

1. Introduction

This Standard Operating Policy (SOP) aims to outline the requirements of UHL staff in providing a standardised, high quality and best practice approach to continence care, and a framework for assessing and managing incontinence when patients are admitted to UHL.

It has been developed in response to NHS guidance, Excellence in Continence Care (2018), and explains how the continence needs of adult patients will be met, emphasising the importance of a person-centred approach when managing incontinence, which is reflected in the choice of continence aids outlined in this SOP.

The Adult Urinary Devices Policy supports this SOP, and its policy appendixes are referred to within this SOP for further guidance and instruction.

Robert Francis described continence as 'the most basic need' (Department of Health, 2010) and this SOP aims to promote continence and empower patients to receive optimum care regardless of age, physical or mental ability.

2. Scope

This SOP applies to any Health Care Professionals (HCP) supporting patients aged 18 years and older admitted to UHL.

3. Recommendations, Standards and Procedural Statements

3a Assessment of Continence Needs

All patients admitted to UHL will have a Core Nursing Assessment (CNA) of their elimination needs completed within 6 hours on Nerve Centre. It is a fundamental core nursing assessment and should be completed objectively with the patient and if not possible, after discussion with a family/carer member and updated throughout a patient's admission and if their continence needs change.

If patients have a Learning Disability (LD) or can't verbalise the need to go to the toilet, please refer to the patient's communication passport for their individualised toileting care plan. Sometimes LD patients have been 'trained' or 'conditioned' to manage their continence by being taken to the toilet or offered the commode at particular times of the day, and, it is important that this is done consistently in line with their plan, to prevent the need for continence pads.

Within the Elimination CNA are links to the Adult Bladder and Bowel Care Pathway to guide staff in the management of bladder and bowel symptoms. The Adult Bladder Care Pathway is a tool to identify different types of urinary incontinence and how to manage symptoms. The Adult Bowel Care Pathway provides a plan to manage constipation, faecal impaction/loading and diarrhoea.

3b. Bladder and Bowel Diagnostic Tools:

3c Bladder Scanning

A bladder scan is an ultrasound scan used as a diagnostic tool for assessing bladder problems and should be performed by a competent HCP. Bladder scans should always be performed post-void to establish an accurate post-void urinary residual and is recommended for all types of lower urinary tract symptoms as per Adult Bladder Care Pathway.

Indications for Bladder Scanning: -

- Measuring urine retention – prior to catheterisation
- Ensure that drug therapy (e.g. anti-cholinergic medication) has not induced any voiding problems
- Assess the volume of urine in the bladder if a catheter is failing to drain
- After a-trial without a catheter to evaluate whether a patient can void and to what degree
- New onset of urinary incontinence

See (Appendix 1) Bladder Scanning Procedure and (Appendix 6) Post-Void Residual Bladder Scan Guidance.

3d Urine Specimen Collection (MSU and CSU)

A mid-stream urine (MSU) sample describes the middle part of the urine flow, not the first or last part. A catheter specimen of urine (CSU) is a sample of urine taken from the port of the catheter by syringe. A CSU and MSU sample should only be collected when a patients displays clinical signs of urinary tract infection/catheter acquired urinary tract infection (CAUTI). Refer to Adult Urinary Devices Policy (Appendix 6), for CSU procedure and clinical indications for CSU.

See (Appendix 2), for MSU and Urinalysis Procedure.

NICE (2024) guidance does not recommend routine dipsticks in the over 65 years. Up to half of older adults, and most with a urinary catheter, will have bacteria present in the bladder/urine without an infection. This “asymptomatic bacteriuria” is not harmful, and although it causes a positive urine dipstick, antibiotics are not beneficial and may cause harm.

3e Digital Rectal Examination (DRE and Digital Removal of Faeces (DRF)

A Digital Rectal Examination (DRE) and Digital Removal of Faeces (DRF) are invasive procedures that can be carried out as part of a nursing assessment, by a Registered Nurse or Nursing Associate, who has received Trust training and has been assessed using the Leicester Clinical Procedure Assessment Tool.

