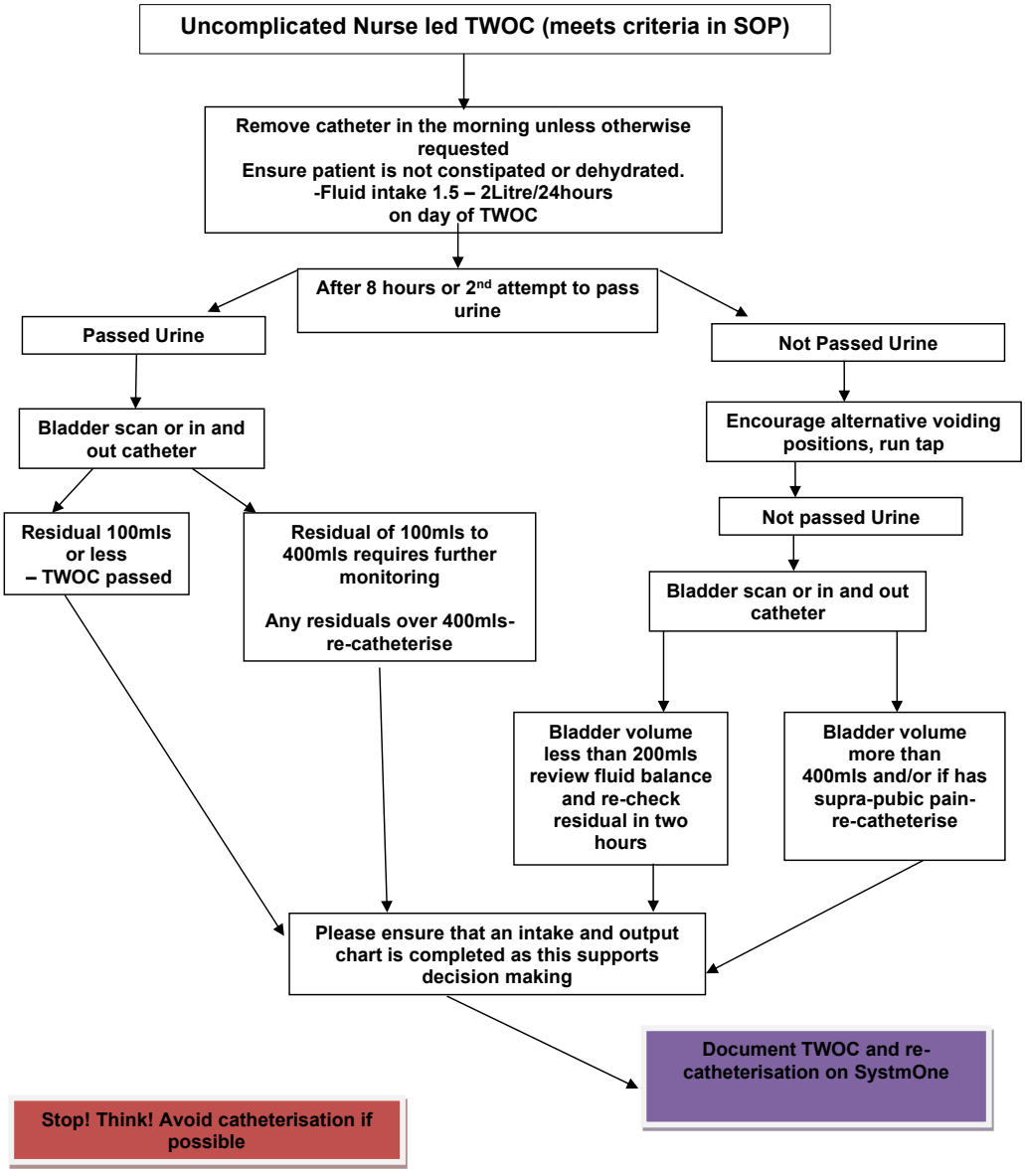
SOP acknowledgement developed in conjunction with N&W ICB working group

SOP reference	**July 2024**	**Author** (name and job title)	Irene Karrouze Quality Nurse NWICB Clarke Watson Lead Urology Nurse Practitioner NNUH Helen Notley Continence Specialist Nurse ECCH

TRIAL WITHOUT CATHETER (TWOC) - General Guide for staff



Useful Contacts

Who can I contact for more help or information?

