

NP16



**Policy and Protocol for Intermittent
Urethral Catheterisation of Adults
and Children**

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POLICY AND PROTOCOL FOR INTERMITTENT URETHRAL CATHETERISATION OF MALE AND FEMALE ADULTS AND CHILDREN

Policy Statement

This policy and protocol covers intermittent urethral catheterisation for male and female adults and children.

1. Definition

- 1.1 O'Hagan (1996) defines intermittent catheterisation as "the episodic introduction of a catheter into the bladder to drain any residual urine, and then the removal of the catheter leaving the patient catheter free between catheterisations".
- 1.2 It is also performed for the treatment of urethral stricture. This is described by Denning (1996) as narrowing of the urethra resulting from scarred healing after an infection (urethritis) or trauma.

There are several types of intermittent catheterisation:

1. "Intermittent Self catheterisation" (ISC) The patient intermittently passes a catheter into the bladder to assist in the drainage of urine where normal voiding is not possible. This is a clinically clean procedure.
2. "Intermittent Catheterisation" by the relative or carer intermittently catheterises the patient to assist in the drainage of urine where normal voiding is not possible. This is a clinically clean procedure; the relative / carer performs the procedure on the patient - always with full consent from the patient. It is advisable that good hand washing practice is explained and demonstrated to the person who will be performing the technique
3. "Intermittent catheterisation" by medical professionals. This is usually performed in an acute or emergency situation to relieve retention of urine prior to the future management of the patient's bladder problem being decided. In this instance catheterisation must always be carried out with a sterile technique. This should not continue as a form of long-term management as:
 - Staff are not always available at set times (the bladder must not be allowed to overflow)
 - Not all staff have specific training.
 - High risk of acquired infection.However in some circumstances staff may drain patients with chronic hypotonic bladders periodically.

2. Rationale

2.1 Intermittent catheterisation is an effective way of managing patients with voiding difficulties. It reduces the risk of common indwelling catheter associated problems such as urethral trauma, urinary tract infection (Hill and Davies 1988 and Maynard and Diokno, 1982) and catheter encrustation. It protects the upper urinary tract from reflux; provides greater freedom for expression of sexuality; improves the patients potential for self-care and independence and reduces the need for equipment and appliances. (Getliffe 1997) It has also been proven that there is a reduction in UTI associated with Intermittent Self Catheterisation.(ISC.) (Bakke and Digranes, 1991) Intermittent catheterisation should be always used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient. (NiCE 2003)

2.2 The technique of ISC can be used for either male or female patients who suffer from some form of neurogenic bladder dysfunction or voiding difficulty.

2.3 Intermittent Catheterisation can be performed for the following:

- Management of urinary retention or incomplete bladder emptying – (RCN Continence Care Forum 1997)
- Measurement of residual urine– RCN Continence Care Forum (1997) (if a Bladder scanner is not available)
- Instillation of drug therapy –(RCN Continence Care Forum 1997).
- Stricture therapy. (Lawrence and MacDonagh 1988 and Robertson et al, 1991)
- Management of a urinary pouch (Mitrofanoff) Norton, 1996)

Some of the most beneficial results of ISC have been reported when the technique is used by those suffering from spina bifida, paraplegia or multiple sclerosis.

In patients who fail to empty their bladder completely the bladder is sometimes referred to as a hypotonic bladder. In such cases ISC is the preferred course of management. (ACA Guidelines 2000)

Age is no barrier to carrying out ISC. Children as young as 5 can be taught and / or a parent of younger children can learn to catheterise their child.

3. **Who Teaches ISC?**

When embarking on teaching this technique it is extremely important to consider practicalities within the patients home situation.

The most common teachers of ISC are nurses.

It is important they are fully conversant with all relevant Trust guidelines and policies and the NMC Codes of Conduct, and when teaching children, the United Nations Convention. (1989) Specific areas to be considered include the giving of information, the role of consent and especially the protection of the child/ adult from abuse, whether physical, psychological or sexual.

