

## Catheter Care Policy

### Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

#### Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

#### Assessing needs

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

#### Delivering evidence-based care and treatment

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

#### Supporting people to live healthier lives

We support people to manage their health and well-being so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

#### Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

#### Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

#### Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

#### Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

#### Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

#### Providing information

We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

#### Scope

Elizabeth Finn Homes Limited believes that every resident should be supported and enabled to maintain normal bladder function for as long as practicably possible. Where all other alternative methods of continence management have been explored, only then will an indwelling urethral catheter be considered for the management of incontinence. We also believe that the resident's clinical need for continuing urinary catheterisation should be reviewed regularly and that the catheter be removed if indicated. Where the issue is of urinary retention the resident should be fully assessed by an appropriate health care professional and urinary output monitored carefully. All urinary catheter insertion, removal and care should be appropriately documented in the resident's care plan.

This policy sets out a clear framework for staff, and provides best practice guidance about supporting residents, both in maintaining independence with their own catheter care and, when required, to be managed by competent and capable staff.

#### Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

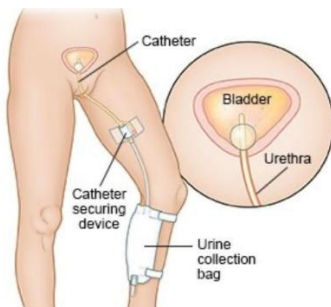
#### Policy Statement

Catheterisation in this home will only be considered on the advice or directions of the residents GP or hospital doctor. Catheterisation is an aseptic non touch procedure and only staff who have undertaken competency based training and assessment in practice should undertake catheterisation and catheter care. Staff should adhere to the procedures and clinical care requirements and comply with the relevant care guidance to reduce the risk of urinary tract infections (UTI'S). Prior to the procedure the resident should be fully assessed for the need for catheterisation; indwelling urethral catheters will only be used after considering alternative methods of management. The resident's clinical need for continuing urinary catheterisation should be reassessed regularly and the catheter removed as soon as possible if indicated. Catheters should not be changed unnecessarily.

#### The Policy

##### Indications for Urinary Catheterisation

- To bypass an obstruction. To relieve retention of urine.
- To measure urine output accurately
- To allow irrigation of the bladder
- To relieve intractable incontinence that hasn't responded to all others methods of care
- In the presence of sacral / perineal wounds where urinary incontinence is delaying healing and no other methods are practicable.
- For urinary incontinence at end of life to reduce discomfort when no other methods are practicable.



Caution should be exercised if:

- Previous urethral trauma
- Previous difficulty with catheterisation
- History of radical Prostatectomy or bladder reconstruction.
- Undiagnosed haematuria
- Congenital abnormalities
- Consent is not given

Advice in these circumstances should be sought by the residents GP.

If on the first attempt the catheter meets resistance on gentle pressure and cannot be inserted there should be a full evaluation before a second attempt is considered. If after two attempts catheterisation fails senior advice should be sought from a practitioner with more extensive relevant experience.

Use of sterile lubricating gel

A sterile lubricating gel containing 2% Lignocaine may be used in both male and female catheterisation to minimise associated trauma, pain, discomfort and catheter associated infection, however this must be prescribed. A sterile lubricating gel with no Lignocaine is a suitable alternative and has been shown to be as effective.

Catheter types

There is a range of catheters available. Each type of catheter is recommended for use up to a certain length of time and this will dictate the type of catheter used.

Suprapubic Catheter

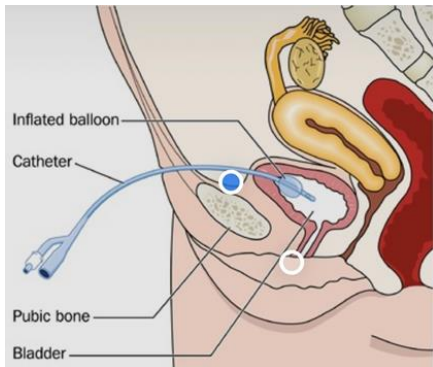
Suprapubic catheterisation is the insertion of a catheter through the anterior abdominal wall into the dome of the bladder. This procedure is performed under general anaesthetic using a percutaneous system.

Caring for a suprapubic catheter is the same as for a urethral catheter.

