Acacium Group Community Urethral Catheterisation (Male & Female)

Procedure Reference | SOP CATH 01

Version | V4.0

Procedure Name	Urethral Catheterisation (Male & Female)
Purpose of Document	To ensure that the correct preparation, procedure and outcome are achieved by implementing a consistent, and systematic, approach to urethral catheterisation
Target Audience	All Healthcare Professionals
Version	V4.0
Author	Karen Matthews-Shard
Date of Approval	June 2010
Published Date	November 2010
Lead Director	Karen Matthews-Shard
Review Frequency	3 yearly, or when clinical or operation guidelines change
Last Reviewed	October 2022
Next Review Date	October 2025
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Dec 2016	Implementation of document history page.	KNF/SJ
V1	Mar 2018	Updated front sheet to include new review frequency date.	KMS/MS
V2	Oct 2019	3 Yearly Review	Clinical Advisory Group
V2.1	Oct 2020	Updated re Rebrand	CC
V3	Dec 2022	Reviewed and updated	Clinical Advisory Group
V4.0	Jan 2024	Rebrand	Clinical Advisory Group

Table of Contents

1. Introduction

1.1 Urinary catheterisation is the insertion of a catheter into a client's bladder. The catheter is used as a conduit to drain urine from the bladder into an attached bag or container. The client is at higher risk of a urinary tract infection (UTI) due to the body's defence mechanisms reacting to the catheter as a foreign body. Therefore, indwelling urinary catheter usage is limited to clients who would be at greater risk if not catheterised. Indwelling urethral catheters must only be used after considering alternative methods of management. To reduce the continuing risk of UTI, the clinical need for catheterisation should be reviewed regularly and the catheter removed as soon as possible.

2. Aim

2.1 To effectively manage the client's urinary catheter and therefore minimise the risk of infection.

3. General

3.1 **This is an aseptic technique and hand hygiene and appropriate PPE are essential.**

3.2 Prior to catheterisation the general condition of the client should be noted.

3.3 **Check the Client does not have an allergy to latex, normal saline or local anaesthetic.**

3.4 If the client is able to wash themselves with soap and water prior to procedure this is acceptable practice. If the client is unable to complete this the worker must assist with this element of personal care.

3.5 If the bladder is grossly distended, the GP/ District nurse should be informed, if the client is unstable dial 999.

3.6 Any change in general condition, before and after, should be recorded. If catheterised for retention of urine, output should be monitored hourly for 4 hours then as detailed in the clients care plan

3.7 Significant quantity of traumatic, post-micturition haemorrhage should be recorded, and reported to the GP/District Nurse and to Acacium Group.

3.8 If this is a re-catheterisation procedure the existing catheter should be removed and discarded at the start of the procedure, ensuring the balloon has been deflated. The tip of the catheter must be observed on removal for soft debris encrustation, or clean tip. This should be documented in the client's notes.

4. Equipment

- Appropriate PPE as per current guidelines
- Catheter or catheter with syringe and sterile water included in packing
- 10mls leur lock syringe
- Sterile water – sufficient to inflate balloon (as per manufacturer instructions)
- Sachet of sterile normal saline
- Sterile dressing pack
- Anaesthetic gel/lubricant – must be sterile and water soluble as prescribed, and in accordance with Medicine Management Policy
- Drainage bag system

- Blanket/towel to cover client's chest – to maintain client dignity
- Bowl, soap, water and towel
- Waste receptacle

5. Consent

5.1 Please read Acacium Group Policy on consent thoroughly and ensure valid consent has been gained.

5.2 **Please now ensure you understand the Consent Policy and Mental Capacity Act in full**

6. Documentation

6.1 Client's Notes –which should include:

- Catheter Care Plan
- Catheter client Information Leaflet

7. Procedure

7.1 Preparation

	Action	Rationale
1	Ensure procedure can be performed in a private room where interruptions are prevented.	Promote privacy and dignity.
2	Explain procedure to Client, to gain informed consent for catheterisation.	Ensure Client has given consent to procedure.
3	Assemble equipment on a clean protected surface.	Minimise the risk of infection.
4	Ensure client is comfortable and in a suitable position.	This ensures that the catheter is inserted minimising potential damage, discomfort or pain.
5	Put on plastic apron, wash hands, don non-sterile gloves.	Minimise the risk of infection.
6	Cover top half of Client with blanket/towel, exposing genitals.	Promote privacy and dignity.
7	Wash Client's genitals with soap and water. Dry thoroughly. Dispose of bowl and water and gloves. Wash hands.	Minimise the risk of infection.
8	Prepare clean protected surface. Open dressing aid placing catheter pack onto sterile field. Open outer catheter package and gel/lubricant, empty onto primary sterile field.	Reduce the risk of infection.