East Coast Community Health

01493 809977

Your Doctor's Surgery, or NHS 111

111

111.nhs.uk

June 2024 adapted from FNHC FLB

Improving lives **together**

Norfolk and Waveney Integrated Care System

Patient information leaflet for a Community trial without catheter (TWOC)

STOP **Think: No Catheter**

To stop CAUTI don't catheterise

This leaflet is for patients who are having a trial of their urinary catheter being removed; carers will also find this information useful.

What is a Trial Without Catheter, also called a TWOC?

A trial without catheter is when a catheter which has been inserted via the urethra (water pipe) is removed from the bladder for a trial period to determine whether you are able to pass urine spontaneously.

Prior to Removal of your Catheter

Your Nurse will give a full explanation of the procedure and any questions you may have can be clarified prior to the removal of your catheter.

The Day Before your Trial without Catheter

You will need to drink normally (1.5 to 2 litres during the day)

On the Day of your Trial Without Catheter

6.30am If you have a **catheter valve** please empty the bladder using the catheter valve. Do not empty it after that.

Before the nurse attends: Please wash your area around the catheter prior to catheter removal.

What will Happen once the Catheter has been Removed?

Early morning

Your urinary catheter is secured in place by a small balloon filled with sterile water. Your nurse will remove this water from the catheter using a syringe. You may feel a slight "twinge'' sensation as the balloon deflates but this is usually painless. Your catheter can now be removed. It is important to be as relaxed as possible during the catheter removal as less resistance is created when the catheter is withdrawn.

During the morning

Following removal of your catheter, your bladder will be empty. It will take a little while for your bladder to fill with urine. You will be encouraged to fill your bladder slowly by drinking sufficient fluid. This normally entails drinking a glass or cupful of liquid (200mls) approximately each hour, or 1 litre by 1pm . You will need to monitor every time you pass urine and measure the volume on a given chart and take normal meals.

Early afternoon

You will be contacted by your Nurse. He or she will ask how much urine you have passed and if you are comfortable, if you are not comfortable and haven't passed sufficient amounts of urine the Nurse will arrange to visit and perform a residual bladder scan.

Late afternoon

The Nurse will contact you and review your charts. He or she may perform a bladder scan. This is a simple ultrasound scan of your lower tummy using some gel. It will determine if your bladder is emptying properly. At this point, if you are unable to pass urine and the bladder scan indicates a large amount of urine in your bladder, the Nurse will discuss teaching you how to perform Intermittent Self Catheterisation or Re-Catheterise you.

What happens if I Cannot Pass Urine

Do not be alarmed if you do not pass urine for a couple of hours, this is not unusual as it takes time for your bladder to fill.

Passing Urine

The first time you pass urine it may sting and you may see a little blood, due to trauma of removing the catheter . You may also have symptoms, such as urinary urgency,
frequency and discomfort, but these symptoms will start to improve the more you pass urine.

Appendix 6

Eastern Pathology Alliance NHS

GUIDANCE AND ALGOROTHM FOR DIAGNOSIS OF CATHETER ASSOCIATED URINARY TRACT INFECTION AND APPROPRIATE SAMPLING

Do not perform urinalysis urine samples from patients with long term catheters to diagnose UTI

Catheters in place for more than a week will normally become colonised with bacteria, and will give positive dipstick for nitrites and/or leucocytes even when there is **no** urine infection present.

Do not send catheter urine for 'routine' culture

Catheters in place for more than a week will normally become colonised with bacteria and give positive microscopy results and significant growth of bacteria even when there is **no** urine infection present. Urine can be offensive due to colonisation **without** infection. Catheter change may help with this.

