CATHETERSATION POLICY

POLICY DEVELOPED: JULY 2004

REVIEW DATE: AUGUST 2006

INTRODUCTION

Catheterisation of the Urinary Bladder either via a urethral route or a suprapubic route carries a high degree of clinical risk (Simpson 2001). Therefore as Newham Primary Care Trust has a duty of care to ensure these risks are minimised. Risks involved include urinary tract infection, encrustation, and urethral trauma and may contribute as an underlying factor in the death of clients.

This catheterisation policy has been developed using evidence-based practice.

SCOPE OF THE DOCUMENT

This document is intended to manage the risks of catheterisation in a timely manner. The policy will encompass the following areas:

- Staff able to undertake this procedure
- Training required
- Identifying Clinical Risk
- Consent
- Clients for whom catheterisation may pose a risk
- Infection control
- Product selection
- Manufacturers liability
- Catheter Maintenance Solutions
- Bladder irrigation
- Incident reporting

OBJECTIVES OF THE POLICY

The intention of this policy is to ensure that each member of Trust staff who undertakes any form of catheterisation is aware of their own accountability and that of the Primary Care Trust. That each person is responsible for his or her own action and that steps are taken to minimise risk. Also that training is accessed to ensure safe practice.

TRAINING

(a) The Primary Care Trust will offer training for every member of qualified staff to ensure that they meet the competencies laid out in appendix 1.

CLINICAL RISK

(a) Catheterisation carries a high clinical risk which involves some of the following; bleeding, infection, urethral tears, false passages and in extreme cases death can occur. It is therefore extremely important that these risks are identified and action plans designed to mitigate the risk.

(b) All patients must be assessed for their suitability for catheterisation extreme care must be taken to ensure that the client can manage their own catheter. If however there is any element of doubt a risk assessment must be completed.

(c) All clients must be asked about allergy to latex and if there is any previous allergic reaction then the nurse must use non-latex products for the client.

(d) Any untoward incidents relating to catheterisation including urethral tears, failure to catheterise and bleeding on insertion of catheter must be reported via the IRIS system.

CONSENT

(a) Prior to catheterisation a valid consent informed consent must be obtained from the client. This will usually be verbal, without consent the procedure cannot take place. If the patient is deemed not able to consent then this should be discussed with the relevant medical staff. (See D.O.H guidelines on consent).

CLIENTS FOR WHOM CATHTERISATION MA POSE A RISK

(a) Clients with dementia need to be considered with care, as they are often unable to understand the procedure and therefor consent, also they may find a catheter intrusive and pull on the catheter.

(b) Clients with invasive tumours of the pelvic region.

(c) Clients with a recent history of sexual abuse.

(d) Clients who are unwilling to have the procedure performed.

INFECTION CONTROL

(a) All staff carrying out this technique must adhere to the hand washing policy laid down by the infection control advisor for the area.

(b) All staff must ensure that they use an aseptic technique for catheterisation.

(c) Clients should have leg bag and night bag where possible and the leg bag should only be changed every 7 days to maintain a closed drainage system.

(d) Where hand-washing facilities are inadequate then refer to the Infection Control Policy for alternative alcohol hand rubs.

(e) All trolleys in hospital must be washed with warm soapy water prior to catheterisation and washed again after use; it is not necessary to use alcohol to clean trolleys, as there is no clinical evidence to prove this is effective.

PRODUCT SELECTION

(a) Catheters must be selected on an individual basis however in the majority of cases for urethral catheterisation a small size catheter i.e. a 12-14 FG should be chosen. This prevents bladder spasm and is more comfortable for the client.

(b) Only use a 10ml catheter balloon with 10mls of sterile water. Do not over inflate balloons or use large balloons as this can cause damage to the bladder neck and bladder.

(c) If a client requires catheterisation for more than seven days a long-term catheter should be used.

(d) If latex allergy is suspected use an all silicone catheter.

(e) For supra pubic catheterisation ensure that the catheter used is suitable for this purpose.

