**Guideline for Indwelling Urinary Catheter Management for Adults**

Cork Kerry Community Healthcare Public Health Nursing Services

<table>
<thead>
<tr>
<th>Title of Development Group:</th>
<th>Indwelling Urinary Catheter (IUC) Guideline Development Group (Appendix 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>Directors of Public Health Nursing, Cork Kerry Community Healthcare (Appendix 2)</td>
</tr>
<tr>
<td>Reference Number:</td>
<td></td>
</tr>
<tr>
<td>Version Number:</td>
<td>1.0</td>
</tr>
<tr>
<td>Publication date:</td>
<td>April 2018</td>
</tr>
<tr>
<td>Date for Revision:</td>
<td>April 2021</td>
</tr>
<tr>
<td>Electronic location:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Version</th>
<th>Date approved</th>
<th>List section numbers changed</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Feb 2018</td>
<td>6.5; 7.1; 7.2; 17.1; 20</td>
<td>IUC Development Guideline Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appendix 4, 5, 10 and 16</td>
<td></td>
</tr>
</tbody>
</table>

Guideline for Indwelling Urinary Catheter Management for Adults Version No:1.0 Approval date: Feb 2018 Revision date: Feb 2021
# Table of Contents

**INTRODUCTION**

1.0 GUIDELINE STATEMENT  
2.0 GUIDELINE PURPOSE  
3.0 SCOPE OF GUIDELINE  
4.0 RELATED POLICY DOCUMENTS  
5.0 GLOSSARY OF TERMS AND DEFINITIONS  
6.0 RESPONSIBILITIES  
   6.1 Director of Public Health Nursing  
   6.2 Assistant Director of Public Health Nursing  
   6.3 The Continence Nurse Advisor  
   6.4 The Public Health Nursing Staff Member  
   6.5 Management of Supplies  
7.0 INFECTION PREVENTION AND CONTROL  
   7.1 Bacteriuria  
   7.2 Catheter Associated Urinary Tract Infection  
8.0 URINARY CATHETERISATION  
   8.1 Indications for catheterisation  
   8.2 Contra-Indications to catheterisation  
9.0 CONSENT  
10.0 CATHETER AND DRAINAGE SYSTEM SELECTION  
   10.01.1 Catheter selection  
   10.01.2 Type of catheter  
   10.01.3 Charriere size of catheter  
   10.01.4 Length of catheter  
   10.01.5 Balloon size  
   10.02 Cleaning solutions  
   10.03 Drainage System  
   10.04 Catheter Stabilisation Device  
11.0 PROCEDURE FOR FEMALE CATHETERISATION  
12.0 PROCEDURE FOR EMPTYING A URINARY CATHETER DRAINAGE BAG  
13.0 PROCEDURE FOR CHANGING A URINARY CATHETER DRAINAGE BAG DIRECTLY ATTACHED TO CATHETER  
14.0 PROCEDURE FOR REMOVAL OF A URETHRAL CATHETER  
15.0 PROCEDURE FOR CHANGING A SUPRAPUBIC CATHETER  
   15.3 Care of cystoscopy site  
16.0 PROBLEM SOLVING  
17.0 CATHETER ENCRUSTATION AND BLOCKAGE  
   17.1 Catheter maintenance solution  
18.0 AUTONOMIC DYSREFLEXIA  
19.0 DOCUMENTATION
20.0 IMPLEMENTATION PLAN

21.0 EVALUATION AND AUDIT

22.0 REFERENCES

23.0 Appendices

Appendix 1: Guideline Development Group
Appendix 2: Public Health Nursing Approval Governance Group
Appendix 3: Signature of Declaration of Understanding
Appendix 4: Information and Instruction for Home Helps Caring for Patients with Indwelling Urinary Catheter
Appendix 5: Template letter for GP Prescription
Appendix 6: My Moments for Hand Hygiene - Focus on caring for a patient with a urinary catheter
Appendix 7: Aseptic Non-Touch Technique for Indwelling Urinary Catheterisation
Appendix 8: Procedure for collecting a catheter specimen of urine
Appendix 9: “My urinary catheter passport”
Appendix 10: Indwelling urinary catheter template for care plan development
Appendix 11: Indwelling Urinary Catheter Change Record
Appendix 12: Aseptic Non-Touch Technique for Insertion of a Suprapubic Catheter
Appendix 13a: Indwelling urinary catheter management guideline Audit Tool
Appendix 13b: Audit of Nursing Documentation for a Patient with an Indwelling Urinary Catheter
Appendix 14: Letter to Directors of Public Health Nursing regarding guideline implementation
Appendix 15: Letter to CHO4, Cork and Kerry Head of Social Care
Appendix 16: Guideline Education Implementation Plan
Introduction

This document relates to the clinical nursing care required by community dwelling adult clients with an indwelling urinary catheter. While developing this guideline it was important to recognise the rights of all individuals regarding consent and refusal of a service (Health Service Executive, 2013).

1.0 Guideline Statement:

1.1 The Public Health Nursing Service in HSE South (Cork and Kerry Community Health Organisation (CHO) 4) is committed to implementing and promoting measures to ensure evidence-based practice in the “Management of Indwelling Urinary Catheter Care in the Community”.

1.2 Each nurse is accountable both legally and professionally for their own practice (Nursing and Midwifery board of Ireland (NMBI), 2015).

2.0 Guideline Purpose:

2.1 The purpose of this guideline is to provide guidance for all nurses working in Cork and Kerry CHO 4 on best practice in the management of Indwelling Urinary Catheter Care which includes both urethral and supra pubic catheters in adults.

2.2 To promote best practice for all of the Public Health Nursing staff members undertaking the insertion, maintenance and removal of urethral and supra pubic catheters in the community setting and in imparting this knowledge to clients and their families.

2.3 To minimize or reduce the incidence of infections / sepsis for patients requiring urethral and supra pubic catheters in the community.

2.4 To promote patient safety during insertion, maintenance and removal of the catheter.

3.0 Scope of Guideline:

3.1 This guideline applies to all nurses in Cork and Kerry CHO 4 involved in the Management of indwelling urinary catheter care. For the purpose of this document Public Health Nursing, Cork and Kerry CHO 4 includes: Directors of Public Health Nursing; Assistant Directors of Public Health Nursing; Public Health Nurses; Community Registered General Nurses and Clinical Nurse Specialists.

3.2 This guideline applies to all patients over 16 years of age in receipt of indwelling urinary catheter care management from Cork and Kerry CHO 4. “In Ireland if you are over 16 you can give your own consent”. National Consent Policy (HSE, 2013, p.4).

3.3 This guideline should also be used in conjunction with relevant national protocols.

3.4 Changing of supra pubic catheter is an expanded nursing role. This procedure is only carried out by nurses who have completed an education programme and competency assessment in these techniques.

3.5 Changing of a male urethral catheter is currently not carried out by nurses in CHO4 and is therefore not included in this guideline.
4.0 Related Policy Documents:


- Nursing and Midwifery Board of Ireland (2015). Scope of Nursing and Midwifery Practice Framework.

- Nursing and Midwifery Board of Ireland (2014). Code of professional Conduct and Ethics.

5.0 Glossary of Terms and Definitions:

5.1 Urinary Catheter - A catheter is a thin hollow flexible tube which can be inserted into the bladder (European Association of Urology Nurses (EAUN), 2012).

5.2 Indwelling Urinary Catheter - A catheter in the bladder, with a balloon inflated at the distal end to prevent it slipping out. It remains in situ and allows continuous drainage of urine (Royal Marsden, 2015).

    Short-term – catheter remains in situ for 28 days or less.
    Long term – catheter remains in situ for longer than 28 days.

5.3 Urethral catheter – A catheter inserted into the urinary bladder via the urethra (EAUN 2012).

5.4 Supra-Pubic Catheter - A catheter inserted into the urinary bladder via the abdominal wall (Health Protection Surveillance Centre (HPSC), 2011).
5.5 Catheterisation - The insertion of a catheter into the bladder either through the urethra (urethral) or supra pubic channel to drain urine (EAUN 2012).

5.6 Aseptic Non-Touch Technique (ANTT) Association for Safe Aseptic Practice (2014) - A method used to prevent contamination of susceptible sites by micro-organisms that could cause infection, achieved by ensuring that only sterile equipment and fluids are used and the part of components that that should remain sterile, e.g. the tip of urinary catheter is not touched or allowed to come into contact with non-sterile surfaces (HPSC, 2011).

5.7 Catheter Stabilisation device - any material or health care product, adhesive or non-adhesive that secures indwelling urinary catheters. These are positioned on the thigh or abdomen to reduce catheter movement and minimise accidental dislodgment. It maximizes patient comfort by eliminating circumferential compression and alleviating urethral traction (Charles, 2016).

5.8 Leg Bag - A sterile leg drainage bag with a drainage tap which is directly attached to the catheter after insertion and secured to the leg.

5.9 Drainage bag with drainage tap which is secured to a catheter stand. The sterile bag is either directly attached to the catheter after insertion or attached to the drainage tap of a leg bag for overnight drainage (link-system).

5.10 Link system – a system by where a drainage bag is attached to the drainage outlet of the leg drainage bag. The link system is predominantly used at night to facilitate overnight drainage due to the small capacity of the leg bag.

5.11 Closed drainage system – A closed catheter drainage system is an aseptic system in which the path from the tip of the catheter inserted into the bladder, to the bag which collects urine, is closed and should not be disconnected. This is required to eliminate exposure of the urinary tract with bacteria via the catheter drainage tubing and from the collection bag (European Association of Urology, 2012).

5.12 Catheter valve: Valves are small devices connected to the catheter outlet instead of a bag to allow for intermittent bladder emptying (EAUN, 2012).

5.13 Catheter Associated Urinary Tract Infection (CAUTI) – The presence of symptoms or signs attributable to microorganisms that have invaded the urinary tract, where the patient has, or recently had a urinary catheter (HPSC, 2011).

5.14 Urethral Stricture - Occurs when part of the urethra narrows. Common causes are enlarged prostate, trauma associated with previous urethral catheterisation, long term intermittent catheterisation or surgery (EAUN 2012).

5.15 Standard Precautions - Are evidenced based work practices and measures for patient/patient care in all settings. These practices are designed to prevent and to reduce the risk of cross infection from both recognised and unrecognised sources of infection (HSE South: Cork Kerry, 2012).

5.16 Consent – is defined as the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in
which the service user has received sufficient information to enable him/her to understand
the nature, potential risks and benefits of the proposed intervention or service (HSE, 2013).

5.17 Catheter maintenance solution - is a solution that is instilled into either the urethral or
suprapubic catheter to avoid catheter blockage that is caused by debris or encrustation and
can be used to prolong catheter life.

NOTE: Patients should be offered a chaperone or be invited to request the presence of a chaperone, a
full explanation of the examination, procedure or treatment to be carried out should be given to the
patient, followed by questioning to ensure the patient has understood the information (Royal College
of Nurses (RCN), 2012).

5.17 Refusal of service - If an adult with capacity to make an informed decision makes a
voluntary and appropriately informed decision to refuse a proposed treatment or service, this
decision must be respected (HSE, 2013).

6.0 Responsibilities:

6.1 Director of Public Health Nursing (DPHN) is responsible for:
• Ensuring this guideline is available to all nurses working within the Public
• Identifying and supporting ongoing educational opportunities for staff to
enhance their knowledge and skills in this area.
• Identifying the needs of the service to HSE management and seeking the allocation
of adequate financial and other resources to facilitate the provision of care that
reflects evidence-based practice.
• Facilitating audit of this guideline.
• Facilitating review and updating of this guideline within the recommended review
date.

6.2 Assistant Director of Public Health Nursing (ADPHN) is responsible for:
• Ensuring that each nurse has access to this guideline and is familiar with same
(Appendix 3 – Declaration of Understanding).
• Identifying and supporting on-going educational opportunities for staff to
enhance their knowledge and skills in this area within allocated resources.
• Informing staff of the availability of educational and training opportunities
to enhance the knowledge and skills in the management of catheter care in the
community.
• Facilitating provision of care within available resources and in line with evidence
based practice in relation to the management of urinary catheter care.

6.3 The Continence Nurse Advisor is responsible for:
• Facilitating patients and staff training/education to support best practices in the
management of indwelling urinary catheter care.
• Provide clinical expertise and support in the management of patients with catheters.
• Promoting implementation of this guideline
• Facilitating clinical audit and evaluation.
• Providing nursing management and practitioners with feedback from clinical audit.
6.4 The Public Health Nursing staff member is responsible for:

- Adhering to this guideline.
- Availing of education and training on the management of urinary catheter care.
- Following the procedure outlined in this guideline in line with their scope of professional practice.
- Developing and maintaining their competence in relation to the management and changing of indwelling urinary catheters and ensuring their knowledge, skills and practices are up to date.
- Acknowledging any limitations in competence, identifying his/her learning needs and discussing ways in which these needs will be met with his/her line manager.
- Checking that the patient has obtained the correct catheter type and size as prescribed by the Consultant or GP.
- Devising and implementing an individualised urinary catheter care plan.
- Delegation – The nurse must be cognisant of their requirement within the scope of nursing practice in their obligation in delegation of tasks (Refer to Scope of Nursing and Midwifery Practice, NMBI, 2015 p21-24). Refer to Appendix 4 “Information and Instruction for Home Helps caring for patients with Indwelling Urinary Catheter”).

6.5 Management of Supplies – It is essential that that each patient gets a prescription from their General Practitioner (G.P.) or Consultant for the catheter that they require and for 10mls sterile water ampoule if catheter does not come pre-filled or incorporate a syringe of sterile water (See Appendix 5 – Template letter for GP Prescription).