9	Fill syringe with sterile water and place to one side unless a syringe and sterile water is included in the catheter packaging.	To reduce the length of time the procedure takes for the client

7.2 **Female Client's**

7.2.1 A 26cm or 43cm length catheter may be used for females

	Action	Rationale
1	Wash hands, put on sterile gloves.	Minimise the risk of infection.
2	Pick up catheter, in dominant hand, holding inner wrapper and expose tip of catheter 1"-2" (5cms), replace on primary field.	To ensure readiness to perform the catheterisation
3	Assemble anaesthetic gel dispenser, place on primary field.	To ensure readiness to perform the catheterisation
4	Place dressing towel below client's genitalia	To collect urine that drains from catheter before the catheter bag is attached.
5	Separate labia with non-dominant hand and identify urethral meatus.	Ensure correct positioning of catheter.
6	Cleanse area with sterile normal saline, swabbing from urethra down to anus then discarding swab.	Reduce the risk of infection.
7	Instil anaesthetic gel (if prescribed) into urethra, allow sufficient time for local anaesthesia to occur (4-5 minutes). Inform the client that the local anaesthetic is cold and may sting.	Promote comfort during the procedure, reduce the risk of pain.
8	Gently insert catheter into urethral meatus, force should not be used, if resistance felt stop and seek advice. Do not touch any part of the vulva with the catheter.	Reduce the risk of urethral trauma.
9	A specimen of urine is collected, if required. (a) When the catheter is to be removed remaining urine may be collected in a receiver. (b) When the catheter is to remain in situ, inflate the balloon with sterile water as advised by manufacturer and attach drainage system.	Assess the presence of infection if required. Collection of urine promoting dignity. To hold the catheter in place.
10	Whenever possible use a catheter fixation device.	To reduce the risk of damage to the urethra / bladder by the catheter/catheter drainage bag.
11	Make Client comfortable and clear away equipment.	Client comfort.

12	Record residual volume and nature of urine obtained –(colour, clear, cloudy, debris). Specimens intended for the laboratory should be sent as soon as possible with a completed request form.	Baseline of urine output and to confirm rationale for catheterisation.
13	Record any difficulties with procedure.	To make the next catheterisation if relevant, more easily managed.
14	Record whether catheter long term or short term, plus length of catheter, balloon volume, reason for catheterisation, lubricant used on the Catheter Management Form Also record batch number.	Client safety. Ensure continuity of care for future catheterisations and identify when catheterisation is next due Confirm use of appropriate catheter and details in case of any reaction to the catheter.
15	Provide Client / carer with catheter information leaflet, explaining importance of hand washing, how to dispose of catheters and bags, how to empty catheter, attach night bag, when catheter will be changed. Also, how to obtain further supplies via prescription from the GP.	Client and/or carers is empowered to self-care and complications associated with catheterisation are reduced.

7.3 **Male Client's**

7.3.1 Preparation for male clients as per Preparation and 1-3 for female above

	Action	Rationale
1	Assemble anaesthetic gel dispenser, place on primary field.	To ensure readiness to perform the catheterisation.
2	Retract foreskin, if applicable with non-dominant hand, holding penis with gauze swab.	Promote ease of insertion and minimise risk of infection. Clinical Advisory Group.
3	Cleanse the penis with sterile normal saline. In non-circumcised clients, retract the foreskin slightly to enable the penis to be cleansed and the urethral opening to be visible. **NB** Do not fully retract a foreskin. Remember to return the foreskin to its normal position once the procedure is completed.	Remove secretions in order to reduce the risk of infection and ease insertion.

4	Instil 10-12mls anaesthetic gel into urethra still holding penis in non-dominant hand. Allow sufficient time for local anaesthesia to occur (4-5 minutes). Inform the Client that the local anaesthetic is cold and may sting.	Reduce the risk of pain upon insertion.
5	Pick up catheter in dominant hand, holding by inner wrapper and expose tip of catheter 1”-2” (5cms).	Prepare for insertion
6	Gently insert catheter into urethra and pass along urethra until urine commences to flow. Insert a further 2” (5cms) to ensure balloon is in bladder.	To minimise trauma and ensure that tip of catheter is in the bladder
7	A specimen of urine is collected, if required. (a) When the catheter is to be removed, remaining urine may be collected in a receiver. (b) When the catheter is to remain in situ, inflate the balloon with sterile water as advised by the manufacturer and attach drainage system.	Assess the presence of infection. Collection of urine promoting dignity. Hold the catheter in situ to maintain the catheter remains in situ.
8	Whenever possible use a catheter fixation device	To reduce the risk of damage to the urethra / bladder by the catheter/catheter drainage bag.
9	Make Client comfortable and clear away equipment.	Enable to Client to “get back to normal” as soon as possible.
10	Record residual volume and nature of urine collected (colour, clear, cloudy, debris) in Daily Records and Fluid Balance.	Baseline information that may be required for ongoing clinical care.
11	Record any difficulties with procedure.	Ensure continuity of care for future catheterisations and identify when catheterisation is next due.
12	Record whether catheter long term or short term and length of catheter balloon volume, reason for catheterisation, lubricant used on the Catheter care plan. Also record batch number.	Promote continuity of care and timely re-catheterisation, where appropriate. Confirm use of appropriate catheter and details in case of any reaction to the catheter.