MANUFACTURERS LIABILITY

(a) All catheters carry a manufacturer's liability therefore staff must ensure that they do not breach this. Breach of liability occurs when catheters are used incorrectly i.e. left in for longer than the time specified in the drug tariff (12 weeks). Or a catheter without a license for instance an all silicone, which states urethral use only, inserted supra pubically.

(b) Care must be taken with storage of catheters as again if stored incorrectly the liability may be void.

(c) Ensure that all the information pertaining to the catheter are recorded in the clients notes as if in future there is a problem with the catheter batch all clients who have used the catheters can be quickly identified.

(d) Staff have a duty to ensure that the catheter inserted is not out of date, as the manufacture cannot be liable for out of date stock.

MAINTENANCE SOLUTION'S

(a) These should be used in accordance with the Trust care pathway for catheter maintenance solution.

INCIDENT REPORTING

(a) All incidents regarding catheterisation must be reported using the Incident Reporting System. Items to report include:

- Urethral Tears
- Unsuccessful Catheterisations due to bleeding/trauma
- Clients pulling out catheters
- Severe catheter related infections

All incidents will be followed up with a root cause analysis to ensure that lessons are learnt from each experience and that safe guards are put into place to prevent future incidents.

This policy needs to be used in conjunction with the Trust Catheter Pathway and the Catheterisation Competencies and Procedure which form the appendix to this document.

Appendix 1

Catheterisation Competencies

After attending is course the participant will be able to explain or describe the following:

THEORY

1. Describe the male urinary tract and explain areas that may be potential problematic for catheterisation.
2. Describe the female urinary tract and explain how it differs from the male tract.
3. Identify three reasons for catheterisation.
4. Identify three reasons for not catheterising a client.
5. Understand the implications of consent and the type of consent required for this procedure.
6. Understand the use of sterile Lidocaine anaesthetic gel.
7. Understand the reasons for non-deflation of catheter balloon and how to manage this potential emergency.
8. Understand the correct usage of catheter maintenance solutions and when to us these.
9. Understand the correct link drainage system for the client.
10. Understand the materials used to manufacture catheters and the risk of latex allergy.
11. Understand about manufacturer liability and safe use of Medical Devices (MDA).
12. Be aware of the correct procedure for reporting incidents with catheters using the Incident Reporting Information System (IRIS form)

This theoretical assessment will take place at the end of the catheterisation course, there will also be a short practical assessment as this is competency-based assessment all nurses are expected to watch two catheterisation and perform two assessed catheterisation in their work place.

PRACTICAL

1. Be able to explain the procedure to the client gaining consent from the client.
2. To position the client comfortably
3. To obtain the correct equipment for catheterisation and prepare a sterile field.
4. To follow the hand washing policy for the area.
5. Change the catheter according to the procedure in Appendix 2.
6. Select the correct drainage system
7. Accurately record all details including consent in the catheter care programme and the client's office notes.

All staff will undertake two assessed catheterisations. Once they have been passed as competent it is the responsibility of the Nurse to inform the Continence Service of this fact so details can be entered on the database. If for any reason a Nurse has not achieved competency then the third assessment

should be undertaken by the Continence Advisor and further educational and practical input will be offered.

The following people can carry out the assessment.

Clinical Nurse Specialist (Continence)/ Peer who has already undertaken the catheterisation course and has been assessed as competent to practice this technique.

Appendix 2

Catheter Theory Assessment

Theory	Competent	Not yet Competent
Be able to describe he female urinary tract and explain how it differs from the male tract.		
Be able to give three reasons for catheterisation		
Be able to give three reason for not catheterising a patient		
Understand the implications of consent and the type of consent required for this procedure.		
To understand the use of sterile Lidocaine gel		
To understand the reasons for non-deflation of catheter balloon and how to manage this potential emergency.		
Understand the correct usage of catheter maintenance solutions an when to use these.		
Be able to select the correct link drainage system for the client.		
Understand the materials used to manufacture catheters and their relationship to latex allergy		
Understand about manufacturer liability and MDA reporting system.		
Be aware of the correct procedure for reporting incidents with catheters using the IRIS system		

Name of Nurse

Name of Assessor for Theory/Designation

Signature of Assessor

Date

Catheter Practical Assessment

Practical	Competent		Not yet Competent	
	1	2	1	2
Be able to explain the procedure to the client gaining consent from the client.				
To position the client comfortably.				
To obtain the correct equipment for catheterisation and prepare a sterile field.				
To follow the hand washing policy for the area.				
Change the catheter according to the procedure in Appendix 2.				
Select the correct drainage/support system.				
Accurately record all details in the catheter care programme and the client's office notes.				

