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in the community – **with** the community*

## Indwelling Urinary Catheter (IUC), including urethral and supra pubic, Insertion Guidance

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## **1. Introduction**

Urinary catheterisation is the insertion of a catheter through the urethra into the bladder (or less commonly insertion of a (supra pubic) catheter through the anterior abdominal wall into the dome of the bladder) for withdrawal of urine.

### **1.1 Aim, purpose and outcomes**

The aim and purpose of this document is to provide guidelines, for health care staff, on the safe and the most up to date knowledge and criteria for urinary catheterisation and the associated risks.

Catheterisation is a common nursing procedure performed by a competent health care professional. It is not without risk and is often associated with complications such as infection, trauma to the urethra or bladder, encrustation and urinary tract stones.

### **1.2 Scope**

This policy is intended to provide guidelines for competent health care professionals involved in the insertion of indwelling urinary catheters in the following patient groups; -

- Adults over the age of 16.

## **2. Education and knowledge**

Prior to assessing for or carrying out insertion of an indwelling catheter staff must have knowledge of current legislation, national guidelines and organisational policies. These include:

- Data Protection Act 2018
- NHS Lanarkshire Antimicrobial Policy [NHSL Guidelines App](#)
- NMC Code 2018
- Infection Control- including hand hygiene (Learnpro module)
- NES Urinary Catheterisation (Learnpro)
- RCN catheter care guidelines 2021
- Undertaken the male and supra pubic catheterisation practical course (available via Practice Development)
- Catheter formulary- Acute & Primary care
- <http://firstport2/staff-support/continence-service>

## 2.1 Anatomy and Physiology

Staff carrying out urinary catheterisation procedure must have knowledge of the anatomy and physiology of the male and female lower urinary tract. In addition, staff should also have knowledge of the following;

- Urine production and what influences this
- Normal micturition
- The prostate gland, urethral sphincters and the urethra
- Stoma site developed for suprapubic catheters
- Nervous system including autonomic dysreflexia
- Bowel and its links to voiding problems
- Sexual function and links to catheter usage
- Voiding dysfunction and why a urethral urinary catheter can relieve this

## 2.2 Criteria for inserting an indwelling catheter

Reasons for catheterisation should be carefully considered and the reason for catheterisation **must be** recorded in the patient's health care records and catheter passport. Reasons for catheterisation include;

### Acute Urinary Retention- Which may occur as a result of

- Obstruction at bladder neck
- Enlarged or inflamed prostate
- Obstruction of the urethra.
- Contraction of urethra during voiding
- Lack of sensation to pass urine
- Neurological dysfunction
- The effects of medication
- Pain overriding normal bladder sensation
- Psychological causes

### Drainage

- Chronic urinary retention, **only** if symptomatic and/or with renal compromise
- Monitoring renal function during critical illness.
- Congenital abnormalities such as Spina Bifida.
- To Improve skin integrity with intractable incontinence
- End Of Life Care

### Specialist Drainage

- Pre and post pelvic surgery,
- In urodynamic/ x-ray investigations by passing an obstruction.
- Enabling bladder function tests e.g. urodynamic.
- Emptying the bladder during labour

### Instillation

- To irrigate the bladder

- To instil medication

#### **Contra-indications for insertion of Urinary Catheter.**

- No consent
- Bladder Tumour history (insertion of supra-pubic catheters)
- Pus/discharge
- Sexual gratification

#### **Special Consideration- Autonomic dysreflexia**

Autonomic dysreflexia (AD), also previously known as mass reflex, is a potential medical emergency classically characterised by uncontrolled hypertension and bradycardia, although tachycardia is known to commonly occur. AD occurs most often in individuals with spinal cord injuries with lesions at or above the T6 spinal cord level, although it has been reported in patients with lesions as low as T10.

The uncontrolled hypertension in AD may result in mild symptoms, such as sweating above the lesion level, Goosebumps, blurred vision, or headache; however, severe hypertension may result in potentially life-threatening complications including seizure, intracranial bleed, or retinal detachment.