- It is the patients/next of kin/carer responsibility to source the prescribed catheter from the Pharmacy.
- It is the responsibility of the nurse to supply the required equipment necessary to change the catheter in the home.
- The nurse should advise the patient/next of kin/carer regarding the importance of keeping a spare catheter and changing equipment in the home. Equipment should be stored as per manufacturer’s guidelines.
- Check all catheters for quality and expiry date and ensure the integrity of the packaging prior to use.

7.0 Infection Prevention and Control:

- Catheterisation carries with it an increased risk of infection and up to 80% of urinary tract infections reported are related to the presence of a urinary catheter (HPSC, 2011). The infection risk is associated with the method and duration of catheterisation, the quality of catheter care and host susceptibility (Loveday et al, 2014).
- The presence of an IUC is a recognised risk factor for colonisation or infection with Multidrug resistant organisms i.e. Extended spectrum β lactamase (ESBL) - producing bacteria (Wilson et al, 2016).
- UTIs are increasingly caused by Multidrug Resistant Organisms (MDROs) including strains that are resistant to all available therapeutic agents, therefore preventing CAUTI may help patients avoid MDRO colonisation or infection (Meddings et al, 2014).
- Avoiding catheter use is the most important strategy in the prevention of CAUTI and therefore urinary catheterisation should be performed only when necessary, for
the shortest time possible and adhering to principles of good practice. Principles of good practice include hand hygiene (Appendix 6 - My moments for hand hygiene) using sterile equipment and an aseptic non-touch technique (ANTT) (Appendix 7 and 12) when catheterising patients.

7.1 Bacteriuria

- The presence of bacteria in urine (bacteriuria) signifies either colonisation or infection (HPSC, 2011). Bacterial colonisation with catheterisation is inevitable and bacteriuria can be found in up to 10-30% of patients with a catheter in situ for greater than 30 days.
- Dipstick urine testing is not a reliable method to detect CAUTI and is not recommended for catheterised patients as false positives will occur.
- It is estimated that approx. 90% of catheter-associated bacteriuria reflects colonisation rather than infection.
- Bacteriuria is therefore almost a universal feature of urinalysis and does not require antibiotic treatment in asymptomatic individuals.
- Urinalysis to detect CAUTI should not be routinely performed on long term catheterised patients as virtually all patients will have bacteria present in their urine (HPSC, 2011).
- Do not use dipstick testing to diagnose UTI in patients with catheters (Scottish Intercollegiate Guideline Network (SIGN), 2012).

7.2 Catheter Associated Urinary Tract Infection (CAUTI)

- Diagnosis of a CAUTI should be based on a full clinical assessment.
- Clinical signs and symptoms suggestive of CAUTI include fever (>38.0°C), chills or rigor, loin pain, new onset confusion or worsening of pre-existing confusion or agitation, nausea/vomiting/malaise, renal angle or supra-pubic pain. Fever is the most common symptom, however the absence of fever does not rule out infection (HPSC, 2011).
- The presence of signs and symptoms of infection will prompt the need for a catheter specimen of urine (CSU) to be sent to the lab (Procedure for collecting a catheter specimen of urine - Appendix 8). Do not send urine for culture solely on the basis of odour or appearance (HPSC, 2011).
- If the patient develops a CAUTI and the indwelling catheter has been in place for more than two weeks and is still indicated the catheter should be changed. A urine sample should be collected from the new catheter so the sample is representative of the microorganisms really present in the bladder and not the microorganisms that have adhered to the interior wall of the catheter (Infectious Disease Society of America, 2010).
- To reach a diagnosis of CAUTI, clinicians rely on a combination of clinical signs and symptoms in conjunction with a laboratory-confirmed bacteriuria which guides antibiotic treatment.
- There is no role for routine antibiotic prophylaxis in patients with urinary catheters (HPSC, 2011 and NICE, 2012).
8.0 Urinary Catheterisation:

- The decision to insert a urinary catheter requires a collaborative approach involving the patient and carer as well as those health professionals administering care in the hospital and community.
- Catheterisation is performed once an assessment has concluded that this is the most efficient and effective method of management and should be clearly documented in the nursing notes.
- All patients with an indwelling urethral catheter should have a plan documenting:
  - Reason for the catheter
  - Clinical indication for continuing catheterisation
  - Date for removal or review by an appropriate clinician overseeing their care (Loveday et al, 2014).
- All patients should be given a “My Urinary Catheter Passport” on initial insertion of a catheter (Appendix 9). This passport facilitates patient education and could be used as a checklist of the information patients may need about the catheter and living with it. It also facilitates documentation of catheter changes and as a shared record of problems identified and actions agreed by the patient and healthcare professional (Prinjha, et al, 2016). The passport should remain with the patient for as long as the catheter remains in place. The passport is not intended to replace nursing documentation/care planning in the patient’s records/notes. (For IUC Template for Care Plan Development - Appendix 10).

8.1 Indications for catheterisation

Indications for catheterisation include the following:

- To relieve acute urinary retention.
- To assist healing of an open sacral or perineal wound.
- To assist in achieving patient immobilisation e.g., required for unstable thoracic or lumbar spine or pelvic fractures.
- To monitor urinary output (e.g., in critically ill patients).
- For patient comfort during end of life care.
- During prolonged surgical procedures with general or spinal anaesthesia.
- During regional analgesia for labour and delivery.
- To allow instillation of drugs.
- As an exception, at patient request to improve comfort.

(Health Protection Surveillance Centre, 2011)

8.2 Contra-Indications to catheterisation:

- The patient withholds consent.
- The patient has a urethral stricture.
- The patient has a new suprapubic catheter site (first catheter change must be undertaken at hospital 4-6 weeks post same).
- The patient has a bladder tumour or is six weeks post transurethral resection of bladder tumour (TURBT).
- The patient has sustained acute pelvic trauma.
- Where the nurse has two failed attempts at catheterising the patient. Refer back to the local continence nurse advisor (where available) or GP to catheterise.
Seek advice if there is a history of difficulties or problematic changes e.g. history of bleeding, obstruction, tumour and bladder stone.

9.0 Consent: The need for consent and the application of the general principles in the Health Service Executive (HSE) National Consent Policy (HSE, 2013) extends to all interventions conducted by or on behalf of the HSE on service users in all locations. Knowledge of the importance of obtaining consent is expected of all staff employed or contracted by the HSE. Consent is the giving of permission or agreement for an intervention, receipt or use of a service following a process of communication about the proposed intervention (HSE, 2013). Catheterization is an invasive procedure that can cause embarrassment; physical and psychological discomfort and impact in the patients’ self-image with risks of bypassing, blockage, infection, MDRO infection and bleeding (RCN, 2012). Patients should be offered a chaperone or be invited to request the presence of a chaperone (RCN, 2012).

The process of communication begins at the initial contact and continues through to the end of the patients’ involvement in the treatment process (HSE, 2013). To ensure the patient is fully prepared for catheterization, it is the responsibility of the healthcare professional to inform the patient of the reasons, the associated potential complications/problems, and the necessity for the procedure and obtain the patients permission.

The validity of consent does not depend on the form in which it is given. Patients may indicate consent orally, in writing or in certain limited circumstances by implication. The requirement for consent is consistent with fundamental ethical principles, with good practice in communication and decision-making and with HSE policy (HSE, 2013). At present it is not common practice within Europe for patients to provide written consent for catheterization. It is however a necessity that verbal consent and agreement is reached and documented and the relevant information is recorded in the patients nursing notes (EAUN, 2012).

Refusal of Service: If an adult with capacity to make an informed decision makes a voluntary and appropriately informed decision to refuse a proposed treatment or service, this decision must be respected (HSE, 2013). In such cases it is particularly important to document the discussions with the patient or service user, including the procedure or service that has been offered, their decision to decline and the fact that the implications of this decision have been fully outlined (HSE, 2013).

10.0 Catheter and Drainage System Selection

10.1.1 Catheter Selection

• The Health Protection and Surveillance Centre (HPSC, 2011) recommends considering type, size and length when choosing the most appropriate catheter to minimize complications.

10.1.2 Type of Catheter

• The choice of catheter used should be governed by the length of time the catheter is likely to remain in situ, taking into account the reason for catheterisation.
• The patient’s lifestyle should be considered.
• The catheter material selected should be chosen for comfort, ease of insertion/removal, minimal risk of complications.
Ascertain if the patient has a known sensitivity to Latex.

**Note:** There are a limited number of silicone catheters licensed for supra pubic catheterisation due to their potential of cuffing. Silicone catheters tend to stick within the tract, requiring more traction to remove them (Charles, 2016).

<table>
<thead>
<tr>
<th>Catheter</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latex</td>
<td>Short term - up to 7 days</td>
</tr>
<tr>
<td>Polytetrafluoroethylene(PTFE)-Teflon coated latex</td>
<td>Medium term - up to 28 days</td>
</tr>
<tr>
<td>Hydrogel coated latex/silicone/100% silicone</td>
<td>Long term - up to 12 weeks</td>
</tr>
</tbody>
</table>

**Table 1:** Types of catheters

10.1.3 **Charriere Size of Catheter**

- The Charriere (Ch) is the outer circumference of the catheter in millimetres and is equivalent to three times the diameter.
- The smallest gauge that meets the needs of the patient should be used - This will minimise urethral trauma, bladder spasm and the amount of residual urine in the bladder, all of which may predispose to CAUTI (HPSC, 2011).

<table>
<thead>
<tr>
<th>Size 10</th>
<th>Clear urine, no debris, no grit (encrustation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size 12-14</td>
<td>Clear urine, no debris, no grit, no haematuria</td>
</tr>
<tr>
<td>Size 16</td>
<td>Slightly cloudy urine, light haematuria with or without small clots, none or mild grit, none or mild debris. A size 16ch is registered for supra pubic use (Charles, 2016).</td>
</tr>
<tr>
<td>Size 18</td>
<td>Moderate to heavy grit, moderate to heavy debris. Haematuria with moderate clots</td>
</tr>
</tbody>
</table>

**Table 2:** Charriere size of catheters (EAUN, 2012)

10.1.4 **Length of Catheter**

Use an appropriate length of catheter to ensure patient safety and comfort.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Catheter length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female urethral</td>
<td>25 cm – (Labelled Female Length) More comfortable and discrete</td>
</tr>
<tr>
<td>Bariatric/Obese Female urethral</td>
<td>40-45 cm (Labelled Standard Length) To improve comfort and drainage</td>
</tr>
<tr>
<td>Male urethral</td>
<td>40-45 cm (Labelled Standard Length)</td>
</tr>
<tr>
<td>Male and Female Suprapubic</td>
<td>40-45 cm (Labelled Standard Length)</td>
</tr>
</tbody>
</table>

**Table 3:** Length of catheter

Please note: In urethral catheterisation the female length catheter should not be used for males as inflation of the balloon within the urethra will result in severe trauma (National Patient Safety Alert, 2009).
10.1.5 Balloon Size

- Nurses should follow manufacturer’s recommendations. For the majority of patients 10ml balloons are satisfactory and are less likely to cause irritation of the bladder mucosa.
- The balloon size is indicated at the catheter connection behind the size of the catheter as a minimum and maximum volume in mls.
- The balloon must inflate with the correct amount of sterile water as indicated by the manufacturer.
- Over or under inflating balloons can lead to an altered shaped balloon that can cause discomfort, bladder spasm and interfere with urine drainage (Charles, 2016).
- Tap water or normal saline should never be used as debris / crystals may form rendering the balloon impossible to deflate.
- 30ml balloons were developed to prevent haemorrhage following prostatectomy, which is their intended use only.

10.2 Cleaning Solutions

- Skin cleaning solution recommended in catheterisation procedure is normal saline 0.9% (Normasol) or with mild soap and water unless patient is allergic to soap.
- Cleanse females from front to back (for urethral catheterisation).
- Avoid use of talcum powder and or ointment in contact with the catheter, as some ointments (e.g. petroleum jelly) can damage the catheter (Charles, 2016).

10.3 Drainage System:

- The recommended drainage system is a sterile closed urinary drainage system. Urine samples are obtained through the sampling port in the drainage tubing and should be needle free (See Appendix 8).
- A closed drainage system reduces the risk of ascending infection from intraluminal transmission (HPSC 2011).
- The choice of drainage system should be decided in accordance with the patient’s needs and preferences. This decision for the most appropriate bag should include the length of the inlet tube/drainage tube in combination with the catheter length. The options for leg bag inlet lengths are either 6cm or 25cm and for 2 litre bags are 100cm or 120cm.
- Single use sterile drainage bags (including night drainage bags) should be used with indwelling urinary catheter drainage systems (HPSC, 2011, EAUN, 2012 and Loveday et al, 2014). Single use items are denoted by the following symbol $\bullet$ and must be discarded after every use. They should never be reused even for the same patient.

For non-ambulant patients:

- A 2 litre sterile drainage bag with a drainage tap which is connected directly to the urinary catheter and supported on a catheter stand is recommended.
- 2 Litre sterile bags should be changed according to manufacturer’s instructions and is usually 5 to 7 days (Charles, 2016, HPSC, 2011).

For ambulant patients:

- A sterile drainable leg bag (350 -800mls) is recommended.
- The leg bag is connected directly to the catheter and only disconnected when the leg bag is being changed (as per manufacturer’s instructions which are usually 5-7 days).
• To facilitate overnight drainage, a single use, sterile, drainable 2 litre bag is connected to the leg bag via the drainage tap. This process supports a closed drainage system (HPSC, 2011).