Name of Nurse

Date of Assessment 1

Signature of Assessor

Print name of Assessor

Date of Assessment 2

Signature of Assessor

Print name of Assessor

Comments

Appendix 3

Catheterisation Procedure - Hospital

This is an aseptic technique.

Latex Allergy

Clients should be asked if thy have a history of latex allergy prior o catheterisation, if present a non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Plastic apron.
- Catheter of appropriate size and length.
- Dressing pack / catheterisation pack.
- 2 pairs sterile gloves – latex/Nitrol latex free for clients/staff with allergy to latex.
- 2 x 10 ml syringes and needle.
- 10mls of sterile water.
- Sterile anaesthetic gel/lubricant in syringe applicator 11 mls for men and 6mls for women.
- Drainage bag system.
- Blanket to cover client's chest.
- Nursing notes.
- Bowl, water, soap and towel, non-sterile latex/nitrol gloves.
- Waste disposal bag for clinical waste.

Preparation

1. Explain procedure to client, ensure privacy.

2. Gain informed verbal consent.

3. Put on plastic apron.

4. Prepare clean trolley surface using hot soapy water to remove gross debris.

5. Assemble equipment on bottom shelf of clean trolley.

6. Cover top half of client with blanket, exposing genitals.

7. Put on the non-sterile gloves. Wash client's genitals with soap and water and dry thoroughly. Dispose of bowl, water and gloves. Wash hands a per the infection control hand-washing policy for the area.

8. Open dressing pack, open the 2 pairs of sterile gloves onto the sterile field. Open outer catheter package and empty gel/lubricant onto the sterile field. Put on sterile gloves - 2 pairs – so the top pair can be removed half way through the procedure leaving a clean pair of gloves for the catheterisation.

9. If preferred, for ease of use with dominant hand, holding the catheter, remove the catheter from the inner packaging and replace on sterile field.

10. Place a dressing towel beneath the client's genitalia.

Re-catheterisation only (if first catheterisation skip the next 2 steps)

11. Pick up the empty syringe that does not contain water and deflate the catheter balloon. Expect between 6-10 mls of water returned.
Do not attempt to cut the inflation arm to remove the water.

12. Remove the catheter using gentle traction. (If there are problems removing the catheter please follow the trouble-shooting guide.)

Female Client's

1. Separate labia with non-dominant hand and identify the urethral meatus.

2. With dominant hand instil 4-6mls of sterile gel into the urethra, allow sufficient time for local anaesthesia to take effect (4-5 minutes).

3. Remove top pair of gloves and dispose of in waste bag. Pick up catheter in dominant hand and gently insert catheter into meatus, approx. 10 – 15 CMS. Force should not b used, if resistance felt, stop and seek advice. Once urine drains from the catheter, collect a specimen of urine if required.

4. Inflate the catheter balloon using the 10 mls of sterile water and attach the drainage system.

5. Make client comfortable and clear away equipment. Ensure that the "peel off" label with all the details of the catheter is retained for sticking in the client's nursing record/catheter assessment form.

6. Record volume and nature of urine obtained. Specimens intended for the laboratory should be sent as soon as possible with a completed request form.

Male clients follow the procedure from 1-8

1. Retract prepuce/foreskin with non-dominant hand, holding penis with sterile gauze swab.

2. Instil 10-15 mls anaesthetic gel into the urethra still holding penis in non-dominant hand. (Gently compress the penis behind the glands to retain the gel). Allow sufficient time for the local anaesthesia to take effect (4-5 minutes).

