University Hospitals of Leicester NHS
NHS Trust

Adult Urinary Devices Policy

Including the Insertion and Care of Urinary Catheters/Devices and Care of Nephrostomies, Purewick™ and Male Urinary Sheath

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Trust Lead:	Elinor Howcroft Continence Specialist Nurse Clair Riddell Urology Matron
Board Director Lead:	Chief Nurse
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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V4 January 2024 policy title changed to urinary devices policy, review and update of catheter types, catheter sizes and length changed to standard length only, statlock information added, equipment updated to the Bard foley tray, Gender affirming surgery guidance added, appendix 11,15,16,17,18,19 ,20 & 21 Urinary Devices Core Nursing assessment care plans added. References updated. Process for monitoring compliance updated. Urinary catheter passport, take home packs and how to register or home delivery and discharge information added.

The following staff groups/committees were consulted on the updated version: Consultant Geriatitions, Continence Nurse Specialists, Practice and Education Team, Urology Specialist Nurses

External devices such as the Purewick™ External Female Catheter and Male urethral Sheath included.

V3 July 2018 – review V2 and community policy, rewritten.

V2 – 2015 - review of V1, complete rewrite of Policy and Procedures

V1 – approved by Policy and Guideline Committee on 13th August 2007

KEY WORDS

Catheter, catheterisation, indwelling, intermittent, urinary, continence, incontinence, nephrostomy, urostomy, neo-bladder, cystostomy

1 INTRODUCTION AND OVERVIEW

1.1. This document sets out the University Hospitals of Leicester (UHL) NHS Trust policy and procedures for Urinary Devices including:

- The insertion, care of and removal of an indwelling urinary urethral catheter in male and female adult patients.
- The changing and care of supra pubic indwelling urinary catheters for male and female adult patients
- Teaching adult's intermittent urethral catheterisation which is the preferred option for patients requiring long term management.
- Care of nephrostomies
- The care of external devices including the Purewick™ (Female External Catheter) and Male Urethral Sheaths.

1.2. Urinary catheterisation is the insertion of a hollow tube into the bladder via the urethra using an aseptic no touch technique (ANTT)

1.3. Indwelling urinary catheters should only be used when no suitable alternative is available and must be left in for as short a time as possible

1.4 This policy aims to ensure male and female patients who have a urinary catheter or other urinary device are:

a) Catheterised safely, appropriately and in accordance with clinical need.

b) Protected as much as possible from catheter related infections.

c) Assessed daily for the need for a catheter and have the catheter removed as soon as it is no longer required.

d) Referred for appropriate long term care should there be an ongoing need for an indwelling catheter or other urinary device.

1.5 This policy also provides guidance on the care of nephrostomies, urostomies, performing bladder washouts and managing continuous bladder irrigation.

1.6 This policy also provides guidance on appropriate urine testing and sampling.

1.7 If a member of staff is required to catheterise a patient of the opposite sex, it is essential that every effort is made to offer the patient choice where possible of a chaperone. as per the Chaperone Policy (Trust Reference B39/2008).

2 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

2.1 This policy applies to Doctors, Registered Nurses, Registered Midwives, Operating Department Practitioners (ODP's) Nursing Associates Assistant Practitioners and health care assistants, who insert/remove care for urinary catheters/devices deliver care of Purewick™, urinary Sheaths and absorbency pads (including bank, agency and locum) and are employed by the University Hospitals of Leicester NHS Trust.

2.2 This policy does not cover the insertion of 3-way catheters, this is a medically led procedure - please refer to the Urology Medical Team for advice.

2.3 This policy does not cover the care of neo bladders or bladder reconstruction; please refer to the Urology Nurse Specialist Team for advice.

2.4 This policy does not cover the insertion of nephrostomies, this is a radiology led procedure.

2.5 This policy does not cover the urethral urinary catheterisation of children (as defined by the Children's Act 2004), infants and neonates. Please refer to the UHL Children's Nursing Guideline on Urethral catheterisation, Trust Reference number C44/2006

2.6 UHL is a teaching hospital and provides placement or work based learning for Pre- registration students such as Medicine, Nursing, Midwifery, Paramedic, Radiography, Physiotherapy, Occupational Therapy and Pharmacy and Trainees in the workplace such as Assistant Practitioners and Nursing Associates. This policy applies to these learners in the following circumstances:

a) If urinary catheterisation and/or care of a urinary catheter is a specific competency requirement of their placement or programme then the pre-registration student/trainee is able to perform the skill under direct supervision of their mentor/supervisor once they have received the relevant underpinning theory and passed a simulated practice

b) If the pre-registration student/trainee have passed an LCAT competency assessment in practice they may be able to perform the

skill with indirect supervision at the discretion of their mentor/ supervisor and the Registered Professional delegating the task.

c) If urinary catheterisation and/or care of are not a specific competency requirement of their placement or programme then the pre-registration student / trainee must only participate in the process as an observer.

d) Please also see section 6 for education and training requirements

3 DEFINITIONS AND ABBREVIATIONS

ANP	Advanced Nurse Practitioner
ANTT	Aseptic Non Touch Technique
AUR	Acute Urinary Retention
BWO	Bladder Wash Out
Body Fluid splashes	Blood / blood stained body fluids or body fluids which have the potential for carrying blood borne viruses which could have the potential for transmitting infection by being splashed into the eyes, nose or mouth.
CAUTI	Catheter Acquired Urinary Tract Infection
CSU	Catheter Specimen of Urine
MSU	Mid-Stream Urine
HCAI	Health Care Associated Infection
ISC	Intermittent Self-Catheterisation
LCAT	LEICESTER CLINICAL procedure ASSESSMENT TOOL
LPT	Leicestershire Partnership Trust
Mucocutaneous exposure	Where the eye(s), the inside of the nose or mouth, or an area of non- intact skin of the healthcare worker are contaminated by blood or other body fluid.
NICE	National Institute for Health Care Excellence
NMC	Nursing and Midwifery Council
Personal Protective Equipment (PPE)	Gloves, aprons, gowns, masks and eye protection.
PTFE	Polytetrafluorethylene
TAP / AP	Trainee / Assistant Practitioner
TNA / NA	Trainee Nursing Associate / Nursing Associate
UHL	University Hospitals of Leicester
UTI	Urinary Tract Infection
Neo bladder	A continent urinary reservoir constructed from a detubularized bowel segment or from a segment of the stomach, with implantation of the ureters and urethra; used to replace the bladder following cystectomy.

4 ROLES – WHO DOES WHAT

4.1 **Executive Lead:** Chief Nurse

4.2 **Clinical Management Group (CMG) Clinical Directors and Heads of Nursing**

a) To ensure their areas of responsibility have a workforce who is fit for purpose and staff have the required education and training to insert and care for urinary catheters and devices.

b) To ensure the appropriate dissemination of the urinary catheterisation policy.

4.3 **Line Managers are responsible for:**

a) Ensuring all their staff are aware of their responsibilities regarding urethral catheterisation and ongoing care.

b) Identifying and supporting the appropriate staff to attend the necessary training and complete the assessment of competence in practice

c) Maintaining a record of staff who are competent in the insertion, care of and removal of a urethral catheter ensuring that numbers of staff trained meet service need

4.4 **Staff who insert urethral catheters:**

a) Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role. This must be identified at appraisal.

b) Have undertaken competency based training and assessment in practice (see section 6)

c) Adhere to the procedures and clinical care requirements set out in this policy and comply with the care pathways to reduce the risk of Urinary Tract Infections (UTI's)

4.5 **Staff who care for and / or remove urinary catheters:**

a) Must be supported by their line manager and carry out this activity as an integral part of their key responsibilities within their role.

b) Have undertaken competency based training and assessment in practice (see section 6)

c) Adhere to the procedures and clinical care requirements set out in this policy and comply with the relevant care pathways and guidance to reduce the risk of Urinary Tract Infections (UTI's)

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

5.1 Patients will be catheterised safely, in accordance with clinical need and have the catheter in place for the shortest time possible. Urethral Catheterisation of patients should be AVOIDED wherever possible and alternatives should be considered first.

5.2 **Indications for Urinary Catheterisation**

- To bypass an obstruction.
- To relieve retention of urine.
- To measure urine output accurately.
- To allow irrigation of the bladder.
- To empty the contents of the bladder
- To introduce intravesical drugs.
- To enable bladder function tests to be performed.
- To determine residual urine, when bladder scan unavailable or inappropriate.
- To relieve intractable incontinence that hasn't responded to all other methods of care and the patient has been assessed by UHL Medical / Urology / Uro- gynaecology Continence team
- In the presence of sacral/perineal wounds (Category 3 – 4) where urinary incontinence is delaying healing and when no other methods are practicable
- For urinary incontinence in End of Life care to reduce distress or discomfort and there are no other methods are practicable.
- During prolonged or pelvic surgery.
- During labour.
- Following urinary tract surgery.
- Following spinal cord injury/surgery

5.3 **Refer to the UHL Consent to Examination or Treatment Policy B35/2024**

If the patient has any of the below:

- Previous urethral trauma/fractured pelvis
- Known history of urethral stricture
- Previous difficulty with catheterisation.
- A history of Radical Prostatectomy or Bladder Reconstruction
- Urethral reconstruction surgery
- Implantation of urethral sphincter/penile rods
- Undiagnosed haematuria.
- A history of lower urinary tract cancers.
- Undiagnosed urethral discharge.
- Congenital abnormalities (e.g. Hypospadias or epispadias).
- A patient has been given unsealed sources of radiation (e.g. Iodine 131 for thyroid cancer).
- Advice in these circumstances can be obtained from the Urology Nurse Specialists or the on call Urology Registrar who is available at the Leicester General Hospital via the switchboard.

5.4 If on the first attempt the catheter meets resistance on gentle pressure and cannot be inserted there should be a full re-evaluation before a second attempt is considered. If after two attempts catheterisation fails senior advice should be sought from a practitioner with more extensive relevant experience.

Special Note - Following radical prostatectomy, urethral reconstruction, implantation of urethral sphincters or, if the catheters cannot be removed ask

for advice before attempting catheterisation from the appropriate Consultant or Specialist Registrar at theUrology Unit, Leicester General Hospital. Contact via switchboard.

5.5 **Use of a Sterile lubricating gel**

a) A Sterile lubricating anaesthetic gel containing 2% Lignocaine may be used in both male and female catheterisation to minimise associated trauma, pain, discomfort and catheter- associated infection, however, this must be prescribed. A sterile lubricating gel with no Lignocaine is a suitable alternative and has been shown to be as effective.(Epic 3 guidelines Loveday et al, 2014)

b) The only exception to this is for women in labour who are at an increased risk of toxicity. A sterile lubricating gel without anaesthetic must be used in all pregnant women.

c) The anatomy of the urethra makes it sensitive to minor injuries and urethral bruising and trauma can occur during trans-urethral intervention which can then serves as an entry point for micro-organisms into the blood and lymphatic system

d) Lignocaine gel is a prescription only medication (POM) and must be prescribed prior to use.

e) The sterile lubricating anaesthetic gel contains a high dose lignocaine and great care must be taken in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity

f) Patients must be observed post procedure for signs of toxicity include loss of consciousness, seizures and cardiac arrest if lignocaine has been used.

5.6 The procedures that support this policy are attached as the following appendices and must be used by all staff within the scope of this policy.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Registered Nurses, Midwives, Operating Department Practitioners, Nursing Associates, Assistant Practitioners must complete an UHL LCAT assessment in catheterisation and feel confident to perform the catheterisation procedure before being deemed as competent.

6.2 Healthcare Assistants receive training in the care of catheters in their Trust Induction programme.

6.3 Staff who are new to the Trust but have been trained elsewhere, or newly qualified practioners who have been assessed as competent within their pre-registration training must:

a) Provide evidence of the training and assessment programme they have successfully completed

b) Comply with the relevant Trust policies and undertake additional training relating to equipment and documentation as required

c) Undertake a one off practical assessment by an appropriate assessor within own CMG/Ward/Unit if deemed necessary or insufficient evidence of previously competence provided

6.4 There may be circumstances and further training involved for specific specialities relating to catheterisation with further local additional assessments may be required.

6.5 Medical staff are expected to be competent to insert a urinary urethral catheter in uncomplicated patients of either gender as part of their registration process.

6.6 For reference only: Chaperoning policy

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements Who or what committee will the completed report go to.
Compliance with UHL catheter policy	Lead Nurse Continence	CAUTI audit	Quarterly	LCCC CMG Heads of Nursing/TIPOC
Compliance with UHL urinary devices	Lead Nurse Continence	Urinary Devices Core Nursing assessments	Quartlery	Nursing and Quality

8 EQUALITY IMPACT ASSESSMENT

If the policy will have any impact on equality, this should be described here. Otherwise the statements below should be inserted (see section 6.6 of the UHL Policy for Policies for more detail):

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 Policies

Chaperone Policy (Trust Reference B39/2008)

Standard for the Completion of Fluid Balance Charts in Adult Patients (Trust Reference B34/2010)

Anti-biotic guidance for treatment of UTI http://insite.xuhl-tr.nhs.uk/antibiotic/Full%20Guidelines/Adult%20Urinary%20Tract%20Infection%20(UTI)%20Tre
atment%20Guidelines%20and%20UTI%20Urine%20Dipstick%20Algorithm.pdf

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Mehnert, U., (2023). Indwelling catheter vs intermittent catheterization: is there a difference in UTI susceptibility?. BMC infectious diseases, 23(1), p.507.

RCN Catheter care guidance for nurses (May 2021) www.rcn.org.uk

Additional competencies related to bladder and bowel assessments can be found on the following link https://tools.skillsforhealth.org.uk/competence-details/html/416/

Diagnosis of urinary tract infection - Public Health England (2018)

Catheter Associated Urinary Tract Infection Device Associated Module, CDC, January 2014.

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epic3: national evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England (2020).

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This Policy will be uploaded and available through PAGL on IN site and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived Through the Trust's PAGL system.

10.2 This policy will be reviewed every three years or sooner in response to identified clinical risks.

1. **Catheter Types:** There is a range of catheters available. Each type of catheter is recommended for use up to a certain length of time and this will usually dictate the type of catheter used. If you require any other catheter please source from the Hubs on each hospital site available from the Duty Manager.

Foley Catheter Types (Guide Only, please refer to manufacturers guidelines)	
Material	**Length of Use**
Plastic (PVC) Nelaton. For Intermittent catheterisation	Use to drain urine from the bladder and is disposed of immediately
Bards trays containing: Latex only Must NOT be used in people with a latex allergy	Short term up to 28 days
Bards trays Lubri-sil Pure Silicone/100% Silicone The only catheter which can be used for patients with latex allergies.	Long term, up to12 weeks
Silicone Elastomer and Hydrogel coated Latex	Long term, up to 12 weeks

2. **Catheter Size**

2.1 As a general rule the smallest lumen catheter that will allow urine to drain is adequate. Patients with large amounts of debris or clots may require a larger size. The following sizes are recommended:

Female: 10-12 Charriere short / long term, or Intermittent

Male: 12-14 Charriere short / long term or Intermittent

2.2 Larger bore catheters may be advocated for long term use in order to reduce incidence of lumen blockage.

2.3 Patients with haematuria may need up to an 18 or 20 Charriere size or a 3-way catheter, following medical advice.

3. **Catheter Length**

3.1 Indwelling urethral catheters - only the Standard length (40 cm) is used for all patients. The Standard length is used in all supra pubic catheterisations - male or female.

3.2 Female and Male length catheters are used for intermittent catheterisation.

4. **Balloon Sizes -** A catheter with a 10 ml balloon should only be used, reducing bladder neck pressure and irritation. Larger sizes up to 30 ml are only used in 3 way catheterisation and with specialist urological advice.

1. Patient Preparation

1.1 The patient must be informed of the reason and risks for the procedure, give their consent and given the choice regarding a chaperone.

1.2 A full explanation must be given and time allowed for patients to ask questions.

1.3 Ensure the patient is in a comfortable position, preferably supine.

2. The use of Sterile lubrication gel

2.1 A Sterile lubricating gel must be used to minimise associated trauma, pain, discomfort and catheter-associated infections, British Journal of Nursing, (2013). If gel contains lignocaine it must be prescribed prior to use.

2.2 If the sterile lubricating anaesthetic gel which contains a high dose lignocaine is used, then great care must be taken in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity.

2.3 Patients must be observed post procedure for signs of toxicity include loss of consciousness, seizures and cardiac arrest if lignocaine gel has been used.

3. Statlock

- Statlock adhesive stabilisation device is to secure the Catheter to the front of the patient's thigh. If the patient is nursed in prone position, consider placing the Statlock on the back of the thigh.
- Click the catheter in statlock before you stick it to the patient's skin.
- Do not place if the patient has fragile skin or allergic to Elastoplast.
- Write the date on sticker and change every 7 days ideally alternate legs.
- Explain rationale for urinary stabilisation – prevention of meatal damage that can also contribute to CAUTI.
- Disengage the Catheter from the Statlock daily for Catheter Care and to inspect the meatus.
- Remove the Statlock using alcohol gel or adhesive remover, wipe the edge of the Statlock and the edges will lift.
- **Do not pull or force Statlock when removing.**

4. Equipment

- **Bard catheter pack includes:**
  - Apron.
  - Waterproof Under pad – place shiny side down under patients buttocks.
  - 2 pairs of sterile latex free gloves are provided -size medium. If you require large or small gloves you will need to obtain these

separately 1st pair should be removed after cleansing the meatus and insertion of the lubrication gel. Hands are then cleaned and 2nd pair of gloves donned before placing the fenestrated drape over the patient's genitals and inserting the Catheter.

- Lubricating gel does not contain antiseptic or lidocaine therefore reducing the risk of adverse reactions, do not need to get prescribed.
- 2 x syringes of sterile water for cleansing the meatus.
- 1 x syringe of sterile water for balloon inflation
- 1 x empty sterile syringe for deflating the balloon if removing catheter before re insertion or obtaining a urine sample.
- 5 gauze swabs.
- Gallipot for cleansing solution.
- Fenestrated drape to be applied before inserting the catheter.
- Catheter is pre- connected to the drainage bag with a Red perforated Tamper- evident seal. This is to maintain a closed system to reduce risk of infection and allows the drainage bag to stay connected for 14 days.
- Urine Meter front chamber is tipped to empty the contents into the collection bag.
- Ensure sheeting clip is used to prevent dependent loops.
- Needle free sample port for CSU

There should never be more than two unsuccessful attempts to catheterise the patient by the same practitioner. If a practitioner is unable to carry out the procedure inform a more experienced practitioner and reassure the patient

Never reinsert the same catheter after an abortive attempt

Urethral Urinary Catheterisation Insertion Procedure for Male Patients	
No.	**Action**
1	• Clean hands • Prepare equipment using ANTT • Apply apron and place waterproof under pad under your patient • Retract foreskin and clean glands penis with sterile normal saline. If the patient is visibly soiled they must be washed prior to performing the catheterisation procedure • Apply sterile gloves.
2	• Insert the sterile lubricating gel into the urethra, using the pre-filled syringe (10ml for men) • Allow gel 5 minutes to take effect **if** using lignocaine based lubricant. • Nelaton catheters for intermittent use usually have a pre-lubricating coating, which may require activating by the use of water. **Please read the manufacturer's instructions**
3	• Remove gloves, decontaminate hands, put on second pair of sterile glove apply drap. • Hold the penis vertically and under tension • Pass the catheter using the sleeve so not to touch the catheter,slowly along the urethra into the bladder, if resistance is felt increase the traction on the penis or ask the patient to cough

4	• Once urine starts to flow advance the catheter another 5 cm before inflating the balloon with 10 ml **sterile** water to avoid inflating the balloon in the urethra (Do not use normal saline) **NB: Do not inflate the balloon if urine is not flowing**
5	• Replace the foreskin
6	• Date the catheter bag. • Ensure the patient is comfortable post procedure • The red seal can stay in place for up to 14 days • Ensure that the catheter is attached securely to the thigh with a statlock and date it. • Correctly dispose of waste material • Remove protective clothing • Clean hands (use soap and water if there has been contact with bodily fluids)
7	Record procedure in patient notes using green catheterisation sticker and on Catheter Care Pathway (for patient bedside notes) to include: • Clinical indication for catheterisation • Verbal consent and allergy information obtained • Date and time of catheterisation • Type and size of catheter used • Amount of water inserted into the balloon • Manufacturer and batch number (use peel off label where available) • Any problems during the procedure • Colour and consistency of urine drained • Residual drained • Specimen obtained or not and documented rationale • Planned date of removal

"Individuals who undergo urethroplasty for congenital or acquired urethral strictures, as well as transgender people undergoing gender-affirming surgery (GAS), may have alterations to the urethral tract and, so, the choice of catheter may be affected (RCN, 2021). It is important to note that the prostate is not removed as part of GAS for trans females, due to the risk of side-effects, such as urinary problems and nerve damage. As such, health professionals must take care when inserting a catheter as a means of bladder management for a trans female, as resistance may be felt when passing the prostate gland. In contrast, for trans males there may be a distinct lack of resistance in the absence of a prostate. In these cases, catheterisation should be carried out under direction of the urology team". **(Massey-Pawadyira J et al (2023), Nursing Times)**

1. Patient Preparation

a) The patient must be informed of the reason for the procedure, give their consent and given the choice regarding a chaperone.

b) A full explanation must be given and time allowed for patients to ask questions.

c) Ensure the patient is in a comfortable position, preferably supine.

2. The use of Sterile lubrication gel

a) A Sterile lubricating gel must be used to minimise associated trauma, pain, discomfort and catheter-associated infections and if using lignocaine based lubrication this must be prescribed prior to use.

b) Do not use lignocaine based lubrication for women in labour who are at an increased risk of toxicity due to the numerous catheterisations that may be required. A sterile lubricating gel without anaesthetic must be used instead.

c) If sterile lubricating anaesthetic gel which contains high dose lignocaine has been used great care must be taken in both its application and observation of the patient post procedure. In traumatic or repeated catheterisations there is a risk that more of the gel is absorbed through the vascular membrane than expected with the potential for patient toxicity

d) Patients must be observed post procedure for signs of toxicity include loss of consciousness, seizures and cardiac arrest if lignocaine has been used.

3. Equipment: All equipment must be checked to ensure that it is in date, intact and not contaminated

- Bard catheter pack includes:

o Apron.

o Waterproof Under pad – place shiny side down under patients buttocks.

o 2 pairs of sterile latex free gloves are provided -size medium. If you require large or small gloves you will need to obtain these separately 1st pair should be removed after cleansing the meatus and insertion of the lubrication gel. Hands are then cleaned and 2nd pair of gloves donned before placing the fenestrated drape over the patient's genitals and inserting the Catheter.

o Lubricating gel does not contain antiseptic or lidocaine therefore reducing the risk of adverse reactions, do not need to get prescribed.

o 2 x syringes of sterile water for cleansing the meatus.

o 1 x syringe of sterile water for balloon inflation

- o 1 x empty sterile syringe for deflating the balloon if removing catheter before re insertion or obtaining a urine sample.
- o 5 gauze swabs.
- o Gallipot for cleansing solution.
- o Fenestrated drape to be applied before inserting the catheter.
- o Catheter is pre- connected to the drainage bag with a Red perforated Tamper-evident seal. This is to maintain a closed system to reduce risk of infection and allows the drainage bag to stay connected for 14 days.
- o Urine Meter front chamber is tipped to empty the contents into the collection bag.
- o Ensure sheeting clip is used to prevent dependent loops.
- o Needle free sample port for CSU

There should never be more than two unsuccessful attempts to catheterise by the same practitioner. If a practitioner is unable to carry out the procedure inform a more experienced practitioner and reassure the patient

Never reinsert the same catheter after an abortive attempt

Urethral Urinary Catheterisation Insertion Procedure for Female Patients	
No.	**Action**
1	• Clean hands • Prepare equipment using ANTT • Apply apron and place waterproof under pad under your patient • If the patient is visibly soiled they must be washed prior to performing the catheterisation procedure • Rectract Foreskin and clean glands penis with sterile normal saline. • Apply sterile gloves.
2	• Insert the sterile lubricating gel into the urethra, using the pre-filled syringe (10ml for females) • Allow gel 5 minutes to take effect if using lignocaine. • Nelaton catheters for intermittent use usually have a pre-lubricating coating, which may require activating by the use of water. **Please read the manufacturer's instructions**
3	• Remove gloves, decontaminate hands, put on second pair of sterile gloves • Pass the catheter slowly along the urethra into the bladder and if resistance is felt ask the patient to cough
4	• Once urine starts to flow advance the catheter another 5 cm before inflating the balloon with **sterile** water to avoid inflating the balloon in the urethra (Do not use Normal saline) **NB: Do not inflate the balloon if urine is not flowing**
5	• Date the catheter bag. • Ensure the patient is comfortable post procedure • The red seal can stay in place for up to 14 days • Ensure that the catheter is attached securely to the thigh with a statlock and

	date it. • Correctly dispose of waste material • Remove protective clothing • Clean hands (use soap and water if there has been contact with bodily fluids)
6	Record procedure in patient notes using green catheterisation sticker and on Catheter Care Pathway (for patient bedside notes) to include: • Clinical indication for catheterisation • Verbal consent and allergy information obtained • Date and time of catheterisation • Type and size of catheter used • Amount of water inserted into the balloon • Manufacturer and batch number (use peel off label where available) • Any problems during the procedure • Colour and consistency of urine drained • Residual drained • Specimen obtained or not and documented rationale • Planned date of removal

"Individuals who undergo urethroplasty for congenital or acquired urethral strictures, as well as transgender people undergoing gender-affirming surgery (GAS), may have alterations to the urethral tract and, so, the choice of catheter may be affected (RCN, 2021). It is important to note that the prostate is not removed as part of GAS for trans females, due to the risk of side-effects, such as urinary problems and nerve damage. As such, health professionals must take care when inserting a catheter as a means of bladder management for a trans female, as resistance may be felt when passing the prostate gland. In contrast, for trans males there may be a distinct lack of resistance in the absence of a prostate. In these cases, catheterisation should be carried out under direction of the urology team". **(Massey-Pawadyira J et al (2023), Nursing Times)**

1) The closed system should be maintained to minimise the risk of infection It should only be broken if there is a clinical need.

2) The drainage bag attached to the catheter must be sterile. This must only be removed for a clinical procedure or when the bag requires changing in fourteen days post insertion, should the red seal be broken, the bag must be changed every seven days. If the change of a bag is clinically needed this must be done using ANTT. Patients who are using leg drainage bags during the day need to have non-sterile single-use 2 litre drainage bag attached to the leg bag for overnight use.

3) The use of non-sterile gloves plus hand decontamination needs to be done before and after all contact with urinary drainage

4) Encourage patient to maintain high levels of personal hygiene with a daily shower if possible

5) If patient is unable to meet own hygiene needs wearing clean sterile gloves and apron clean the catheter, urethral meatus first then clean the glans penis at least daily with soapy (or equivalent) water in a clean bowl or as part of the patient's bath/shower. In women, ensure that the meatus inside the labia is cleaned ensuring that any visible faecal soiling is removed. In men ensure that the area under the foreskin is cleaned and their foreskin is returned to normal position. Always clean the catheter away from the urethra and document the daily clean.

6) Ensure the drainage system is appropriate to the individual's needs. If the patient is sitting out or is mobile, use leg drainage bags or catheter valve for dignity and to aid rehabilitation, unless contra-indicated.

7) Ensure patient is well hydrated. Encourage patient to drink at least 1½ to 2 litres of fluid in 24 hours or has adequate IV hydration unless contraindicated by clinical condition.

8) Prevent tension / traction on drainage tube by using a statlock if skin can tolerate, leg straps and a drainage bag stand

9) Empty bags when 2/3 full or every 4 hours, whichever comes first, do not allow bags to overfill. Urinary drainage bags must be emptied frequently enough to prevent reflux and maintain flow. (NICE 2012)

10) Wearing non sterile disposable gloves and apron, empty drainage bag into a clean receptacle or toilet ensuring that the bag outlet does not touch receptacle or the floor and drying the outlet after emptying.

11) Accurately measure and record urine output if required. as per UHL Fluid Balance Guidelines (Trust Reference B34/2010)

12) Drainage bags attached directly to the catheter need to be changed every 14 days if the red seal is still attached, unless clinically indicated, or more frequently if outlet becomes blocked or following bladder washout.

13) Once the red seal is broken the catheter bag needs to be changed every 7 days

14) The need for the patient's indwelling catheter must be reviewed daily as the risk of infection increases the longer the catheter is left in situ.

15) To ensure all documents are completed on the urinary devices core nursing assessment.

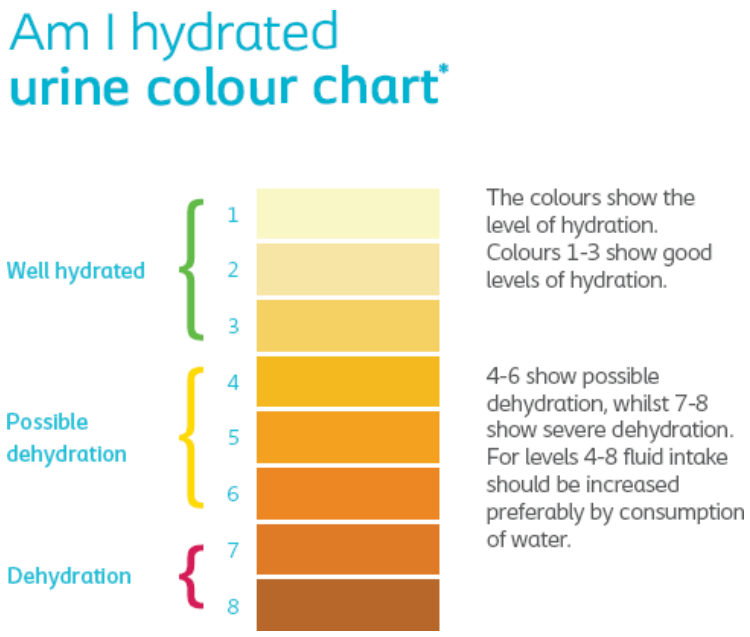
16) Uro –meter Catheter tubing must not have any loops where urine will be able to collect and pooling of urine in the tube must not occure. Always use the green bed sheet clip to keep the tubing streamline if the patient is laying in bed.

17) Daily cleaning of the catheter tubing needs to be documented.

18) Removal (TWOC) / change date must be documented at the time of insertion and reviewed daily.

Catheterised patients:

- Do not routinely perform urine dip in catheterised patients.
- Do not culture routinely.
- Do not treat ASYMPTOMATIC bacteriuria in those with indwelling catheters as bacteriuria is very common and antibiotics increase side effects and antibiotic resistance.
- Check hydration status of patient prior to assuming UTI present
- Only send urine for culture in catheterised patients if features of infection, however, always exclude other sources.
- Consider changing catheter before/when starting antibiotics.
- Consider awaiting cultures and follow microbiology guidance on any known positive urine culture prior to prescribing antibiotics.
- No routine anitibiotic cover is required for the insertion, removal or changing of urinary catheters. Consider antibiotic prophylaxis for urine catheter insertions if the patient: has UTI with signs of sepsis, has undergone a recent urological procedure, has a newly confirmed urinary tract infection and not yet received antibiotic therapy, or is neutropenic.



Catheter specimen of urine (CSU)	University Hospitals of Leicester NHS NHS Trust **Appendix 6**

Catheter specimens of urine (CSU) are usually collected for microscopy, culture and sensitivity (MC&S) testing when an infection is suspected. The urine is tested to identify the organisms causing the infection as well as their sensitivities to antibiotics.

A CSU should only be collected when a patient has clinical signs of a CAUTI.

Clinical signs of CAUTI:

- Fever, 38c and above.
- Renal angle pain
- New onset or worsening confusion/delirium
- Suprapubic pain
- Bypassing urethral catheter

Equipment required:

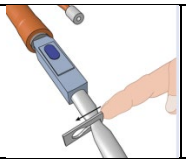
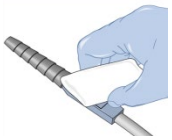
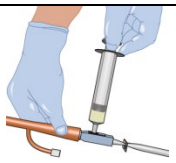
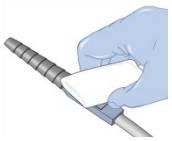
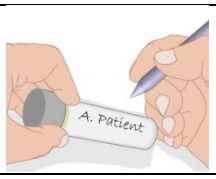
- Clean tray to hold equipment;
- Non-sterile gloves;
- Apron;
- Sterile 10ml syringe
- Non-traumatic clamp
- Red top boric acid specimen pot;
- Alcohol-impregnated swabs (2% chlorhexidine in 70% isopropyl alcohol);
- Documentation and forms.

A **fresh** sample of urine is required for a CSU and this must be obtained from the sampling port on the catheter bag, the sampling port is designed to be accessed directly, using a syringe and do **not** require a needle.

Samples should not be collected from the drainage bag tap as the urine specimen may be contaminated

Step by Step guide: Obtaining a catheter specimen of urine CSU check list

Healthcare worker	
An Aseptic Non-Touch Technique (ANTT) must be used to obtain a CSU to reduces the risk of cross infection	
Pre-procedure	**Rational**
1 Explain and discuss the procedure with the patient.	To ensure that the patient understands the procedure and gives their valid consent.
2 Ensure a suitable private location.	To ensure the patient understands the procedure and gives valid consent.
3 Assemble and check all the equipment packaging is in date before then place on sterile trolley.	To ensure all equipment is in date and not contaminated.

Procedure		Rational	
4	If urine visible in catheter tubing: Wash/decontaminate your hands with alcohol rub, don apron and apply non-sterile gloves prior to manipulating the catheter tubing.	To minimise the risk of infection.	
5	Apply non-traumatic clamp a few centimetres distal to the sampling port.		To ensure sufficient sample has collected to allow for accurate sampling.
6	Wash hands with soap and water, or decontaminate physically clean hands with alcohol rub and don gloves.	To prevent cross-contamination.	
7	Wipe sampling port with 2% chlorhexidine in 70% isopropyl alcohol (alcohol wipe) and allow drying for 30 seconds.		To decontaminate sampling port and prevent false-positive results.
8	Using a needle-less system, insert syringe firmly into centre sampling port, aspirate the required amount of urine and remove syringe.		To enable safe inoculation of urine specimen.
9	Transfer an adequate volume of the urine specimen (approx. 10 mL) into a boric acid bottle immediately.		To avoid contamination and to allow for accurate microbiological processing.
10	Wipe the sampling port with an alcohol wipe and allow to dry.		To reduce contamination of access port and to reduce risk of cross-infection.
11	Unclamp catheter tubing.	To allow drainage to continue.	
Post-procedure		**Rational**	
12	Dispose of waste, remove apron and gloves and wash hands.	To ensure correct clinical waste management and reduce risk of cross-infection.	
13	Label sample and complete microbiological request form including relevant clinical information, such as signs and symptoms of infection, antibiotic therapy.		To maintain accurate records and provide accurate information for laboratory analysis.
14	Dispatch sample to laboratory immediately (within 4 hours).	To ensure the best possible conditions for microbiological analysis and to prevent micro-organism proliferation.	
15	Document the procedure in the patient's records.	To ensure timely and accurate record keeping.	

Flow Chart for the Management of CAUTI

(Catheter-associated Urinary Tract Infection)

NHS
University Hospitals of Leicester
NHS Trust

PATIENT PRESENTS WITH SYMPTOMS SUGGESTIVE OF A CATHETER INFECTION
Exclude possible causes for symptoms

SYMPTOMS

- Rigors
- Shivering
- Raised temperature
- Supra pubic pain
- Delirium or
- Worsening confusion

DON'T DIPSTICK!
Urinalysis dipstick should not be used

- **OBTAIN A CSU (CATHETER URINE TEST) PRIOR TO COMMENCING ANTIBIOTICS**
- Take from the clean needle free sample port
- **DO NOT WITHOLD TREATMENT** AND PRESCRIBE EMPIRICALLY UNTIL RESULTS ARE AVAILABLE

- **Send CSU for culture** and sensitivity to identify correct treatment and antimicrobial resistances
- **Review results** within 72 hrs

REVIEW THE ONGOING NEED FOR THE CATHETER

- Consider alternative management e.g. ISC, Purewick or a sheath
- Review hygiene practices and catheter care
- Review bowel management plan and hydration

If urethral catheter is still required, change the catheter

(22414553)KR

For further information or advice contact
adultcontinence@uhl-tr.nhs.uk

The Continence Team

Urinary Catheter Not Draining – Performing a Bladder Washout

University Hospitals of Leicester NHS
NHS Trust

Appendix 8

1. Why might the catheter not be draining?

1.1 Things to consider:

a) The patient's general condition, could they be dehydrated?
b) Does this catheter regularly block?
c) If it is a long term catheter investigate if patient is normally prescribed catheter maintenance solutions and ensure they are prescribed.
d) Is the patient constipated?
e) Is the catheter obstructed?

1.2 Check the following:

a) Is the drainage bag below bladder level? Reposition
b) Is the tubing twisted? Reposition
c) Is the patient sitting on the tubing? Reposition
d) A vacuum may have occurred in the bladder causing blockage of eyelets by bladder mucosa - Lift the drainage bag above bladder level and then down back to below
e) If the catheter is still not draining, is a rectal examination required to rule out faecal impaction/ faecal loading? Treat as necessary.

1.3 Registered nurses should only perform bladder washouts if they have been taught at ward level and been assessed by a competent Practitioner using the UHL LCAT assessment tool.

2. When to perform a Bladder Washout

a) Remember disconnecting the catheter from drainage bag puts the patient at risk of Catheter associated urinary tract infections (CAUTI).
b) Bladder washouts should not be used for catheters blocked due to infection or to treat CAUTIs. (Yokoe, D.S. and Meddings, J., (2023.)
c) Saline bladder washouts should only be used for mechanical blockages
d) All bladder washouts / catheter maintenance solutions should use with caution in patients with spinal injury particularly above T6 due to the possibility of autonomic dysreflexia.
e) If catheter still not draining after doing all the checks in section 1.2 then the following should be done:
    - Inform Doctor.
    - Is the catheter definitely blocked? Is the bladder palpable? Is the patient in discomfort? Could the patient's urinary output be low? If in doubt perform a bladder scan before using a bladder washout.
    - Check the catheter bag tubing for blood clots and debris. If blood or debris present then using ANTT, warmed sterile saline 0.9% can be GENTLY instilled into the bladder using 50ml syringe and using ANTT

to dislodge any debris from eyelets. Do not aspirate as it may cause damage to the bladder mucosa.
- Saline used - Catheter still not draining – change catheter.
- No blood or debris in catheter bag tubing – Change catheter

f) If catheter still not draining
- Inform Doctor
- Consider removing catheter and re-catheterising patient.
- NB – Registered Nurses should only perform bladder washouts if competent to do so. The practitioner should be experienced in urinary urethral catheterisation and assessed as competent using UHL LCAT assessment.

1. Bypassing

a) Bypassing occurs when urine leaks between the catheter and the urethral wall. The cause of this may be: -
   - blocked catheter - forcing urine down an alternative route
   - bladder spasm - forcing urine down an alternative route
   - the use of a catheter which is too large or has a large balloon resulting in residual urine lying below the eye of the catheter

b) Bladder spasm can be reduced by the selection of small lumen and small balloon size catheters. In addition the use of silicone or hydrogel catheters can also reduce spasm

c) If bladder spasm persist anticholinergic medication can be considered to the patient unless this is contraindicated.

2. Blockage

a) Blockage may occur as a result of debris or encrustation, urinary tract infections, as a result of the catheter eyes becoming occluded with bladder mucosa, because the catheter has kinked or the patient is sitting on the tubing or because the rectum is loaded with faeces.

b) If blockage by debris or encrustation persists it is advisable to treat any proven UTI's

c) The position of the patient and the tubing should be checked to ensure that there is no kinking; if the catheter does not drain following the position change then it is advisable to change the catheter.

d) In some circumstances, (for example, clot retention) a bladder wash out may be indicated. (See appendix 7)

e) It has been advocated that the risk of encrustation can be reduced and the catheter life extended by lowering the pH of urine by dietary means, e.g. Ascorbic Acid

f) (Vitamin C) cranberry juice, pulses and cereals and ensuring a good urine output may help maintain catheter patency. The use of a catheter maintenance product (e.g. Urotainer) has NOT been shown to be effective

3. Infection

a) Invasion of the bladder by micro-organisms may result in colonisation with no clinical symptoms or invasion of the bladder tissues causing clinical symptoms. Generally treatment with antibiotics is only advocated if there are clinical symptoms present

b) Bacteria gain entry to the bladder at the time of catheterisation, immediately following catheterisation or at a later time due to bacteria colonizing the catheter surface (as a bio film), becoming invasive and causing an infection.

c) Prevention of infection relies upon;

- Compliance with high impact intervention care bundles during insertion and ongoing care of the device.
- Maintenance of a closed system
- Positioning the drainage system to prevent reflux
- Using the sampling port to obtain urine samples, cleaning the port with a 70% alcohol swab and allowing time to dry prior to sampling.
- Ensuring that the drainage system does not come into contact with the floor
- Good standards of patient personal hygiene, the urethral meatus should be cleansed daily
- Adequate fluid intake

4. Discomfort

a) Following initial insertion of a catheter, the patient may experience some discomfort which should settle after 24 hours. If discomfort continues this may be due to bladder spasm, irritation and subsequent inflammation following catheterisation. This can be minimised by using the smallest catheter for the purpose and less irritant products.

5. Stricture Formation

Strictures may be caused by:

a) Urethritis resulting from trauma on insertion, inflating the balloon in the urethra, traumatic removal of the catheter or sensitivity to the products used.
b) Attention to technique and theoretical knowledge relating to asepsis and catheter selection will reduce the risks of stricture formation.
c) Tissue necrosis can be caused by pressure on blood vessels in the urethra. Practitioners should be aware that the incidence of this might be increased in the vascular compromised patient.
d) Using a catheter which is too large and blocks the Para urethral ducts may cause Para- urethral abscess.

6. Creation of a False Passage

a) The mucosal lining of the urethra is delicate and at risk of trauma during catheterisation. Though some resistance may be felt in men when 15-20 cm of the catheter has been inserted (which can be overcome by asking the patient to cough or bear down) undue force should not be used. Advice should be sought from an experienced nursing or medical practitioner, should the patient complain of more than discomfort.

7. Pain or Haematuria from Traumatic Insertion

a) The instillation of local anaesthetic lubricant into the urethra should reduce pain and friction on insertion of the catheter if is allowed to work effectively (i.e. it is left for at least 5 minutes to become effective). Attention to technique and correct selection of catheter will reduce risks of trauma. Full explanation to the patient and reassurance will help the patient to relax making the procedure less difficult.

8. Potential Psychological Problems

a) Catheterisation is an invasive procedure and requires full explanation and consent obtained wherever possible. For some patients there may be cultural implications which require understanding and sensitivity. Some female patients may prefer a female practitioner to perform the catheterisation and male patients may require a male practitioner. Whenever possible their wishes should be respected.

b) Practitioners should provide reassurance, emotional support and practical advice to catheterised patients. It is desirable that staff performing the procedure should be chaperoned by a member of staff of the same sex as the patient

Equipment

- Personal protective equipment
- Collecting vessel (eg. disposable cardboard tray)
- Sterile normal saline 0.9%
- Syringe for deflating the balloon

Removal of a Male / Female Urethral Catheter	
No	**Action**
1	Remove catheter at midnight (this will allow the bladder to fill naturally, allowing the patient to wake with a full bladder) or early morning (any retention problems can be addressed during the day). Catheters must not be removed just prior to discharge or transfer from hospital. (Nollen, J.M., Pijnappel, L., Schoones, J.W., Peul, W.C., Van Furth, W.R. and Brunsveld-Reinders, A.H., (2023)
2	Explain the procedure to the patient and inform him/her of possible post –catheter symptoms. (Urgency, frequency, discomfort) which may have been caused by irritation of the urethra, by the catheter.
3	Check the documentation in the patient's notes to establish the amount of water that was used to inflate the balloon to ensure that it is fully deflated beforeremoval. **Remember that a silicone catheter balloon will allow water to permeate through the balloon wall and be lost. Therefore the volume may be lower after a period of time.**
4	Perform hand hygiene as per policy. Put on gloves and apron. Release any leg support. Use the Normal Saline 0.9% to clean the meatus and catheter always cleaning away from the urethral opening
5	Deflate balloon by attaching syringe to valve and allowing pressure of the water to push the plunger out – if water is withdrawn forcibly, it may cause vacuum and cause the balloon to cuff making removal difficult and painful. If water filling is slow or no water is removed, gently re-site the syringe If no water is withdrawn seek medical assistance/ refer to urology registrar
6	Ask the patient to breathe in and then out to help relax the pelvic floor muscles As the patient exhales, gently, but quickly, withdraw the catheter.
7	Ask the patient to drink approximately 2litre fluid in the following 24 hours – if their medical condition allows to ensure that the patient is sufficiently hydrated to pass urine
8	Leave the patient clean and dry and has access to a toilet or the call buzzer if necessary Tidy away equipment. Document the procedure in the patient's notes and on Catheter Care Pathway. Date and sign it.
9	Observe patient regularly following Trial Without Catheter Care Guidance (Appendix Nine) To ensure patient is passing urine and is not developing urinary retention. Assess for any incontinence and provide appropriate pads if necessary (referral to community nurses will be required on discharge if pads are necessary following a formal continence assessment on the ward)

Inpatient Trial without Catheter Pathway Outside of Urology Wards

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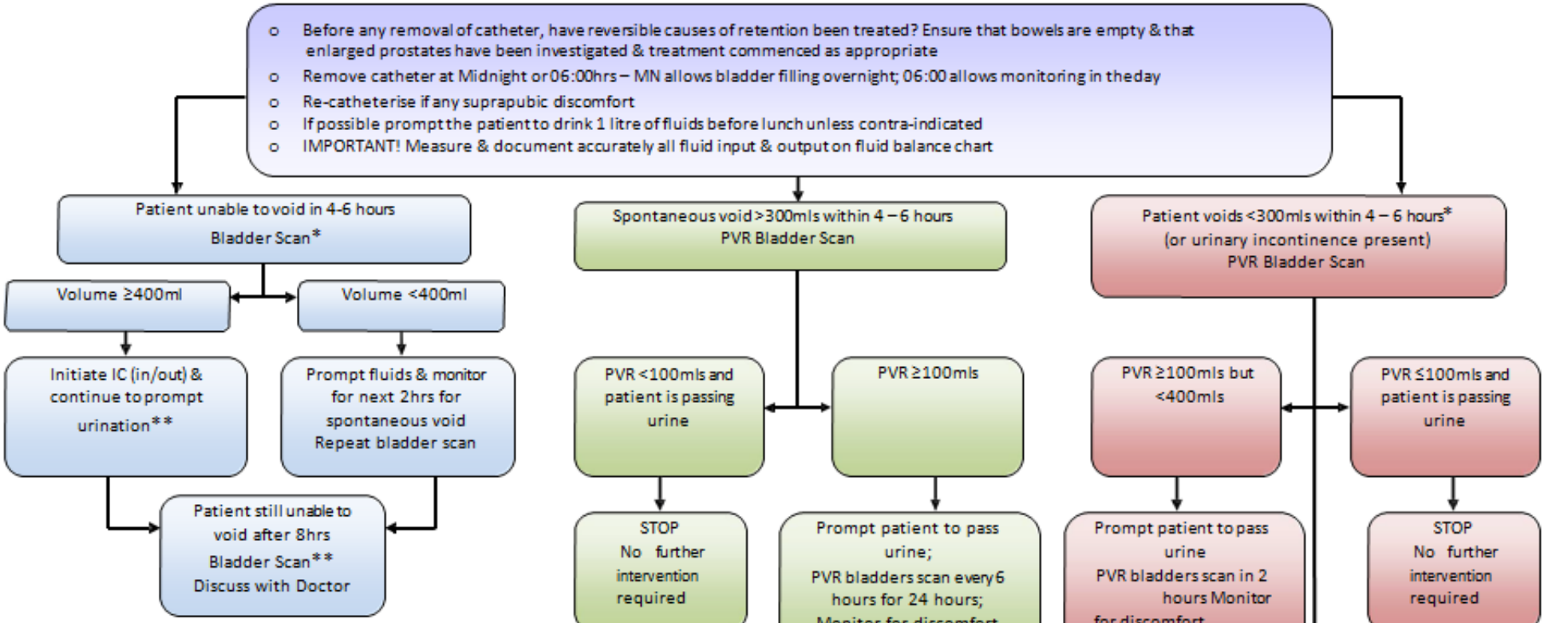
Appendix 11



Factor in volume of fluid intake when assessing bladder emptying. Consider oliguria

*If patient in any suprapubic discomfort, re-catheterise

**Post void residuals ≥500mls

- Consider IC catheters over 24hrs
- Re-catheterise - repeat TWOC pathway. Consider DN visit for TWOC
- 2 failed TWOCs - on discharge send home with catheter, arrange referral to urology/uro-gynae or, for frail older patients, to the Castle den Clinic for older people.

*** Promptly Refer to Medical Continence Team for adult

PVR = Post void residual - Volume of urine left in bladder 10-20 minutes after passing urine
IC = Intermittent catheterisation
ISC – Intermittent self-catheterisation

Intermittent self-catheterisation guide for nurses

University Hospitals of Leicester NHS
NHS Trust

Appendix 12

Intermittent catheterisation is the intermittent passing of a small catheter into the bladder Intermittent catheterisation (IC) is considered the gold standard and is preferred over continuous catheterisation, since it is considered to cause fewer urinary tract infections (UTIs) than indwelling catheterisation (BMC 2023). When undertaken by a patient the procedure is known as Intermittent Self Catheterisation (ISC). It is a clean clinical procedure which can be undertaken by patients or carers.

NB. When intermittent catheterisation is undertaken/taught by a health care professional, a sterile technique must be used to prevent cross infection.

Only staff assessed as competent in urethral catheterisation and who have an in depth knowledge of the urinary tract and the principals of catheterisation should perform/teach this procedure. If unsure, please discuss with your local Continence Advisor.

If there is any doubt, please refer to Urology Nurse Specialists/DNs/Medical Continence Service for advice. All patient information regarding ISC is available at Ward 28a or the Coleman Centre LGH and should be related to the product of choice.

1	Check rationale/indication for ISC
2	Check no contra indications to ISC • Known urethral obstruction • Prostatic stent Caution should be exercised in • Active inflammation of urinary tract – recent UTI, urethritis, prostatitis • Recent radiotherapy • Penile/vaginal pain or discharge • Haematuria • Autonomic dysreflexia (in spinal injuries) • Congenital abnormalities
3	Patient information. Ensure patient has received verbal, written or visual information prior to commencing teaching
4	Consent. Patient consent must be valid (as per UHL consent policy) and consent must also be obtained from the Doctor responsible for the patient's care and documented in the medical notes.
5	Assessment of patient should include • Fluid balance/bladder chart record pre ISC

	• Patients understanding of their individual indications for requiring ISC and complications if non-compliance of ISC • Patients understanding of complication signs and symptoms to look for (Retention/UTI/Haematuria/stricture formation) and how to seek advice. • Patients mobility/dexterity/eyesight etc. – assess for ability to perform safely and compliantly and consider if any deterioration of existing conditions could affect this. I.e. memory loss. And if any further support/tools can be implemented to assist in maintaining compliance. • Physical examination is important as identification/location of the urethral opening is not always obvious. • Pre and post void bladder scan can be helpful in monitoring effectiveness in the teaching stage of emptying bladder fully. Staff should be competent in the use of the bladder scanner. • Sexual activity discussion – This should be discussed with all patients requiring catheters and is not contra indicated in ISC or indwelling. • Bowel habit assessment should include advice on constipation and this should be addressed prior to commencing ISC as it can adversely affect bladder emptying.
6	Catheter selection – type, size, length. There is a wide variety of sizes and types of intermittent catheter. Consider your individual patients needs i.e. dignity, poor dexterity and select most appropriate catheters **with** your patient, taking into account local formulary for patient to trial. The ideal catheter should be simple and easy to use with no touch technique.
7	The use of a lubricating gel will depend upon the type of catheter selected as many are pre lubricated. Always check manufacturer's guidance on lubrication.
8	Demonstrate to patient how to drain the bladder completely – first with the use of diagrams/videos/leaflets and then practically on the patient. Ensure you have obtained all equipment needed prior to teaching and that the environment is conducive to maintaining dignity. Demonstrate that urine can continue to flow on withdrawal of the catheter and to wait for full drainage and place a finger over the tip of the catheter to prevent dribbles or spillages.
9	Each patient should have a personalised care plan regarding frequency of catheterisation. As a general rule, the residual urine should not be >400mls, however, this can be assessed and adjusted to the individual patient's needs. The plan upon learning will need to be reassessed and updated.
10	Record keeping – ISC teaching to patient should be clearly documented in patients' Medical/Nursing notes and on discharge paperwork for follow up purposes. These should be detailed and legible and include patient specific regime. Patients should be encouraged to keep records of volumes passed, frequency of catheterisation (to monitor compliance against regime recommended) complications and other problems encountered
11	Obtaining equipment - intermittent catheters are only available on prescription. Patients should be advised on monthly quantities required and the importance of not running out. The catheters can be ordered through chemists and home delivery

	services which can offer quick delivery to the patients' home. Contact your local continence advisor for more information.
12	Manufacturers' guidance on storage should be followed – generally not to remove from box and store at room temperature. Disposal guidance should also be followed but generally used catheters can be disposed of in general waste (clinical waste in acute settings) – do not flush down the toilet!
13	Complications tend to be inability to insert catheter or haematuria. • Difficulty inserting - Advising on using additional lubricating gel, coughing, sneezing can help. If patient or carer unable to insert, refer to GP/DN for reassessment or insertion of indwelling catheter until reassessment. • Haematuria – usually settles with good hydration. If clots are seen or haematuria continuous, insert indwelling catheter and seek medical advice from patients responsible Doctor. If urine rose in colour, offer reassurance.
14	Follow up and reassessment – Arrange appropriate follow up and reassessment of patient either via community continence team, district nurses, urology services or medical continence clinic and provide contact details to patient for support at home.

Flushing and ongoing care of Nephrostomy Pigtail	University Hospitals of Leicester NHS NHS Trust Appendix 13

1. Introduction

Flushing should be necessary only if the Nephrostomy is blocked. This procedure can be performed by interventional radiology staff, urologists and medical staff.

Registered nurses/midwives/operating department practitioners/nursing associates/assistant practitioners must have received an underpinning theory relating to nephrostomies and had opportunities to practice under supervision prior to completing and being assessed as competent using the UHL LCAT assessment. This is only likely to occur on the urology wards.

Prior to commencing nephrostomy flushing,

- Check insertion site to ensure pigtail catheter has not fallen out. If it is not in situ, contact radiology/medical team urgently.
- Check both the catheter and tubing is not bent, broken, or positioned badly, potentially causing reduced drainage. If this is the case, reposition tubing and check for drainage. If still no drainage, proceed to flushing using ANTT.

2. Equipment

- 20ml Syringe
- 10mls
- Normal Saline*0.9%
- 70% alcohol swab x 2
- Sterile J Tray x 2
- Sterile gloves

3. Procedure

- Wearing sterile gloves
- Draw up 10mls Normal Saline
- Disconnect tubing from catheter, placing end in J tray to keep it clean Clean catheter end with 70% alcohol swab
- Attach syringe to catheter and aspirate
- Inject 10mls Normal Saline slowly into pigtail catheter.
- If the patient complains of any pain stop procedure immediately
- Wipe end of tubing with 70% alcohol swab and connect to pigtail catheter
- NB Ensure patient is well hydrated prior and post procedure.
- On flushing, if resistance is felt and you are unable to inject or if it is ineffective, contact interventional radiology or urology on call SPR via switchboard.

4. Ongoing Care

Follow the principals of ongoing care for urinary catheter bundle by documenting daily checks of indication, site, drainage bag position, change of drainage bag weekly and sampling information.

Utilise the care bundle for urinary catheters and change the heading to nephrostomy. If your patient has a urethral catheter and bilateral nephrostomies, you will require 3 care bundles to be in use, one for each device.

Maintain accurate fluid balance measurements clearly indicating source of output. i.e. Left nephrostomy, urethral catheter.

If drainage is less than expected (check with medical team as expected nephrostomy output may be different to total expected urine output) and flushing has not improved urine output, escalate to medical team urgently even if the total urine output meets the expected volume.

Patient information leaflets on nephrostomy care are available on Your Health:

Having a drainage tube in your kidney (percutaneous nephrostomy)

Having the drainage tube in your kidney (nephrostomy tube) changed

1. Introduction

This procedure can be performed by staff trained and experienced in urinary urethral catheterisation, who have underpinning theory relating to supra pubic catheters and have been assessed as competent following an opportunity to practice under supervision and a UHL LCAT assessment

2. Equipment

3.Procedure for Changing a Supra Pubic Catheter	
No.	**Action**
1	Explain and discuss the procedure with the patient and gain consent. Allow time for questions and provide clear understandable answers. This will ensure that the patient understands the procedure and gives their valid consent and help reduce anxiety
2	Check the patient has no known allergies to prevent anaphylaxis or skin irritation
3	Throughout this procedure ensure hands are cleaned and wear personal protective equipment (PPE) as per UHL IP standards (available on IN site) changing them as needed. Prepare the trolley and equipment for and perform the procedure using aseptic no-touch technique (ANTT) Ensure there is appropriate protection on the bed. Screen the bed. Ensure/assist the patient the patient into a comfortable supine position, allowing the nurse access to the catheter by removing clothing to the area.
4	Clean hands and wear PPE. Open the outer wrappings of the packs and put it on the top shelf of the dressing trolley at patient bedside or within easy reach.
5	Check catheter is licensed for Supra pubic use, not all urinary catheters are licensed for this procedure.
6	Place small amount of instillagel or alternative sterile lubricant on tip of catheter to be inserted. This will lubricate the catheter to ensure smoother insertion down tract.
7	Fill catheter tip 50ml syringe with 50mls of sterile water 0.9% sodium chloride for instilling into the bladder.
8	Drape sterile towel around cystostomy site and clean area using 0.9% sodium chloride or suitable anti-bacterial agent, maintaining ANTT
9	Place a small amount of instillagel around cystostomy site. Disconnect and discard leg bag from old catheter, maintaining ANTT to catheter tip. Pre fill bladder slowly until patient is aware of filling sensation or until 50mls inserted. This relaxes the detrusor muscle and aids the removal of the existing supra pubic catheter.
10	The HCA assisting removes the existing catheter by deflating the balloon as per manufacturer's instructions – deflate catheter balloon with 10 ml syringe allowing the syringe to fill without applying traction. This will prevent cuffing of the balloon and thus reducing cystostomy site trauma.
11	Gently insert new catheter via the cystectomy channel into the bladder to the length of the removed catheter or until urine drains, some resistance may be felt which will ease at the catheter enters the bladder.

12	Do not inflate the balloon until urine drains. Once urine drains, slowly inflate the balloon with 5mls of pre filled syringe – no resistance should be felt. This will ensure catheter is in the bladder and not the urethra.
13	Gently withdraw catheter until it is felt to be firm against the bladder wall, then completely fill the balloon with the remainder of the pre filled syringe. Total of 10mls.
14	Attach the catheter to previously selected drainage system or valve, maintain a closed drainage system and secure to limb to reduce erosion and increase comfort.
15	Ensure the patient comfortable by checking the cystectomy site is clean and dry. Dampness around the site can cause redness and irritation to skin. Avoid dressing the site which can make this worse.
16	Remove used and unnecessary equipment and dispose of as per UHL waste policy and clean the trolley.
17	Clean hands.
18	Document procedure in nursing/medical documentation, ensuring date, type, size and rational are clearly explained. Any other instructions, difficulties encountered must be clearly documented and follow up plans discussed, made and documented**.**

Purewick™ Female External Catheter Guidelines

Appendix 15

The Purewick™ is a product for female patients that acts as an external female catheter to manage incontinence. The Guidelines and Care plan are below.
If a Purewick™ is used the patient needs to have the care plan completed on the Urinary Devices Assessment on Nerve Centre

PUREWICK® FEMALE EXTERNAL CATHETER CARE PLAN

Attach patient label here:

Patient ID Label *or write name and number*

Hospital No.:
Name:
Address:
D.O.B.: Sex:
Telephone No.:

Confirm the patient meets the appropriate indications for the female external catheter.

The PUREWICK® Female External Catheter is intended for non-invasive urine output in female patients.

ELIGIBLE PATIENTS INCLUDE:

- Patient requiring urine output monitoring but does not meet indications for indwelling Foley catheterisation
- Urinary incontinence and/or frequent urination
- Difficulty walking from bed or chair to toilet
- Difficulty using a bedpan
- Post-surgical or procedure immobility
- Skin injury or irritation related to urinary incontinence or incontinence pads
- End-of-life care

PRIOR TO USING THE FEMALE EXTERNAL CATHETER - PUREWICK®:

- **Explain procedure** to the patient, offer a chaperone (request additional staff as needed), obtain and document informed consent according to Trust policy and document in the medical notes.
- **Obtain equipment**: Connect canister to wall suction and set to a minimum of 5-10Kpa continuous suction. Always use the minimum amount of suction necessary.
- **Verify wall suction function** by covering the open end of the suction tubing with one hand and observing the pressure dial. If the pressure does not increase when the line is covered, verify that the tubing is secured, connected and not kinked.
- **Connect the PUREWICK®** to the collection canister using standard suction tubing.

PREPARATION:

a. Put on disposable apron.
b. Prepare the patient, ask/help the patients to undress from the waist down and ensure the patient is covered to maintain dignity and always assess skin for compromise and perform perineal care prior to placement of every new PUREWICK®
c. Perform a bladder scan if patient has more than 250mls in Bladder and unable to void do not use PUREWICK®
d. Perineal Wash:
- Wash hands and put on clean gloves
- Wash and dry perineal area and assess skin integrity (document per hospital protocol).
- Remove gloves and wash hands

PLACEMENT:

a. Perform each step with clean technique.
Wash hands and put on clean gloves and apron.
b. Separate legs, gluteus muscles, and labia.
Palpate pubic bone as anatomical marker.
c. Place the PUREWICK® with soft gauze side facing the patient, align distal end of the wick at gluteal cleft.
Gently tuck soft gauze side between separated gluteus and labia.
d. Ensure that the top of the gauze is aligned with the pubic bone.
Slowly place legs back together once the PUREWICK® is positioned.
Properly placing the PUREWICK® snugly between the labia and gluteus holds the PUREWICK® in place for most patients.
Stretch pants may be useful for securing the PUREWICK® for some patients
e. Remove gloves and apron and wash hands.

(How.pdf)(023 14133

REVIEW:

a. Assess PUREWICK® placement and patient's skin integrity every 2-4 hours.
Ensure the device remains in the correct maintain dignity

b. Position after repositioning the patient

c. Replace the PUREWICK® at least every 8-12 hours or if soiled with faeces or blood

d. Change suction tubing as per hospital protocol.

e. Single patient use.

f. Remove the PUREWICK® prior to ambulation.

g. Verify wall suction function by covering the open end of the suction tubing with one hand and observe the pressure dial every 8-12 hours. If pressure does not increase when line is covered, verify that the tubing is secured, connected and not kinked, report any faults to the Medical Physics department without delay.

REMOVAL:

a. Wash hands and put on gloves and apron.

b. To remove the PUREWICK®, fully separate the legs, gluteus, and labia.

c. Maintain suction until the PUREWICK® is fully removed from the patient to avoid urine backflow.
Gently pull the PUREWICK® directly outward to avoid potential skin injury.

d. After use, this product may be a potential biohazard.
Dispose of in an orange clinical waste bin in accordance with local Trust policy and wash hands.

WARNINGS:

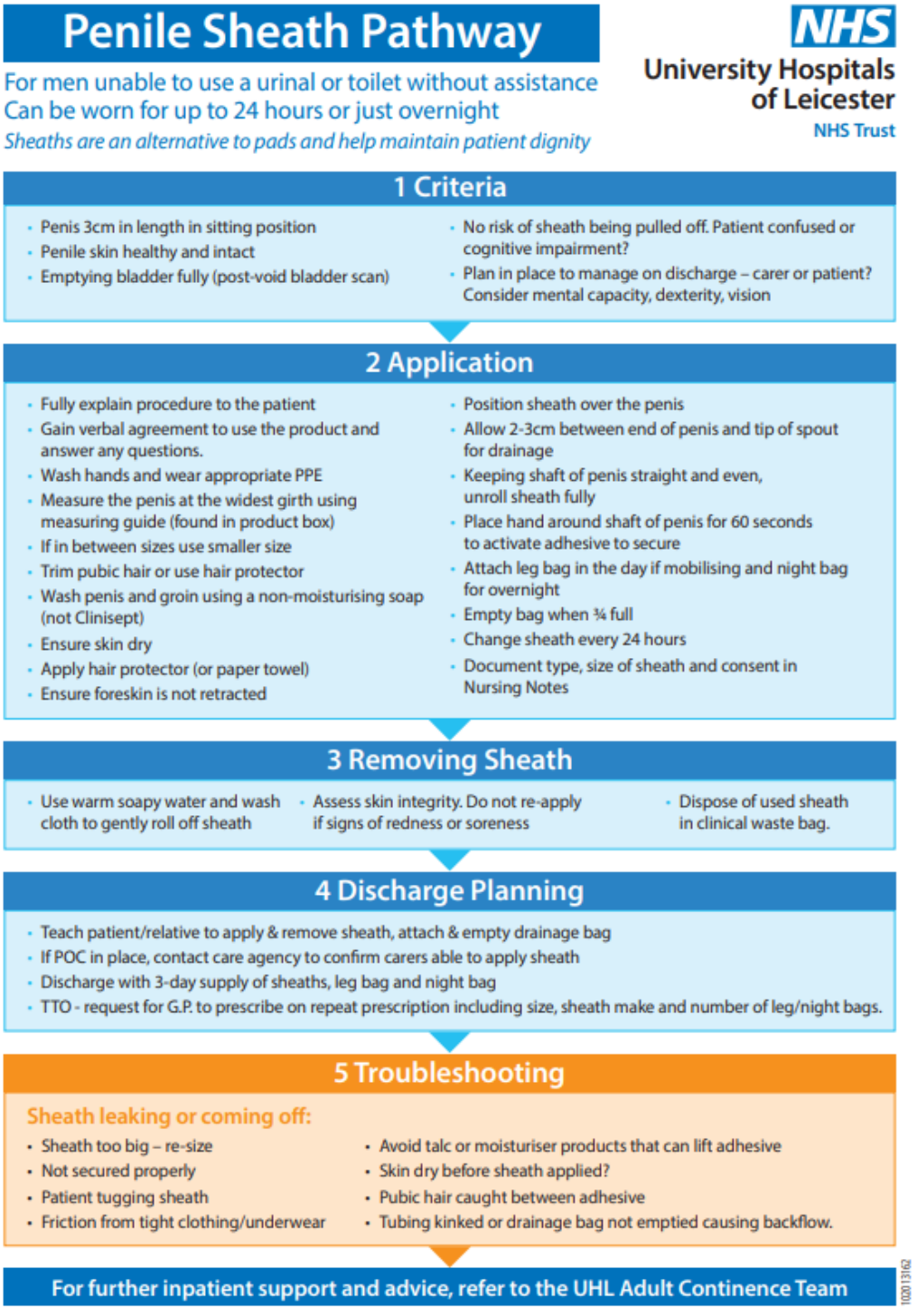
- Ensure emergency suction tubing present when PUREWICK® in use
- Assess PUREWICK® placement and patient's skin integrity every 2-4 hours
- Change PUREWICK® every 8-12 hours or if soiled with blood or faeces
- Remove PUREWICK® when patient mobilising and if clean it can be replaced
- Remove device when patient using bedpan or commode
- If patient has a post void residual of more than 250mls and they are unable to void do not use PUREWICK® and refer to Continence Nurse Specialists
- Ensure the suction liner is changed every 24 hours.

TO BE RECORDED TWICE A DAY	Date	Time PUREWICK® PLACED	Time PUREWICK® and suction liner CHANGED	Perineal skin area CHECKED & INTACT?	Low continuous suction set CHECKED	Staff Print Name & Sign
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						
AM						
PM						

APPENDIX 16

Male Penile Sheath Pathway	University Hospitals of Leicester NHS Trust **Appendix 16**

The Male Urethral Sheath is a containment device to manage urinary incontinence in men. The patient or carer can be taught to apply the sheath. The guidelines are contained in the Penile Sheath Pathway.



Penile Sheath Pathway

For men unable to use a urinal or toilet without assistance
Can be worn for up to 24 hours or just overnight
Sheaths are an alternative to pads and help maintain patient dignity

NHS
University Hospitals of Leicester
NHS Trust

1 Criteria

- Penis 3cm in length in sitting position
- Penile skin healthy and intact
- Emptying bladder fully (post-void bladder scan)
- No risk of sheath being pulled off. Patient confused or cognitive impairment?
- Plan in place to manage on discharge – carer or patient? Consider mental capacity, dexterity, vision

2 Application

- Fully explain procedure to the patient
- Gain verbal agreement to use the product and answer any questions.
- Wash hands and wear appropriate PPE
- Measure the penis at the widest girth using measuring guide (found in product box)
- If in between sizes use smaller size
- Trim pubic hair or use hair protector
- Wash penis and groin using a non-moisturising soap (not Clinisept)
- Ensure skin dry
- Apply hair protector (or paper towel)
- Ensure foreskin is not retracted
- Position sheath over the penis
- Allow 2-3cm between end of penis and tip of spout for drainage
- Keeping shaft of penis straight and even, unroll sheath fully
- Place hand around shaft of penis for 60 seconds to activate adhesive to secure
- Attach leg bag in the day if mobilising and night bag for overnight
- Empty bag when ¾ full
- Change sheath every 24 hours
- Document type, size of sheath and consent in Nursing Notes

3 Removing Sheath

- Use warm soapy water and wash cloth to gently roll off sheath
- Assess skin integrity. Do not re-apply if signs of redness or soreness
- Dispose of used sheath in clinical waste bag.

4 Discharge Planning

- Teach patient/relative to apply & remove sheath, attach & empty drainage bag
- If POC in place, contact care agency to confirm carers able to apply sheath
- Discharge with 3-day supply of sheaths, leg bag and night bag
- TTO - request for G.P. to prescribe on repeat prescription including size, sheath make and number of leg/night bags.

5 Troubleshooting

Sheath leaking or coming off:

- Sheath too big – re-size
- Not secured properly
- Patient tugging sheath
- Friction from tight clothing/underwear
- Avoid talc or moisturiser products that can lift adhesive
- Skin dry before sheath applied?
- Pubic hair caught between adhesive
- Tubing kinked or drainage bag not emptied causing backflow.

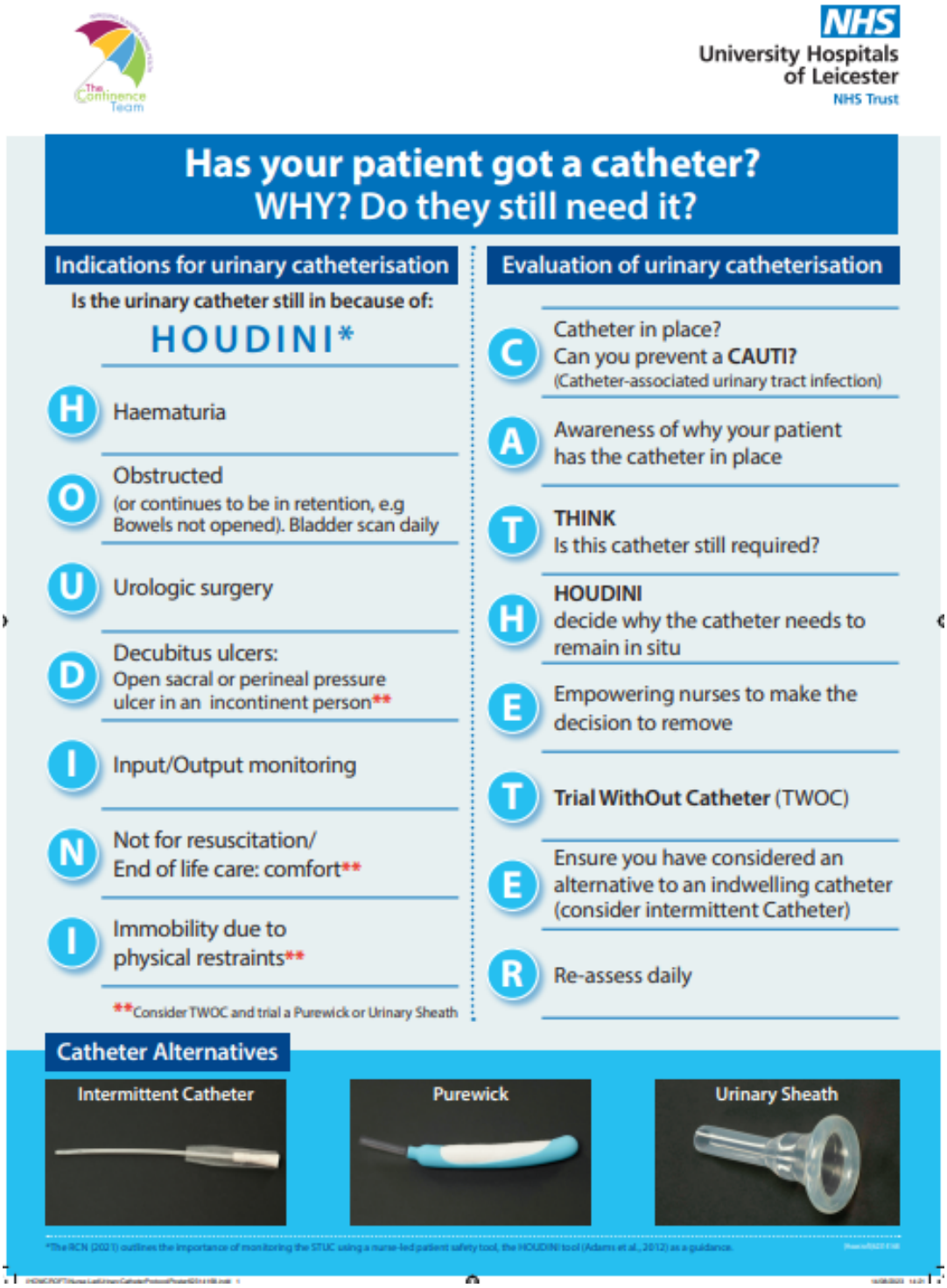
For further inpatient support and advice, refer to the UHL Adult Continence Team

100113162

Rationale for Catheter Removal – HOUDINI.

Appendix 17

HOUDINI is a decision making tool that Health Care Professionals can use to rationalise if a urethral catheter is still required.



Absorbant Pads

Appendix 18

An absorbency pad is classified as a medical device (MHRA 2014) and therefore safety and fitness for purpose is fundamental in achieving quality care.

Best practice is where individualised clinical assessment and personalised care planning is a fundamental activity prior to any provision of product, from the age of 18 years old, and if there is a need for a containment product the most effective low risk product is chosen.

The clinician who assesses an individual to provide an absorbent pad is accountable for that decision; and needs to ensure that the chosen pad is fit for purpose and safe to use at the time of assessment (in accordance with MRHA 2014).

Men and women should be treated equally in relation to absorbencies and product range available.

Reassessment of product provision should be undertaken annually as a minimum.

Absorbent pads should not be supplied for treatable medical conditions (or for bodily fluids other than urine or faeces).

Alternative collection devices should be considered for example urinary sheath, Purewick™ or intermitant catheters.

Always choose the lowest absorbency pad to reduce the risk of moisture assosiasted skin damage.

Always put in datix for any incidents of double padding, this can lead to patient harm due to shearing and friction.

The Bariatric slip pad is available to order via procurement.

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Choose the correct Continence Pad for your patient

General Instructions:

- DO NOT use a pad for patients with Urinary Catheter and no Faecal Incontinence
- For damp episodes: TENA Men Level 1 (Men) or TENA Comfort Mini Extra (Women)
- TENA Flex for patients nursed in bed or unable to reposition
- Penile Sheath considered to promote Continence for Male patients
- Faecal Incontinence : TENA Comfort Normal - change pad immediately when soiled
- Patients who change own Pad - Use lowest absorbency

Registered Nurse should:

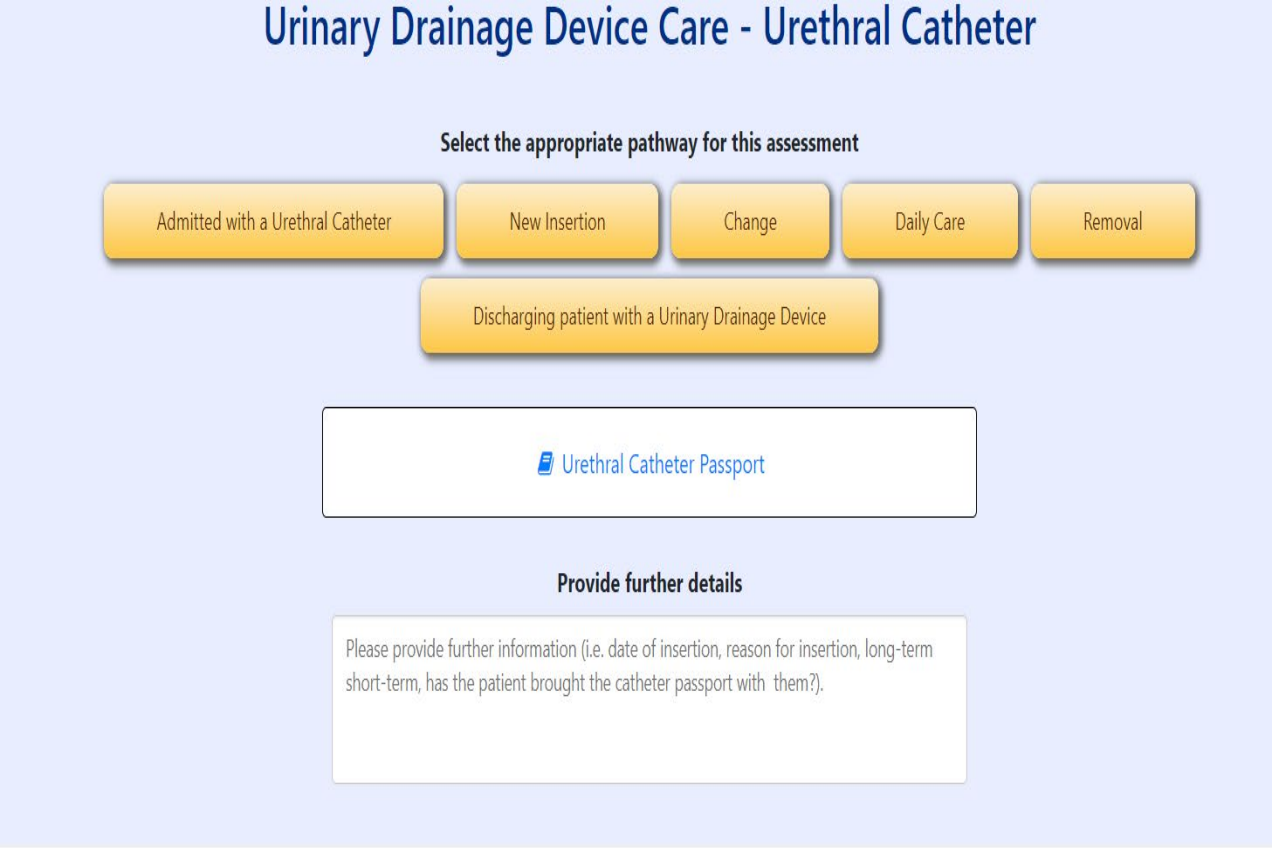
- Complete Elimination/Core Nursing assessment to identify patient needs
- Assess degree of Incontinence, Day & Night
- 'Offer the toilet' frequently - on waking, pre-meal and bedtime regardless of continence status or cognition
- Prescribe the appropriate product

Instructions for application:

- Fold pad in half lengthways before applying
- Ensure fixation pants are applied to secure TENA Comfort and pulled up to groin to minimise leakage
- Ensure TENA Men/Comfort Mini secured by patients own 'snug' underwear (no Boxers etc.)
- Bariatric Net Pants are available which can be used with the TENA Comfort range

Product Name		NHS SC Article Code	Working Absorbency
Male Products : Light - Moderate Incontinence			
TENA Men Active Fit Level 1		CFP211	150mls
Shaped Products : Light - Moderate Incontinence			
TENA Comfort Mini Extra		CFP2165	250mls
All In One Products : Moderate - Heavy Incontinence (measure hip size)			
TENA Slip Bariatric XXL 163 - 178cm		CFP1324	1200mls
Shaped Products : Moderate - Heavy Incontinence			
TENA Comfort Normal		CFP4391	450mls
TENA Comfort Plus Compact		CFP85097	650mls

Urinary Devices Core Nursing assessment and care plans are to be completed for all urinary devices including Purewick™, ureatheral sheath And ISC via Nerve centre.



During periods of nerve centre downtime, the below booklet needs to be used print room Code LLR0019WE

Patient ID Label *or write name and number*
Hospital No.:
Name:
Address:
D.O.B.: Sex:
Telephone No. 1:
Telephone No. 2:

STOP THE LINE

Safer Surgery Checklist

Invasive Procedure Safety Checklist

Uretheral Catheterisation (Adults)

LocSSIPs

NHS University Hospitals of Leicester NHS Trust

Assistant completing the form (signature):
Operator inserting urethral catheter (signature):

Patient specialty:		**Procedure date:**	
Indication for catheterisation:		**Time:**	
Operator grade:		**Operator:**	
Site/Ward:	GH ☐ LRI ☐ LGH ☐ Ward/Department:	**Supervisor/Assistant:**	

BEFORE THE PROCEDURE/SIGN IN	TIME OUT	SIGN OUT
Prior to list with all team members	**Verbal confirmation between team members before start of procedure**	**Before patient or team members leave room**
Confirm patient's Name, DOB and Hospital Number with patient and against wristband Yes ☐ No ☐	Reason for catheter insertion confirmed? Yes ☐ No ☐	Record number of attempts?
Appropriate patient consent Yes ☐ No ☐	Optimal patient position? Yes ☐ No ☐	Any equipment issues? Yes ☐ No ☐
Any known allergies Yes ☐ No ☐	All team members identified and roles assigned? Yes ☐ No ☐	Sterility maintained? Yes ☐ No ☐
Has the patient had a Bladder Scan performed? Yes ☐ No ☐	Any concerns about procedure? Yes ☐ No ☐	**Document any issues during insertion below:**
Residual volume (Bladder Scan) mls	If you had any concerns about the procedure, how were these mitigated? Yes ☐ No ☐	
Any contraindications to perform procedure? Yes ☐ No ☐	**Document mitigations below:**	
Any concerns about this procedure? Yes ☐ No ☐		
If Yes, please document below:		
Read out by: (PRINT)	Read out by: (PRINT)	Read out by: (PRINT)
Signed: Date:	Signed: Date:	Signed: Date:

SKW1168

Adult Urinary Devices Policy (B29/2007)
Approved by Corporate Continence meeting April 2024 & Safe Surgery May 2024

PLEASE TURN OVER

STOP THE LINE

Safer Surgery Checklist

Invasive Procedure Safety Checklist

Uretheral Catheterisation (Adults)

LocSSIPs

NHS University Hospitals of Leicester NHS Trust

DURING THE PROCEDURE

TYPE OF CATHETER (circle)	If other, document:	Catheter Batch No:	CATHETER SIZE:
Standard Short term (28 days)			Size 8 ☐ Size 10 ☐ Size 12 ☐ Size 14 ☐ Size 16 ☐
Standard Long term (12 weeks)			Other: (If other, document):
Female Intermittent			
Male Intermittent			
Other			

CATHETER INSERTION:

Catheter inserted using aseptic technique - Ensuring strict adherence to hand hygiene and PPE	Yes ☐ No ☐	Sterile closed drainage system used *(N/A if Intermittent Catheter)*	Yes ☐ No ☐ N/A ☐
Urethral Meatus cleaned with 0.9% sodium chloride	Yes ☐ No ☐	TWOC date/Change date	Yes ☐ No ☐
Sterile lubricating/Anaesthetic gel used	Yes ☐ No ☐	Catheter drainage bag dated *(N/A if Intermittent Catheter)*	Yes ☐ No ☐ N/A ☐
Balloon inflated with recommended amount of sterile water *(N/A if Intermittent Catheter)*	Yes ☐ No ☐ N/A ☐	Catheter bag below the bladder and not in contact with the floor *(N/A if Intermittent Catheter)*	Yes ☐ No ☐ N/A ☐

CATHETER PASSPORT:

Does the patient have a catheter passport **If No,** start a catheter passport	Yes ☐ No ☐

SKW1168

Adult Urinary Devices Policy (B29/2007)
Approved by Corporate Continence meeting April 2024 & Safe Surgery May 2024

'Based on the WHO Surgical Safety Checklist, URL http://www.who.int/patientsafety/safesurgery/en, © World Health Organization 2008 All rights reserved'

Urethral Catheter Daily Care Plan

Patient ID Label *or write name and number*
Hospital No.:
Name:
Address:
D.O.B.: Sex:
Telephone No. 1:
Telephone No. 2:

NHS University Hospitals of Leicester NHS Trust

DAILY REVIEW AND CARE DELIVERY RECORD

Record each element as indicated daily to evidence care given.

Any positive responses to Catheter Associated UTI (CAUTI) require a CSU to be sent.

Date/ Time	Is catheter still required? If Yes, record the clinical indication If No, arrange TWOC		Is the patient symptomatic to a CAUTI?*		Does the patient have a statlock? If Yes, date needs removing		Daily hygiene for meatal cleansing performed		Drainage bag dated		Record date of drainage bag change every 14 days (if red seal attached). If no red seal, change every 7 days		Catheter bag is below the bladder level and not in contact with the floor		Samples collected via sampling port using Aseptic Non-Touch Technique		TWOC date	Signature	Print Name
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			
																	Date:		
																	Date:		
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***CAUTI Symptoms**
- Lower back pain or suprapubic tenderness
- Temperature under 35°C
- Temperature 38°C or above/rigors
- Confusion (new onset)
- Bypassing catheter

Date removed:	Time removed:
Signature:	Print name:

Retain in medical notes once catheter removed

Urethral Catheter Daily Care Plan

NHS University Hospitals of Leicester NHS Trust

DISCHARGE HOME WITH A CATHETER

	Yes	No	Comments/Staff name
Has discharge information and urethral catheter passport been given/discussed to the patient/ carer?			
Has education/practical education been provided to patient/ carer on care of the urethral catheter?			
Has the district nurse referral been completed?			
The patient has been registered with Clinidirect at home **(0800 142 2950)**			
Has any other follow up been arranged?			

Additional Information

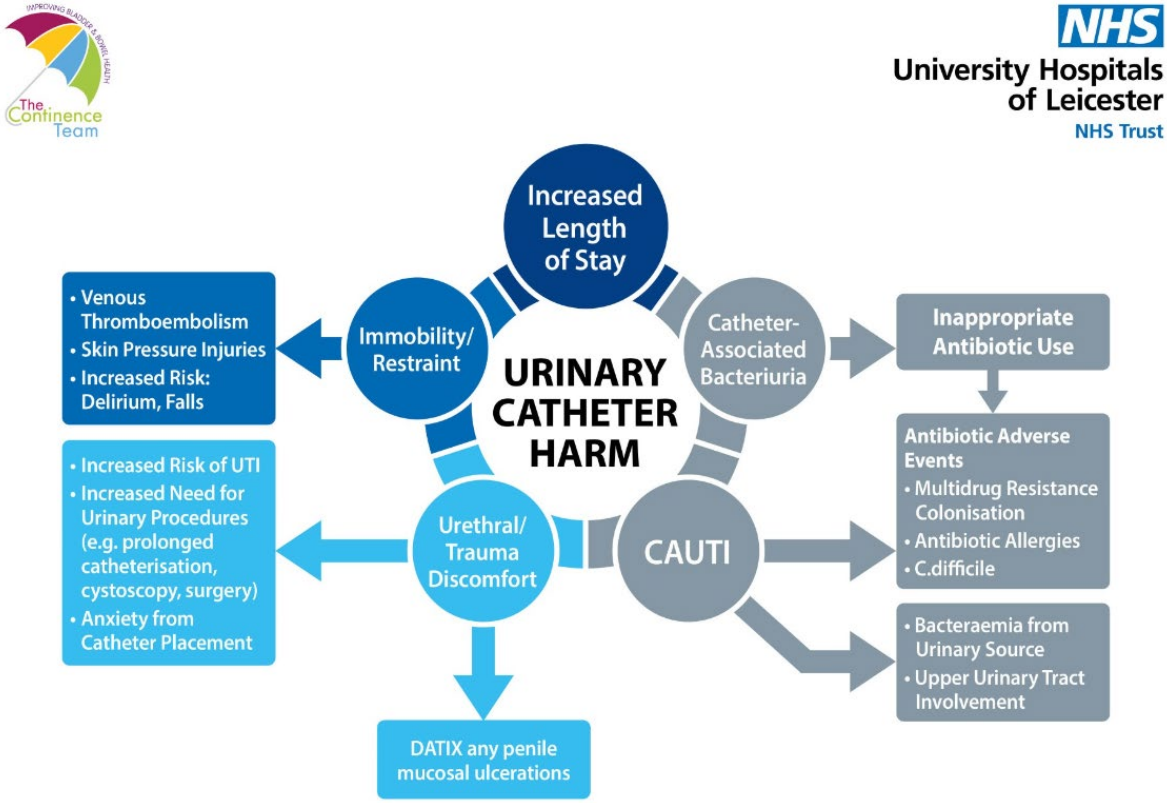
Date removed:	Time removed:
Signature:	Print name:

Retain in medical notes once catheter removed

Catheter harm cycle

Appendix 21

Catheter harm cycle that can delevlop if a catheter is not managed correctly as per this policy.



All patients are to be registered with CliniDirect if being discharged with A Catheter or a sheath. The patient will then get a delivery of supplys 24 hours later.

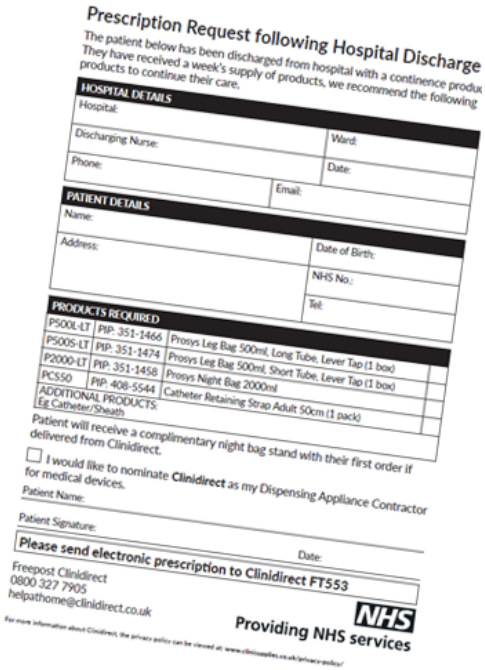
Discharging patients with a Catheter or Sheath

1. Provide Patient with a Discharge Pack and Hanger

2. Register Patient to CliniDirect via telephone or online for ongoing product delivery

Clinidirect

3. Use Patient Form in pack to register for further supplies if unable to register via CliniDirect



Prescription Request following Hospital Discharge

The patient below has been discharged from hospital with a continence produ
They have received a week's supply of products, we recommend the following
products to continue their care.

HOSPITAL DETAILS	
Hospital:	
Discharging Nurse:	Ward:
Phone:	Date:
	Email:

PATIENT DETAILS	
Name:	
Address:	Date of Birth:
	NHS No.:
	Tel:

PRODUCTS REQUIRED		
P500L-LT	PIP: 351-1466	Prosys Leg Bag 500ml, Long Tube, Lever Tap (1 box)
P500S-LT	PIP: 351-1474	Prosys Leg Bag 500ml, Short Tube, Lever Tap (1 box)
P2000-LT	PIP: 351-1458	Prosys Night Bag 2000ml
PCS50	PIP: 408-5544	Catheter Retaining Strap Adult 50cm (1 pack)
ADDITIONAL PRODUCTS: Eg Catheter/Sheath		

Patient will receive a complimentary night bag stand with their first order if delivered from Clinidirect.

☐ I would like to nominate **Clinidirect** as my Dispensing Appliance Contractor for medical devices.

Patient Name:

Patient Signature: Date:

Please send electronic prescription to Clinidirect FT553

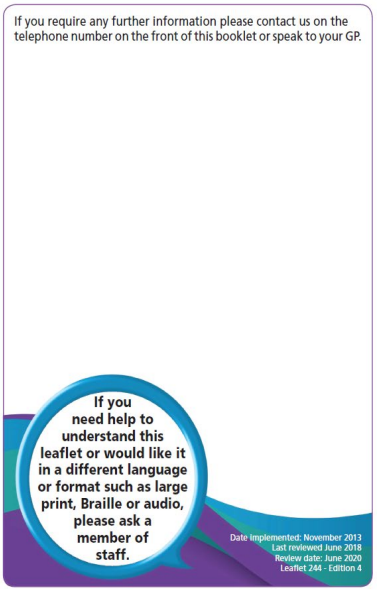
Freepost Clinidirect
0800 327 7905
helpathome@clinidirect.co.uk

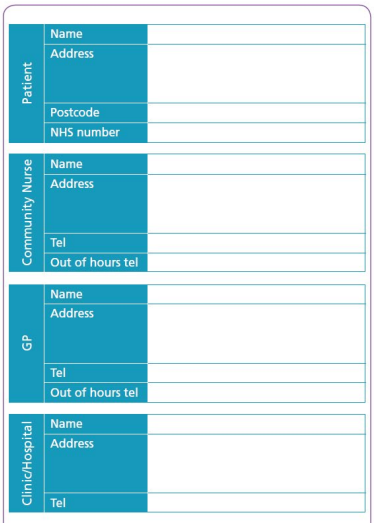
NHS Providing NHS services

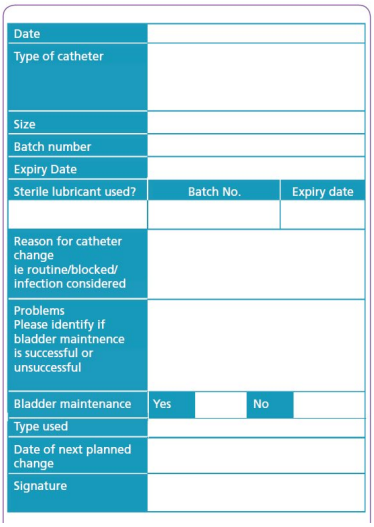
Clinidirect

All patients who are discharged with a urinary catheter in situ should be provided with a completed Urinary Catheter Passport and Looking After Your Urinary Catheter at Home Leaflet. Patients should be provided with basic education regarding how to care for their catheter.

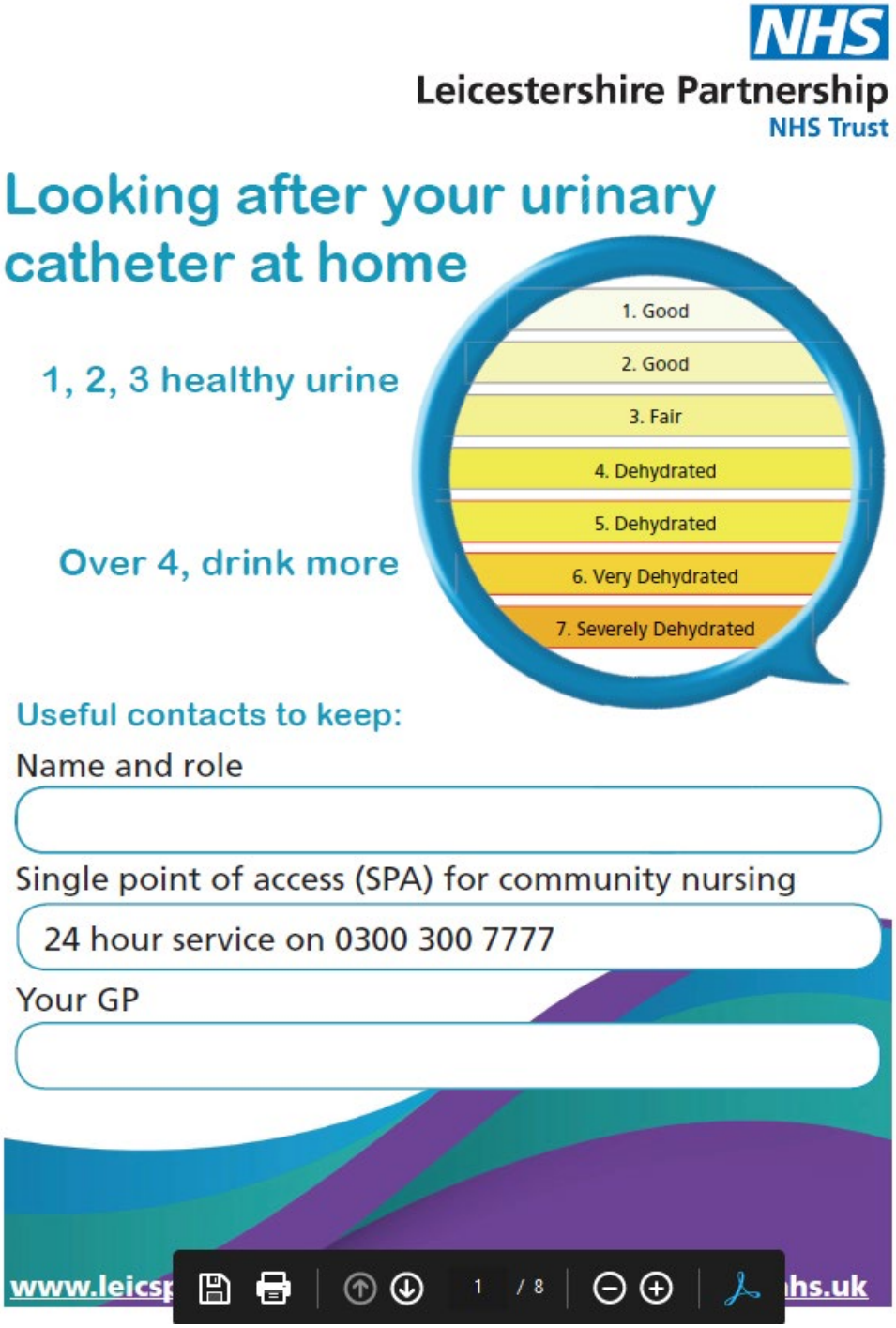
A referral to the Single Point of Access Community Nursing Services should be made for follow up. Patients should be given a supply of appropriate catheter care products on discharge – eg: Take Home Pack.







http://insitetogether.xuhl-tr.nhs.uk/patientexperience/Patient%20Experience%20documents/Continence/LPT%20-%20Urinary%20Catheter%20Passport.pdf



This information leaflet can be printed out via
http://insitetogether.xuhl-tr.nhs.uk/patientexperience/Patient%20Experience%20documents/Continence/LPT%20-%20Looking%20After%20Your%20Urinary%20Catheter%20at%20Home.pdf

and needs to be given to the patient/relative/carer at the point of discharge.