**Good practice in the management of the drainage system includes:**
1. Using an appropriate catheter stabilisation device to minimise pulling or movement of catheter thus avoiding bladder neck and urethral trauma.
2. Clean the meatal area or suprapubic insertion site (once healed) daily using unperfumed soap and water.
3. Maintaining the bag below the level of the bladder.
4. Minimising contamination of the drainage bag outlet port by use of a catheter stand and avoiding contact with the floor or other surfaces.
5. Accessing the catheter drainage system only when absolutely necessary (e.g. changing the drainage bag as per the manufacturer’s instructions)
6. Empty the drainage bag regularly using a clean container and avoid touching the drainage tap with the container – do not allow the urinary drainage bag to fill beyond ¾ full.

Encourage good fluid intake (25-35mls per kg body weight) to maintain an output of between 50 to 100 mls hour, if not clinically contraindicated (EAUN, 2012)

10.3.1 Catheter Valve
• **Catheter valves** are small devices connected to the catheter outlet instead of a bag to allow for intermittent bladder emptying and may be suitable for some patients using either urethral or supra pubic catheters.
• It is essential that an assessment of bladder function is carried out by an appropriate medical professional/urology specialist prior to use. When used from the start the catheter valve can help to maintain bladder tone and capacity.
• It is recommended that the catheter valve is changed every 5-7 days and that a 2 litre sterile night bag is attached at night.
• Contra-indications to catheter valve use includes, reduced bladder capacity, cognitive impairment, impaired bladder sensation, immobility, reflux or renal impairment and insufficient manual dexterity (HPSC, 2011).

10.4 Catheter Stabilisation Device
• Their use is recommended to reduce adverse events such as dislodgement, tissue trauma, inflammation and urinary tract infection (EAUN 2012).
• The securement device should be placed at the stiffest part of the catheter (usually just below the bifurcation where the balloon is inflated), to prevent occlusion of the lumen.
• In males with chronic urethral catheters, abdominal placement and stabilisation of catheter may be necessary to avoid downward pressure on the meatus that can contribute to meatal erosion. The drainage bag is still placed below the level of the bladder and should provide enough gravity necessary for proper urine flow (Ansell, 2016 and Yates, 2014).
• The use of elasticised/Velcro straps should be used with caution in patients with Peripheral Vascular Disease (PVD).
• Regular assessment is necessary to avoid skin irritation from excess traction and or irritation from the device – remove immediately if skin becomes irritated and do not re-site.
• The suprapubic catheter emerges at right angles to the abdomen and needs to be secured in this position.
• Devices may be either adhesive or non-adhesive, positioned on thigh or abdomen.
• Use the one that the patient finds the most suitable.
• Change as per manufacturer’s instructions or sooner if issue observed.
• Rotate and change site regularly.
• Verbal and written (manufacturers) instructions on how to apply and remove the catheter securement device should be given to the patient/family/carer (Charles 2016).
11. Procedure for Female Catheterisation

11.1 Equipment:
- Clean area
- Sterile catheterisation pack
- Towel or waterproof sheet (where available) to protect the bed
- Alcohol hand rub
- 1 x 10mls sterile syringe to deflate balloon
- 1 x 10mls sterile syringe and 10mls of sterile water as per manufacturer’s instructions on catheter
- Prescribed charriere size sterile catheter
  - It is advisable to take a spare catheter in addition to the one you want.
  - Hydrogel coated latex catheters are the recommended catheter.
  - Consider 100% silicone in cases of suspected latex allergy (EAUN, 2012).
- Cleansing solution e.g. normal saline (NaCl)
- Sterile water soluble lubricating jelly (1 to 2 tubes or sachets)
- Personal protective equipment - Disposable plastic apron, sterile gloves (2 Pairs)
- Universal specimen container, if required
- A closed urinary drainage system e.g. sterile 2 litre bag, sterile leg bag or sterile catheter valve
- Clean urinary drainage bag stand, if required
- Catheter Stabilisation Device
- Scissors, if required to examine the catheter lumen to check for encrustation.
- Light source

11.2 Technique for female catheterisation:
Please refer to "Appendix 6 "My Moments for Hand Hygiene” and Appendix 7 – Aseptic Non Touch Technique (ANTT) Standard Operating Procedure for Insertion of an Indwelling Urethral Catheter

Please note further opportunities for hand hygiene may present as the need is influenced by the sequence of the procedure, the environment and the assistance required by the patient.

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.2.1 Discuss with the patient the reason for and possible complications associated with catheterisation. Document consent for procedure Check notes and confirm if the patient has any known sensitivity to latex or other allergies.</td>
<td>To ensure the patient understands and obtain their consent and co-operation. To reduce risk of adverse reaction.</td>
</tr>
<tr>
<td>11.2.2 Provide for patient privacy such as closing door and curtains or screens. Keep patient warm. Prepare the patient by placing a waterproof pad/sheet on the bed and if able, request the patient to position themselves in a supine position.</td>
<td>To ensure privacy, dignity and comfort for the patient during procedure.</td>
</tr>
<tr>
<td>11.2.3 Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean –Moment 1*</td>
<td>To protect the patient from transient microorganisms that may be on the healthcare workers hands</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11.2.4</td>
<td>Ensure that the groin / perineal area are socially clean. If assistance needed with positioning or washing of perineal area – Decontaminate hands following same (Moment 4*) Do not expose the patient at this stage. Ask the patient to lift covers before step 10.2.10.</td>
</tr>
<tr>
<td>11.2.5</td>
<td>Ensure good light source is available.</td>
</tr>
<tr>
<td>11.2.6</td>
<td>Clean and prepare the area, collect all equipment required.</td>
</tr>
<tr>
<td>11.2.7</td>
<td>Decontaminate hands before preparing equipment by applying alcohol hand rub on visibly clean hands for 30 seconds (Antiseptic hand hygiene) – Moment 2*</td>
</tr>
<tr>
<td>11.2.8</td>
<td>Put on disposable plastic apron. Open catheter pack and position waste bag. Open equipment onto aseptic field using non touch technique.</td>
</tr>
<tr>
<td>11.2.9</td>
<td>Decontaminate hands using alcohol hand rub for 30 seconds (antiseptic hand hygiene) -Moment 2* and apply sterile gloves. Prepare equipment using non touch technique. Ensure at this point that the sterile catheter / sterile water soluble lubricating gel is open and placed on the insertion pack.</td>
</tr>
<tr>
<td>11.2.10</td>
<td>Ask the patient to lift covers, draw knees up. Apply aseptic field drapes over genitals and between legs. If assistance is required, provide before decontaminating hands and applying sterile gloves.</td>
</tr>
<tr>
<td>11.2.11</td>
<td>Cleanse the perineum by swabbing the labia majora, labia minora and urethral orifice with sterile normal saline, in an anterior posterior direction discarding each soiled cotton wool ball/ gauze swab after use.</td>
</tr>
<tr>
<td>11.2.12</td>
<td>Remove gloves and clean hands using alcohol hand rub for 30 seconds (Moment 3 &amp; 2*) and put on new pair of sterile gloves</td>
</tr>
<tr>
<td>11.2.13</td>
<td>Apply sterile lubricant to the catheter tip.</td>
</tr>
<tr>
<td>11.2.14</td>
<td>Separate the labia with the non-dominant hand and give traction upwards.</td>
</tr>
<tr>
<td>11.2.15</td>
<td>Pick up the catheter with the other hand. Insert the catheter and gently advance the catheter along the urethra until it reaches the bladder and urine flows out. Then insert the catheter 2 cm deeper. Stop the procedure if continued resistance is felt or the patient complains of undue pain or is actively bleeding.</td>
</tr>
<tr>
<td>11.2.16</td>
<td>Hold the catheter in position, and insert the appropriate amount of sterile water according to manufacturer instructions to inflate the balloon. When the balloon is inflated pull the catheter back gently until you feel resistance.</td>
</tr>
<tr>
<td>11.2.17</td>
<td>Take urine sample if required</td>
</tr>
<tr>
<td>11.2.18</td>
<td>Attach the catheter to the sterile drainage bag using non touch technique.</td>
</tr>
<tr>
<td>11.2.19</td>
<td>Remove gloves and apron, decontaminate hands – Moment 3*</td>
</tr>
<tr>
<td>11.2.20</td>
<td>Where a 2ltr drainage bag is in use, attach to a clean catheter stand below the level of the patient’s bladder.</td>
</tr>
<tr>
<td>11.2.21</td>
<td>Secure the catheter using a catheter stabilisation device such as a catheter support strap or a catheter secure adhesive dressing. The manufacturer’s instructions on how to apply and remove the catheter stabilisation device should be given to the patient / family.</td>
</tr>
<tr>
<td>11.2.22</td>
<td>If a leg bag is used, attach to the patient’s leg with either the straps provided or leg bag sleeve. If a catheter valve is being used, the catheter is placed in the patient’s underwear.</td>
</tr>
<tr>
<td>11.2.23</td>
<td>Ensure the patient is clean, dry and comfortable.</td>
</tr>
<tr>
<td>11.2.24</td>
<td>During and following the procedure ask the patient to report any signs of pain or discomfort.</td>
</tr>
<tr>
<td>11.2.25</td>
<td>Apply non sterile gloves if risk of contact with body fluids to tidy/clear equipment, segregate waste to recycling and domestic disposal and advice family to dispose. Decontaminate area used.</td>
</tr>
<tr>
<td>11.2.26</td>
<td>If blocked, cut the lumen of the old catheter and examine for signs of encrustation</td>
</tr>
<tr>
<td>Section</td>
<td>Task</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>11.2.27</td>
<td>Remove gloves and apron, decontaminate hands – Moment 3*.</td>
</tr>
<tr>
<td>11.2.28</td>
<td>Educate the patient and carer and encourage the patient to drink 25ml to 35 mls per kg body weight unless contra-indicated.</td>
</tr>
<tr>
<td>11.2.29</td>
<td>Educate and provide patient with “My urinary catheter passport”.</td>
</tr>
<tr>
<td>11.2.30</td>
<td>Document the procedure in • The nursing notes using the “Catheter change record” (Appendix 11) and • “My urinary catheter passport”. (Appendix 9) • Include catheter size, type, and amount of water in the balloon and date of insertion.</td>
</tr>
<tr>
<td></td>
<td>Remove both batch stickers from packaging and place one in the patient’s notes and one on the passport.</td>
</tr>
<tr>
<td></td>
<td>Record a review date to assess the need for continued catheterisation or date to change catheter.</td>
</tr>
<tr>
<td></td>
<td>Record any problems/difficulties encountered during the procedure and actions taken.</td>
</tr>
</tbody>
</table>
12.0 Procedure for emptying a urinary catheter drainage bag

12.1 Equipment:
- Clean jug / container.
- Disposable non sterile gloves.
- Disposable apron

12.2 Technique for emptying urinary catheter drainage bag:

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.2.1 Empty the drainage bag before ¾ full.</td>
<td>To maintain the flow of urine and prevent reflux (back flow) in the drainage system.</td>
</tr>
<tr>
<td>12.2.2 Explain and discuss the procedure with the patient.</td>
<td>To ensure the patient understands the procedure.</td>
</tr>
<tr>
<td>12.2.3 Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean –Moment 2*. Don disposable gloves and plastic apron.</td>
<td>To reduce the risk of cross infection. To prevent contact with body fluids.</td>
</tr>
<tr>
<td>12.2.4 Open the outlet tap and allow the urine to flow into a clean jug/container. Ensure that the tap does not touch the jug/container.</td>
<td>To empty the drainage bag and observe urinary output – if required, measure the volume of urine. To prevent cross infection.</td>
</tr>
<tr>
<td>12.2.5 Close the outlet tap. If required, use a clean tissue to dry outlet tap.</td>
<td>To maintain closed drainage system.</td>
</tr>
<tr>
<td>12.2.6 Observe urine for presence of blood, cloudiness or offensive odour and follow up with appropriate action by referring to PHN or GP if necessary.</td>
<td>To identify any potential problems.</td>
</tr>
<tr>
<td>12.2.7 Cover the jug/container and dispose of contents in toilet and then clean and dry the jug. The jug should be stored in a clean area.</td>
<td>To reduce the risk of environmental contamination.</td>
</tr>
<tr>
<td>12.2.8 Dispose of gloves and apron as household domestic waste.</td>
<td>Dispose of waste safely</td>
</tr>
<tr>
<td>12.2.9 Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean –Moment 3*.</td>
<td>To protect the healthcare worker and reduce risk of environmental contamination.</td>
</tr>
</tbody>
</table>

*Appendix 6 –My Moments for Hand Hygiene

Please refer to either “My Urinary Catheter Passport” or to “Information and Instructions for Home Helps caring for patients with indwelling urinary catheter” if this care has been delegated to Home Helps for the following procedures:
- Procedure for attaching bed bag
- Procedure for disconnecting the bed bag
13.0 Procedure for changing a urinary catheter drainage bag which is attached directly to the catheter

**NOTE:** The changing of the urinary catheter drainage bag is breaking the closed urinary drainage system which increases the risk of infection. Therefore, it is the clinical responsibility of the nurse to assess the clients / families ability to change the catheter drainage bag using aseptic non touch technique (ANTT). If the client or family are unable to carry out same it remains the responsibility of the nurse.

The nurse must be cognisant of their requirement within the scope of nursing practice in their obligation in delegation of this task (See Scope of Nursing Practice, NMBI, 2015 p21-24).