The examination should only be performed for specific reasons. See Digital Rectal Examination and Digital Removal of Faeces for Healthcare Professionals Management Policy.

Spinal injury patients needing DRF should be referred to the Spinal Specialist Nurses. All other adult patients can be referred to the Medical Continence Team for DRF.

4 Management of Continence

4a Continence Aids

Offering the patients the toilet/commode or a male/female urinal to help a patient maintain their continence is the optimum standard of continence care. Where patients do not have control of their bladder or bowels additional continence aids are available in hospital to manage incontinence: -

4b Management of Urinary Incontinence for a patient with Male Anatomy: Penile Sheath

Penile sheaths also described as condom catheters, are for males who are unable to use a urinal or other toileting facilities. They can be worn for up to 24 hours or short periods of time, e.g. overnight.

Refer to the Penile Sheath Pathway in the Adult Urinary Devices Policy (Appendix 16) for guidance on criteria, application and discharge planning.

Visit the Urinary Device CNA on Nerve Centre to complete the Penile Sheath Care Plan and update every 24 hours or as required.

4c Management of Urinary Incontinence for a patient with Female Anatomy: Female External Catheter

Purewick is a female external catheter to manage urinary incontinence.

Refer to the Adult Urinary Devices Policy (Appendix 15) for criteria and application. For further guidance watch a Purewick demonstration video:

<https://bd.showpad.com/share/MZe29933DDLuNpzRR7In7/0>

Visit the Urinary Device CNA on Nerve Centre to complete the Purewick Care Plan and update at least twice daily or as required.

For patients requiring regular suctioning, contact Medical Physics for a portable suction unit to use with the Purewick.

4d Continence Pads

Pads should only be offered to patients if they are incontinent. Refer to the UHL Pad Formulary for choosing the correct absorbency of pads in the Adult Urinary Devices Policy (Appendix 18).

Pads should never be double padded.

Patients who have developed new incontinence during hospital admission are offered 24-hour supply of continence pads when discharged. For further supplies, Registered Nurse/HCP should refer to the Community Continence Team via SPA 0300 300 1000 for a Continence Assessment.

4e Intermittent Catheterisation

If a patient is not emptying their bladder fully, with a post-void bladder scan residual of between 250mls and below 500mls, intermittent catheterisation (IC) is the gold standard practice. See (Appendix 6) for Post-Void Residual Bladder Scan Guidance.

Intermittent catheters are available to order from UHL stores, size ch12 and ch14 in male and female. The Urinary Device CNA for intermittent catheterising must be completed on Nerve Centre if patients are either having intermittent self-catheterising or are self-catheterising.

The Adult Urinary Devices Policy includes the, Intermittent Self-catheterisation Guide for Nurses (Appendix 12) to teach patients how to self-catheterise.

The Post-Operative Urinary Retention Pathway (POUR) (Appendix 4) introduces a plan for IC in post-operative patients who are in urinary retention.

5 Urethral Catheterisation

Urethral catheterisation procedure must comply with (Appendix 2 and 3) the Adult Urinary Devices Policy.

Urinary Device CNA on Nerve Centre must be completed for insertion, on-going care review, removal or when discharging a patient with a catheter still in place.

The Adult Urinary Devices Policy (Appendix 21 and 22) explains the discharging process for patients with a catheter, including the completion and provision of the Catheter Passport and explaining the 'Looking after your Urinary Catheter at Home' leaflet, by the Registered Nurse to patient or carer. Patients should be referred via SPA for Community Nurse on-going care and registered with Clinisupplies for delivery of catheter products within 24hours.

5a Trial Without Catheter (TWOC)

See Adult Urinary Devices Policy for TWOC procedure (Appendix 10) and TWOC pathway (Appendix 11).

Urethral catheters should be removed using a sterile procedure to minimize risk of infection on removal. It is preferable to remove in the early morning or midnight, to enable any problems of retention to be resolved during the daytime hours.

Patients that have failed a TWOC and are being discharged home with a Catheter to have a TWOC in the community must have a completed Catheter Passport to take home with them.

5b Bladder Washout Procedure

If the urinary catheter is not draining, refer to the Adult Urinary Devices Policy (Appendix 8), to determine if a bladder washout is indicated. Identify if there are reversible cause first to promote catheter draining, including: -

- Drainage bag is not positioned below the bladder. Hourly monitoring urometers and overnight drainage bags must be hung on the end of the bed or on a stand that prevents contact with the floor. Drainage bags not positioned below the bladder can cause hydrostatic suction, which can cause damage to the bladder mucosa. Lift the drainage bag above bladder level and then down back to below bladder level. Higher rates of bacteraemia have been linked to incorrect positioning
- Tubing twisted or patient laying on tubing
- Is the patient constipated? DRE to rule out impaction/faecal loading?
- If it's a long-term catheter, does that patient have regular blockages and uses a regular catheter maintenance solution?
- Only competent practitioners should perform bladder washouts.

5c Emptying Urinary Catheter Bag

Night bags should be changed every 24 hours and leg bags/urometers once weekly. Urethral catheters with a closed system and a pre-connected leg bag (red seal/tape applied), then the leg bag is changed every 2 weeks.

See (Appendix 3), How to Empty a Urinary Catheter Bag.

5d Catheter Flip-Flow Valve

A catheter flip-flow valve is a tap-like device that fits to the end of a catheter (urethral or supra-pubic) and is an alternative to a drainage bag. It allows the bladder to continue to store urine and is emptied by releasing the valve.

See (Appendix 4), for Flip Flow Valve Procedure.

Benefits of Flip Valve: -

- Allow greater freedom
- Encourage the normal activity of the bladder (recommended after failed TWOC)
- Promote usual bladder capacity
- Maintain a closed system, minimising infection

6. Management of Faecal Incontinence

6a Faecal Collectors

Faecal Collectors are designed to manage faecal incontinence of any stool type and can be used for up to 48 hours or changed daily to monitor perianal skin. The dressing is applied to the perianal skin and stool is collected in the attached pouch. Contra-indication: broken excoriated skin or allergies to components.

See (Appendix 5), for Procedure for Applying a Faecal Collector.

6b Bowel Management Systems (BMS)

A BMS can be used for bed-bound or very limited mobility patients for up to 29 days, with intractable faecal incontinence or persistent diarrhoea, i.e. 4 or more episodes of faecal incontinence in 24 hours (liquid to semi-liquid stools type 6–7 as per Bristol stool chart).

- They are used to reduce the risk of skin breakdown
- To reduce the risk of spread of infection
- To protect wounds, surgical sites and burns
- To improve patient comfort
- To promote patient dignity
- To assist with faecal management (burn injured patients).

Refer to the BMS Policy for contra-indications, procedure and maintenance of BMS and Out of Hours/In-hours support for BMS.

Unless otherwise regularly using BMS (e.g. ITU), BMS cascade trainers must complete the annual refresher training on HELM to maintain competency.

6c Trans Anal Irrigation (TAI)

Some patients with a neurogenic bowel or problems with defaecation, use trans-anal irrigation to facilitate evacuation of faeces from the bowel to manage constipation or faecal incontinence. TAI is a specialist skill and should not be attempted by a HCP who is not trained and competent. Refer to the Medical Continence Team if a patient who normally does TAI needs support.

7. Incontinence Associated Skin Damage (IAD)

All episodes with IAD, including patients admitted with or who have developed IAD during admission must be reported through the hospital Datix system.

Refer to the MASD categorisation tool for descriptors to categorise MASD. The MASD pathway outlines treatment of IAD, including referral to TVN and Medical Continence Team for moderate to severe IAD.

8. Referral to Continence Nurse Specialists

Refer to the Adult Continence Nurse Specialists via ICE (Medical Continence Team), or email Continence Referral Service. The CNS aim to see patients within 24 hours of referral and operate Monday to Friday, 8.30-4.30pm. Do not refer on day of discharge.

9. Education and Training

All relevant staff must implement the procedures outlined in this document to ensure standardised and efficient care for their patients.