AD is triggered by either noxious or non-noxious stimuli, resulting in sympathetic stimulation and hyperactivity. The most common causes include bladder or bowel over-distension, from urinary retention and faecal impaction.

#### **Symptoms of AD:**

- Flushing
- Sweating and goose pimples
- Pounding headache
- Peripheral cyanosis
- Blurred vision and dizziness
- Shortness of breath
- Slow pulse

Staff must consider AD and assess for potential causes listed below, as early recognition of AD is essential in order that treatment can be initiated immediately.

Most common causes:

#### **Bladder: -**

- Distended bladder
- A kink in the catheter
- An over-full leg bag
- Blockage or obstruction that prevents urine flowing from the bladder
- Urinary tract infection or bladder spasms
- Bladder stones
- Distended bowel which can be due to a full rectum, constipation or impaction.

**\*\*Do not attempt to administer a catheter maintenance solution as this could increase the blood pressure\*\***

If the patient has an indwelling urethral or suprapubic catheter, check the following:

- Is the drainage bag full?
- Is the tubing kinked?
- Is the drainage bag at a higher level than the bladder?
- Is the catheter blocked?

After correcting the obvious problem, and if the catheter is still not draining after 2-3 minutes, **change the catheter immediately.**

Treatment If AD is suspected:

- Assist the patient to sit upright as soon as possible
- Record BP
- If the systolic BP is elevated (>150mmHg) it should be treated until the cause is found and eliminated
- Give GTN spray or Nifedipine as prescribed

Once the cause has been addressed continue to monitor blood pressure. This **MUST** be monitored at least 2 hours after it has been stabilised. Identify and remove the cause.

Prevention - Prevention is essential as most causes can be avoided by:

- Change catheter regularly to prevent blockage
- Use fixation devices and keep catheters free of kinks
- Check signs of urinary tract infection (UTI's)
  - Ensure Intermittent Self Catheterisation (ISC) regime is adhered to to prevent a distended bladder
- Have regular bladder and bowel check-ups with either the GP, Community Nurse or Spinal Injuries Unit.

### **3. Procedure for inserting a urinary catheter**

#### **3.1 Inserting a Urinary Urethral Catheter in the Male patient**

**A standard length catheter must be used in Male Catheterisation.**

**Never insert a female length catheter in a male patient.**

Procedure	Rationale
1. All staff, prior to every catheter insertion, should assess or review if a catheter is required and record the reason in the patient's records and catheter passport.	To ensure clinically indicated and to reduce inappropriate catheterisation
2. Always ensure as small a catheter as possible is used allowing for good drainage. During routine indwelling urinary catheterisation catheter sizes 12ch is suitable for both adult male and female patients (unless on specialist advice)	To reduce the risk of urethral trauma, discomfort, pain and urethritis and bladder spasms
3. Perform hand hygiene using an alcohol based hand rub. WHO key moment 1. If hands are visibly soiled, then hand hygiene should be performed using liquid soap and water.	For procedure adhere to the World Health Organisation (WHO) 5 moments for hand hygiene guidelines. (Appendix 1) To reduce cross contamination and infection.  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
4. Explain and discuss the procedure with the patient in order to obtain consent.	The NMC Code (2018) which states '4.2 make sure you get properly informed consent and document it before carrying out any action'.  <a href="https://www.nhslanarkshire.scot.nhs.uk/download/consent-for-healthcare-policy/">https://www.nhslanarkshire.scot.nhs.uk/download/consent-for-healthcare-policy/</a>
5. Ensure privacy; assist the patient to get into the most comfortable position to undertake the procedure.	To ensure area is easily accessible and the patient is comfortable and dignity maintained.
6. Perform hand hygiene, WHO key moment 2	To reduce cross contamination and infection

	Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
7. Prepare a suitable work surface for aseptic technique. Decontaminate according to local policy and gather all equipment on bottom shelf of trolley (where available).	To minimise risk of contamination to equipment.
8. Put on a disposable plastic apron.	To protect uniform from contamination.  Link to National Infection control Manual ( includes video on this correct procedure for donning and doffing) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
9. Check condition and expiry date off all sterile equipment.	Sterility of items can be compromised if packaging expired or damaged.
10. Open the outer cover of the sterile pack and position waste bag.	To prepare equipment.
11. Open equipment onto the aseptic field using non-touch technique.	To prepare for procedure
12. Perform hand hygiene, WHO key moment 2	To reduce the risk of infection.  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
13. Apply one pair of sterile gloves	To reduce the risk of introducing infection into the urinary tract during catheterisation
14. Pre-connect catheter to drainage bag place on sterile field.	To reduce risk of infection and to prevent bed clothes becoming wet.
15. Inflate and deflate balloon using sterile water (as per manufacturer's instructions)	To check balloon integrity
16. Place sterile drape over patient meanwhile allowing access to urethra.	To create a sterile field.
17. Wrap a sterile gauze swab around the penis, retract the foreskin and clean the glans	To reduce the risk of introducing infection into the urinary tract during catheterisation.

penis with sterile saline soaked non linting gauze.	
<p>18. Insert the nozzle of the syringe of sterile lubricant into the urethra and massage the gel along the urethra.</p> <p>(Check the manufacturer's instructions for the amount recommended usually 11mls or 12.5 g for male)</p> <p>Wait 2-5 minutes</p>	<p>Adequate lubrication with anaesthetic gel prevents urethral trauma.</p> <p>To lubricate and locally anaesthetise</p>
<p>19. Dispose of gloves. Decontaminate hands using alcohol based hand rub. Apply clean pair of sterile gloves.</p>	To reduce the risk of infection.
<p>20. Hold the penis behind the glans at a 90-degree angle to insert the pre-connected catheter using non touch technique in to the meatus without force.</p> <p>If resistance is prolonged or there is pain stop the procedure and seek advice.</p>	<p>This manoeuvre straightens the penile urethra and prevents contamination and retraction of the penis.</p> <p><b>Slight resistance may be felt on insertion.</b></p> <p><b>No excessive pressure should be applied.</b></p>
<p>21. Check urine begins to flow before advancing the catheter almost to its bifurcation point.</p>	To ensure the catheter is correctly positioned in the bladder.
<p>22 Inflate the balloon with sterile water according to manufacturer's instructions and gently pull back until resistance is felt.</p>	To allow catheter eyelets free drainage
<p>23. Support the catheter and drainage system with appropriate support garment/equipment.</p>	To hold the catheter in place, make patient comfort and to reduce the risk of urethral and bladder neck trauma.
<p>24. Check the glans penis is clean and dry <b>reposition the foreskin back to its normal position.</b></p>	To ensure paraphimosis does not occur.

25. Make sure the patient is comfortable and dry.	To maintain patient comfort.
26. Dispose of equipment including gloves and apron in waste bag.	To prevent environmental contamination.
27. Decontaminate trolley/surface (where appropriate) according to local policy.	To reduce the risk of cross infection.
28. Perform hand hygiene WHO moment 4	To reduce cross contamination and infection  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
29. Record information in patient records <b>and</b> catheter passport such as any problems during procedure, batch, expiry date and review date.	The NMC Code 2018, which states you must 'keep clear and accurate records'.
30. Patient information is held within catheter passport, which includes details of the product and emergency contact details.  Discuss care of catheter with patient/carer and check for understanding.	To provide patient with sufficient information to ensure product prescription is consistent.  Contact number is given in case of emergency.  To teach patient how to care for catheter to reduce risk of CAUTI

### 3.2. Inserting a Urinary Urethral Catheter in the Female patient

Procedure	Rationale
1. All staff, prior to every catheter insertion, should assess or review if a catheter is required and record the reason in the patient's records and catheter passport.	To ensure clinically indicated and to reduce inappropriate catheterisation  ·
2. Always ensure as small a catheter as possible is used allowing for good drainage. During routine indwelling urinary catheterisation catheter size 12ch is suitable for adult male and female patients (unless on specialist advice)	To reduce the risk of urethral trauma, discomfort, pain and urethritis and bladder spasms