13.1 Equipment:
- Clean area
- Alcohol hand rub
- Clean laundered towel or waterproof sheet to protect the bed
- Appropriate sterile drainage bag
- Disposable non sterile gloves
- Disposable apron
- Household Waste bag

13.2 Technique for changing a urine catheter drainage bag or valve directly attached to the catheter:

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.2.1</td>
<td>Change the drainage bag or valve connected directly to the catheter in line with the manufacturer’s recommendations (usually 5 to 7 days), unless there are other clinical reason e.g. leakage, contamination.</td>
</tr>
<tr>
<td>13.2.2</td>
<td>Empty the bag as per procedure for emptying a urine drainage bag – see 11.0 or open catheter valve and empty bladder. Remove leg straps or sleeve.</td>
</tr>
<tr>
<td>13.2.3</td>
<td>Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean – Moment 2* Place clean towel beneath the connection between the catheter and drainage bag. Put on disposable gloves and apron.</td>
</tr>
<tr>
<td>13.2.4</td>
<td>Prepare new sterile bag/valve, by opening the packaging and loosening the protective cap.</td>
</tr>
<tr>
<td>13.2.5</td>
<td>Hold the catheter securely near the connection point with one hand. With the other hand remove the emptied bag/valve using a twisting motion from the catheter. Avoid touching the end of the catheter. Put the used bag down.</td>
</tr>
<tr>
<td>13.2.6</td>
<td>Take up the new bag, remove loosened cap and avoid touching the nozzle of the drainage bag/valve. Insert nozzle into the catheter opening and secure using a twisting motion. This should be done as quickly as possible.</td>
</tr>
<tr>
<td>13.2.7</td>
<td>Place used drainage bag in a plastic bag to dispose of as household waste.</td>
</tr>
<tr>
<td>13.2.8</td>
<td>Remove gloves and apron and dispose of as in household waste.</td>
</tr>
<tr>
<td>13.2.9</td>
<td>Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub-Moment 3*.</td>
</tr>
<tr>
<td>13.2.10</td>
<td>Secure the drainage bag as appropriate i.e. with a leg bag strap or attach to a urinary drainage stand.</td>
</tr>
<tr>
<td>13.2.11</td>
<td>Ensure the patient is comfortable.</td>
</tr>
<tr>
<td>13.2.12</td>
<td>Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub-Moment 4*.</td>
</tr>
<tr>
<td>13.2.13</td>
<td>Document the change in the patient record.</td>
</tr>
</tbody>
</table>

*Appendix 6 – My Moments for Hand Hygiene*
14.0 Procedure for Removal of Urethral Catheter:

14.1 Equipment:
- Clean area.
- Clean laundered towel or waterproof sheet to protect the bed
- Alcohol hand rub
- Personal Protective clothing: Disposable non sterile gloves and disposable apron.
- Appropriate sized sterile syringe for deflating the balloon.
- Gauze swab / disposable wipes
- Household waste bag

14.2 Technique for removal of urethral catheter:

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.2.1 Review patient care records and remove the catheter within the recommended life span as indicated by the manufacturer instructions or as clinically indicated.</td>
<td>Catheters left in situ longer than the recommended time can cause bladder/urethral trauma on removal. The manufacturers recommended life span must not be exceeded.</td>
</tr>
<tr>
<td>14.2.2 Catheters are best removed early in the morning</td>
<td>So that any retention problems can be followed up during the day.</td>
</tr>
<tr>
<td>14.2.3 Explain/discuss the procedure with the patient. Inform the patient of possible effects following removal e.g. discomfort, incontinence, urgency, frequency, dysuria and retention. Discuss the need for good fluid intake following removal.</td>
<td>To ensure the patient understands the procedure and obtain their consent. To inform the patient of what to expect and enable the patient to plan daily activities accordingly. For adequate flushing of the bladder.</td>
</tr>
<tr>
<td>14.2.4 Check patient care records to establish the volume of water used to inflate the balloon</td>
<td>To ascertain the amount of water in the balloon and to use the appropriate size syringe and avoid bladder trauma.</td>
</tr>
<tr>
<td>14.2.5 Provide for patient privacy by closing doors and windows, curtains or screens. Place towel or waterproof sheet on the bed.</td>
<td>To ensure privacy, dignity and comfort for the patient during the procedure.</td>
</tr>
<tr>
<td>14.2.6 Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean – Moment 1*</td>
<td>To protect the patient from risk of infection.</td>
</tr>
<tr>
<td>14.2.7 Prepare the patient by assisting into bed and into a supine position. Release drainage bag support.</td>
<td>For ease of catheter removal.</td>
</tr>
</tbody>
</table>
| 14.2.8 | Decontaminate hands using an alcohol hand rub if hands are visibly clean (antiseptic hand hygiene)– Moment 2*  
Put on disposable gloves and apron. | To protect the patient from risk of infection.  
To protect the healthcare worker from risk of contamination from body fluids. |
| 14.2.9 | Clean the meatus and catheter using soap and water or disposable wipe. Clean away from the urethral opening. | To reduce the risk of bacteria from the vagina/perineum contaminating the urethra. |
| 14.2.10 | Insert appropriate sized syringe into the inflation lumen and slowly withdraw the sterile water, noting the amount returned. Do not use suction on the syringe but allow the solution to come back spontaneously. | To ensure the balloon is completely deflated before attempting removal. |
| 14.2.11 | Inform male patients of possible discomfort as the deflated balloon passes through the prostatic sphincter. Ask the patient to breathe in and out, as the patient exhales. Gently pull the catheter out. Stop the procedure if resistance is felt or the patient complains of pain.  
**Do not:**  
• Cut the catheter or inflation port.  
• Attempt to burst the balloon by over-inflating it.  
Inform the patient’s doctor if difficulties are experienced in deflating the balloon fully or removing the catheter.  
| To inform the patient of what to expect and gain the patient’s co-operation.  
To relax the pelvic floor muscles.  
The balloon may not be fully deflated.  
Catheter particles may remain in the bladder.  
The catheter may require surgical removal. |
| 14.2.12 | Dispose of catheter in a plastic bag. Remove gloves and apron dispose of into household waste  
Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean – Moment 3*  
| To dispose of waste safely.  
To protect the healthcare worker and reduce risk of environmental contamination. |
| 14.2.13 | Ensure the patient is clean, dry and comfortable.  
If patient or clothes are wet may cause skin irritation.  
| 14.2.14 | If patient assistance is required, decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub-Moment 4*.  
| To protect the healthcare worker and reduce risk of environmental contamination. |
| 14.2.15 | Document the procedure, any problems encountered and actions taken, in the nursing notes and “My urinary catheter passport” (See Appendix 9)  
| To provide an accurate record of care given |

*Appendix 6 – My Moments for Hand Hygiene
15.0 Procedure for changing a Suprapubic Catheter:

15.1 Equipment:

- Clean area
- Sterile catheterisation pack
- Clean laundered towel or waterproof sheet (where available) to protect the bed.
- Alcohol hand rub
- Personal protective equipment - Sterile disposable gloves x 2 and disposable plastic apron
- 1 x 10mls. sterile syringe to deflate balloon
- 1 x 10mls. sterile syringe and 10mls of sterile water (prescribed) as per manufacturer’s instructions on catheter
- Prescribed charriere sized sterile catheter (normally size 16Ch) –
  - Hydrogel coated latex catheters are the recommended catheter.
  - Consider 100% silicone in cases of suspected latex allergy (EAUN, 2012).
  - It is advisable to take a spare catheter.
- Solution to clean site, i.e. Normal Saline 0.9% (NaCl)
- Sterile water soluble lubricating jelly (1 to 2 single use tubes or sachets).
- Closed urinary sterile drainage system – sterile leg bag, sterile 2ltr bag or catheter valve
- Clean urinary drainage bag stand if required.
- Single use scissors if required to cut and examine catheter lumen.
- Catheter Stabilisation device
- Universal specimen container, if required.
- Scissors, if required to examine the catheter lumen to check for encrustation
- Light source.

When performing a supra-pubic re-catheterisation ‘three golden rules apply’ (Rigby, 2009)

Rule 1: Four week rule: Do not change a newly inserted catheter for four weeks, this allows the catheter tract to be established. Please note the first change is carried out in hospital by a doctor.

Rule 2: Speed: when changing a supra pubic catheter (SPC) speed is very important. The new catheter should be inserted within 5 to 10 minutes of removal of the old catheter. Never remove a SPC unless it is going to be changed immediately.

Rule 3: Spare catheter: always have a spare catheter and appropriate equipment available in case of accidental removal.

Please refer to *Appendix 6 “My Moments for Hand Hygiene” and Appendix 12 - Aseptic Non Touch Technique (ANTT) Procedure for Insertion of a Suprapubic Catheter

Please note further opportunities for hand hygiene may present as the need is influenced by the sequence of the procedure, the environment and the assistance required by the patient.
<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.2.1 Discuss with the patient the reason for and possible complications associated with catheterisation and document consent for procedure. Check notes and confirm if the patient has any known sensitivity to latex or other allergies.</td>
<td>To ensure the patient understands and obtain their consent and co-operation. To reduce risk of adverse reaction.</td>
</tr>
<tr>
<td>15.2.2 Provide for patient privacy such as closing door and curtains or screens. Keep patient warm. Place towel or waterproof sheets on the bed and if able request the patient into a supine position.</td>
<td>To ensure privacy and dignity and comfort for the patient during procedure.</td>
</tr>
<tr>
<td>15.2.3 Decontaminate hands with liquid soap and water and dry thoroughly or use an alcohol hand rub if hands are visibly clean – Moment 1*</td>
<td>To protect the patient from transient microorganisms that may be on the healthcare workers hands.</td>
</tr>
<tr>
<td>15.2.4 Release drainage bag support</td>
<td>To facilitate easy removal of catheter.</td>
</tr>
<tr>
<td>15.2.5 Ensure good light source is available.</td>
<td>To facilitate catheter insertion.</td>
</tr>
<tr>
<td>15.2.6 Clean and prepare the area, collect all equipment required.</td>
<td>To ensure the procedure can be carried out efficiently.</td>
</tr>
<tr>
<td>15.2.7 Decontaminate hands before preparing equipment by using alcohol hand rub for 30 seconds on visibly clean hands. (aseptic hand hygiene) –Moment 2*</td>
<td>To reduce risk of contaminating the sterile equipment.</td>
</tr>
<tr>
<td>15.2.8 Put on disposable plastic apron. Open catheter pack and position waste bag. Open equipment onto aseptic field using non touch technique.</td>
<td>To prepare equipment for catheterisation and to maintain sterility.</td>
</tr>
<tr>
<td>15.2.9 Decontaminate hands using alcohol hand rub for 30 seconds (antiseptic hand hygiene) –Moment 2* and apply sterile gloves. Prepare equipment using non touch technique.</td>
<td>Hands may have become contaminated by handling the outer packs.</td>
</tr>
<tr>
<td>15.2.10 Ask the patient to remove covers and apply aseptic field drapes over abdomen and between legs</td>
<td>To create a protective field.</td>
</tr>
<tr>
<td>15.2.11 Observe the current suprapubic site for the lie of the catheter, angle of insertion and how much of the catheter length is visible outside the body.</td>
<td>This information will be a useful guide for the insertion technique.</td>
</tr>
<tr>
<td>15.2.12 Clean the suprapubic site with normal saline using a forceps and sterile gauze swab each time.</td>
<td>To reduce risk of introducing infection.</td>
</tr>
<tr>
<td>15.2.13 Attach appropriate sized syringe to catheter valve to deflate the balloon. Do not use suction on the syringe but allow the solution to come back spontaneously. Note the amount of water returned.</td>
<td>Pulling the syringe plunger may collapse the inflation channel. To ensure the balloon is fully deflated before attempting removal.</td>
</tr>
</tbody>
</table>
| 15.2.14 | Ask the patient to breathe and out and on exhalation, withdraw the catheter from the tract by gently pulling on the catheter. The catheter may need to be twisted slightly using a corkscrew motion.  
• Note the angle of the catheter as it leaves the abdomen.  
• Observe how much of the catheter was within the bladder wall.  
• Put the removed catheter to one side. | This will indicate the angle of the established tract into which the new catheter will be inserted.  
To identify how far the new catheter needs to be inserted.  
To check later for encrustation |
| 15.2.15 | Remove gloves clean your hands using alcohol hand rub for 30 seconds (antiseptic hand hygiene) – Moment 3 & 2* | To protect the patient against microorganisms including the patients own and to protect the healthcare worker after potential exposure to body fluids |
| 15.2.16 | Apply new sterile gloves.  
Apply sterile sheet over supra pubic site. | The new catheter must be inserted as quickly as possible (i.e. within 5-10mins) after removing the old catheter as the catheter tract may become partially obliterated by constriction of the detrusor fibres |
| 15.2.17 | Clean suprapubic site with 0.9% normal saline and sterile gauze using non touch technique | To reduce the risk of introducing infection |
| 15.2.18 | Lubricate new catheter tip with water soluble sterile lubricating gel. Insert 3-5mls of lubricant gel into tract. | To assist with insertion of catheter if prescribed anaesthetic gel may be used at this stage. This may be contraindicated with some medications and medical conditions |
| 15.2.19 | Using the non dominant hand support the abdomen above cystoscopy site.  
Immediately insert the new catheter into the supra pubic opening at the same angle and length as the previous catheter  
Advance the catheter 3 cm deeper than it was before and not more to prevent the tip of the catheter irritating the bladder wall. If no urine drains gently apply pressure over the symphysis pubis area. | To prevent suprapubic site from narrowing or closing.  
To ensure the balloon of the catheter is positioned inside the bladder |
| 15.2.20 | Check that urine is draining before gently inflating the balloon as per manufacturer’s instructions.  
Once inflated, gently pull back the catheter until resistance is felt. | Urine drainage confirms that the catheter is in the bladder.  
To ensure catheter is correctly positioned in the bladder |
| 15.2.21 | Stop the procedure if the client experiences pain or if the catheter is difficult to pull back. | The catheter may not be in the bladder |
| 15.2.22 | Attach the catheter to the sterile drainage bag using non touch technique. Observe urine drainage. | To close the drainage system. 
To monitor drainage (urine drainage may be slightly blood stained) |
| 15.2.23 | Remove gloves and apron, decontaminate hands – Moment 3 &1* | To prevent environmental contamination and protect the patient. |
| 15.2.24 | Secure the catheter to the abdomen or mid thigh using a catheter stabilisation device such as a catheter support strap or a catheter secure adhesive dressing. 
The manufacturer’s instructions on how to apply and remove the catheter stabilisation device should be given to the patient / family. | This prevents traction and tension which may cause bleeding / trauma 
To ensure the correct application and removal of the catheter stabilisation device |
| 15.2.25 | If a leg bag is used, attach to the patients leg with either the straps provided or leg bag sleeve. | To anchor the drainage bag in order to prevent trauma to the bladder/suprapubic tract due to traction. |
| 15.2.26 | Ensure the patient is clean, dry and comfortable. | If the patient or clothes are left wet, skin irritation may occur. |
| 15.2.27 | During and following the procedure ask the patient to report any signs of pain or discomfort and encourage fluids. | To identify any problems at an early stage and to encourage flushing effect. |
| 15.2.28 | Apply non-sterile gloves and apron. | To protect the healthcare worker from risk of contamination from body fluids. |
| 15.2.29 | Clear and decontaminate equipment used. Segregate waste to recycling and domestic disposal and dispose into household waste | To dispose of waste safely. |
| 15.2.30 | If blocked, cut the lumen of the old catheter and examine for signs of encrustation | To reveal crystal like deposits of mineral salts within the lumen (encrustation) as a cause of blockage. |
| 15.2.31 | Remove gloves and apron, decontaminate hands – Moment 3* | To prevent the healthcare worker and prevent environmental contamination. |
| 15.2.32 | Educate and provide patient with “My urinary catheter passport”. | To educate and involve the patient in his/her self care and promote independence. |
15.2.32 Document the procedure in
- The nursing notes using the “Catheter change record” (Appendix 11) and
- “My urinary catheter passport” (Appendix 9).
- Include catheter size, type, and amount of water in the balloon and date of insertion.