Immediately following insertion, aseptic technique should be employed to clean the insertion site, which will usually be performed by the District Nurse or the Homes Registered Nurses until the wound is healed.

Dressings may be required if secretions soil clothing, but they are not essential.

Once the insertion site has healed (seven to 10 days) the site and catheter can be cleaned using soap and water and a clean cloth.



### Catheter size

As a general rule the smallest lumen catheter that will allow urine to drain is adequate. Residents known to have large amounts of debris or haematuria will require a larger size.

Female – 12Ch short / Long term  
Male – 12-14 Ch short / Long term

### Catheter length

The standard length (40cm) is usually for male use but can be used by females in some circumstances (for example wheelchair user)

The female length (23cm) must only be used for female use as it may cause urethral trauma if the balloon is inflated in the male urethra.

### Procedure

- The resident must be informed of the reason and risks for the procedure, give consent and given the choice regarding a chaperone.
- A full explanation must be given and time allowed for residents to ask questions.
- Where a resident has capacity, informed consent must be obtained and documented in the care records. If they are unable to give informed consent, then this must be discussed with the GP and the Mental Capacity Act guidelines followed.
- Ensure the resident is in a comfortable position, preferably supine.
- Ensure the residents dignity is maintained at all times.
- A sterile lubricating gel must be used to minimise associated trauma and pain and catheter associated infections.
- All equipment must be checked to ensure that it is in date, intact and not contaminated.
- Wash hands and put on PPE.
- Equipment should be prepared using a non touch aseptic technique.
- The resident's urethral area should be cleaned with sterile normal saline.
- Lubricating gel should be applied using the prefilled syringe.
- Remove gloves, decontaminate hands and replace with second pair of gloves.
- Visualise the urethra and pass the catheter slowly along the urethra into the bladder.
- Once urine starts to flow advance the catheter another 5cm before inflating the balloon with 10ml of sterile water. N.B. Do not inflate the balloon if urine is not flowing.
- Attach the selected drainage system and date the catheter bag.
- Ensure the resident is comfortable post procedure.
- Ensure the catheter is attached securely to the thigh with an appropriate adhesive appliance.
- Remove protective clothing
- Clean hands.

## Documentation

Record procedure in the residents Bowel and Bladder Assessment documentation Form 2.09. with the following information:

- Clinical indication for catheterisation
- Verbal consent
- Date and time of catheterisation
- Type and size of catheter used
- Amount of water inserted into the balloon
- Manufacturer and batch number
- Any problems during the procedure
- Colour and consistency of urine drained
- Residual drained
- Planned date of removal.

## Continuing care of a urethral Urinary catheter

The closed system should be used to minimise risk of infection.

Where possible, educate and encourage the resident to empty and manage their own drainage bag, using a clean technique and effective hand hygiene.

Mobile residents will use a leg bag, which should be changed every seven days, to maintain a closed drainage system. If the closed system is broken for any reason, for example to perform a bladder wash out, then a new bag must be attached to the catheter.

To reduce the risk of pressure ulcers developing, it is important that leg bag straps are moved frequently, and that the leg bag is worn on different legs in rotation. For residents being cared for in bed, a night bag only should be used. This will usually be a reusable night bag with a tap for emptying. This should be changed weekly, or sooner if the closed system is broken for any reason.

It is recommended that a single use, non-drainable night bag is used for residents with a leg bag in place. This will significantly reduce the risk of urinary tract infections and cross contamination. The night bag is connected to the leg bag to hold all the urine that drains from the bladder overnight. Night bags must be hung on a stand, by the side of the bed.

Urine drainage bags should be emptied regularly, usually when they are about two thirds full to avoid backflow, and positioned below the level of the bladder. Gloves are to be worn to empty drainage bags. Handwashing must take place following the removal of gloves. The resident's privacy and dignity must be upheld by completing catheter care in a suitable environment.

The drainage bag attached to the catheter must be sterile. Residents who use leg drainage bags during the day need to have non sterile single use night drainage bag attached over night.

## Procedure for attaching a night bag.

- Wash and dry hands.
- Put on non-sterile gloves and disposable apron.
- Insert connector of the two litre night bag into the tap of the leg bag.
- Check that there is an adequate seal.
- Open the tap on the leg bag and drain the urine into the larger bag.
- Attach the night bag to the frame of the stand ensuring it does not pull on the urethra or bladder.
- Urine drainage bags must be positioned below the level of the bladder and should not be in contact with the floor.
- Remove gloves and apron and wash hands.