The instructor needs to be supportive and skilled stressing the positive values of ISC. Psychosexual awareness means being alert to the sexual anxieties of all patients whenever present. ISC is an extremely intimate technique and privacy must be ensured at all times. Those teaching ISC must be skilled in interpreting both verbal and non-verbal behaviour of the patient when being examined during this sensitive time. A sympathetic approach must be provided by those involved in teaching ISC; equally important is the attitude and motivation of the patient when faced with a totally new approach to bodily function.

4. **Criteria for performing the role**

Doherty (1998) indicates that Registered Nurses (In Brent this includes all Level 1 and 2 nurses on PCT contract and agency nurses) who have been trained and supervised and are able to demonstrate theoretical and practical competence appropriate to the particular individual needs of their patients may perform the procedure and instruct them and their carers in the technique. Winder (1992) stresses that patients must be taught by an adequately prepared health care professional. The nurse must acknowledge any limitations in her knowledge and competence and decline any duties or responsibilities unless able to perform them in a safe and skilled manner. (NMC Code of Professional Conduct 2002)

NB. Training needs will be addressed in liaison between the nurse, the manager and the continence advisor.

Nurses are accountable for ensuring they promote and protect the interests and dignity of patients and clients irrespective of gender, age, race, ability, sexuality economic status, lifestyle, culture, religious and political beliefs. (NMC Code of Conduct 2002)

5. **Expectations of the Nurse by the Trust**

- 5.1 The nurse must ensure that a medical practitioner assesses the patient and that the procedure is appropriate care for the individual before it takes place.

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- 5.2 Children for whom intermittent catheterisation is indicated will be under the care of specialist paediatric services, who will initiate the procedure. There must be ongoing liaison between the nurse and the specialist unit.
- 5.3 The nurse must obtain informed consent to the procedure from the patient and parent/guardian in the case of a child. (NMC Code of Professional Conduct 2002). A child may give or refuse consent, if they have sufficient knowledge and understanding, as described in the Children's Act 1989. Nurses may seek advice from their professional lead in these circumstances.
- 5.4 The nurse must ensure that a Statement of Special Educational Need is drawn up in accordance with the Code of Practice(Education Acts 1993 and 1996) to ensure that school children receive adequate and private facilities for the procedure to be performed safely in school
- 5.5 The nurse will comply with all NMC requirements as detailed in the Code of Professional Conduct (2002), NMC Guidelines for Records and Record Keeping (2002) and NMC Administration of Drugs (2002)
- 5.6 The nurse will use equipment as instructed by the manufacturer to comply with the Product Liability Act. The catheter packaging must have a CE marking.
- 5.7 The nurse will comply with any other legal requirements or Trust policies, such as: -
- Health & Safety Regulations
 - Infection Control Policy
 - The Latex Policy (Risk Management Policy)
- 5.8 The nurse will seek medical advice if there is a history of: -
- Recent surgery
 - Trauma to the pelvis or abdomen
 - Carcinoma of the lower urinary tract.
 - Haematuria.
 - Abnormal urethral discharge
 - Difficult catheterisation
 - Acute urinary retention
 - Congenital abnormality (RCN Continence Care Forum 1997)
 - Current symptomatic urine infection.
 - Current pregnancy
 - Immuno-suppression
- 5.9 The nurse will record a minimum of the following information in the nursing notes and care plan.
- The medical practitioner who has assessed the patient and decided the procedure is appropriate care.

