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Clinical guideline for insertion and removal of an intermittent urethral catheter

Lead executive	Lead Clinical Director
Authors details	Community Urology Lead Nurse – Community Continence Lead Nurse

Type of document	Guidance
Target audience	All clinical staff within CCWC
Document purpose	This guideline is intended to serve as an evidence based guide for Competent Practitioners employed by Cheshire and Wirral Partnership NHS Foundation Trust (CWP), in the aseptic insertion and the removal of an intermittent urethral catheter for both male and female patients. This guideline also gives Competent Practitioners guidance on how to teach patients how to perform clean intermittent urethral self-catheterisation. Please note this guideline is intended for adult patients only.

Approving meeting	Neighbourhood Based Care Governance Group	Date Sep 2020
Implementation date	01.09.2020 followed by an annual compliance review	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
IC2	Hand decontamination policy and procedure
HS1	Waste management policy
IC3	Standard (universal) infection control precautions policy
IC8	Policy for the procedure for aseptic non-touch technique (ANTT)
CP3	Health records policy
CC7	Clinical guidelines for urethral indwelling catheterisation
MP16	Non-medical prescribing policy
GR26	Safe manual handling of people and loads policy
MH1	Mental Health Law policy suite

Document change history	
What is different?	Additional catheter related procedures & updated research based evidence New Guidance regarding Personal Protection Equipment (PPE)
Appendices / electronic forms	New Appendices - Additional catheter related procedures & updated research based evidence Additional Guidance related to procedures & equipment
What is the impact of change?	Additional catheter related procedures & updated research based evidence New Guidance regarding Personal Protection Equipment (PPE)

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Via policy discussion forum
Corporate services	Via policy discussion forum

External agencies	N/A

Financial resource implications	Additional resources required for related procedures

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Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
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- Religion or belief	No	
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- Age	No	
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N/A		
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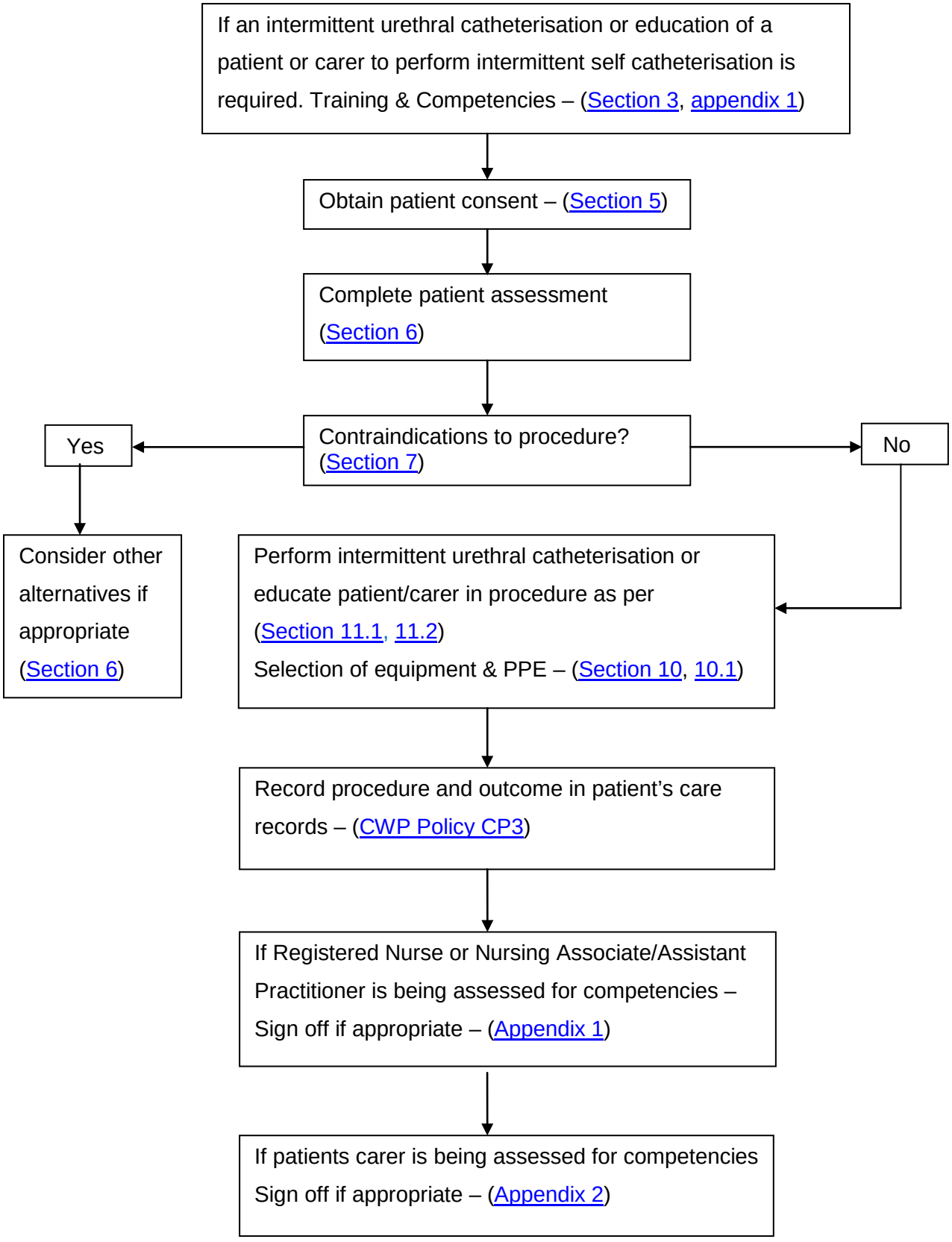
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart
for Registered Nurse or Nursing Associate/ Assistant Practitioner to perform an intermittent urethral catheterisation or to educate a patient/carer to perform intermittent self catheterisation



1. Introduction

This guideline is intended to serve as evidence based guide for Registered Nurses and Nursing Associate/ Assistant Practitioners employed by CWP in the aseptic insertion and the removal of an intermittent (in/out) urethral catheter for both male and female patients. This guideline also gives Registered Nurses and Nursing Associates/Assistant Practitioners guidance how to teach patients / carers to perform clean intermittent urethral self-catheterisation (ISC).

Please note this guideline is intended for adult patients only.

If a Registered Nurse or Nursing Associate/Assistant Practitioner is performing intermittent catheterisation an aseptic technique must be used (Section 11.1). If a patient/carer carries out the procedure a non-touch or clean technique can be used (Wynedale, 2002)). (Section 11.2).

2. Definitions

To provide guidance for Registered Nurses in:

- Performing an initial intermittent catheter assessment and review;
- The education, teaching and support of the patient/carer regarding clean intermittent urethral self-catheterisation;
- The insertion and removal of an intermittent urethral catheter using an aseptic technique;
- The delegation and supervision of intermittent catheterisation to Nursing Associates/ Assistant Practitioners, patient/carers.

To provide guidance for Nursing Associates/Assistant Practitioners following delegation from a Registered Nurse in

- The insertion and removal of an intermittent urethral catheter using an aseptic technique;
- Support of the patient/carer regarding clean intermittent urethral self-catheterisation (ISC).

Carer definition – A “carer” is someone who helps another person, usually a relative or friend, in their day-to-day life. The “Care Act” of 2015 relates mostly to adult “carers”- people over 18 who are caring for another adult. A carer who provides care professionally, or through a voluntary organization must produce evidence to the Registered Nurse before teaching takes place, which the carer is covered by their employers’ indemnity insurance. This should be documented in the patient’s care records.

3. Qualification and training

This guidance applies to all clinical staff employed by CWP:

- Registered Nurses who are currently registered with the Nursing and Midwifery Council (NMC);
- Nursing Associates/Assistant Practitioners who have completed a recognised Nursing Associate/Assistant Practitioner’s course.

Following completion of CWP catheterisation training the Registered Nurse or Nursing Associate/Assistant Practitioner should complete the minimum number of supervised practices until competencies are achieved (normally 1 - 3 supervised practices).

The supervision of these practical procedures can only be undertaken by a Registered Nurse who has:

- Completed CWP catheterisation training within the last three years;
- Is confident and experienced in inserting and removing a urethral intermittent catheter in male and female adult patients;
- Has a completed and valid competency document – female / male intermittent urethral catheterisation (Appendix 1).

In order to maintain knowledge and skills the Registered Nurse or Nursing Associate/Assistant Practitioner should complete CWP catheterisation training every three years as per Trust – Wide learning and development requirements included in the HR6 – Mandatory learning (MEL) Policy.

A Registered Nurse who can demonstrate competence to this professional level may delegate those procedures to Nursing Associates/Assistant Practitioners, patients/carers as appropriate. However it is the Registered Nurse's responsibility to ensure that the Nursing Associates/Assistant Practitioners and patient/carer competencies are assessed and reviewed.

4. Background

Intermittent catheterisation or Intermittent Self-Catheterisation (ISC) is the insertion of a catheter into the bladder via the urethra or other catheterisable channel such as Mitrofanoff continent urinary diversion to drain urine (EAUN, 2010). The catheter is removed immediately after emptying the bladder – in/out technique (Moore, Getliffe, 2009).

ISC is considered the "gold standard" of urine drainage for bladder emptying dysfunction (Geng et al, 2006) therefore intermittent catheterisation is the preferred choice to indwelling urethral catheterisation (NICE, 2017). IC/ISC can reduce complications such as urinary tract infection, bacteraemia, local infections such as epididymitis and prostatitis. It also avoids risks associated with long-term catheterisation, i.e. calculus disease, bladder spasms, leakage, blockage of the catheter and renal damage (Turi et al, 2016). ISC also reduces interference in sexual activity as opposed to an indwelling urethral catheter.

Intermittent catheterisation can be implemented for the following reasons:

- To relieve retention of urine – Bladder outlet obstruction, Detrusor dysfunction.
  Acute retention of urine is defined as a painful, palpable or percussable bladder, when the patient is unable to pass urine (Abrams, Cadazo, 2002);
- To assist in protecting renal function due to poorly emptying bladder;
- Following procedures that increase risks of urinary retention: intradetruser Botox, tension free vaginal tape (TVT), colposuspension;
- To determine residual volumes in the absence of a portable ultrasound bladder scanner when performing a trial without catheter (TWOC);
- To perform bladder instillation of medications;
- To manage urinary incontinence;
- To reduce the risks of urinary tract infections (UTI) due to urinary stasis;
- To improve lower urinary tract symptom control and enhance quality of life (Logan, 2012).

5. Patient consent

The consent of the patient must be verbally obtained and documented following a full explanation of the procedure, potential complications and alternative options. To support any verbal explanation the appropriate manufacturers leaflet, relevant to that brand of intermittent catheter should be provided.

6. Assessment

A full continence assessment of the individual and their needs is required before intermittent catheterisation is contemplated.

Many patients will express embarrassment at such an intimate procedure especially in company during initial teaching. Recognising the patient's emotional reaction to ISC can improve motivation and compliance. Psychological support is required to allay fears or misconceptions. (Logan et al, 2008)

It is the Registered Nurse's responsibility to be aware of the medical / surgical diagnosis and the reasons for catheterisation. This will ensure that no contra-indications exist prior to catheterisation as well as identify any known allergies. If the Registered Nurse has any concerns prior to initial catheterisation medical advice should be sought.

Factors that need to be considered before either performing intermittent catheterisation or before teaching patient/carer intermittent self-catheterisation (ISC):

- Patient's physical independence;
- Cognitive ability or lack of motor skills;
- History of urethral trauma;
- Compliance;
- Patient's preference (Ramakrishnan,Mold, 2005).

Following assessment the best approach to catheterisation should be selected that takes account of clinical need, patient preference and risk of infection. (NICE, 2017)

7. Risks & contraindications associated with intermittent urethral catheterisation

Urinary tract infections are the commonest source of acquired infection particularly when inserting a catheter into the bladder. Most catheter-associated infections are derived from the patient's own colonic flora. (Urology Foundation, 2020) Intermittent catheterisation is a safer practice with fewer complications and lower infection rates than with indwelling catheters (Baines, 2017).

Routine urine culture in an asymptomatic catheterised patient is not recommended because treatment is generally not necessary, except for some special cases. Antibiotic treatment is recommended only for symptomatic infection (Trautner, 2010) (Tenke et al, 2008).

Pain or discomfort may be experienced on insertion/removal of catheter. This can result in a bladder spasm. Fear if pain or discomfort can hinder the learning process at initial instruction. Painful insertion can be caused by incomplete relaxation of the pelvic floor therefore proper training is required to educate the patient in any potential risk (Van Achterberg et al, 2008).

Urethral trauma is common in patients performing ISC. The use of lubrication either incorporated into the catheter device or externally applied reduces the risk (Abrams et al, 2010).
Urethral stricture (narrowing of the urethra due to scar tissue) can develop over time in about 5% of male patients. Patients/carers should be encouraged to perform gentle catheter insertion and ensure adequate lubrication (Perrouin-Verbe, 1995).

8. Nursing intervention to educate patient/ carer

The purpose of education is to empower the patient and/or caregiver to enable them to have more control and to ease problem solving. Education needs to be directed to both the patient and the caregiver.

When it is not possible for the patient to carry out IC, the procedure can be taught to an appropriately trained caregiver. The health professional needs to counsel both the patient and the caregiver regarding the:

- Potential benefits and difficulties with this method of bladder management;
- Knowledge and skills required to perform the procedure;
- Commitment required carrying out IC on a regular basis;
- Potential lifestyle adjustment.

If the patient/carer is performing clean intermittent self-catheterisation the Registered Nurse or Nursing Associate/Assistant Practitioner should review the following:

- How often the patient will need to self-catheterise, this will depend on the residual volumes;
- Signs of any complications (urinary tract infection, bleeding, urethral tear or false passages);
- Still using the correct technique?
- Is the patient compliant?
- Does the catheter meet the patient's current needs?

Teaching ISC may be carried out in the patient's home or in clinic.
More than one appointment may be necessary to ensure compliance (Bagi et al, 2011).

Knowledge required

Patients/carer need to have a basic knowledge of the urinary tract. In elderly women, mastery of IC is often complicated by limited knowledge of their bodies. [Mody, 2014]
In caregivers, long-term adherence to catheterisation can be influenced by fear of damaging the urinary tract. [Health Quality Ontario, 2019] Therefore, teaching strategies for clean or no touch intermittent catheterisation should ensure that caregivers are familiar with the basic anatomy and function of the lower urinary tract. [EAUN, 2013]

Ability to perform the skill
Poor manual dexterity in the absence of an appropriately trained caregiver/attendant is a contra-indication. Lack of motor skills, neurological problems, tetraplegia, fine motor skills (dexterity, limited hand function), and sensory skills (poor vision/hearing) can cause difficulties when learning or performing clean intermittent self-catheterisation.
In particular, women can experience difficulties in finding the urethra and need to use a mirror prior to inserting the catheter (Wilde, Brasch, 2010)

Frequency of catheterisation
The required frequency of intermittent catheterisation and Intermittent Self Catheterisation can vary (Mangnall, 2012)**.** Urinary frequency, post void residual and bladder capacity should be assessed to establish the required frequency of ISC. ISC should be performed at regular intervals to prevent bladder distention and in general the total volume drained should not exceed 400 - 500ml.

If the Registered Nurse or Nursing Associate/Assistant Practitioner is performing intermittent catheterisation on a patient they should keep a record of the amount of urine the patient voids naturally and the amount that is drained via an intermittent catheter. This will enable Registered Nurses to make a clinical decision on how often the patient needs to be catheterised intermittently;

Urine volumes therefore should determine the catheterisation schedule. Unnecessary catheterisation should be avoided to decrease the risk of Catheter Associated Urinary tract infection CAUTI (Tenke, 2008) As a general guide if the patient is unable to void, they may have to catheterise up to 4 - 6 times a day depending on oral fluid intake however some patients may only require one catheterisation per day depending on the rationale for ISC. Patients/carers should be encouraged to keep a voiding/ISC diary to identify how many times per day ISC is required (Newman, Wilson, 2011).

The oral fluid intake of the patient will affect urinary production volumes. When less than 1200 mls of urine per day is produced, patients are less inclined to empty at desired intervals, producing stagnation and distension, this can lead to an increase in infection rate. Excessive fluid intake increases the risk of overdistension of the bladder and overflow incontinence (Heard, Buhrer, 2005). The recommended amount of fluid needed varies and depends on patient size (25-35 ml/kg/day)

9. Monitoring patient safety
The patient/carer must be provided with contact details of their Community Care Team and/or Community Continence & Urology Service should they have any quires or concerns.
Following tuition in ISC, patients/carers should be offered an early review by a health care professional to ensure that they are successfully performing the procedure, and to offer help with any difficulties they may have experienced. This can be given in an evaluation by telephone consultation afterwards or during consultation at a clinic (Winders, 2010).

10. Equipment required

10.1 Selection of catheter
The CWP catheterisation training incorporates an in-depth education in the procedures of IC and covers products and equipment available.

Pre lubricated single use catheters or single use catheter with surface to activate/lubricate is the most commonly used. There are numerous catheters and combinations available for patients. At initial assessment it is important that patients/carers are fully assessed for suitability to the catheter of choice (Fader et al, 2001).

CWP practitioners should consider the most cost-effective intermittent catheter after careful consideration of the patient's needs. Please refer to the most up-to-date Continence Prescribing Formulary. It is the Registered Nurse and Nursing Associate/Assistant Practitioner's responsibility to use the products that are available in this formulary as first line unless they are contra-indicated or unsuitable for the patient. Check patient's records for any allergies to catheter materials/gels.

10.2 Personal Protective Equipment (PPE) - Transmission of infection risk
CWP Practitioners must check for the latest Trust guidelines on PPE requirements.
COVID-19: Personal Protective Equipment (PPE) as required by Cheshire and Wirral Partnership NHS Foundation Trust
http://nww.cwp.nhs.uk/TeamCentre/EmergencyPlanning/Pages/CoronavirusInfo.aspx

To become an infection risk a microorganism has to get from the source into the host by some means. Most micro-organisms usually have a particular route of entry. Infection at work can occur via:

- breathing in infectious aerosols/droplets from the air, eg respiratory discharges such as coughs and sneezes;
- splashes of blood and other body fluids into the eye and other mucous membranes, such as the nose and the mouth (HSE, 2003).

Components must include;

- Gloves (Sterile gloves if aseptic technique);
- Apron;
- Mouth/Nose mask;
- Goggles or face shield (Godoy et al, 2020).

Expert opinion recommends that face and eye protection reduce the risk of occupational exposure of healthcare practitioners. Face masks and eye protection must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes. To be effective, face masks and eye protection must be worn correctly, changed frequently, removed properly, disposed of safely and used in combination with good universal hygiene behaviour (PHE, 2020)

11. Procedures

11.1 Procedure for Registered Nurses or Nursing Associates/Assistant Practitioners performing intermittent catheterisation

This procedure is performed to alleviate urinary residual or to ascertain a post void residual in patients having a trial without catheter (TWOC) for diagnostic purposes in the absence of a portable ultra sound bladder scanner.

An **aseptic technique** and must be used when a Registered Nurse or Nursing Associate/Assistant Practitioner performs this procedure on behalf of the patient using a no touch technique (ANTT) as per; (IC3 Standard (universal) infection control precautions policy)

Don Protective Personal Equipment PPE during patient/carer contact (Section 10.2).

Equipment:
Personal Protective Equipment (PPE) including eye protection (Section 10.2) Sterile Intermittent catheter: standard length for male patients – Female length for female patients If the catheter is not pre-lubricated, follow manufacturers guidelines e.g. fill pouch containing catheter with water or; Catheter lubricating Gel Catheterisation / Sterile dressing pack containing: Sterile gloves - Disposable plastic apron - Disposable bag - Sterile non-woven swabs - Disposable procedure sheet or towel - Receiver tray. Sterile saline 0.9% cleansing solution Sterile drainage system

No.	Action	Rationale
1.	Explain the procedure to the patient	To ensure that the patient understands the procedure and gives informed consent as per (MH1 Consent to treatment)
2.	Prepare working area	To provide a clean clutter free working surface.
3.	Wash hands as per (IC2 Hand decontamination policy)	To minimise risk of cross infection.
4.	Assist patient into an appropriate position as per (GR26 Policy for the safe manual handling of people and loads)	The supine position is recommended
5.	Prepare intermittent catheter as per manufacturer's guidelines and place near to patient/working area	To ensure safe & correct procedure
6.	Adhering to strict aseptic technique as per (IC3 Standard universal infection control precautions policy) Open the outer package of the catheterisation pack or dressing pack. Carefully open the inner package remembering no touch technique (ANTT). Place all necessary equipment on sterile field disposing of outer packaging as required.	To correctly prepare equipment and to reduce the risk of introducing infection into the bladder
7.	Wash hands as per (IC2 Hand decontamination policy)	To minimise risk of cross infection.
8.	Don sterile disposable plastic apron & gloves	To minimise risk of cross infection
9.	Tear a hole in the sterile towel and place on the patient's groin (Male) or place under patient's buttocks (Female) .	To create a sterile field.
10.	Place the receiver between the legs.	To reduce the risk of urinary spillage
11.	Male patients - By using the sterile swabs expose the penis through the sterile towel hole and hold the shaft of the penis, retract any foreskin and clean with sterile saline. Then raise the penis into an upright position. Female patients – Ask or assist patient to spread legs. Separate the labia minora so that the urethral meatus can be seen. Clean the urethral orifice with an downwards motion using sterile saline (Rantell, 2012)	Retraction of the foreskin prevents contamination. Raising the penis in an upright position straightens the penile urethra . Inadequate cleaning of exposed genitalia is a major cause of post catheterisation infection.