## Procedure for removing a night bag.

- Wash and dry hands.
- Put on non-sterile gloves and disposable apron.
- Close the tap on the leg bag.
- Disconnect the night bag.
- Empty the urine from the night bag into the toilet (remember to measure the volume if required).
- Dispose of the night bag in household waste.
- Remove gloves and apron and wash hands.

Catheter valves are sometimes used for residents with urological conditions as an alternative to a leg bag. They need to be changed every five to seven days as per manufacturer's instructions, using a rigorous non-touch clean technique, to avoid backflow.

The use of non-sterile gloves plus hand decontamination needs to be done before and after all contact with urinary drainage.

The resident should be encouraged or assisted where necessary with high levels of personal hygiene.

Ensure the urinary drainage system is conducive with the individuals needs e.g. Flip Flow valve or leg drainage bags.

Ensure adequate hydration.

Urinary drainage bags should be emptied when 2/3 full or every four hours. Urinary drainage bags should be emptied frequently enough to prevent reflux and maintain flow (NICE).

Accurately document urine output if required on Fluid balance chart on Access and Clinical

The need for the residents indwelling catheter must be reviewed regularly with the residents G.P.

Registered nurses should only perform bladder washouts if they have attended practical competency based assessment training.

Where intermittent self catheterisation is indicated staff will assist the resident to perform this procedure. This should be discussed with the local continence advisor.

The National Institute for Health and Clinical Excellence (MTG69) (NICE) has recently approved the use of the Uroshield as an add on treatment to reduce bacteria in the urine by using an ultrasound device which reduces the ability of bacteria to adhere and form a biofilm and reduce friction between the person's internal tissue and the catheter leading to reduction in pain, discomfort and spasm, as well as infection reduction. This would be instigated by the healthcare professional managing the resident's catheter care according to local policy and training in the use and maintenance of the device would need to be considered. It has been mentioned in this document as a large majority of people with long term indwelling catheters are found in the community setting, therefore care staff will come across this device. See 'UroShield for preventing catheter-associated urinary tract infections' for more information.

Having a catheter means that the bladder contains more bacteria that can cause a urinary tract infection, with 80% of UTIs being secondary to indwelling catheters. Even a few days after insertion of a new catheter, micro-organisms can often be isolated and this is known as bacteriuria.

For each day post catheterisation, the risk of acquiring bacteriuria increases by 5%, within approximately a month almost every resident with an indwelling catheter will develop bacteria in their urine (bacteriuria).

Approximately 24% of residents will go on to develop catheter acquired urinary tract infection (CAUTI), 4% of those will develop a severe secondary infection, (e.g. Bacteraemia) and 10-33% of those will die.

Staff should look out for the following signs and symptoms of a urinary tract infection in residents with a catheter:

- A temperature of above 38 degrees.
- Cold and shivery.

- New onset of confusion or worsening of pre-existing confusion or agitation.
- Central low back pain/tenderness or pain in the abdomen or groin.
- Change in normal urine or the volume of urine in catheter bag.
- Nausea/ vomiting/ or generally unwell.
- Suprapubic discomfort.
- Offensive smelling and cloudy urine. NB changes in urine should not be considered in isolation or to be the driver for prescribing antibiotics as all indwelling catheters will have a biofilm of bacteria within hours of insertion resulting in asymptomatic bacteraemia.
- Urgency/Bypassing and bleeding (this can also be a sign of bladder stones).
- General malaise.
- Loin pain.

Where staff are concerned a resident may have a CAUTI they should escalate this to the Registered Nurse or duty manager, so that they can inform the resident's GP.

Treating a resident with no signs or symptoms of CAUTI with antibiotics will do more harm than good, as it risks them developing multi-resistant organisms, e.g. MRSA.

#### Training

Care staff are provided with training and competency assessment on catheter care at all suitable stages of their employment from induction onwards.

#### Seeking Feedback about communication

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of EFH communication. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

#### References

RCN Guidance for health professionals – Catheter Care – February 2019  
 NICE – Infection Prevention and Control – April 2014  
 NHS Urethral Catheterisation Policy January 2019

Review date	Next Review Date
May 2024	May 2027