- How consent has been obtained.
- The reason for the procedure (RCN Continence Care Forum, 1997).
- The type of catheter used, Charriere gauge, length, material, batch number expiry date and manufacturer (RCN Continence Care Forum, 1997).
- The type of cleansing agent used. Soap and water are recommended.(antiseptic is not recommended)
- Lubricant / anaesthetic agents used, their manufacturer and batch number (RCN Continence Care Forum, 1997).
- Any problems negotiated (RCN Continence Care Forum, 1997).
- The date and time the procedure took place
- The date for reassessment (RCN Continence Care Forum, 1997).
- The printed name, signature (and designation) of the nurse who carried out the procedure (RCN Continence Care Forum, 1997, UKCC, 1993).

6. How often does the patient catheterise?

The frequency is very individual and is dependent upon individual needs.

A useful guide is based upon the measurement of voided volumes and residual urine. For adults, Voiding urinary volume + residual = less than 500ml. (Alderman 1988) (For children see page 8).

Although this type of management is very individual ISC is usually not beneficial to the patient if the bladder capacity is lower than 100mls or if residuals are lower than 50 ml .

This is because catheterisation would need to be carried out too frequently.

If the patient is wet between catheterisation they may require catheterisation more frequently, similarly if they have some detrusor instability they may require ISC plus antimuscarinic therapy.

It is vital that a comprehensive fluid chart is maintained for at least 2 weeks to ensure that a correct and safe management plan can be implemented.

**Stricture programmes differ with each individual.
Always check with the urologist.**

(Usually 3 insertions per day culminating in a weekly dilatation with a size 18fg where possible)

PROCEDURE

7. Where possible the patient/carer should be taught in their own home in the position that is most appropriate for them. If they are taught in hospital they must be reassessed at home and where appropriate, at school/nursery subsequently. If a health professional is carrying out the procedure the policy for indwelling catheterisation must be followed i.e. an aseptic technique is to be used.

ASSESSMENT

The nurse will carry out a comprehensive assessment of the patient's needs. Pomfret (1994) highlights the following:

- Consideration of physical, social, sexual, psychological and cultural needs. In children at school the developmental, educational, emotional and special needs must be considered.
- The identification, past or present history of upper or lower urinary tract disease or current symptomatic infection
- Injury or surgery and relevant medical and social histories, including allergies, in particular latex allergy.
- The individuals voiding pattern, fluid intake, personal hygiene
- The physical / mental abilities of the patient/carers to perform intermittent
- The assessment will provide a method of identifying any potential complications or contraindications; offer an opportunity for the nurse to discuss the implications of intermittent catheterisation and to enable the patient/carer to make an informed decision.
- The patient must have an adequate sphincter mechanism and the bladder capacity should be sufficient to prevent the need for catheterisation more often than 2 hourly. However the voided volume plus residual urine must not exceed 400-500ml in adults. Getliffe (1997) Lancet (1979)
- If the procedure is being performed for the management of urinary retention or incomplete bladder emptying there must be a micturition residual urine volume of over 100mls in adults.
- For children up to the age of 12, the upper limit of physiological bladder capacity in millilitres is calculated by multiplying the age in years by 30 and adding 50. Rickwood (1992) Specialist medical advice must be sought regarding the size of residual volumes for the individual child.
- The patient must have adequate manual dexterity to perform the procedure, and have good standards of hand washing and general hygiene. They must also be motivated and able to understand the principles of the technique. Winder (1992)
- A single use, low friction, self-lubricating hydrophilic coated catheter can be used as there is some evidence that there is less association with urethral complications over time. (Waller, 1995 Sutherland et al, 1996). After each use the catheter must be placed in a plastic bag and disposed of. New patients are therefore recommended to use single use catheters.

- Advice about the most suitable catheter to meet the individual patients needs can be obtained from the Continence Service: Telephone No. 8795 6454
- **If an obstruction or any other difficulty is encountered the procedure must not continue. Medical advice should be sought as soon as possible. If the procedure is being carried out for urinary retention medical advice must be sought immediately and if necessary the patient transferred to an accident and emergency department.**

8. Use of antibiotics.

Once established on a programme of intermittent catheterisation routine antibiotic therapy for clients with bacteriuria is not recommended unless the client has symptoms of a urinary tract infection. Where the client is asymptomatic, antibiotics should be avoided in order to prevent the selection of resistant strains of colonising organisms. However, in certain specific circumstances such as pregnant women or the immunocompromised client, antibiotic therapy may be considered. In these circumstances microbiological advice must be sought.