Do not prescribe antibiotics to 'treat' bacterial growth from a catheter urine in asymptomatic patients

Bacterial colonisation of long term catheters is normal. Inappropriate antibiotic treatment of colonised catheter specimens selects for antimicrobial resistance and puts the patient at unnecessary risk of complications of antibiotic use **including C. difficile infection**

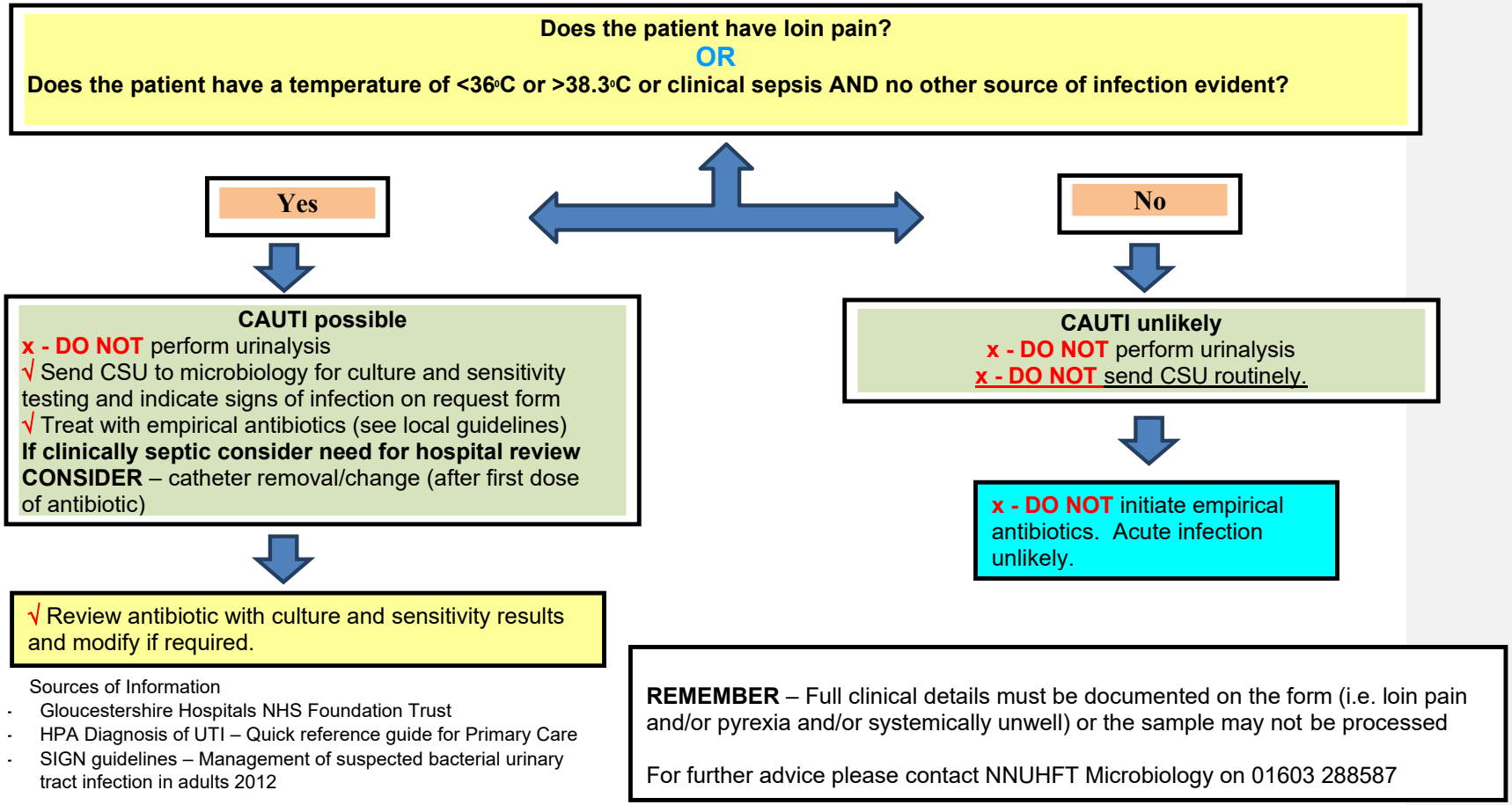
Use the enclosed algorithm to guide when to sample and when to treat