3. Remove gloves and dispose of in waste bag.

4. Pick up the catheter in dominant hand. Gently insert the catheter into the meatus and pass along the urethra until urine commences to flow. Insert another 2” (5cm) to ensure the balloon is in the bladder.

5. Collect a specimen of urine if required.

6. Inflate the balloon using the 10mls of sterile water if at this stage resistance is felt, stop, deflate the balloon and insert the catheter another 1” then re-inflate the balloon.

7. Make the client comfortable, retract the foreskin and clear away equipment. Ensure that the “peel off” label with all the details of the catheter is retained for sticking in the client’s nursing record/catheter assessment form.

8. Record volume and nature of urine obtained. Specimens intended for the laboratory should be sent as soon as possible with a completed request form.

Notes

Prior to first catheterisation the client’s bladder is palpated and general condition noted.

If the bladder is grossly distended and the client is in shock the Doctor should be informed. The bladder should be drained by slow decompression under medical supervision. Any change in general condition, before and after should be noted.

Significant quantity of traumatic, post micturition haemorrhage should be noted.

Appendix 4

Catheterisation Procedure – Community

This is an aseptic technique.

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation. If present a non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Plastic apron
- Catheter of appropriate size and length and pre filled if possible.
- Dressing pack/Catheterisation pack.
- 2 pairs of Sterile Gloves Latex/Nitrol latex free for clients/staff with allergy o latex.
- 2x10 ml of Sterile Water (only if non pre filled possible)
- Sterile anaesthetic gel/lubricant in syringe applicator 11mls for men and 6 mls for women
- Drainage bag system
- Blanket to cover client's chest
- Nursing notes
- Bowl, soap, water and towel, non-sterile latex gloves
- Waste disposal bag for clinical waste.

Preparation

1. Explain procedure to client, ensue privacy, if possible remove any animals from the room.

2. Gain informed verbal consent

3. Put on apron

4. Assemble equipment on a clean protected surface (table top, bedside table etc)

5. Cover top half of client with blanket, exposing genitals.

6. Put on the no-sterile gloves. Wash client's genitals with soap and water and dry thoroughly. Dispose of bowl and water and gloves. Wash hands as per the infection control hand-washing policy for the area.

7. Open dressing pack, open the 2 pairs of sterile gloves onto the sterile field. Open outer catheter package and gel/lubricant empty onto the sterile field.

8. Fill syringe with water and place to one side.

9. Assemble anaesthetic gel dispenser, place on sterile field.

10. Wash hands as per the infection control hand-washing guidelines for the area. Put on the 2 pairs of sterile gloves (this ensures that the procedure can be carried out completely without having to leave the client).

11. Place dressing towel beneath the client's genitalia.

12. For re-catheterisation, pick up syringe that does not contain water and deflate the catheter balloon. Expect between 6-10mls of water returned.

DO NOT ATTEMPT TO CUT THE INFLATION ARM TO REMOVE THE WATER

13. Remove the catheter using gentle traction. If there are problems removing the catheter follow the trouble-shooting guide.

Female Client's

1. Separate labia with non-dominant hand and identify the urethral meatus.

2. With dominant hand instil 4-6mls of sterile gel into the urethra; allow sufficient time for local anaesthesia to occur (4-5 minutes).

3. Remove top pair of gloves. Pick up catheter in dominant hand and gently insert catheter into meatus, approx. 10-15cms. Force should not be used, if resistance is felt, stop and seek advice. Once urine drains from the catheter, collect a specimen if required.

4. Inflate the catheter balloon using the 10mls of sterile water and attach the drainage system.

5. Make client comfortable and clear away equipment. Ensure that the "peel off" label with all the details of the catheter is retained for sticking in the client's nursing record / Catheter assessment form.

6. Record volume and nature of urine obtained. Specimens intended for the laboratory should be sent as soon as possible with a completed request form.