9. Re usable catheters.

- Single use catheters are preferred. However, some patients may still be using re-usable catheters and prefer to continue using them.
- Following catheterisation, the catheter must be washed in detergent and hot water in a clean sink (Moore, 1990). A disinfectant must **not** be used due to the potential for resistant organisms to develop. The catheter must **never** be soaked due to potential bacterial contamination. Catheter cleaning must always be carried out in a clean area.
- Once cleaned, the catheter must be rinsed in tap water and dried with a disposable paper kitchen towel. (Lavalley et al 1995)
- When fully dry, the catheter should be stored in a clean sealed container until re-used.(Lavalley et al , 1995)
- This container must be washed with soap and water and thoroughly dried on a daily basis.
- The catheter must be changed in accordance with the manufacturers instructions (usually every 7 days).
- See appendix for patient information sheet.

10. Programme for teaching ISC.

The programme is to be carried out by a suitably trained community nurse and should include:

Patient Selection	Well motivated, good cognitive skills, manual dexterity, physical ability.
Patient Discussion	Knowledge regarding anatomy and reason for ISC, type of bladder instability.
General Discussion	Personal hygiene, hand washing technique, (see appendix for patient information sheet) storage, cleaning and disposal of catheters, travel, lifestyle.
Health Issues	ISC problem solving, diet, sexual activity, Exercise.
Observations	Observe / technique.

Hand washing technique must be assessed on a regular basis .

Following initiation of ISC all patients must be followed up in 2 weeks and subsequently 6-12 monthly intervals by the community nurse to ensure safe practice.

Brent Teaching PCT
Patient / Carer Information Sheet
Hand Hygiene

To help prevent any infection, it is very important to wash your hands thoroughly before and after touching any of the equipment.

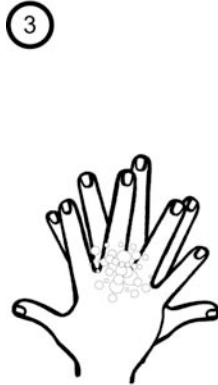
Liquid soap and either a clean dry towel or a disposable paper towel should always be used.



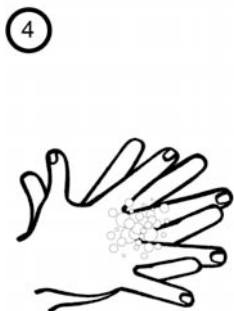
Wet your hands thoroughly and apply liquid soap



Rub hands together palm to palm



Rub back of hands with the palm of the other hand (with both hands)



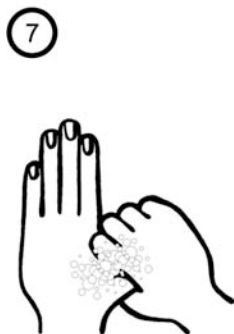
Rub palms together with your fingers interlocked