Urinary tract infection should only be suspected and investigated in catheterised patients with suggestive signs of infection (i.e. loin pain and/or pyrexia and/or systemically unwell) where no other source can be found.
If the patient is clinically septic or has features of pyelonephritis consider referral for hospital review and further investigation.

When sending urine from a catheterised patient for culture, please indicate clinical signs and symptoms of infection on the form, and identify that the sample is from a catheter.

The Microbiology laboratory reserves the right **not** to process inappropriately labelled specimens of catheter urine which do not suggest possible infection. If the request relates to a catheter is newly inserted or intermittent catheterisation please indicate this on the request form.

Algorithm for diagnosis of Catheter-Associated Urinary Tract Infection (CAUTI) in adults



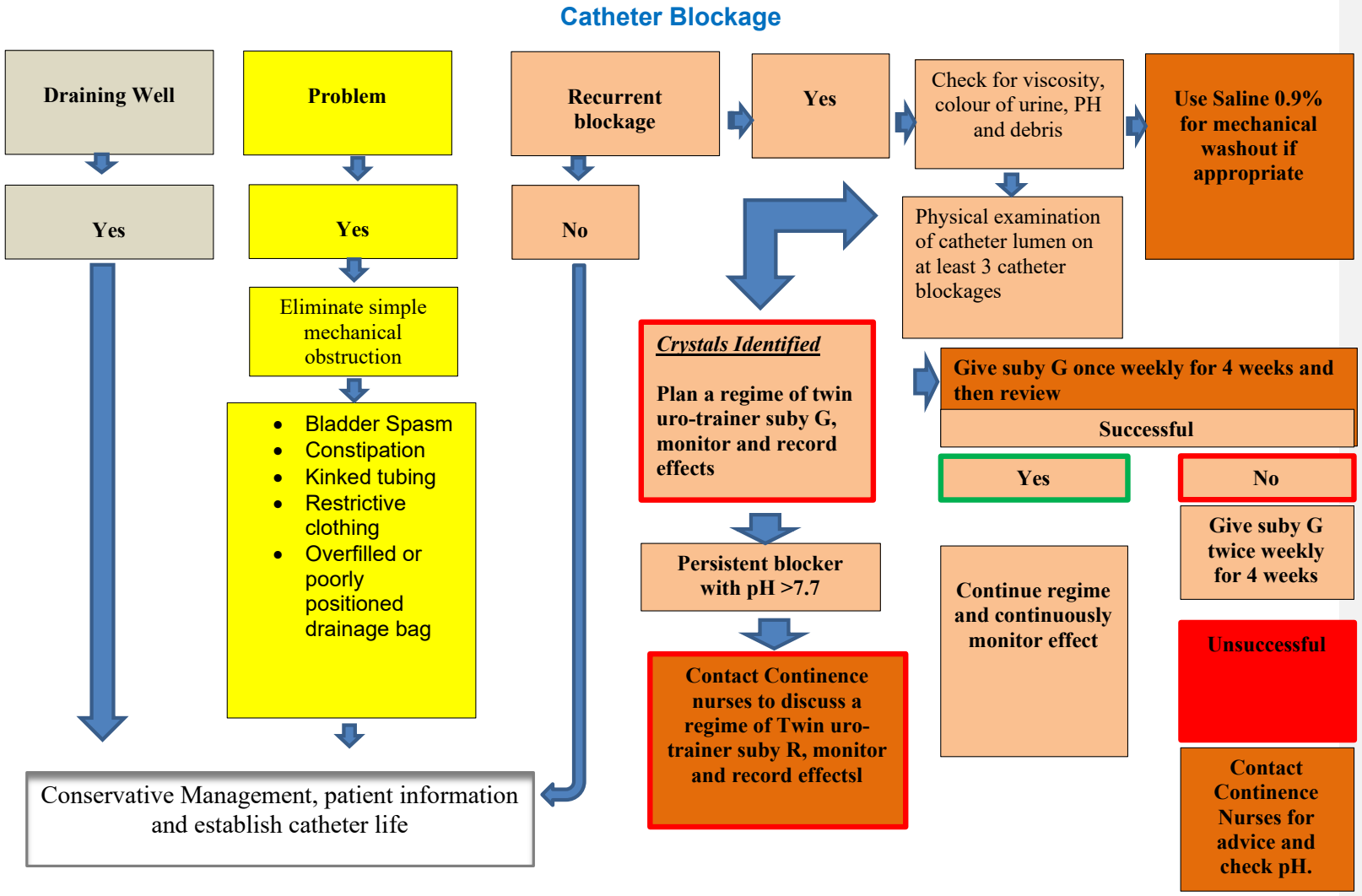
Sources of Information

- Gloucestershire Hospitals NHS Foundation Trust
- HPA Diagnosis of UTI – Quick reference guide for Primary Care
- SIGN guidelines – Management of suspected bacterial urinary tract infection in adults 2012

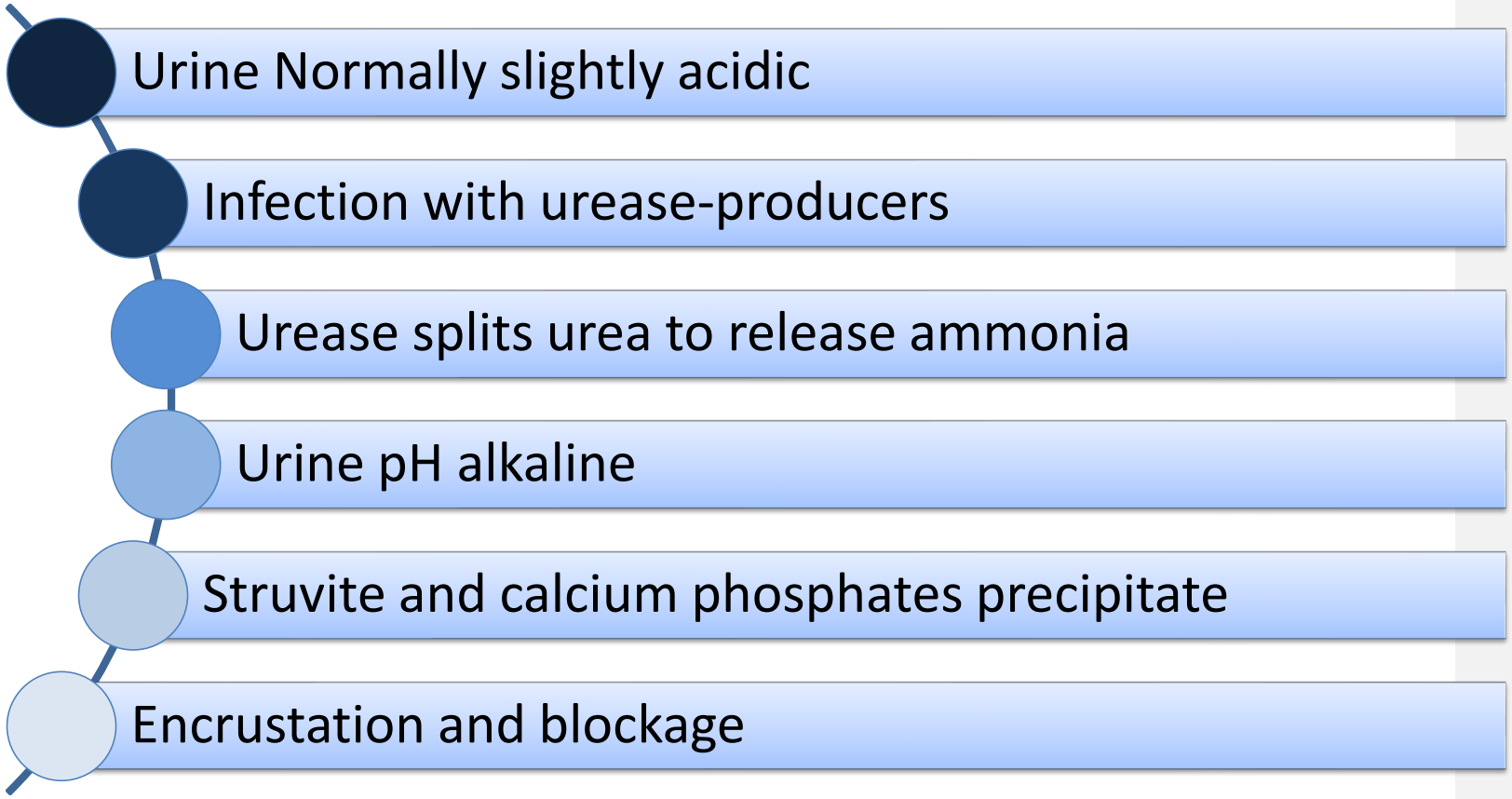
REMEMBER – Full clinical details must be documented on the form (i.e. loin pain and/or pyrexia and/or systemically unwell) or the sample may not be processed