<p>3. Perform hand hygiene using an alcohol based hand rub. WHO key moment 1 If hands are visibly soiled then hand hygiene should be performed using liquid soap and water.</p>	<p>For procedure adhere to the World health Organisation (WHO) 5 moments for hand hygiene guidelines. To reduce cross contamination and infection</p> <p>Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a></p>
<p>4. Explain and discuss the procedure with the patient in order to obtain consent.</p>	<p>The NMC Code (2018) which states '4.2 make sure you get properly informed consent and document it before carrying out any action'.</p>
<p>5. Ensure privacy; assist the patient to get into the most comfortable position to undertake the procedure.</p>	<p>To ensure area is easily accessible and the patient is comfortable and dignity maintained.</p>
<p>6. Perform hand hygiene. WHO key moment 2</p>	<p>To reduce cross contamination and infection</p> <p>Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a></p>
<p>7. Prepare a suitable work surface for aseptic technique. Decontaminate according to local policy and gather all equipment on bottom shelf of trolley (where available).</p>	<p>To minimise risk of contamination to equipment.</p>
<p>8. Put on a disposable plastic apron.</p>	<p>To protect uniform from contamination.</p> <p>Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a></p>
<p>9. Check condition and expiry date off all sterile equipment.</p>	<p>Sterility of items can be compromised if packaging expired or damaged.</p>
<p>10. Open the outer cover of the sterile pack and position waste bag.</p>	<p>To prepare equipment.</p>
<p>11. Open equipment onto the aseptic field using non-touch technique.</p>	<p>To prepare for procedure</p>
<p>12. Perform hand hygiene, WHO key moment 2</p>	<p>To reduce the risk of infection.</p> <p>Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a></p>
<p>13. Apply one pair of sterile gloves</p>	<p>To reduce the risk of introducing infection into the urinary tract during catheterisation</p>
<p>14. Pre-connect catheter to drainage bag place on sterile field.</p>	<p>To reduce risk of infection and to prevent bed clothes becoming wet.</p>

15. Inflate and deflate the balloon as per manufacturer's instructions	To ensure balloon patency
16. Place sterile drape over patient meanwhile allowing access to urethra.	To create a sterile field.
17. Clean the Meatus with normal saline swabbing away from the urethra towards anus.	To reduce the risk of introducing infection into the urinary tract during catheterisation
18. Dispose of gloves. Decontaminate hands with alcohol based hand rub. Apply clean pair of sterile gloves.	To reduce the risk of infection.
19. Insert the nozzle of the syringe of sterile lubricant into the urethra and administer the gel along the urethra.  (Check the manufacturer's instructions for the amount recommended usually <b>6mls</b> or 8.5g female).  Leave for 2-5 minutes	Adequate lubrication with anaesthetic gel prevents urethral trauma.  To lubricate and anaesthetise
20. Introduce the tip of the catheter with pre-connected catheter bag into the urethra in an upward and backward direction using non touch technique holding only the plastic wrapper. Pick up the catheter with the sterile gloved hand. Insert the catheter in to the meatus and gently advance the catheter along the urethra until it reaches the bladder and urine flows out.	The direction of insertion should bear relation to the anatomical structure  <b>If any resistance is felt during catheter insertion, then stop and consult medical staff for guidance.</b>  <b>No excessive pressure should be applied.</b>
21. Advance the catheter until 5-6cm has been inserted.	This prevents the balloon becoming trapped in the urethra
22. Check urine starts to flow before inflating the balloon with sterile water according to manufacturer's instructions, gently pull back until resistance is felt and observe for urine drainage.	To allow the catheter eyelets to drain freely
23. Make sure patient is dry and comfortable.	To promote patient comfort.