Remove both batch stickers from packaging and place one in the patient’s notes and one on the passport.

Record a review date to assess the need for continued catheterisation or date to change catheter.

Record any problems/difficulties encountered during the procedure and actions taken.

15.3 Care of Cystoscopy Site

- Following initial insertion a clean keyhole dressing should be applied to the site and changed as required until insertion site is free from discharge.
- Always ensure hand hygiene is performed prior to any intervention and use protective equipment e.g. gloves
- Suprapubic catheter site should be cleaned daily with soap and water and surrounding area dried carefully.
- Excess cleansing is not required and may increase the risk of infection
- Observe the suprapubic site for signs of infection and over granulation
- To minimise excess movement at the suprapubic site, secure the catheter with a catheter stabilisation device on the abdomen or mid-thigh. Suprapubic catheters emerge at right angles to the abdomen and needs to be secured in this position. The position should be rotated regularly.
- Antimicrobial agents should not routinely or as prophylactic treatment be applied to the suprapubic site to prevent infection.
- Dressings are best avoided.
- If a dressing is used to contain a discharge:
  - this should be undertaken with strict non touch technique to protect against infection
  - Wherever possible, patients should be encouraged to change their own dressings
- If over granulation occurs which can be as a result of an over sized incision site or a response to a foreign body, i.e. catheter, change the position of the catheter against the abdomen by changing leg bag attachment or securing the catheter in a different direction in the catheter stabilisation device. If over granulation persists seek further advice.
- Document all activities in patient’s records include client/carer instruction (EAUN, 2012).
### 16.0 Problem Solving:

<table>
<thead>
<tr>
<th>Catheter Problem</th>
<th>Possible Reason</th>
<th>Possible Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Urine not draining into bag</td>
<td>Incorrect position of the drainage bag.</td>
<td>Check bag /tubing to ensure both are below the level of the bladder.</td>
</tr>
<tr>
<td></td>
<td>Catheter may be against bladder wall.</td>
<td>Gently reposition catheter and stabilise.</td>
</tr>
<tr>
<td></td>
<td>Drainage tubing may be kinked.</td>
<td>Check tubing to rule out mechanical obstruction. Loosen restrictive or tight clothing.</td>
</tr>
<tr>
<td></td>
<td>Catheter may be blocked.</td>
<td>If still not draining after excluding mechanical causes, remove and replace.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Catheter blockage is a common problem that needs to be approached methodically by identifying the cause and taking remedial action to prevent it re-occurring – see section 17 for Catheter Encrustation and Blockage.</td>
</tr>
<tr>
<td></td>
<td>Encrustation</td>
<td>Liaise with GP in relation to replacing if catheter blocked.</td>
</tr>
<tr>
<td></td>
<td>Constipation</td>
<td>Assess for mineral salt deposits by cutting lumen of removed catheter</td>
</tr>
<tr>
<td></td>
<td>Inadequate fluid intake.</td>
<td>Assess and treat constipation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage and promote fluids to maintain adequate hydration</td>
</tr>
<tr>
<td>i. Haematuria.</td>
<td>Trauma post catheterization.</td>
<td>Increase fluid intake.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check, observe and record urinary output/drainage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seek medical advice if clinically indicated</td>
</tr>
<tr>
<td></td>
<td>Infection.</td>
<td>Seek immediate medical advice.</td>
</tr>
<tr>
<td></td>
<td>Prostatic Enlargement.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renal Calculi.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carcinoma.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication.</td>
<td></td>
</tr>
<tr>
<td>iii. By-passing of urine around the catheter.</td>
<td>Drainage bag over full.</td>
<td>Empty drainage bag regularly to maintain urinary flow, prevent reflux and avoid traction.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Bladder spasm/instability.</td>
<td></td>
<td>Check prescription to ensure correct CH size in situ. If prescribed catheter in use, review with prescriber.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider replacing with smaller size catheter (urethral catheters only). Catheter size may be too large.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure the balloon is not under or over inflated – check patient catheter record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure appropriate catheter stabilisation device in use. Anti-cholinergic medication may need to be prescribed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seek advice from continence nurse adviser (if available) or medical advice if required.</td>
</tr>
<tr>
<td>Constipation.</td>
<td></td>
<td>Assess and treat.</td>
</tr>
<tr>
<td>Encrustation.</td>
<td></td>
<td>Assess for evidence of encrustation by cutting lumen of blocked catheter after it has been replaced. This will identify if mineral salts (crystals) are present and confirm encrustation. (See section 17 on blockage).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Document findings in catheter passport and nursing notes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review length of time of planned catheter changes e.g. reduce time from 12 to 10 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Catheter maintenance solution may be prescribed if appropriate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obtain a sterile specimen of urine using the sampling port to rule out</td>
</tr>
<tr>
<td>Consider Infection based on a full clinical assessment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guideline for Indwelling Urinary Catheter Management for Adults Version No:1.0  Approval date: Feb 2018  Revision date: Feb 2021
<table>
<thead>
<tr>
<th>iv. Pain or Discomfort</th>
<th>Bladder spasm.</th>
<th>See above for possible solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kinked tubing or blocked catheter</td>
<td>Complete pain assessment using the 0-10 visual analogue scale.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palpate bladder to determine presence of distension;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check drainage tubing for kinks;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Observe drainage for adequate amount, presence of clots that might be blocking drainage tube.</td>
</tr>
<tr>
<td></td>
<td>May indicate infection.</td>
<td>Carry out full clinical assessment and obtain specimen of urine if clinically indicated to out rule infection. Seek medical advice. (Refer to 7.1 for signs and symptoms.) (HPSC, 2011).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>v. Catheter balloon will not deflate</th>
<th>Channel obstruction - valve port/balloon inflation channel may be compressed.</th>
<th>Water from the balloon should be allowed to come back spontaneously - if done forcefully the valve may collapse.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Attach syringe to the inflation arm and leave in place for 20-40 minutes. The effect of gravity will help with the deflation process.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Squeeze the visible tubing to try and displace crystal formation in inflation channel.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check the valve for evidence of damage. Try adding 2-3 ml of sterile water into inflation channel to dislodge blockage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If unsuccessful use a syringe and needle to aspirate the fluid from the inflation arm (above the valve).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If not successful, seek immediate medical advice. Do not cut catheter, as this may result in the catheter retracting into the bladder and nullifies manufacturer catheter warranty.</td>
</tr>
</tbody>
</table>

*Adapted from European Association of Urology Nurses, 2012.*
17.0 Catheter Encrustation and Blockage

Patients with a predisposition to experiencing catheter blockages can be identified on the basis of frequent catheter blockage associated with alkaline urine and the presence of encrustation in the lumen of the catheter or around the catheter tip. Proactive planned care to prevent and manage patients at risk of blockage can reduce crisis intervention and regular unplanned re-catheterisation.

Management should include:

- Maintenance of a Catheter Change Record and a catheter passport.
- Each patient should have an individual care plan designed to minimise the problems of blockage and encrustation (HPSC, 2011), including proactive management with a good fluid intake, prevention of constipation, good personal hygiene and catheter stabilisation.
- Visual inspection and documentation of the catheter tip and lumen (cut lengthways) following removal (routine or due to blockage).
- Consider trial of catheter maintenance solution if other proactive measures alone do not resolve frequent blockages and the inspection of at least three catheters identifies debris/encrustation on catheter tip or in catheter lumen (EAUN, 2012).
- A patient experiencing frequent blockages should prompt referral to the local urology department for further investigation and management (Harrison et al, 2010).

17.1. Catheter Maintenance Solution

- There is currently insufficient evidence from randomised controlled trials (RCTs) to guide clinical practice regarding all aspects of using washouts for long-term indwelling catheters. It is unknown if washouts convey any benefits or harms for patients using indwelling catheters in the long-term (Shepherd, 2017).
- The use of catheter maintenance solutions (CMS) may be effective in removing debris (using saline solution) or in the prevention and dissolution of encrustation (using citric acid solution); however this evidence is not conclusive in clinical trials (Shepherd et al, 2017).
- Where frequent blockage from encrustation would lead to frequent re-catheterisations, the potential infection risk associated with CMS use may be outweighed by increasing catheter life and reducing patient discomfort (HPSC, 2011).
- It may be more effective to consider changing the catheter sooner rather than commence a CMS regime for patients with recurrent blockages. The literature advises to review at least 3 catheter changes to aid this decision (EAUN, 2012).
- A full assessment of the patient’s catheter history should be completed prior to making the decision to commence a CMS as well as contributory factors such as fluid intake, constipation and hygiene.
- If the use of a CMS is being considered, it must be prescribed on an individual patient basis.
- There is no clear evidence of how often a catheter maintenance solution should be administered for it to be effective in keeping the catheter patent. The frequency of the instillation of catheter maintenance solutions should be regularly reassessed taking into consideration how often the catheter blocks and the extra risk of introducing infection.
- An aseptic non touch technique should be used for instillation including providing a clean area, a clean laundered towel or waterproof sheet to protect clothing, alcohol handrub, appropriate personal protective equipment and a new sterile drainage bag attached after the procedure (HPSC, 2011).
• The administration should follow the manufacturer’s ‘procedure for instillation’ instructions.

Note: Catheter maintenance solutions should be used with caution in patients with spinal cord injury due to the possibility of autonomic dysreflexia (HSE, 2012).

18.0 Autonomic Dysreflexia

18.1 Autonomic dysreflexia (also known as autonomic hyper-reflexia) is an abnormal sympathetic nervous response to a noxious stimulus below the level of injury in individuals with spinal cord injury (SCI) above the sixth thoracic vertebra. An acute episode results in rapidly rising blood pressure and is regarded as a medical emergency (HSE, 2012).

18.2 Symptoms may be mild or severe and present with one or more of the following symptoms:
• Pounding headache.
• Flushing and/or blotching of skin (above the level of the injury).
• Pallor below the level of the injury.
• Elevated blood pressure.
• Decreased heart rate.
• Profuse sweating.
• Palpitations.
• Goosebumps.
• Blurred vision/ spots before the eyes.
• Stuffy nose.
• Feelings of anxiety, apprehension.

18.3 Bladder problems most commonly associated with autonomic dysreflexia
• Overfull bladder.
• Blocked catheter.
• Renal/ bladder calculi.
• Urinary tract infection.
• High pressure voiding.
• Defective drainage system (kinked tubing/ leg bag too full).

Note: A person with a spinal cord injury may have a low blood pressure (90/60) therefore a rise of 20mmHg may be significant and could lead to an emergency situation (HSE, 2012).

18.4 Treatment
• Seek medical advice.
• Reduce blood pressure by returning the patient to bed and place in a sitting position (If the cause is bladder related place at 90 degrees, to reduce pressure on full bladder).
• Identify source of noxious stimulus and remove, this will allow the symptoms to settle.
• If the person is catheterised, empty leg bag, check tube for kinking, if catheter is blocked change immediately. Do not attempt to introduce any solutions into the bladder; this will distend the bladder further with potential fatal consequences.
• If the patient is not catheterized and bladder is full, catheterise immediately.
• Assess for constipation and treat appropriately

19.0 Documentation

19.1 All nursing documentation should adhere to the Recording Clinical Practice Guidance for Nurses and Midwives (NMBI 2015) and the Code of Professional Conduct and Ethics (NMBI 2014).

19.2 The nurse must document the following in the patient care plan:
• Any known allergies.
• Reason for catheterization.
• State if consent was obtained.
• Date of insertion.
• Catheter type / brand/ material.
• Code batch number and expiry date.
• Catheter length.
• Charriere size.
• Balloon volume / amount of sterile water inserted.
• State if any problems were encountered.
• Urine drainage system.
• Change date.
• Verbal advice given and the provision of the patient held shared healthcare record/ booklet on catheter care and management i.e. “My urinary catheter passport”.
• Signature and title.
See appendices for supporting documentation

Note: The catheter passport should accompany the patient when he / she attends other healthcare professionals in relation to their catheter i.e. General Practitioner, Emergency Dept, South Doc, Urology.