13	Provide Client with catheter information leaflet, explaining importance of hand washing, how to dispose of catheters and bags, how to empty catheter, attach night bag and when catheter will be changed. Also, how to obtain further supplies via prescription from the GP.	Client and/or carers are empowered to self-care and complications associated with catheterisation are reduced.

8. Aftercare

- Regularly review the continuing use of a urinary catheter
- Document continuing care and review
- Ensure that the connection between the catheter and the urinary drainage system is not broken except for good clinical reasons e.g. changing the bag as per the manufacturer's recommendation
- Wearing plastic apron and gloves and using a disposable container, wipe the tap with an alcohol wipe prior to emptying the catheter bag. A catheter drainage bag should not be emptied more often than necessary as the increases the risk of infection. However, the bag must be emptied before it becomes completely full e.g. 2/3rds full, to avoid back flow of urine to the bladder. Wash hands after removing gloves. Where possible, educate and encourage the service user to empty their own drainage bag, ensuring their hands are washed before and after emptying
- To ensure that no part of the catheter drainage system comes into contact with the floor and urine does not flow back into the bladder, position the urinary drainage bag below the level of the bladder; on a stand for bed-bound client or leg bag for mobile clients
- Clients with long-term catheters must have an individual catheter regimen designed to minimise problems of blockage and encrustation. Care should be planned to minimise (eliminate) emergency catheterisations out-of-hours
- Record input and output where appropriate
- After 4 hours clients who drain more than what is detailed in care plan per hour will need immediate referral to Accident & Emergency or GP as the client may be in danger of hypovolaemic shock
- Monitor and record urine flow, colour and debris
- Monitor and record Client's temperature where appropriate and if commissioned to do so as part of the commissioned service.
- Send a specimen of urine for culture if client is feverish, develops abdominal pain or urine appears cloudy using an aseptic technique via the designated sampling port not catheter bag
- Provide routine personal hygiene to maintain cleanliness – antiseptics are not required
- Do not change catheters unnecessarily or as part of routine practice. Catheters should be changed in accordance with manufacturers' guidelines and the needs of the client
- Do not add antiseptic or anti-microbial solutions into urinary drainage bags
- Do not use bladder irrigation, installation or washouts to prevent catheter associated infection unless prescribed and written on MAR Chart.
- Do not use catheter maintenance solutions to prevent UTI unless prescribed by a urologist
- An overnight drainage bag can be attached to the day bag/leg bag to facilitate drainage overnight
- If pre-connected catheters are in use the initial bag can remain connected for two weeks

9. Associated Policies / SOPs

Policies

CLIN 04 Urinary Catheterisation
CLIN 14 Health Records Management
CLIN 06 Consent
CLIN 07 Infection Prevention and Control

SOPs
SOP CATH 01 Urethral Catheterisation (Male & Female)
SOP CATH 02 Suprapubic Re-catheterisation (Male & Female)
SOP CATH 03 Guidance for Care of Clients Catheterised for Retention of Urine
SOP CATH 04 Catheter Management for urinary catheters that block, bypass or are expelled with balloon intact
SOP CATH 05 Intermittent Self-Catheterisation
SOP CATH 06 Urinary Catheter Removal
SOP CATH 07 Urinary Catheter Bag Emptying
SOP CATH 08 Bladder Washouts
SOP CATH 09 Urinalysis
SOP CATH 10 Collection of a catheter urine specimen
SOP CATH 11 Penile sheath application
SOP CATH 12 Attaching and detaching a night bag
SOP CATH 13 Mitrofanoff Management

10. References

- https://www.infectionpreventioncontrol.co.uk/content/uploads/2020/01/DC-19-Urinary-catheter-care-2020-Version-1.00.pdf

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

pulse Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group