URINARY CATHETER MANAGEMENT CARE PLAN
Care planning:

• Clear set of actions that enable a patient/ client and nurse to achieve a goal in relation to a specific problem or need.

• Focus for care

• Continuity of care

• Monitor progress

• Communication- allowing the sharing of information between all nursing staff

• Enables timely referrals

• Allows transfer of care which is clearly defined and what is required

• Legal document – Recording Clinical Practice (NMBI, 2015)

• Care-Plans can be written, computerised or pre-printed, however they have to be client/ patient centred and individualised
Components of the plan of care plan:

• The plan of care is designed to be a patient centred, holistic, action orientated document based on the following components:
  • Problem/ identified nursing need
  • Goal
  • Nursing intervention/ plan of care
  • Evaluation

and delivered within the framework of assessment, identification of problems, planning and implementing care
Care-plan:

• Every care-plan should be personalised, it’s important to involve the patient/client in the decision making process as much as possible which can be evidenced by referring to the patient/client by their preferred name in the care-plan

• How can the patient/client contribute towards their care needs

• What decisions can they make

• Ensuring where appropriate that the patient/client takes ownership of their care and plan which switches ownership of the care-plan from the nurse to the patient/client

• It should be to the point and all nursing staff should be able to co-ordinate patient/client care as it is planned
Who contributes towards achieving the goal of a care-plan

• Family
• Allied health Professionals
• Specialists
• Carers
Assessment:
• Based on the information that is obtained during the comprehensive nursing assessment. It identifies what is wrong with the client/patient - identifying the problem and helps the nurse to determine the nursing care that needs to be provided

Setting goals:
• Provide a clear focus for the types of interventions necessary for client care and provide a focus for the interventions. Serves as a criteria for evaluating patient client progress. Relevant to the patient/clients problem
• What is important to the client/patient
• What do we want to achieve
• What is the achievable goal
Intervention/ Plan of Care:

• Reflects the problem and helps to achieve the goal based on the nursing assessment and developed in collaboration with the patient/client.
• Focus is on eliminating or reducing the problem.
• Focus on clients' risks factors.
• Plan of action carried out by the nurse to implement the nursing plan of care.
• What needs to happen to achieve the goal.
• Specific and clearly stated, beginning with an action indicating what the nurse is planning to do, for example:
• Assess the urine for colour, amount, odour.
• Educate patients/clients/carers etc.
Evaluation:

Important aspect of the nursing process

On-going process of reviewing and reflecting

Was the goal achieved/ partially achieved/ not achieved

Enables nurses to discuss what nursing interventions worked well and what didn’t work well

Should the nursing intervention be continued, changed or terminated

When goals are not met and the nursing interventions are ineffective the plan of care will need to be revised in order to develop more appropriate nursing interventions for the client/ patient
**Indwelling Urinary Catheter (Urethral/ Suprapubic)**

<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></td>
</tr>
<tr>
<td>______ has an indwelling urethral or suprapubic catheter in place due to</td>
<td>To minimise the risk of acquiring a CAUTI</td>
<td>• Review the continued clinical indication for use.</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>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute urinary retention</td>
<td>Early recognition of the signs and symptoms of UTI allowing for prompt treatment</td>
<td>• 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</td>
<td>Good hand hygiene reduces the risk of cross infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chronic urinary retention</td>
<td></td>
<td>• 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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comfort/ palliative care</td>
<td></td>
<td>• Ensure that the correct principles of hand hygiene are adhered to before and after direct client care (HPSE, 2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Healing of sacral/perineal wounds</td>
<td></td>
<td>• 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</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Maintain a sterile closed drainage system with the choice of urine bags based on individual assessment and in line with local</td>
<td>Reduces the risk of cross infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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 as appropriate. |

-
### 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 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 night 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 the Public Health Nursing Dept/ GP if pain and comfort occurs due to the catheter not draining.
- Change urinary catheter if clinically indicated or seek medical assistance from the GP

| 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
- Blocked catheter
- Bladder spasm
- Incorrect size of catheter
- Incorrect balloon size

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 clients thigh or abdomen
- Always advise the client/ family /carer to contact the GP/ Public Health Nursing Dept 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 washout. Once removed – cut catheter lengthways to see what has caused the

| Reduces urethral trauma, bladder spasm from pressure and traction and allows for adequate drainage |
| Altered ability to maintain sexual relations | To ensure client and their partner can maintain sexual relations | Discuss clients’ needs sensitively  
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. |
Accurate documentation on the Indwelling Urinary Catheter change record

• Document medical indications for placement
• Date in situ
• Reason for change
• Verbal consent
• Insertion documentation (size of catheter used, patient response, amount and color or urine obtained, etc...), findings of visual inspection of catheter lumen and tip
• Volume of sterile water
• Date of next planned change
• Completion of my Urinary Catheter Passport
• Affix adhesive catheter label
<table>
<thead>
<tr>
<th>T</th>
<th>Day</th>
<th>Vol. steril. water removed</th>
<th>catheter lumen &amp; tip (1)</th>
<th>Vol. of steril. water insert post insertion</th>
<th>change</th>
<th>catheter passport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐</td>
<td></td>
<td>mls</td>
<td>Planned</td>
<td>Blocked</td>
<td>mls</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>No ☐</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td>No ☐</td>
</tr>
<tr>
<td>Yes ☐</td>
<td></td>
<td>mls</td>
<td>Planned</td>
<td>Blocked</td>
<td>mls</td>
<td>Yes ☐</td>
</tr>
<tr>
<td>No ☐</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td>No ☐</td>
</tr>
<tr>
<td>Yes ☐</td>
<td></td>
<td>mls</td>
<td>Planned</td>
<td>Blocked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No ☐</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thank You for your attention