For further advice please contact NNUHFT Microbiology on 01603 288587

Appendix 7 – Catheter Blockage



Causes of Catheter blockage



Appendix 8

Catheter Passport

https://www.england.nhs.uk/wp-content/uploads/2023/11/Catheter-passport-v8-complete-patient-and-clinical-Nov-2023.pdf

21. EQUALITY & DIVERSITY IMPACT ASSESSMENT

In reviewing this policy, the HR Policy Group considered, as a minimum, the following questions:

- Are the aims of this policy clear?
- Are responsibilities clearly identified?
- Has the policy been reviewed to ascertain any potential discrimination?
- Are there any specific groups impacted upon?
- Is this impact positive or negative?
- Could any impact constitute unlawful discrimination?
- Are communication proposals adequate?
- Does training need to be given? If so is this planned?

Adverse impact has been considered for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Blank version of the full Equality & Diversity Impact assessment can be found here:

http://eccho/Home/FormsGuidance.aspx?udt_575_param_index=E&udt_575_param_page=2

22. DOCUMENT CONTROL

Version Date	Version No.	Author/ Reviewer	Comments
March 2012	5	IP&CT	Updated Infection Control information
December 2012	6	IP&CT	Updated Infection Control information
December 2014	7	IP&CT	Updated Infection Control information
December 2016	8	IP&CT	Updated Infection Control information
September 2018	9	IPC&CT	Updated Infection Control information
January 2019	10	IPC&CT	Updated wording by Continence Lead
December 2020	11	IPC&CT	Updated wording by Continence Lead
October 2022	12	Continence	Added SOP's
July 2025	13	Continence team	Updated and added SOPs

DOCUMENT CONTROL SHEET

Name of Document:	Policy for Catheter Management
Version:	13
File Location / Document Name:	ECCHO
Date Of This Version:	July 2025
Produced By (Designation):	Continence Team
Reviewed By:	Clinical Quality Group
Synopsis And Outcomes of Consultation Undertaken:	Changes relating to relevant committees/groups involved in ratification processes.
Synopsis And Outcomes of Equality and Diversity Impact Assessment:	National EIA gives more details on measures to reduce HCAI's.
Ratified By (Committee): -	Clinical Quality Group
Date Ratified:	15/07/2025
Distribute To:	ECCHO
Date Due for Review:	July 2027
Enquiries To:	Continence Team
Approved by Appropriate Group/Committee **Approved by Policy Group** **Presented to IGC for information**	x Date: 15/07/2025 ☐ Date: ☐ Date: