

<p><b>Status: Standard Procedure:</b> Specifies the procedures to be followed, only in exceptional circumstances should these not be followed.</p>	<p><b>Policy No: CLSP 24</b>  <b>Revision No:</b>  <b>Date Approved: 01/03/11</b>  <b>Review Date: 01/03/13</b></p>
<p><b>Title:</b>  Standard Procedure for the Insertion of a Urethral Catheter to a Cheshire Ireland Service User.</p>	
<p><b>Written by:</b>  Clinical Practice Project Group</p>	
<p><b>Approved by:</b></p>	
<p><b>Cross Reference: BPH02, ICG01, ICGO2</b></p>	

### 1.0 Purpose

The purpose of this standard procedure is to ensure safe technique during the insertion of a urethral catheter to a Cheshire Ireland service user.

### 2.0 Scope

Cheshire Ireland services/centres where Cheshire service users require assistance with the insertion of urethral catheters.

### 3.0 Responsibility

- It is the responsibility of all staff who perform this practice to follow the standard procedure.
- It is the responsibility of service managers to ensure staff are familiar with the standard procedure and to monitor compliance.

### 4.0 Definitions

**Urethral Catheterisation** is the introduction of a tube into the bladder via the urethra using aseptic technique. The catheter is anchored inside the neck of the bladder by a water filled balloon and is attached to a drainage bag. Catheters come in various sizes and lengths depending on whether one is male or female. Silicone catheters are usually used for long-term catheterization.

**Drainage bags** also come in various sizes i.e. 1½ litre bags that can be attached to the leg for daytime use and 2 litre bags for use at night. Leg bags can be attached to the larger night bag for convenience at night. Most bags come with a self-sealing sleeve that can be used to obtain samples of urine without introducing infection.

## 5.0 Procedure

### Equipment

- Clean trolley or other appropriate surface
- Sterile catheterisation pack
- Sterile gloves
- Disposable incontinence pads
- Two Appropriate sized catheters
- Drainage bag and stand
- Lubrication jelly/anesthetic gel (single service user use only)
- Antiseptic solution or sterile saline for perineal cleansing
- Sterile water for inflating balloon
- Needle and 10ml syringe
- Disposable bag
- Good light source

### Procedure for Urethral Catheterisation:

- Explain the procedure to the service user, ensuring the service user understands and consents to the procedure.
- Take the prepared trolley to the bedside of the service user.
- Provide adequate privacy.
- Raise the bed to an appropriate height to suit the staff member.
- Ensure a good light source.
- Wash the perineal area with soap and water and dry the area.
- Assemble equipment on a clean trolley.
- Assist the service user into the supine position with knees drawn up onto his/her side with upper legs flexed at hip and knee.
- Arrange the bedclothes to expose genital area. Place disposable pads under buttocks.
- Place disposable pads under buttocks.
- Wash hands using aseptic technique (Ref ICG 02).
- Using aseptic technique open packaging on catheter pack and any additional packets including the needle and syringe (without touching the sterile contents).
- Attach yellow biohazard bag to an accessible surface.
- Open catheter but do not remove from internal wrapping and place on sterile field.
- Pour the sachet of sterile saline into gallipot provided.
- Open catheter bag and arrange it at the side of the bed ensuring that the catheter connection is easily accessible and remains sterile.
- Squeeze a small amount of lubrication/anesthetic gel onto gauze swab.

- Wash hands using aseptic technique.
- Apply sterile gloves.
- Draw up sterile water required to inflate the balloon.
- Remove gallipot from receiver and place on sterile field.
- Expose the tip of the catheter and place on lubricated gauze in receiver.
- Drape sterile towels across thighs and between legs to create sterile field.
- Using a gauze swab in the non-dominant hand retract the labia minora. This hand should be used to maintain labial separation until catheterisation has been completed.
- Clean the perineal area using a new swab for each downward stroke disposing of each one in yellow bag.
- Place the receiver between the service user 's thighs on the sterile towel.
- Lubricate the catheter tip with lubricating gel.
- Holding the catheter so the distal end of the catheter remains in the sterile receiver and gradually advancing it out of its wrapper, introduce the catheter into the urethra in an upward and backward direction for approximately 5-7cms, or until there is a flow of urine into the receiver.
- Advance a further 5cms to prevent the balloon being inflated in the urethra.
- **DO NOT FORCE THE CATHETER.** (Stop the procedure if continued resistance is felt or the person complains of undue pain or is actively bleeding.)
- Slowly inflate the balloon with recommended amount of water using syringe.
- Collect a small amount of urine from the receiver to put into a sterile specimen jar if required.
- Attach to the catheter drainage bag and secure to prevent pulling.
- Secure the catheter to the leg using straps provided with the leg bag or secure to an appropriate catheter stand.
- Reposition and make sure the service user is dry and comfortable.
- Dispose of all equipment appropriately.
- Encourage service user to drink fluids.
- Record the procedure in the Best Possible Health Continence Care Plan personal record of the service user. The Best Possible Health Continence Care Plan records re-assessment of all needs at agreed intervals or when circumstances change. Any support or information offered must be documented here.
- Keep a Catheter Diary which records information for planned removal of the catheter and plan for service user monitoring.