Male Client's

1. Retract prepuce with non-dominant hand, holding penis with sterile gauze swab.

2. Instil 10-15 mls anaesthetic gel into the urethra still holding penis in non-dominant hand. (Gently compress the penis behind the glands to retrain the gel) Allow sufficient time for the local anaesthesia to occur (4-5 minutes).

3. Remove gloves and dispose of in waste bag.

4. Pick up the catheter in dominant hand. Gently insert the catheter into the meatus and pass along the urethra until urine commences to flow. Insert another 2" (5cms to ensure the balloon is in the bladder. Collect a specimen of urine if required.

5. Inflate the balloon using the 10mls of sterile water if at this stage resistance is felt, stop, deflate the balloon and insert catheter another 1" then re-inflate the balloon.

6. Make client comfortable and clear away equipment. Ensure that the "peel off" label with all the details of the catheter retained for sticking in the client's nursing record / catheter assessment form.

7. Record volume and nature of urine obtained. Specimens intended for the laboratory should be sent as soon as possible with a completed request form.

Notes

Prior to first catheterisation, the client's bladder is palpated and general condition noted.

If the bladder is grossly distended and the client is in shock, the Doctor should be informed. The bladder should be drained by slow decompression under medical supervision. Any change in general condition, before and after should be noted.

Significant quantity of traumatic, post micturition haemorrhage should be noted.

Appendix 5

Suprapubic Re-catheterisation Procedure – Hospital

This is an aseptic technique.

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation. If present, a non-latex based catheter and sterile gloves should be used in the procedure.

NB Nurses do not insert the first catheter, as this is a surgical technique.

Equipment

- Plastic apron
- Catheter of appropriate size and length and pre filled if possible.
- Dressing pack/Catheterisation pack.
- 2 pairs of Sterile Gloves Latex/Nitrol latex free for clients/staff with allergy o latex.
- 2x10 ml of Sterile Water (only if non pre filled possible)
- Sterile anaesthetic gel/lubricant in syringe applicator 11mls for men and 6 mls for women
- Drainage bag system
- Blanket to cover client's chest
- Nursing notes
- Bowl, soap, water and towel, non-sterile latex gloves
- Waste disposal bag for clinical waste.

Preparation

1. Explain procedure to client, ensure privacy

2. Gain informed verbal consent

3. Put on plastic apron

4. Prepare clean trolley surface, using hot soapy water to remove gross debris

5. Cover top half of client with blanket, exposing abdomen / catheter site

6. Put on the no sterile gloves. Wash around the catheter site with soap and water and dry thoroughly. Dispose of bowl and water and gloves. Wash hands as per the Infection Control hand-washing policy for the area.

7. Open dressing pack; open he 2 pairs of sterile gloves onto the sterile field. Open outer catheter package and gel/lubricant empty onto the sterile field.

8. Fill syringe with sterile water and place to one side.

9. Remove catheter from inner package and place on the sterile field.

10. Using a syringe deflate the balloon of the old catheter bot do not remove the catheter.

11. Place dressing towel below catheter.

12. Remove first pair of gloves.

13. Pick up the new catheter in the dominant hand. Apply lubricating gel to catheter tip and around catheter site.

14. Using a piece of sterile gauze and non-dominant hand remove the old catheter noting length and angle of removed catheter. Discard old catheter.

    If resistance is felt or the balloon does not deflate please seek medical advice. Please DO NOT attempt to cut the catheter or deflation arm. If h old catheter is all silicone, follow advice in the trouble-shooting guide. Deflation may be due to cuffing of the catheter. If there is still resistance after trying the tips in the trouble shooting guide, please re-inflate the catheter and inform medical staff.

15. Gently insert new catheter using dominant hand to the same length and same angle.

16. Inflate the balloon with appropriate volume of sterile water usually 10ml.

17. Attach a sterile drainage bag.

18. Cleanse around the catheter site. Only apply a small keyhole dressing if there is a large amount of exudate present.

19. Make client comfortable and clear away equipment. Ensure that the “peel off” label with all the details of the catheter is retained for sticking in the client’s nursing record/catheter assessment form.

Appendix 6

Suprapubic Re-catheterisation Procedure – Community

This is an aseptic technique.

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present a non-latex based catheter and sterile gloves should be used in the procedure.

NB Nurses do not insert the first catheter, as this is a surgical technique.

Equipment

- Plastic apron
- Catheter of appropriate size and length and pre filled if possible.
- Dressing pack/Catheterisation pack.
- 2 pairs of Sterile Gloves Latex/Nitrol latex free for clients/staff with allergy o latex.
- 2x10 ml of Sterile Water (only if non pre filled possible)
- Sterile anaesthetic gel/lubricant in syringe applicator 11mls for men and 6 mls for women
- Drainage bag system
- Blanket to cover client's chest
- Nursing notes
- Bowl, soap, water and towel, non-sterile latex gloves
- Waste disposal bag for clinical waste.

Preparation

1. Explain procedure to client, ensure privacy

2. Gain informed verbal consent.

3. Assemble equipment on a clean protected surface.

4. Put on plastic apron

5. Prepare clean trolley surface, using hot soapy water to remove gross debris

6. Cover top half of client with blanket, exposing abdomen / catheter site

7. Put on the no sterile gloves. Wash around the catheter site with soap and water and dry thoroughly. Dispose of bowl and water and gloves. Wash hands as per the Infection Control hand-washing policy for the area.

8. Open dressing pack; open he 2 pairs of sterile gloves onto the sterile field. Open outer catheter package and gel/lubricant empty onto the sterile field.

9. Fill syringe with sterile water and place to one side. If not using a pre-filled catheter.

10. Remove catheter from inner package and place on the sterile field.

11. Using a syringe deflate the balloon of the old catheter bot do not remove the catheter.

12. Place dressing towel below old catheter.

13. Remove first pair of gloves.

14. Pick up the new catheter in the dominant hand. Apply lubricating gel to catheter tip and around catheter site.

15. Using a piece of sterile gauze and non-dominant hand remove the old catheter noting length and angle of removed catheter. Discard old catheter.

    If resistance is felt or the balloon does not deflate please seek medical advice. Please DO NOT attempt to cut the catheter or deflation arm. If h old catheter is all silicone, follow advice in the trouble-shooting guide. Deflation may be due to cuffing of the catheter. If there is still resistance after trying the tips in the trouble shooting guide, please re-inflate the catheter and inform medical staff.

16. Gently insert new catheter using dominant hand to the same length and same angle.

17. Inflate the balloon with appropriate volume of sterile water usually 10ml.

18. Attach a sterile drainage bag.

19. Cleanse around the catheter site. Only apply a small keyhole dressing if there is a large amount of exudate present.

20. Make client comfortable and clear away equipment. Ensure that the “peel off” label with all the details of the catheter is retained for sticking in the client’s nursing record/catheter assessment form.

Appendix 7

Administration of Catheter Maintenance Solutions – Hospital

This is an aseptic technique

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Catheter maintenance solution, as prescribed by Doctor or Nurse Prescriber
- 1 Sterile Latex/Nitrol gloves
- 1 pair non-sterile gloves
- Apron
- Bowl containing warm water
- New urine drainage bag

Preparation

1. Check drainage bag / catheter and establish need/cause for this procedure. If catheter appears to be blocked by blood/pus then use a saline washout. If there is debris/crystals and urine pH is between 6.7 and 9 then use a citric acid based solution. See catheter maintenance solutions (Appendix 2).

2. Explain procedure to the client, ensure privacy.

3. Put on plastic apron and wash hands according to local Infection Control policies.

4. Put on sterile gloves

5. Lace sachet in warm water

Method

6. Disconnect urine drainage system

7. For remove sachet from outer bag

8. Put on sterile gloves and remove cap from the end of the nozzle

9. Insert nozzle into catheter, avoiding touching catheter maintenance solution nozzle.

10. Allow the solution to drain into the bladder by elevating the bag **do not apply pressure.** Allow fluid to find its own level, approx. 25mls.

11. When fluid ceases to flow close clamp on the bag.

12. Leave solution instilled in catheter/bladder for the required time, usually 20 minutes.

13. Open clamp, allow solution to drain back into sachet.

14. Close clamp, disconnect catheter maintenance solution.

15. Connect **new** drainage system to catheter.

16. Dispose of equipment, remove gloves, ash hands.

17. Record mature of washout, debris etc in nursing records along with lot number and type of wash out solution given.

Please note catheter maintenance solution should be used in the presence of debris, all clients who are suspected of having a blocked catheter must have their urine tested with indicator paper available from the pharmacy at Mile End.

Please do not use maintenance solutions as a prophylactic measure.

GP, other medical practitioner or nurse Prescriber must prescribe all treatment. There are no client group directives for this treatment at present.

For more information contact the Continence Advisory Service, Plaistow Day Hospital, Samson Street, Plaistow, E13 9EH.

Appendix 7

Administration of Catheter Maintenance Solutions – Community

This is an aseptic technique

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Catheter maintenance solution, as prescribed by Doctor or Nurse Prescriber
- 1 Sterile Latex/Nitrol gloves
- 1 pair non-sterile gloves
- Apron
- Bowl containing warm water
- New urine drainage bag

Preparation

1. Check drainage bag / catheter and establish need/cause for this procedure. If catheter appears to be blocked by blood/pus then use a saline washout. If there is debris/crystals and urine pH is between 6.7 and 9 then use a citric acid based solution. See catheter maintenance solutions (Appendix 2).

2. Explain procedure to the client, ensure privacy.

3. Put on plastic apron and wash hands according to local Infection Control policies.

4. Put on sterile gloves

5. Lace sachet in warm water

Method

6. Disconnect urine drainage system

7. For remove sachet from outer bag

8. Put on sterile gloves and remove cap from the end of the nozzle

9. Insert nozzle into catheter, avoiding touching catheter maintenance solution nozzle.

10. Allow the solution to drain into the bladder by elevating the bag **do not apply pressure.** Allow fluid to find its own level, approx. 25mls.

11. When fluid ceases to flow close clamp on the bag.

12. Leave solution instilled in catheter/bladder for the required time, usually 20 minutes.

13. Open clamp, allow solution to drain back into sachet.

14. Close clamp, disconnect catheter maintenance solution.

15. Connect **new** drainage system to catheter.

16. Dispose of equipment, remove gloves, ash hands.

17. Record mature of washout, debris etc in nursing records along with lot number and type of wash out solution given.

Accordion dispensing pack

Follow steps 1-9

a. Use a 50ml dispensing pack. Agitate the pack gently. The pack will dispense approx. 5-10 mls at a time. Allow solution to entire and return, keep agitating until all the solution has been used.

b. Use two packs of the solution. One after the other (research evidence to support his)

c. Disconnect the container.

d. Connect **new** drainage system to catheter.

e. Remove the “peel off” labels from the base of each container.

f. Dispose of equipment, remove gloves, wash hands.

g. Record nature of washout, debris, all clients who are suspected of having blocked catheter must have their urine tested with indicator paper available from the pharmacy at Mile End.

Please note catheter maintenance solution should be used in the presence of debris, all clients who are suspected of having a blocked catheter must have their urine tested with indicator paper available from the pharmacy at Mile End.

Please do not use maintenance solutions as a prophylactic measure.

GP, other medical practitioner or nurse Prescriber must prescribe all treatment. There are no client group directives for this treatment at

present. For more information contact the Continence Advisory Service, Plaistow Day Hospital, Samson Street, Plaistow, E13 9EH.