20.0 Implementation Plan:

20.1 Following review by the Regional Practice Development Steering CHO4 Group and Key Stakeholders this guideline and associated documents will be disseminated by the Director of Public Health Nursing to all staff. An education programme to support implementation will be delivered (see Appendix 16).

The ADPHN / Line Manager will:
• Discuss with nursing staff their education and training needs relevant to the implementation of this guideline.
• Disseminate and support the implementation of this guideline.

21.0 Evaluation and Audit:

• 21.1 This guideline will be reviewed 3 years from the date specified on the front page of the document.
• **21.2** This guideline will be audited using all or individual sections of the Management of Catheter Care in Audit Tools (See Appendix 13a and b).
22.0 References/Bibliography

Ansell, T. (2016) Indwelling urinary catheters: should we secure them? British Journal of Nursing Vol 25, 18; S22-25

Association for Safe Aseptic Practice (2014) Available at http://antt.org/ANTT_Site/home.html


National Patient Safety Alert (2009) Female Urinary Catheters causing trauma to adult males. Available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59897


Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework. Dublin: NMBl.

Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice Guidance to Nurses and Midwives. Dublin: NMBl.


Appendix 1 – Membership of the Guideline Development Group

Members of the working group involved in the development of this guideline.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Elizabeth Healy</td>
<td>Assistant Director Public Health Nursing</td>
<td></td>
<td>01/04/1918</td>
</tr>
<tr>
<td>Ms. Mary Hardy</td>
<td>Assistant Director Public Health Nursing</td>
<td></td>
<td>07/02/2018</td>
</tr>
<tr>
<td>Ms. Anna Marie O’Gorman</td>
<td>Assistant Director Public Health Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Margaret Bradley</td>
<td>Public Health Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Rachel Long</td>
<td>Continence Nurse Adviser</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Patricia Coughlan</td>
<td>Infection Prevention and Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Elizabeth Fossey</td>
<td>Infection Prevention and Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms. Helena Sheahan (Member from July 2017)</td>
<td>Infection Prevention and Control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chairperson:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Joan McCarthy</td>
<td>Interim Director Public Health Nursing</td>
<td></td>
<td>Apr 2018</td>
</tr>
</tbody>
</table>

Appendix 1A – Acknowledgements

Ms. Mary O’Flynn, Director Public Health Nursing
Chair of Guideline Development Group from Oct 2014 to July 2017
Ms. Gillian Moore, Continence Nurse Adviser
Member of Guideline Development Group to Jan 2017

The group would like to acknowledge the generous assistance of the following:

Ms. Mary Ring, Nurse Tutor, Centre of Nurse Education, University Hospital Kerry
Ms. Angela Geary, Nurse Tutor, Centre of Nurse Education, Mercy University Hospital
Dr. Bartley Cryan, Consultant Microbiologist, Cork University Hospital
## Appendix 2 – Membership of the Approval Governance Group

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Mary B. O’ Sullivan</td>
<td>Interim Director Public Health Nursing</td>
<td>[Signature]</td>
<td>1/2/2018</td>
</tr>
<tr>
<td>Ms. Rosemary O’ Callaghan</td>
<td>Interim Director Public Health Nursing</td>
<td>[Signature]</td>
<td>1/2/2018</td>
</tr>
<tr>
<td>Ms. Cora Williams</td>
<td>Director Public Health Nursing</td>
<td>[Signature]</td>
<td>1/2/2018</td>
</tr>
<tr>
<td>Ms. Brenda Golden</td>
<td>Interim Director Public Health Nursing</td>
<td>[Signature]</td>
<td>1/2/2018</td>
</tr>
<tr>
<td>Ms. Joanne McCarthy</td>
<td>Interim Director Public Health Nursing</td>
<td>[Signature]</td>
<td>1/2/2018</td>
</tr>
</tbody>
</table>
Appendix 3- Signature Declaration of Understanding

<table>
<thead>
<tr>
<th>CH04 Area Employee PPPG Signature Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration: I have read, understand and agree to the CHO 4 Guideline on Indwelling Urinary Catheter Management for Adults.</td>
</tr>
</tbody>
</table>

**Department and Health Centre:**

<table>
<thead>
<tr>
<th>NAME (Print)</th>
<th>SIGNATURE</th>
<th>DISCIPLINE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appendix 4: Information and Instruction for Home Helps caring for patients with indwelling urinary catheters
Information and instruction for Home Helps caring for clients with indwelling urinary catheters

This leaflet provides you with information and instructions on caring for clients who have an indwelling urinary catheter.

If you are unsure of any aspect of the care to be provided you must inform the Public Health Nurse and Home Help Line Manager.

The client will have a copy of ‘My Urinary Catheter Passport’ which contain information to assist them in looking after their catheter and can also be referred to.

This leaflet is appendix 4 of Guidelines on Indwelling Urinary Catheter Management for Adults, (2018) for Public Health Nursing Services, Cork Kerry Community Healthcare.

Contents

• What is a urinary catheter?
• Why is a urinary catheter needed?
• Caring for a client who has a urinary catheter
• Urinary catheter hygiene
• Urinary drainage bag systems
• Urinary catheter drainage bags
• Emptying the urinary drainage bags
• Diet and drinks
• Problems with catheters
• Instructions for
  o Emptying the urinary drainage bag
  o Connecting the 2 litre urinary drainage bag to the leg bag
  o Removing the 2 litre urinary drainage bag from the leg bag
What is a urinary catheter?
A urinary catheter is a flexible, soft, hollow tube that is placed into the bladder to drain urine. The catheter is inserted into the bladder by the same route that urine comes out (known as a urethral catheter), or it may be placed into the bladder through the tummy (known as a supra-pubic catheter). The catheter allows urine to drain from the bladder into a drainage bag. A small balloon keeps the catheter in place inside the bladder.

Why is a urinary catheter needed?
In the community the most common reasons why a urinary catheter is needed are:

- There is a blockage in the system from where urine usually flows out.
- There is a risk of urine leaking onto a wound in the buttock area and preventing the wound healing.
- There is a medical condition and the bladder is not emptied completely when urine is passed.
• To provide comfort when a person is very ill at the end of life.
• To record how much urine is being passed.

**Caring for a client who has a urinary catheter**

Having a urinary catheter significantly increases the risk of a person developing a urinary tract infection.

**Key points for Home Help staff to prevent urinary catheter infection**

1. Good personal hygiene for the person is essential.
2. Good urinary catheter hygiene is essential.
3. Always wash your hands and put on disposable gloves **before** caring for your clients’ catheter.
4. Always wash your hands **after** removing gloves and caring for your clients’ catheter.

**Urinary catheter hygiene**

• Wash the area where the catheter enters the body and the catheter daily with unperfumed soap and water. For clients with a urethral catheter the area should also be washed after each bowel motion.

• In women with a urethral catheter always clean the skin from front to back to minimise the risk of infection.

• In men with a urethral catheter pay particular attention to washing under the foreskin (unless the person has been circumcised) by gently pulling back the foreskin to clean the whole area. When cleaning is finished it is very important the foreskin is returned to its normal position (you may ask the client themselves or family carer to do this).

• Dry the area where the catheter enters the body by patting dry with a clean towel.

• Never use talc or creams around the catheter. These can cause irritation and some can damage the catheter e.g. petroleum jelly.

• When cleaning the catheter tube always wash away from the body using single downward strokes. Hold the tube with one hand and wash downwards with the other hand to ensure that there is no pulling of the tube.

• Any discharge around the catheter should be observed and reported. The frequency of cleansing may need to be increased.

• If you have any concern about the site or a discharge from the site you should contact the clients Public Health Nurse.
• When emptying the leg bag always leave the urinary drainage bag attached to the catheter.

• When the client has a bath or shower
  o Empty the urinary drainage bag first
  o The urine drainage bag attached directly to the catheter should not be disconnected
  o Ensure you dry the bag well and do not use talcum powder near the catheter.

**Suprapubic catheter hygiene**

Unless otherwise instructed:

• Suprapubic catheters should have the area around the entrance site and the catheter washed with non performed soap and water, rinsed and dried daily. Use a clean towel to pat the area dry.

• Any ooze or discharge around the catheter should be noted, observed and reported. The frequency of cleansing may need to be increased.

• If you have any concern about the site or a discharge from the site you should contact the clients PHN.

**Urinary drainage bag systems**

The urinary catheter is connected to a sterile urine drainage bag. There are two types of drainage bags

• a leg bag, which can hold between 350 and 800 mls and is attached to the leg and

• a drainage bag which can hold 1.5- 2litres (which may be called a bed or night bag)

The catheter is attached to a drainage bag in one of two ways:

1. The catheter is attached directly to a leg bag.
   • The leg bag is worn under normal clothing during the day
   • The leg bag is worn on the thigh or the calf and held in place with elasticated /velcro straps or a stretchy sleeve.
   • The straps should not be too tight; the straps should be at the back of the leg bag and not across the front of the bag.
   • At night or when the person goes to bed a new, single use 2 litre sterile drainage bag is connected on to the valve at the bottom of the leg bag.
• The 2 litre sterile drainage bag is then attached to a catheter stand (see diagram 1). This is referred to as a Link Drainage System.

**OR**

2. For clients who are less mobile and spend more time in bed, the catheter is attached directly to a 2 litre sterile drainage bag which is attached to a catheter stand (See diagram 2).

**Diagram 1**
Link Drainage System.

**Diagram 2**
Drainage bag attached directly to the catheter.

**Urinary catheter drainage bags**

• It is very important that any urinary drainage bag doesn’t become too full. The bag should not become more the 2/3 full. If overfull it can pull on the bladder and can cause irritation.
• The catheter and drainage bag tube must always be free from kinks or twists to allow drainage.
• The catheter drainage bag must be kept below the level of the bladder; you can judge this by not allowing the bag above the level of the hip. This is to prevent urine flowing back up into the bladder.
• Do not allow the catheter drainage bag or opening port to touch the floor.
Emptying urinary drainage bags

Emptying the leg bag and 2 litre drainage bag (link system)
1. The leg bag will need to be emptied when it is no more than 2/3 full or when it is 2/3 full.

2. At night the 2 litre drainage bag (which may be called a bed or night bag) is connected to the leg bag (see diagram 1). This is to prevent the leg bag over filling and allows for undisturbed sleep for the client.

3. This 2 litre drainage bag should be emptied and removed in the morning, and disposed of in the household waste.

4. The 2 litre drainage bag is single use only and should never be re-used

Emptying the 2 litre drainage bag attached directly to the catheter
1. This bag will need to be emptied when it is no more than 2/3 full or when it is 2/3 full

2. In this, the catheter is attached directly to a 2 litre sterile drainage bag which is attached to a catheter stand. The sterile 2 litre drainage bag is only disconnected every 5-7 days when it is changed (see diagram 2).

Diet and drinks
To help keep a catheter draining well the client should be encouraged to drink at least 8 cups or 5 mugs of fluid per day (unless their Doctor advises otherwise). Urine should be light yellow in colour.

The client should be encouraged to eat plenty of fruit and high fibre foods to prevent constipation (unless their Doctor advises otherwise). Constipation can put extra pressure on the bladder and cause urine leakage. Please contact the Public Health Nurse if you have a concern or if there is an identified change in the clients’ normal bowel pattern.
Problems with catheters

The following are some problems which can occur with catheters.

1. Catheter Leaking (By-passing)

This can have a number of causes including position of the tube and kinks in the catheter. Check the position of the tube and remove kinks.

If the catheter continues to leak, inform the clients PHN or Home Care Office.

2. No urine draining

This can be caused by kinks in catheter or drainage bag tube, poor fluid intake or constipation.

- Check the position of tube - remove any kinks, make sure the tubing is not restricted by tight clothing.
- Check that the tubing is not pulled tight or stretched as this may restrict urine draining.
- Check the drainage bag is below the level of the bladder, particularly if the client is sitting on a low chair.
- Check you have opened the leg bag tap after you have connected it to the bed bag.
- Check that the drainage bag is connected correctly.

If urine drainage does not drain promptly, inform the clients PHN or Home Care Office.

3. Cloudy, strong smelling urine, pain / discomfort around catheter, bleeding, itching and soreness- these may be signs of a urinary tract infection. Inform the clients PHN or Home Help Office.

4. Catheter falls out- contact the clients PHN or Home Care Office immediately. If unable to contact the PHN or Home Care Office, advise the client/family to contact the GP urgently.

In relation to all problems outlined

- outside of office hours advise the client or their family to contact the GP/South Doc
- the Home Care Service will liaise with the Public Health Nursing Service.

Contact Details

PHN name ____________________Contact number ________________

GP name  ____________________Contact number  ________________

Family Contact  _______________Contact number  ________________
# Instruction for Emptying The Urinary Drainage Bag

The urinary drainage bag should be emptied when it is approximately two thirds full.