The Continence Specialist Nurses will be responsible for offering training to all relevant staff with regards to the standards outlined in this document.

The Continence Specialist Nurse will be responsible for the monitoring and review of this document.

The SOP is brought to the attention of all new starters as appropriate.

Within the Specialist Continence training the SOP will be referenced.

This will be held centrally on the University Hospitals of Leicester NHS Trust intranet and accessible to all relevant members of staff.

10. Monitoring and Audit Criteria

All guidelines should include key performance indicators or audit criteria for auditing compliance,

if this template is being used for associated documents (such as procedures or processes) that support a Policy then this section is not required as all audit and monitoring arrangements will be documented in section 8 of the Policy.

Key Performance Indicator	Method of Assessment	Frequency	Lead
Elimination CNA	Annual Review	Annual	CNS
Continence Questionnaire	Inpatient Questionnaire	Annual	CNS
CAUTI Monitoring	Urinary Devices Care Plan	Monthly	CNS/IP

11. Legal Liability Guideline Statement

See section 6.4 of the UHL Policy for Policies for details of the Trust Legal Liability statement for Guidance documents

12. Supporting Documents and Key References

- Excellence in Continence Care (NHS, 2018)
- Adult Urinary Devices Policy
- Adult Bladder and Bowel Care Pathway
- Purewick Video: <https://bd.showpad.com/share/MZe29933DDLuNpzRR7In7/0>
- MASD categorisation Tool
- MASD Pathway
- Bowel Management System Policy
- Urinary Tract Infection (lower) (NICE, 2024)
- RCN Bladder and Bowel Guidelines (2022)
- Lower urinary Tract Symptoms in Men (NICE, 2015)
- Lower Urinary Tract Symptoms in Women (NICE, 2019)

12. SOP Appendixes:-

- Appendix 1 Bladder Scanning Procedure
- Appendix 2 MSU & Urinalysis
- Appendix 3 Emptying Urinary Catheter bag
- Appendix 4 Catheter Flip Flow Valve Pathway
- Appendix 5 Faecal Collector
- Appendix 6 Post-Void Residual Bladder Scan Guidance
- Appendix 7 Empty Your Bladder Fully
- Appendix 8 Post-Operative Urinary Retention (POUR)

14. Key Words

BMS – Bowel Management System

TAI- Trans Anal Irrigation

DRE – digital rectal examination

DRF – digital removal of faeces

MSU – mid stream urine

CSU – catheter specimen urine

IAD – incontinence associated dermatitis

MASD – moisture associated dermatitis

TWOC – trial without catheter

IC – intermittent catheter

ISC – intermittent self-catheter

CNS– continence nurse specialist

CNA– core nursing assessment

This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT			
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REVIEW RECORD			
Date	Issue Number	Reviewed By	Description Of Changes (If Any)
DISTRIBUTION RECORD:			
Date	Name	Dept	Received

Procedure for Bladder Scanning

A bladder scan is an ultrasound scan used as a diagnostic tool for assessing bladder problems and should be performed by a competent HCP. Bladder scans should always be performed post-void to establish an accurate post-void urinary residual and is recommended for all types of lower urinary tract symptoms as per Adult Bladder Care Pathway.

Indications for Bladder Scanning:

- Measuring urine retention - prior to catheterisation
- Ensure that drug therapy (e.g. anti-cholinergic medication) has not induced any voiding problems
- Assess the volume of urine in the bladder if a catheter is failing to drain
- After a trial without a catheter to evaluate whether a patient can void and to what degree
- New onset of urinary incontinence

Procedure:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Equipment required: Bladder scanner, Ultrasonic Gel, Paper towels, Disinfection wipes for medical devices. • All staff must be trained in using the equipment before performing the procedure. • Explain the procedure to the patient and gain verbal patient consent. • Patient should be in a supine position with the head slightly raised on one pillow. • Expose lower abdomen to the symphysis pubis. • Apply a generous amount of transmission gel to the dome of the scan head and not directly on to the patient. • Place scanner head midline about 2.5cms superior to the symphysis pubis. | <ul style="list-style-type: none"> • Angle scanner head so it is angled slightly downwards towards the expected location of the patient's bladder, then move around the bladder in a circular movement. • When procedure is completed, wipe the remaining gel from the patient's abdomen and scan head with a paper towel. Scan head needs to be cleaned with a Clinell Wipe. • Print reading and document results in patient's notes. • Escalate finding if appropriate to the nurse in charge or a doctor. • If the patient has an abdominal surgical wound, PEG/RIG, Suprapubic catheter then sterile ultrasonic gel should be used. |
|---|--|

Appendix 2

Procedure for taking Mid-Stream Urine (MSU) Sample and Urinalysis

A mid-stream urine (MSU) sample describes the middle part of the urine flow, not the first or last part.

Indications for MSU:

- Temperature, 38c and above
- New frequency or urgency
- New incontinence
- New or worsening delirium/confusion
- New suprapubic pain
- Visible haematuria
- Renal angle pain

NICE (2024) guidance does not recommend routine dipsticks in the over 65 years. Up to half of older adults, and most with a urinary catheter, will have bacteria present in the bladder/urine without an infection. This "asymptomatic bacteriuria" is not harmful, and although it causes a positive urine dipstick, antibiotics are not beneficial and may cause harm.

MSU Procedure:

- Explain the procedure to the patient and support with toileting if required.
- Ask the patient to pass the first few mls of urine in the toilet/bedpan/commode and the middle portion into a sterile disposable tray. Having collected this, advise the patient to finish their urine flow.

Urinalysis

- Dip the reagent strip into the urine sample
- The strip should be completely immersed in the urine and removed immediately
- Run the strip along the urine container to remove excess urine
- Pat the back of the test strip onto a disposable paper towel
- Hold the strip at an angle to prevent mixing of reagents
- Wait the required time before reading the strip against the interpretation chart
- Inform Nursing/Medical Team of results and document on Nerve Centre
- If required, decant sample into urine bottle with red lid and attach patient ID sticker
- Send MSU via ICE to Microbiology.

Urinalysis Machines: Some clinical areas will have a urinalysis machine, also known as a urinalysis analyser, that will evaluate the urine and provide a print out of the results. Only use a urinalysis machine if you have received specific training from your ward area.

Appendix 3

Emptying Urinary Catheter Bag

Cross infection is most likely to occur during changing and emptying of drainage bags therefore bags should be emptied often enough to maintain urine flow to prevent reflux, i.e. no more than 2/3 full, but not unnecessarily.

Procedure:

- Discuss procedure with the patient and explain why necessary.
 - Wash and dry hands as per hospital policy and apply disposable gloves
 - Ensure drainage bag is positioned below the level of the bladder at all times.
 - Ensure bag is on a stand on the floor or attached firmly to the leg or bed frame.
 - Clean the outlet valve with alcohol swab.
 - Allow urine to drain into appropriate jug.
 - Close outlet valve and clean it again with alcohol swab.
 - Cover jug and dispose of contents in sluice
 - Note amount for the fluid balance record
 - Wash and dry hands thoroughly.
- Night bags should be changed every 24 hours and leg bags/urometers once weekly.
- Urethral catheters with a closed system and a pre-connected leg bag, i.e., red seal/tape applied, then the leg bag is changed every 2 weeks.

Appendix 4

Catheter Valve Pathway (Flip-Flow)

Catheter valves provide patient dignity, comfort, independence and discretion



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Benefits

- Maintains bladder tone and capacity
- Allows bladder to fill and empty
- Maintaining normal function
- Reduces traction on bladder neck caused by weight of urine bag

1 Criteria

- Long-term catheterisation (*see contraindications*)
- 1st failed TWOC (Trial Without Catheter)
- Patient has dexterity, vision, cognition to operate catheter valve independently or has carer able to support on discharge