24. Support the catheter and drainage system with appropriate support garment/equipment.	To support the catheter in place, maintain patient comfort and to reduce the risk of urethral and bladder neck trauma
25. Dispose of equipment including gloves and apron in waste bag.	To prevent environmental contamination.
26. Decontaminate trolley/surface (where available) according to local policy.	To reduce the risk of cross infection.
27. Perform hand hygiene WHO key moment 5.	To reduce the risk of infection  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
28. Record information in patient <b>and</b> catheter passport such as any problems during procedure, batch, expiry date and review date.	The NMC Code 2018 states you must, 'Keep clear and accurate records'.
29. Patient information is held within catheter passport, which includes details of the product and emergency contact details.  Discuss care of catheter with patient/carer and check for understanding.	To provide patient with sufficient information to ensure product prescription is consistent.  Contact number is given in case of emergency.  To teach patient how to care for catheter to reduce risk of CAUTI

#### 4 Suprapubic catheterisation

The supra pubic route is chosen when a urethral catheterisation is not suitable. Initial supra pubic catheterisation involves draining the bladder using a catheter that is passed through the anterior abdominal wall under general anaesthetic.

**The first change can be done in the community**, in the patient's own home or community clinics as per consultant's instructions.

#### **4.1 Indications for Supra Pubic Catheterisation**

- Acute retention of urine
- Chronic retention **with** renal impairment
- Disorders of the genitalia or urethral trauma
- Unable or unwilling to perform intermittent self-catheterisation (ISC)
- Persistent expulsion of the urethral catheter
- Patient preference
- Poor mobility

#### **Unsuitable Patients**

- Unable to fill bladder to a minimum of 300mls
- Previous abdominal surgery
- Blood clotting disorders
- Ascites
- Suspicion of ovarian cyst
- Peri prosthetic device eg hernia mesh

#### **Advantages of Supra Pubic Catheterisation**

- Reduced risk of urinary tract infection
- Urethral integrity is maintained
- Some patients feel more independent
- Sexual intercourse can occur with fewer impediments
- Comfort in wheelchair users

#### **Disadvantages of Supra Pubic Catheterisation**

- Colonisation, infection, swelling and encrustation at insertion site
- Bowel perforation at time of insertion
- Pain or irritation for some patients
- Bladder stone formation
- Leaking from urethra

## 4.2 Removing and Inserting a Urinary Supra Pubic Catheter

Procedure	Rationale
1. Always select the size of catheter that is currently being used.	To maintain stoma site.
2. Explain and discuss the procedure with the patient in order to obtain consent.	The NMC Code (2018) which states '4.2 make sure you get properly informed consent and document it before carrying out any action'.
3. Perform hand hygiene using an alcohol based hand rub. WHO key moment 1 If hands are visibly soiled then hand hygiene should be performed using liquid soap and water.	For procedure adhere to the World health Organisation (WHO) 5 moments for hand hygiene guidelines. To reduce cross contamination and infection  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
4. Ensure privacy; assist the patient to get into the supine position.	To ensure area is easily accessible, the patient is comfortable and dignity maintained.
5. Prepare a suitable work surface for aseptic technique. If in a clinical area decontaminate trolley with detergent wipe and gather all equipment on bottom shelf.	To minimise risk of contamination to equipment.
6. Put on a disposable plastic apron.	To protect uniform from contamination.  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
7. Check condition and expiry date off all sterile equipment.	Sterility of items can be compromised if packaging expired or damaged.
8. Open the outer cover of the sterile pack and position waste bag.	To prepare equipment.
9. Open equipment onto the aseptic field using non-touch technique	To prepare for procedure