Interlock fingers as close to the palm as you can and rub fingers together



Rub the backs of the fingers with the palm of the other hand



Clasp your thumb with the palm and rotate your thumb



Rub your fingers in a circular motion

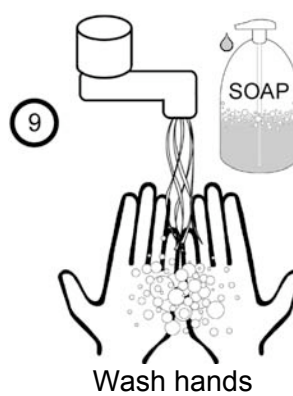
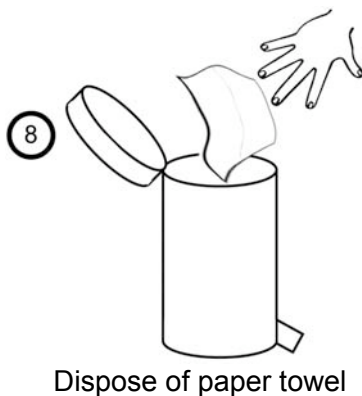
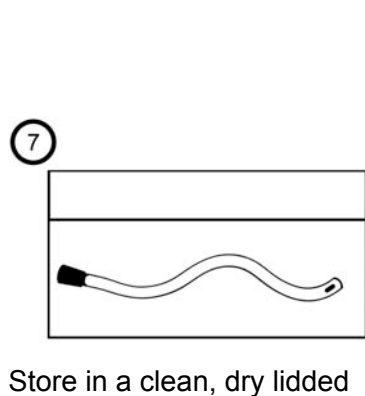
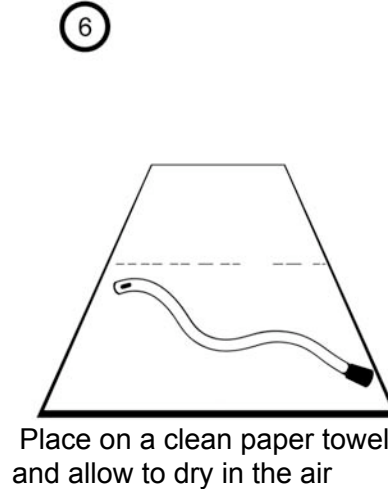
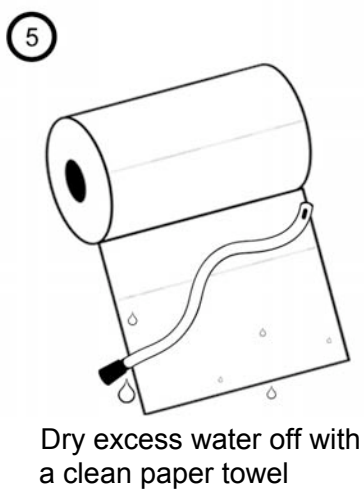
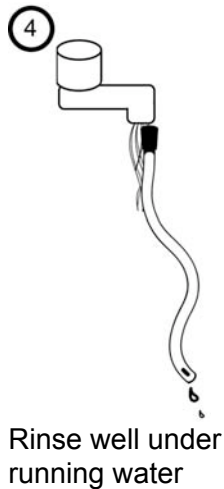
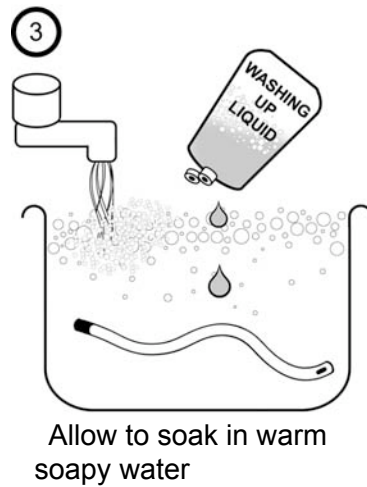
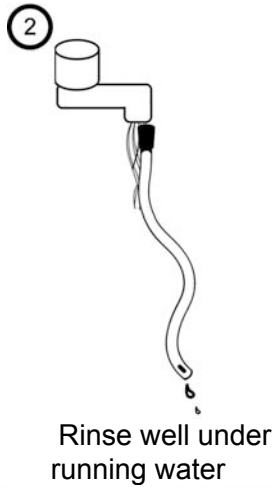


Rinse hands. Pat dry with paper or clean fabric towel from your fingertips to wrist

Brent Teaching PCT
Patient / Carer Information
Washing Your Re-Usable Equipment

Your Catheter can be used for _____ days before disposal

Instructions:



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