<table>
<thead>
<tr>
<th>1.</th>
<th>First, explain what you are about to do for the client and assist them to a comfortable position or to the bathroom, if appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Assemble all equipment you will need- disposable gloves and apron, clean jug or container kept specifically for emptying the urinary drainage bag, clean tissue.</td>
</tr>
<tr>
<td>3.</td>
<td>Wash your hands using liquid soap and water and dry with paper towel or if your hands are clean use an approved alcohol hand rub for 20-30 seconds.</td>
</tr>
<tr>
<td>4.</td>
<td>Put on your apron and clean disposable gloves.</td>
</tr>
<tr>
<td>5.</td>
<td>Open the tap at the bottom of the bag to allow the urine to empty into either a clean flushed toilet or a clean, dry jug or container. Avoid splashing and take care that the tap does not touch the toilet or container; this is to reduce the risk of infection.</td>
</tr>
<tr>
<td>6.</td>
<td>Close the tap and if required, dry with a clean tissue.</td>
</tr>
<tr>
<td>7.</td>
<td>Flush toilet or empty the container into the toilet and flush.</td>
</tr>
<tr>
<td>8.</td>
<td>Wash the container with a household detergent and dry well Store the container in a clean area such as a press.</td>
</tr>
<tr>
<td>9.</td>
<td>Remove your gloves, apron and wash and dry your hands or if your hands are clean use an approved alcohol hand rub.</td>
</tr>
<tr>
<td>10.</td>
<td>Ensure the client is comfortable.</td>
</tr>
</tbody>
</table>
**Instructions for Connecting the Two Litre Urinary Drainage Bag to the Leg Bag**

**Do not remove the leg bag when attaching the bed bag**

1. First, explain what you are about to do for the client and assist them to a comfortable position in bed. Empty the leg bag before connecting the two litre urinary drainage bag. When in bed, the leg straps on the leg bag should be loosened or removed.

2. Assemble all equipment you will need - gloves, apron, two litre bed drainage bag and clean tissue.

3. Wash your hands using liquid soap and water, dry with paper towel or if your hands are clean use

4. Open the packaging of the bed bag.

5. Put on disposable gloves

6. Remove the protective cover from the top of the drainage tube connection and avoid touching it.

7. Insert the drainage tube of the 2 litre bag into the outlet of the leg bag securely. Do not touch the points where these bags connect to each other.

8. Open the tap from the leg bag to allow urine to drain into the night bag.

9. Attach the night bag to a suitable stand so that the drainage bag or tap does not touch the floor.

10. Remove your gloves, wash and dry your hands, or if your hands are clean use an approved alcohol hand rub clean your hands.

11. Ensure the client is comfortable.
## Instructions for Removing the 2 litre drainage bag attached to the leg bag

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First, explain what you are about to do for the client and assist them to a comfortable position. The bed bag should be removed before the client gets out of bed.</td>
<td></td>
</tr>
<tr>
<td>2. Assemble all equipment you will need- gloves and apron.</td>
<td></td>
</tr>
<tr>
<td>3. Wash your hands using liquid soap and water, dry with paper towel or if your hands are clean use an approved alcohol hand rub, put on disposable gloves.</td>
<td>![Image of hand washing]</td>
</tr>
<tr>
<td>4. Drain any urine from the leg bag into the bed bag and close the outlet valve from the leg bag.</td>
<td>![Image of urine draining]</td>
</tr>
<tr>
<td>5. Secure the leg bag straps and ensure the client is comfortable.</td>
<td></td>
</tr>
<tr>
<td>6. Remove the 2 litre bed bag.</td>
<td></td>
</tr>
<tr>
<td>7. Empty the bed bag into the toilet, and flush the toilet.</td>
<td></td>
</tr>
<tr>
<td>8. Dispose of the bed bag in a plastic bag and then place into the household waste.</td>
<td></td>
</tr>
<tr>
<td>9. Remove your gloves, wash and dry your hands, or if your hands are clean use an approved alcohol hand rub clean your hands.</td>
<td>![Image of hand washing]</td>
</tr>
<tr>
<td>10. Ensure the client is comfortable</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Template letter for GP Prescription

**Catheterisation**  Male [ ]  Female [ ]

**Urethral [ ]**  **Suprapubic [ ]**

Date: __________ 20

RE:  Name:  
DOB:  
Address:  

Dear Doctor,

Please provide a letter confirming your agreement that the above named patient requires catheterisation.

I would be grateful if you would prescribe the following:

<table>
<thead>
<tr>
<th>Items (indicate requirements with tick in box)</th>
<th>Type</th>
<th>Code</th>
<th>Size</th>
</tr>
</thead>
</table>
| Catheter x 2  
(Includes spare)               |      |      |      |
| Catheter stabilisation device                           |      |      |      |
| 10 ml. sterile water  
(not on GMS)               |      |      |      |
| Water soluble lubricating gel  
- single use sachets               |      |      |      |
| Anaesthetic gel  
(if indicated)               |      |      |      |

**Drainage system – Ambulant**

Link System
- Sterile Leg Bags – Day  
- 2ltr sterile single use bed bag
- Urinary catheter stand
- Sleeve for leg bag

**Drainage system – Non-Ambulant**

- Single Use 2 Litre Sterile bed drainage bags

Yours sincerely,

___________________________________  
PHN /RGN  (Contact number:  ).
Appendix 6 My Moments for Hand Hygiene – Focus in caring for patient with a Urinary Catheter

My 5 Moments for Hand Hygiene
Focus on caring for a patient with a Urinary Catheter

1. BEFORE TOUCHING A PATIENT

2. BEFORE CLEAN/SEPTIC PROCEDURE

3. AFTER BODY FLUID EXPOSING RISK

4. AFTER TOUCHING A PATIENT

5. AFTER TOUCHING PATIENT SURROUNDINGS

**CLEAN YOUR HANDS WHEN HANDLING A URINARY CATHETER AND DRAINAGE SYSTEM**

- **Immediately before** any manipulation of the urinary catheter or drainage system that could lead to contamination of the sterile urine, such as:
  - 2a. Inserting or applying an indwelling, intermittent, or condom catheter, immediately before putting on sterile gloves
  - 2b. Accessing the drainage system to collect a urine sample or to empty the drainage bag

  **WHY?** To protect the patient against harmful germs, including the patient's own, from entering his/her body.

- **Immediately after** any task involving the urinary catheter or drainage system that could lead to urine exposure, such as:
  - 3a. Collecting a urine sample
  - 3b. Emptying the drainage bag
  - 3c. Removing the urinary catheter

  **WHY?** To protect yourself and the healthcare environment from harmful patient germs.

**5 KEY ADDITIONAL CONSIDERATIONS FOR A PATIENT WITH A URINARY CATHETER**

- Make sure that there is an appropriate indication for the indwelling urinary catheter.
- Use a closed urinary drainage system, and keep it closed.
- Insert the catheter aseptically using sterile gloves.
- Assess the patient at least daily to determine whether the catheter is still necessary.
- Patients with indwelling urinary catheters do not need antibiotics (including for asymptomatic bacteriuria), unless they have a documented infection.

**World Health Organization**

**SAVE LIVES**
Clean Your Hands

**No Action Today**
No Cure Tomorrow
Appendix 7 Aseptic Non Touch Technique for Indwelling Urinary Catheterisation - male or female
# Appendix 8: Procedure for collecting a catheter specimen of urine

## Procedure for Collecting a Catheter Specimen of Urine

### Equipment

- Isopropyl alcohol 70% impregnated swabs
- Clean sterile, leak proof specimen container
- For samples which may be delayed in delivery to the lab (>24 hrs) a sample container containing boric acid (preservative) should be used. These containers are red topped.
- Laboratory request form
- 5ml sterile needle and syringe or if a needle free sampling port - 5ml sterile syringe only
- Alcohol hand rub
- Disposable gloves
- Sharps bin

### Technique

<table>
<thead>
<tr>
<th>Action</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Pre-procedure: Explain the procedure to the patient and discuss the need for specimen collection.</td>
<td>To ensure the patient understands the procedure and gives his/her valid consent.</td>
</tr>
<tr>
<td>Screen the bed area</td>
<td>To ensure patient’s privacy</td>
</tr>
<tr>
<td>Decontaminate hands using alcohol handrub for 30 secs (antiseptic hand hygiene) – Moment 2</td>
<td>To protect the patient from transient microorganism that may be on the healthcare workers hands before a clean technique.</td>
</tr>
<tr>
<td>Don gloves and disposable apron.</td>
<td>To obtain an adequate urine sample.</td>
</tr>
<tr>
<td><strong>Only</strong> if there is no urine in the tube, apply a non-traumatic clamp to the drainage tubing below the sampling port and wait until urine is visible in the drainage tube.</td>
<td></td>
</tr>
<tr>
<td><strong>2a. Needle Free Sampling Port System</strong> Clean the sampling port with the alcohol swab. Allow to dry.</td>
<td>To reduce the risk of introducing microorganisms into closed drainage system.</td>
</tr>
<tr>
<td>Using a sterile syringe and aseptic non touch technique, aspirate 5 mls of urine* from the sampling port. (No needle required).</td>
<td>If the catheter bag or tubing is punctured it increases the risk of catheter-related infection and causes leakage of urine.</td>
</tr>
<tr>
<td>Place the specimen in the sterile specimen container and dispose of syringe in a sharps bin. Re-clean access point with an alcohol swab.</td>
<td>To ensure that only organisms for investigation are preserved.</td>
</tr>
<tr>
<td>Un-clamp the drainage tubing if required.</td>
<td>To allow urine to drain into collection bag.</td>
</tr>
<tr>
<td><strong>Note</strong> never take a specimen from the drainage</td>
<td>Specimens collected from the catheter</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| **2b.** | **Sampling port requires a needle and syringe**  
Clean the sampling port with the alcohol swab and allow drying.  
Insert the sterile needle using a non touch technique into the sampling port at an angle of 45° and aspirate 5 mls of urine*.  
Place the specimen in the sterile specimen container and dispose of syringe in a sharps bin.  
Re-clean access point with an alcohol swab.  
Un-clamp the drainage tubing if required.  
**Note** never take a specimen from the drainage bag.  
Un-clamp the drainage tubing if required.  
**To reduce the risk of introducing microorganisms into closed drainage system.**  
**To ensure that only organisms for investigation are preserved.**  
**To allow urine to drain into collection bag.**  
**Specimens collected from the catheter bag may give a false positive reading due to organism growth in the bag.**|
|   |   |
|   | **3.** Remove gloves and apron, decontaminate hands –Moment 3.  
Label container and dispatch to laboratory with the completed request form as soon as possible. **  
Document the procedure including date and time specimen sent to laboratory in the nursing record  
**To protect the healthcare worker and prevent environmental contamination.**  
**To ensure the best possible conditions for laboratory tests.**  
**To provide an accurate record of care. To facilitate follow up and maintain continuity of care.**|

*A minimum of 1ml is required for routine culture if sent in clean sterile leak proof specimen container.  
A minimum of 5 mls is essential for boric acid samples.  

Do not use urinary dipsticks on boric acid samples as this leads to erroneous results.  

**Urine specimens should be transported to the laboratory without delay. If delay is unavoidable please store at 2-8°C.**
Appendix 9: “My urinary catheter passport”
**Appendix 10: Indwelling Urinary Catheter Template for Care Plan Development**

<table>
<thead>
<tr>
<th>Date</th>
<th>Assessed Need</th>
<th>GOAL</th>
<th>INTERVENTION</th>
<th>Evaluation of intervention/ Goals &amp; review date</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A urinary catheter should be a last resort when all other options have been considered and the continued clinical need reviewed. Providing information reduces anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Good hand hygiene reduces the risk of cross infection</td>
</tr>
</tbody>
</table>

|      |               |      |              |                                               |           |
|      |               |      |              |                                               |           |

|      |               |      |              |                                               |           |
|      |               |      |              |                                               |           |

**Indwelling Urinary Catheter (Urethral/ Suprapubic)**

__________ has an indwelling urethral or suprapubic catheter in place due to

- Acute urinary retention
- Chronic urinary retention
- Comfort/palliative care
- Healing of sacral/perineal or decubitus ulcers

Therefore, __________ has an increased risk of acquiring a catheter Associated Urinary Tract Infection (CAUTI).

To minimise the risk of acquiring a CAUTI

- Early recognition of the signs and symptoms of UTI allowing for prompt treatment

- Review the continued clinical indication for use.

- Ensure client/family/carer are given information regarding the reason for insertion of the catheter, plan for review and replacement as per “My Urinary Catheter Passport” HSE South, 2018

- Prior to insertion of a urinary catheter explain and discuss the procedure with the client/family/carer obtaining consent and always checking for any known allergies (latex/anaesthetic gel)

- Ensure that the correct principles of hand hygiene are adhered to before and after direct client care (HPSE, 2015)

- Maintain clients dignity and respect at all times by ensuring that they are in a comfortable position and not exposed before the urinary catheter insertion procedure commences

Guideline for Indwelling Urinary Catheter Management for Adults Version No:1.0 Approval date: Feb 2018 Revision date: Feb 2021 Page 56
- Maintain a sterile closed drainage system with the choice of urine bags based on individual assessment and in line with local policy (HSE South, Urinary Catheter Care, 2018)
- Secure the catheter tubing with a stabilisation device either adhesive or straps (if appropriate and suitable) to the thigh or abdomen to minimise the risk of accidental traction on the catheter preventing potential trauma to the bladder and urethra
- Secure the drainage bag with either straps or sleeve as appropriate
- Advise the client/family/carer that the IUC will be changed at least every ____ weeks or when clinically indicated
- Advise the family that the drainage bag/leg bag attached directly to the catheter will be changed once a week
- Advise the client/family/carer that the drainage bag has to be emptied on a regular basis (when 2/3 full) to prevent the catheter pulling due to the weight of the urine.
- Advice client/family/carer wearing a leg bag that that a sterile single use drainage bag is to be attached each night and disposed of in the morning – empty the bed bag before disposal in household waste.
- Always document, urinary catheter changes in “Indwelling urinary catheter change

<table>
<thead>
<tr>
<th>Reduces the risk of cross infection</th>
</tr>
</thead>
</table>

Clinical indications for more frequent change of a Urinary catheter
- Catheter encrustations
- Leakage
- Bleeding
- Catheter associated UTI

Documentation provides point of reference/
• Record" i.e. date, reason for insertion, consent, catheter type, amount of water removed/instilled into the balloon, manufacture and batch number with the signature of the nurse undertaking the urinary catheter procedure.