Appendix 8

Procedure for use of Link Drainage System – Hospitals

Unless a client needs regular monitoring of urine output, for which you are using an urometer, each client should be provided with link drainage system (leg bag and night bag)

Connecting night bags (leg bags to be emptied as per emptying urinary drainage bags)

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Drainable/Non-drainable night bag dependant on infection control policy
- Non-sterile Latex/Non-latex gloves
- Tissue
- Apron

Preparation

1. Explain procedure to client, ensure privacy

2. Put on plastic apron, wash hands

3. Put on gloves

Method

4. Remove cap from top of night bag

5. Insert night bag connector in to the end of the leg drainage bag connector.

6. Support night bag on an appropriate stand ensuring that it does not fall / rest on the floor.

7. Open leg drainage bag to allow free drainage over night.

In the morning or when client gets up

8. Put on plastic apron, wash hands and put on gloves.

9. Close drainage bag tap.

10. Dry outlet port with tissue.

11. Re-position bags as per fixation straps/sleeves used.

12. Empty night bag in sluice, if using a drainable bag then empty urine via tap. Dispose of bag and remove gloves.

13. If using a non-drainable bag cut the bag diagonally across the corner and empty. Clean scissors with soap and water and dry. Remove gloves and wash hands.

14. Record volume and nature of urine if required.

Appendix 9

Procedure for use of Link Drainage System – Community

Unless a client needs regular monitoring of urine output, for which you are using an urometer, each client should be provided with link drainage system (leg bag and night bag)

Connecting night bags (leg bags to be emptied as per emptying urinary drainage bags)

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Drainable/Non-drainable night bag dependant on infection control policy
- Non-sterile Latex/Non-latex gloves
- Tissue
- Apron

Preparation

1. Teach carer to undertake the following procedure for client.

2. Put on plastic apron, wash hands.

3. Put on gloves.

Method

4. Remove cap from top of night bag

5. Insert night bag connector in to the end of the leg drainage bag connector.

6. Support night bag on an appropriate stand ensuring that it does not fall / rest on the floor.

7. Open leg drainage bag to allow free drainage over night.

In the morning or when client gets up

8. Put on plastic apron, wash hands and put on gloves.

9. Close drainage bag tap.

10. Dry outlet port with tissue.

11. Re-position bags as per fixation straps / sleeves used.

12. Empty night bag in toilet, via tap. Rinse the bag out with hot water and hang up to dry replacing the top cap.

13. Remove gloves.

14. Change night drainage bag every 7 days on the day that the leg drainage bag is changed.

For clients in residential or nursing homes, please use the hospital policy and change bags daily o prevent cross infection/contamination.

Appendix 10

Procedure for emptying Urinary Drainage Bags – Hospital and Community

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present a non-latex based catheter and sterile gloves should be used in the procedure.

Equipment

- Plastic apron
- Tissue
- Clean receptacle
- Non-sterile latex/non-latex gloves

Preparation

1. Explain procedure to client, ensure privacy

2. Put on plastic apron, wash hands

3. Put on gloves

Method

4. Place receptacle under tap and open, allowing urine to drain avoid spillage.

5. When empty close tap.

6. Dry outside of drainage tap with tissue.

7. Re-position bag.

8. A) Community disposes of urine, cleansing receptacle in hot soapy water and drying thoroughly.

   B) Hospital disposes of urine in sluice and place receptacle in bedpan washer.

9. Remove gloves, wash hands.

10. Record volume and nature of urine if required.

Note Clients emptying their own leg bags need to clean the tap with tissue after emptying and ensure that they have thoroughly washed their hands both before and after procedure.

Clients may wish to empty their bags directly into the toilet, ensure that they avoid contact with the toilet surfaces.

Leg drainage bags need to be changed every 7 days.

Catheter Care – Meatal Cleansing

Aim to keep the catheter and urethral meatus clean and to promote social hygiene.

Latex Allergy

Clients should be asked if they have a history of latex allergy prior to catheterisation, if present non-latex based catheter and sterile gloves should be used in the procedure.

Frequency of Procedure – Twice daily and after each bowel movement.

Comments, where possible the client following instructions/guidance from the nurse should undertake this procedure.

If the client is unable to perform the procedure for himself or herself then the nurse should take the following precautions to prevent infection:

a) Wash hands according to local infection control policy.
b) Wear sterile latex/non-latex gloves.
c) Wash hands, follow procedure.

Male clients please note that urethral discharge is a normal body reaction to a foreign body.