2 Contraindications

- Cognitive impairment - unless assisted with emptying valve
- Uncontrolled Detrusor Overactivity - bladder spasms and urine bypasses catheter (common in neurological conditions)
- Poor manual dexterity - unless assisted with emptying valve
- Ureteric reflux - men at risk of acute or chronic retention due to enlarged prostate or prostate problems
- Frank haematuria
- Renal impairment
- Immediately after prostate surgery
- Risk of Autonomic Dysreflexia - Spinal Injury T6 and above if catheter valve not released

3 Procedure

- Explain procedure to patient, answer questions and gain consent
- Wash hands and wearing appropriate PPE attach catheter valve to urinary catheter and secure with g-strap to thigh
- If using with long-term catheter, and patient assessed to use independently, provide patient education when/how often to empty and how/when to change catheter valve. Discuss hand hygiene
- Empty catheter valve regularly every 2-4 hours daily or when feeling of full bladder
- Attach 2 litre bag overnight using free drainage if unable to store urine overnight
- Change catheter valve every 7 days
- Document urine output on patient's fluid balance chart

4 Using Catheter Valve after 1st Failed TWOC

- Why TWOC failed? Enlarged Prostate? Patient constipated? Review bowel chart. DRE. Treat constipation.
 - If 1st TWOC failed due to enlarged prostate, do not use catheter valve. Attach drainage bag. Dr to refer to Urology as part of discharge plan.
 - If no enlarged prostate continue.
- Plan:**
- 1 Catheter valve in situ for 7 days
 - 2 Emptying valve every 2-4 hours daily
 - 3 Use free drainage overnight with 2 litre bag if unable to store urine overnight
 - 4 TWOC on 7th day (refer to UHL TWOC pathway)
- If 2nd failed TWOC, Dr to refer to Urology as part of discharge*

5 Discharge Planning

- Refer to DN (District Nurse) for catheter change if long-term catheter
- Discharge with catheter passport
- If using with long-term catheter, TTO to request G.P. to prescribe catheter valve (one per week, plus 2 litre night bag - check if required)
- If discharged with Flip Flow Valve as part of (2nd) TWOC plan, refer to DN to TWOC on 7th day from date of re-catheterisation
- Provide carer education if operating catheter valve

6 Troubleshooting

Urine not draining:

- Poor fluid intake
- High fluid output - vomiting and diarrhoea
- Catheter tubing kinked
- Flip flow valve not opened fully
- Constipation - R/V bowel Chart. DRE
- Catheter blocked - bladder scan, flush catheter, if unsuccessful, re-catheterise

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Appendix 5

Procedure for applying a Faecal Collector

Faecal Collectors are designed to manage faecal incontinence of any stool type and can be used for up to 48 hours or changed daily to monitor perianal skin. The dressing is applied to the perianal skin and stool is collected in the attached pouch. Contra-indication: broken excoriated skin or allergies to components

Procedure:

Skin Preparation:

- Cleanse perianal skin with warm water, gently pat dry. Avoid Clinicept wipes, stops adhesive from sticking. Trim pubic hair if needed.
- Collector application - cut entrance of pouch if needed. Should be slightly larger than the size of the anus to allow for anal dilation.
- Remove paper backing from skin adhesive first, apply to skin.
- Remove the outer backing paper and apply. If tape impinges on vagina or scrotum, carefully trim the tape border.
- Hold firmly in place for 1 minute.

Collector Positioning:

- Position pouch between legs, avoid wrinkling of material or pressure areas.
- To smooth uneven surface around anus, apply Stoma Paste (Welland, product code WSP100) to inner ring of Faecal collector.
- Stool Type - for liquid stool use tap. Holds up to 1000mls. For semi - formed stool. Cut off lower end of collector bag above the tap and attach the tail closure to close the collector. To do this, fold the tail of the collector over the knife edge of the closure only once, hold in place. Press firmly on raised bar until it snaps securely closed.
- Open and close as needed to drain. Do not allow the collector to be more than 1/3 full.

Removal:

Gently peel the skin barrier away from the patient's skin. If skin is fragile, use Medical Adhesive Remover (spray), Clinipeel (Welland, code 4501). To remove residue and to lift excess glue, use non-sting barrier film wipes (LBF, code: 3820, alcohol free). The LBF wipe also acts as a barrier film.