• Issue My Urinary Catheter Passport (if not already provided)

• Educate the client/family/carer on Urinary Catheter management in association with the Urinary Catheter Passport on the importance of when and how to carry out hand hygiene, catheter hygiene & perineal care, and the importance of cleaning the perineal area from front to back after defecation and also how to clean the urethral meatus with un-perfumed soap and water during the daily bathing/showering routine.

• Instruct the client/family/carer on which signs and symptoms to report to the Public Health Nursing service/General Practitioner, using My Urinary Catheter Passport. i.e. fever, chills, rigors or body aches/malaise, cloudy/bloody urine or pus in the urine or around supra-pubic site/loin/flank pain, renal angle or suprapubic pain, associated nausea/vomiting.

• If CAUTI develops, advise client/family/carer that the catheter should be changed if it has comparison in the event of later queries.
| Patient requires assistance with catheter care | To support the patient in catheter care management | • Delegate care of urinary catheter as outlined in the leaflet “Information and Instruction for Home Helps Caring for Patients with Indwelling Urinary Catheters” to competent and confident formal or informal carer.  
• Issue information leaflet for inclusion in Home Support Plan | Increased fluid dilutes urine, reduces irritation and helps to flush out bacteria from the bladder |
| Urine retention/ catheter not draining:  
  • due to blockage  
  • displacement  
  • mucosal occlusion | To minimise the risk of the urinary catheter blocking | • Educate and advise the client to check the tubing of the catheter & drainage bag is not kinked.  
• Ensure that the client/ family/ carer understands that the catheter bag should never be more than 2/3 full  
• Advise the client/ family or carer not to lie or sit on the catheter tubing and to hang the bed bag on a catheter stand and not in the bed or on the floor  
• Encourage and advise the client to prevent constipation by eating a high fibre diet with an adequate fluid intake  
• Advise the client/ family/ carer about the importance of washing the urethral meatus with un-perfumed soap and water during the daily bathing or showering routine  
• Advise the client/ family/ carer to contact Presence of faeces in the rectum may press against the catheter occluding it  
Formation of crusts around the meatus can cause blockage |
| By passing/ leakage of urine around the catheter  | Minimise the risk of the catheter falling out | Ensure that the correct urinary catheter size has been used  
Ensure that the balloon is inflated as per instructions with no more than 10mls of sterile water  
Always ensure/ advise the client/ family and carer that the catheter tubing is secured appropriately to the client's thigh or abdomen  
Always advise the client/ family /carer to contact the Public Health Nursing Dept/ GP if the catheter falls out, always ensuring that there is a spare catheter available in the home.  
If catheter blocks check for any obvious blockages. Check the catheter and tubing, gently rotating the catheter in line with guideline to help dislodge any debris. If none evident remove it and re-catheterise using ANTT. Do not use a catheter maintenance solution to try and unblock the catheter. Once removed – cut catheter lengthways to see what has caused the blockage and record findings. A trial of catheter maintenance solutions may be prescribed if the catheter remains blocked. | Reduces urethral trauma, bladder spasm from pressure and traction and allows for adequate drainage |
<table>
<thead>
<tr>
<th>Altered ability to maintain sexual relations</th>
<th>To ensure client and their partner can maintain sexual relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Discuss clients needs sensitively</td>
<td></td>
</tr>
<tr>
<td>• Advice on suggestions to allow for intercourse, by referring to advice included in “My Urinary Catheter Passport” e.g. using a condom to hold the catheter in place, tapping the catheter tubing securely, use of flip flow valve.</td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 11: Indwelling Urinary Catheter Change Record**

<table>
<thead>
<tr>
<th>Name: ____________________</th>
<th>DOB: ____________________</th>
<th>MRN: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Days in situ</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Inspect tip & lumen - record findings. If blocked, cut catheter longitudinally & record findings as either clear, soft mucus or mineral encrustation.

2. Adhesive label records catheter name & type, size, Lot/Batch number and expiry.

Guideline on Indwelling Urinary Catheter Management for Adults, PHN Services, 2018
Appendix 12 - Aseptic Non Touch Technique (ANTT) Procedure for Insertion of a Suprapubic Catheter
Appendix 13a: Indwelling Urinary Catheter Management Guideline Audit Tool

The Auditor will select every 5\textsuperscript{th} client file on the database/list and apply the following questions:

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a copy of the Indwelling Urinary Catheter Management Guideline for Adults available in the health centre?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Has the client’s nurse signed the declaration of understanding (Appendix 3) which accompanies the guideline?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does the prescription for the indwelling urinary catheter correspond to the documented catheter in use?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is there a Urinary Catheter Care Plan in the client’s records?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is there evidence of the client being given instructions on the care of the indwelling catheter using “My urinary catheter passport”?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Areas where deficits were identified?
____________________________________________________________________
____________________________________________________________________

Action Plan to redress the deficits?
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

On Completion of audit, discuss changes where deficits were identified, planning and implementing the changes into practice.

Date: ________________________Signature___________________

Review Date: __________________________
Appendix 13b: Audit of Nursing Documentation for a Patient with an Indwelling Urinary Catheter

This audit tool will audit the nursing documentation i.e. care plan and indwelling urinary catheter (IUC) change record. It may be used by the Nurse and/or the Auditor to assist in the maintenance of high quality documentation for patients with an indwelling urinary catheter.

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comment (Please comment if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Does the care plan state what method of urinary catheterisation has been used? E.g. urethral catheter, supra-pubic catheter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is the reason for catheterisation recorded in care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Is the reason documented appropriate according to the guidelines?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Is the date of first catheterisation recorded in the care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Is there documented evidence that the continued need for the catheter has been reviewed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Is the frequency of the planned catheter change been recorded in the care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Is the next scheduled catheter change date recorded in the IUC Change Record?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Does the IUC change record identify the size, type and length of catheter used, as per the catheter label?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Is the type of drainage bag / catheter valve used recorded in the care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Is there evidence in the care plan that a closed system of drainage is adhered to?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Is the frequency of drainage bag change recorded in the care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Is there a record in the care plan that the patient received verbal education on catheter care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Comment</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>13</td>
<td>Is there a record in the care plan that the patient received a copy of “My Urinary Catheter Passport”?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are the risk factors of urinary catheterisation reflected in the care plan”? (outlined in “My urinary catheter passport)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Has the correct method of cleansing the patient’s meatus prior to catheterisation been outlined in the care plan?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Is there documented evidence in the IUC Change record that the catheter lumen was cut and examined post removal, <strong>if blocked</strong>?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Is there evidence of problem solving where applicable in the care plan? E.g. the management of a blocked catheter, a bypassing catheter or an expelled catheter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please map outcome on result grid for audit
### Appendix 13b: Results Grid for Audit of Nursing Documentation for a Patient with an Indwelling Urinary Catheter

<table>
<thead>
<tr>
<th>File No.</th>
<th>Q1 Yes</th>
<th>No</th>
<th>Q2 Yes</th>
<th>No</th>
<th>Q3 Yes</th>
<th>No</th>
<th>Q4 Yes</th>
<th>No</th>
<th>Q5 Yes</th>
<th>No</th>
<th>Q6 Yes</th>
<th>No</th>
<th>Q7 Yes</th>
<th>No</th>
<th>Q8 Yes</th>
<th>No</th>
<th>Q9 Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total % Compliance per question**

<table>
<thead>
<tr>
<th>File No.</th>
<th>Q10 Yes</th>
<th>No</th>
<th>Q11 Yes</th>
<th>No</th>
<th>Q12 Yes</th>
<th>No</th>
<th>Q13 Yes</th>
<th>No</th>
<th>Q14 Yes</th>
<th>No</th>
<th>Q15 Yes</th>
<th>No</th>
<th>Q16 Yes</th>
<th>No</th>
<th>Q17 Yes</th>
<th>N/A</th>
<th>Q18 Yes</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overall % Compliance**

Guideline for Indwelling Urinary Catheter Management for Adults Version No:1.0  Approval date: Feb 2018  Revision date: Feb 2021  Page 67
Appendix 14: Letters to Directors of Public Health of Public Health Nursing regarding Guideline Implementation

Public Health Nursing Service,
North Cork
MPHC- Floor 2
Gouldshill,
Mallow,
Co. Cork
022-58645

Ms. Monica Sheehan, DPHN Kerry
Ms. Cora Williams, DPHN North Lee
Ms. Brenda Golden, Interim DPHN South Lee
Ms. Joanna McCarthy, Interim DPHN West Cork.

Date: 11 July 2017

Dear Colleagues,

A working group was commissioned by the Cork Community Infection Prevention & Control Committee. The group consisted of representatives from Public Health Nursing service in Cork and Kerry, Continence Nurses and Infection Prevention & Control Nurses.

The purpose was to provide guidance on Catheter Care Management in Adults.

The outcome is a Public Health Nursing Guideline for Indwelling Urinary Catheter Management for Adults (July 2017) which includes instruction for Home helps on Urinary Catheter Care (July 2017) and a Urinary Catheter Passport for Service Users to be provided for each client with a urinary catheter in hospitals and the community, which are attached for your attention.

Please ensure that this guideline is brought to the attention of all relevant personnel and implemented within your area of responsibility.

Yours Sincerely,

Mary O'Flynn
(DPHN)
(Chairperson)
Appendix 15: Letter to CHO 4, Cork and Kerry Head of Social Care

Public Health Nursing Service,  
North Cork  
MPHC- Floor 2  
Gouldhill,  
Mallow,  
Co. Cork  
022-58645

Ms. Teresa O’Donovan, Head of Primary Care  
Ms. Gabrielle O’Keeffe, Head of Social Care  
Ms. Priscilla Lynch Head of Service, Health & Wellbeing

11th July 2017

Dear Colleagues,

A working group was commissioned by the Cork Community Infection Prevention & Control Committee. The group consisted of representatives from Public Health Nursing service in Cork and Kerry, Continence Nurses and Infection Prevention & Control Nurses.

The purpose was to provide guidance on indwelling Urinary Catheter Care Management for Adults.

The outcome is a Public Health Nursing Guideline for Indwelling Urinary Catheter Management for Adults (July 2017) which includes Instruction for Home helps on Urinary Catheter Care (July 2017) and “My Urinary Catheter Passport” for Service Users. The guideline is attached for your attention.

“My Urinary Catheter Passport” is to be provided for each client with a urinary catheter in hospitals and the community and a copy will be forwarded when printed.

Please ensure that this guideline is brought to the attention of all relevant personnel and implemented within your area of responsibility.

Yours Sincerely,

Mary O’Flynn  
DPHN (Chairperson)

Cc: Ms. Monica Sheahan, DPHN Kerry  
 Ms. Cara Wilmam, DPHN North Lee  
 Ms. Brenda Golden, Interim DPHN South Lee  
 Ms. Joanna McCarthy, Interim DPHN West Cork.
### Appendix 16: Guideline Education Implementation Plan

**Masterclass**

**Assessment of Self-Neglect & Research Messages**

**Guidelines on Indwelling Urinary Catheter Management for Adults**

**Launch for Public Health Nursing 2018**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic/content</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-1300</td>
<td>Refreshments</td>
<td></td>
</tr>
<tr>
<td>1300-1320</td>
<td>Welcome, Introduction to Self-Neglect Definitions, Policy &amp; legislation</td>
<td>Dr Mary Rose Day</td>
</tr>
<tr>
<td>1320-1430</td>
<td>Domains of Assessment</td>
<td>Dr Mary Rose Day</td>
</tr>
<tr>
<td></td>
<td>• Physical/Medical, Psychological/Mental Health, Environment, Financial, Social/Cultural</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Capacity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assessment of Self-Neglect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ethical Decision Making Framework to explore responses to self-neglect</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Documentation recording decisions and actions fulfilling legal responsibilities harm reduction</td>
<td></td>
</tr>
<tr>
<td>1420-1430</td>
<td>Questions &amp; Answers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Guideline Development Process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Roles/responsibilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scope of Practice</td>
<td></td>
</tr>
<tr>
<td>1445-1530</td>
<td>Infection Prevention and Control</td>
<td>Liz Forde or Helena Sheahan. Infection Prevention &amp; Control Nurses</td>
</tr>
<tr>
<td></td>
<td>• Indwelling Urinary Catheter (IUC) Infection Risks,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Signs and Symptoms of CAUTI, Multi Drug Resistant Organisms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prevalence &amp; Appropriateness of IUC in Community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Introducing My Urinary Catheter Passport</td>
<td></td>
</tr>
<tr>
<td>1530-1550</td>
<td>Planning and Recording Nursing Care</td>
<td>Margaret Birtley, PHN</td>
</tr>
<tr>
<td></td>
<td>Introducing IUC Template Care Plan &amp; IUC Change record</td>
<td></td>
</tr>
<tr>
<td>1550-1600</td>
<td>Comfort Break</td>
<td></td>
</tr>
<tr>
<td>1600-1655</td>
<td>An update on Clinical Practice</td>
<td>Rachel Long, Continence Nurse Advisor</td>
</tr>
<tr>
<td></td>
<td>• Use of appropriate products and devices - catheters, catheter valves, and drainage system collections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Catheterisation procedures</td>
<td></td>
</tr>
<tr>
<td>1655-1700</td>
<td>Evaluation &amp; Close</td>
<td></td>
</tr>
</tbody>
</table>

**NMBI Category 1 approval and ? Continuing Education Units**