10. Perform hand hygiene WHO key moment 2	To reduce the risk of infection.  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
11. Apply one pair of sterile gloves.	To reduce the risk of introducing infection into the urinary tract during catheterisation
12. Pre-connect catheter to drainage bag place on sterile field.	To reduce risk of infection and to prevent bed clothes becoming wet.
13. Inflate and deflate the balloon as per manufacturer's instructions	To ensure balloon integrity.
14. Place sterile drape over patient meanwhile allowing access to the supra pubic site.	To create a sterile field.
15. Use of anaesthetic lubricant gel. The gel can be applied around the side of the Catheter before removal.	Helps to reduce infection. Facilitate ease of insertion and removal and reduces trauma.
16. Deflate the catheter balloon with 10ml syringe.	To be able to remove catheter.
17. Make a note of how much of the catheter is in the abdominal wall.	To insert new catheter into same position.
18. Withdraw the catheter from the tract note the angle it came out.	To ease insertion of new catheter.
19. Dispose of gloves. Decontaminate hands alcohol based hand rub. Apply clean pair of sterile gloves.	To reduce the risk of infection.
20. Insert the new catheter with pre-connected drainage bag into the abdominal tract 3cm further than the previous catheter, noting the angle of insertion and the length of catheter to be inserted. Wait for urine to drain then inflate the balloon as per manufacturer's instructions. Gently pull back until resistance is felt.  Occasionally urine does not drain immediately, ask the patient to move or cough or apply gentle abdominal pressure, this can prompt urine drainage.	To ensure catheter is in correct position.

21. Support the catheter and drainage system with appropriate support fixation devices.	To secure the catheter, maintain patient comfort and to reduce the risk of urethral and bladder neck trauma
22. Make sure patient is dry and comfortable.	To promote patient comfort.
23. Check the removed catheter tip	To ensure the catheter has been removed intact and to check for any encrustation
22. Place all used equipment, gloves and apron in appropriate waste stream.	To reduce risk of environmental contamination
24. Decontaminate trolley/surface (where appropriate) according to local policy.	To reduce the risk of cross infection.
25 Perform hand hygiene WHO key moment 4	To reduce risk of infection
26 Record information in patient <b>and</b> catheter passport such as any problems during procedure, batch, expiry date and review date.	The NMC Code 2018, which states you must, 'Keep clear and accurate records'.
27. Patient information is held within catheter passport, which includes details of the product and emergency contact details.  Discuss care of catheter with patient/carer and check for understanding.	To provide patient with sufficient information to ensure product prescription is consistent.  Contact number is given in case of emergency.  To teach patient how to care for catheter to reduce risk of CAUTI

## 5. Care of an indwelling catheter

All patients must have a catheter passport which includes information on how they can care for their catheter.

### 5.1 Removing an indwelling catheter

Indwelling urinary catheters must be removed in a manner that reduces the risk of potential problems such as trauma. Catheters that are encrusted will prove difficult to remove. It is essential therefore that the patient is regularly assessed to ensure that the catheter is removed at the most optimum time.

**The Catheter must never be cut and the balloon must never be over-inflated (inflate only as manufacturer's instructions).**

#### When to Remove an Indwelling Urinary Catheter

- When no longer required.
- If infection is present prior to commencing antibiotic therapy for a symptomatic UTI (New catheter must be inserted prior to commencing antibiotics).
- When there is evidence of severe ventral erosion of glans penis and penile shaft
- When incorrectly placed in the urethra (prior to inflation to prevent trauma)
- As part of a trial of voiding procedure.
- If patient wishes and is safe to do so
- If the patient is at risk of harm with having a urinary catheter in place

### Procedure for Removing an Indwelling Urethral Urinary Catheter

Procedure	Rationale
1 Perform hand hygiene using an alcohol based hand rub. WHO key moment 1 If hands are visibly soiled then hand hygiene should be performed using liquid soap and water.	For procedure adhere to the World health Organisation (WHO) 5 moments for hand hygiene guidelines. To reduce cross contamination and infection  Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
1. Explain and discuss the procedure with the patient in order to obtain consent.	The NMC Code (2018) which states '4.2 make sure you get properly informed consent and document it before carrying out any action'.
2. Ensure patient is comfortable, and ensure privacy.	To protect dignity of patient.
3. Perform hand hygiene WHO key moment 2	To reduce the risk of infection
4. Clinical staff must wear disposable gloves and apron.	To protect themselves, their uniform and to reduce the risk of cross infection.