## Troubleshooting

- Infection is an inevitable consequence of long-term catheterisation (Winson 1997). Most infections are asymptomatic as a protective layer of mucus on the bladder wall limits bacterial invasion and helps prevent systemic invasion (Getliffe 2003).
- Urinary catheterisation is not without complications, therefore a comprehensive assessment of the individual and his/her needs should be carried out prior to catheterisation using the **Bladder Assessment Tool**.
- Prior to catheterisation, check if the person has any known sensitivity to lignocaine, chlorhexidine or latex. Anesthetic gel may be contraindicated with some medications and medical conditions.

To reduce risk of cross-infection and catheter-related infection:

- Daily bathing or showering is encouraged.
- Gloves are worn to empty drainage bags and changed after hand washing between each individual.
- A closed drainage system is maintained as far as possible. Maintaining a closed drainage system reduces the risk of catheter-related infection (Kunin, 1997).
- Encourage service user to drink at least 3 litres of fluids (8 glasses) per day to flush through the kidneys and bladder, and to prevent urinary tract infections.
- If the urine is cloudy, has a bad smell, or has blood in it, seek medical help as there is probably a bladder infection.
- Be careful with drinks that have caffeine or alcohol. They can make the bladder fill up suddenly and cause one to get dehydrated.

### **Regular observation;**

- Constipation
- Incorrect positioning of drainage tube
- Drainage bag over full
- Balloon under or over inflated.
- Encrustation (Up to 50% of all users of long term catheters)
- Debris- If a service user's intake is low the urine becomes concentrated and any debris is less likely to be flushed from the bladder.

## 6.0 References

Mallett, J. & Dougherty, L. (2000). *The Royal Marsden Hospital Manual of Clinical Nursing Procedures*. Blackwell Publishing, Oxford.

Nicol, M., Bavin, C., Bedford-Turner, S., Cronin, P. & Rawlings-Anderson, K. (2004). *Essential Nursing Skills*. Mosby, United Kingdom.

Robertson, B. & O’Kell, S. (1995). *Study Guide for Health and Social care Support Workers*. First Class Books Pub., Bristol.

Best Practice Statement June 2004, *Urinary Catheterisation and Catheter Care*. NHS Quality Improvement Scotland.

*Catheter Care*, RCN Guidance for Nurses 2008.  
NICE, *Urinary Incontinence* 2011.

**7.0 Appendices**  
**Appendix 1**

**Catheter Diary**

Please ensure this booklet is completed  
Each time your catheter is changed

Service user: .....

Address: .....

.....

G.P. Name and contact details: .....

Consultant: .....

Health Care Professional (PHN Nurse/Cheshire Nurse Etc.) Name and contact  
details:

.....

1a. Reason for catheterization: .....

1b. Date of initial catheterization: .....

2. Recommended catheter: .....

Manufacturer: .....

Type: .....

Charrière (Ch.) size: .....

Balloon size: .....

3. Residual: .....

4. How often catheter should be changed: .....

5. Known Allergies: .....

### Catheter Diary continued

Catheter Change Date: ..... Insertion Easy: Yes/No  
..... Comments/Problems: .....  
.....  
.....

Reason for change:  
Routine  Fallen Out  Balloon Burst  Blocked   
Catheter Maintenance Solutions/Antibiotic Therapy  
Give Details: .....  
.....  
.....

CSU Yes  No

Name of Nurse/Doctor/Carer: .....  
Due Date of Catheter Change: .....  
Recorded in BPH Daily Continuation sheet: .....

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Catheter Change Date: ..... Insertion Easy: Yes/No  
..... Comments/Problems: .....  
.....  
.....

Reason for change:  
Routine  Fallen Out  Balloon Burse  Blocked   
Catheter Maintenance Solutions/Antibiotic Therapy  
Give Details: .....  
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.....

CSU Yes  No

Name of Nurse/Doctor/Carer: .....  
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Recorded in BPH Daily Continuation sheet: .....

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