Faecal Collector Stores code: NHSSC GCT077 (box of 10)

Post-Void Residual Bladder Scan Guidance

Following a post-void bladder scan, if a patient is not emptying their bladder fully, please use this decision tool for post-void residuals (PVR), to plan care that includes intermittent catheterisation and urethral catheterisation:-

- PVR < 100mls - no action.
- PVR > 100mls - < 250mls Prompted voiding and encourage patient to double void (Appendix 7, Continence SOP) and monitor post-void bladder scans daily.
- PVR > 250mls - < 499mls intermittent catheterisation 2-3 times daily
- PVR > 500mls - Urethral Catheterisation
- Ensure that causes of urinary retention ruled out - eg: constipation, enlarged prostate, prolapse, medication and perform DRE and treat appropriately.
- If PVR of > 250mls - < 499mls continue after the above is ruled out and treated, then refer to the Continence Team.

Further PVR Guidance

- Refer to TWOC pathway, (Appendix 11, Adult Urinary Devices Policy) for managing PVR, post-TWOC.
- Refer to Post-Operative Urinary Retention (POUR) pathway for managing PVR. (Appendix 8, Continence SOP)

(Contingency 11.10.21)

Caring at its best

Empty your bladder **FULLY**

Always dripping after passing urine?
Try the double void technique
(Emptying your bladder twice)



5-Step Technique

STEP

1

After passing urine, if standing, sit down, or remain seated on the toilet.

STEP

2

Massage your tummy and rock gently forward and backwards, side to side for 30 seconds.

STEP

3

Stand up and (if able) march on the spot for 10 seconds.

STEP

4

Imagine that you are blowing through a straw for 10 seconds to relax your bladder.

STEP

5

Either sit down on the toilet or stand and then try to pass urine again.

Adult Continence Service for Inpatients & Outpatients

- If you are an Inpatient ask your Nurse or Doctor to refer you to the University Hospitals of Leicester, Adult Continence Team.
- If you are an Outpatient, ask your G.P. to refer to you to the Castleden Bladder & Bowel Clinic at Leicester General Hospital for continence problems.



Post-Operative Urinary Retention Pathway (POUR)

Risk Factors to consider and resolve

- Male, Elderly, Previous urological disease eg: BPH/PMH of retention/ Pre-Op PVR ≥ 150 mls.
- DRE to assess for enlarged prostate and treat appropriately
- Type of surgery: - Abdominal / Gynaecology / Bowel / Hip / Knee replacement.
- Anaesthetic - Spinal / Epidural, post-op analgesia, medications - eg: anticholinergic.
- Excessive fluid administration.
- **Rule out Constipation - DRE +/- enema and oral laxatives - follow UHL Faecal Impaction Pathway (Appendix 4 DRE Policy).**

Post- Operative assessment and care

Following Trial without catheter or if patient has new lower urinary tract symptoms eg: incontinence/dysuria follow guidance below:

Post Void Residual bladder scan 6-8 hours post-surgery.

- If ≥ 500 mls – Indwelling catheter 48 hours then TWOC and follow TWOC Pathway.

If Post Void Residual Volumes:

- 150ml - 300mls – Intermittent catheters 1-2 times daily
- 300mls - 500mls – Intermittent catheters 2-3 times daily

Continue Intermittent catheters until PVR ≤ 150 mls and asymptomatic.

Perform a daily Post void residual bladder scan and if there is persistent POUR of ≥ 400 mls insert indwelling catheter for 48 hours.

Refer to the Community Nursing Service via Spa for a TWOC if discharged home with an indwelling catheter.

- Rule out other factors eg: Medication, constipation, enlarged prostate, vaginal prolapses and treat appropriately.
- Mobilise patient early.

IUGA 2013. Griesdale DE, Neufeld J, Dhillon D, et al 2011. Markopoulos G, Kitridis D, Tsikopoulos K et al 2019.

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