	Link to National Infection control Manual ( includes video on this correct procedure) <a href="http://www.nipcm.hps.scot.nhs.uk/">http://www.nipcm.hps.scot.nhs.uk/</a>
5. Clean the meatus with normal saline swabbing away from the opening of the urethra. (In women swabbing away from the urethra towards anus).	To reduce the risk of infection.
6. From the documentation check the volume of water in the balloon and deflate using syringe.	To ensure balloon is fully deflated prior to removal of the catheter.
7. Ask the patient to breath in and out. (inhale and exhale) When the patient breaths out (exhales) remove the catheter.	To relax the pelvic floor muscles and increase comfort.
8. Clean the meatus with normal saline swabbing away from the opening of the urethra. (In women swabbing away from the urethra towards anus).	To clean any residual urine and make patient comfortable.
9. Make sure patient is dry and comfortable, replace foreskin in male patient.	To promote patient comfort.
10. Dispose of all equipment including gloves and apron in appropriate waste stream.	To reduce risk of contamination of the environment.
11 Perform hand hygiene WHO key moment 3	To reduce the risk of infection
12. Record information in clinical records. This should include reasons for removal and any problems occurred.	The NMC Code of conduct which states you must keep clear and accurate records.
13. If not re-catheterised always check with the patient 4-6 hours after removal that urine has been passed and patient feels comfortable.  A post void bladder ultrasound scan should be carried out ( for housebound patients please refer to Continence Service)	To ensure bladder is emptying.

## 6. Responsibilities and Accountabilities:

NHS Lanarkshire (NHSL) Registered Nurses, Clinical Support Workers or Student Nurses obtaining clinical competencies under supervision of a Registered Nurse, using this protocol must ensure:

That all staff have access to this protocol

To have in place a system that ensures the availability of safe appropriate equipment for staff to use for this procedure.

Appropriate training is available to staff in order to carry out these procedures.

Individuals have a professional responsibility to recognise the limits of their own competence. Initial training and ongoing mentoring is considered best practice and should be something to which all practitioners achieve. Nurses must be competent and confident that their skills and knowledge are maintained and up to date (NMC 2019).

Areas for training needs must be highlighted and addressed. This can be undertaken through appraisals or supervision and a record of competencies kept for audit and standard purposes

## **7. Principles;**

This protocol should be read in conjunction with the following documents:

NHS Lanarkshire Consent Policy (2020)  
[online]<https://www.nhslanarkshire.scot.nhs.uk/download/consent-for-healthcare-policy/>

NHS Lanarkshire Information Governance (2020) [Online] Available from:<https://www.nhslanarkshire.scot.nhs.uk/download/information-security-policy-data-protection/>

Health Protection Scotland, National Infection Control Manual 2021 [online]  
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## **8. Consent;**

Patients have the right to make choices about their own lives and therefore healthcare staff have an ethical and legal responsibility to involve patients as much as possible in making decisions about their own health and care. No adult can give valid consent for another unless legally authorised to do so. The consent process should be a partnership based on openness, honesty, trust and good communication following the principles of shared decision making. It is, therefore, a process in which healthcare professionals and individuals work together to select tests, treatments, management or support packages, based on evidence and the individuals informed preferences.

[NHSL Consent for Healthcare Policy. March \(2020\)](#)

## **9. Equipment Required:**

As per the Royal Marsden Manual (2020), Royal Marsden Clinical Procedures Manual (2020) Royal Marsden Hospital: (Wiley Blackwell) [Online] Available from: <https://www.rmmonline.co.uk/> [Accessed 24 May 2022]

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## **Appendix 1**

The My 5 Moments for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.

This evidence-based, field-tested, user-centred approach is designed to be easy to learn, logical and applicable in a wide range of settings.

This approach recommends health-care workers to clean their hands

- **before touching a patient,**
- **before clean/aseptic procedures,**
- **after body fluid exposure/risk,**

- after touching a patient, and
- after touching patient surroundings.