No.	Action	Rationale
12.	If catheter is not pre lubricated administer catheter lubricating gel Male patients – Hold penis upright and insert 8 – 9 mls – Remaining 2 - 3 mls into sterile tray Female patients – Expose labia minora and locate urethral meatus – Insert 4 – 5 mls into urethra – Remaining 1 - 2 mls into sterile tray	Adequate lubrication minimises urethral trauma Note – An anaesthesic gel is only indicated in patients who have a low tolerance to pain or a history of UTIs.
13.	Insert the catheter into the urethra until urine flows. Gently advance further into the urethra. If unable to insert the catheter, stop the procedure and seek medical advice if appropriate.	Advancing the catheter ensures the catheter is in the bladder To ensure safety of patient
14.	Attach sterile drainage system to intermittent catheter	To reduce the risk of urinary spillage & to ascertain urinary residual
15.	When urinary drainage stops slowly remove intermittent catheter in stages – Urine may start to flow again	To ensure bladder is fully emptied
16.	Observe amount of urine in sterile drainage system	To ascertain a urinary residual & awareness of bladder capacity
17.	Ensure that the glans penis is clean and if foreskin present is returned to its normal position.	To minimise risk of a penile phimosis
18.	Remove gloves and apron and wash hands as per hand decontamination policy and procedure as per (IC2 Hand decontamination policy)	To minimise risk of infection.
19.	Dispose of equipment as per policy as per (HS1 Waste Management Policy)	To prevent contamination to the surroundings
20.	Advise patient on problems that may occur, i.e. symptoms of infection, haematuria.	To allow for prompt intervention if patient requires advice.
21.	Supply contact numbers to the patient/carer. - The relevant Community Care Team - Community Continence & Urology Service 0151 488 8230	To enable the patient to have access to advice and support

No.	Action	Rationale
22.	Record information using catheter EMIS template as per (CP3 Health Records Policy); this should include: • consent • reasons for catheterisation • residual volume • date and time of catheterisation • catheter type and size • colour and odour of urine • problems negotiated during the procedure • patient experience and problems	To provide a point of reference to ensure accurate record keeping.

11.2 Procedure for education of instruction of patient/carer in intermittent self-catheterisation (ISC) - Male & Female

This procedure must only be used when the patient/carer performs the insertion & removal of intermittent urinary catheter. A no touch technique or a clean technique is used by a patient /carer.

It is advisable to supply the patient/carer with ISC information before the procedure to allow for informed consent by utilising educational booklet/DVD or Internet resources.

Equipment:
Personal Protective Equipment (PPE) (Section 10.2) Intermittent catheter: standard length for male patients – Female length for female patients If appropriate an intermittent catheter with pre attached drainage system Reusable intermittent catheters should be cleaned with water and stored dry in accordance with the manufacturer's instructions. • Soap, water; • Cloth / wipe to wash genital area; • If procedure is carried out on the bed: towel; • Female patients – Mirror; • All patients a clean measuring jug or receptacle.

No.	Action	Rationale
1.	Explain the procedure to the patient/carer.	To ensure that the patient understands the procedure and gives informed consent as per (MH1 Consent to Treatment)
2.	Advise patient to try and empty their bladder if possible.	To minimise volumes drained and increase urethral lubrication
3.	Discuss with the patient/carer different positions in which intermittent catheterisation can be performed, i.e. - Sitting on the toilet; - Standing over the toilet; - On the bed. - In their wheelchair.	To ensure a comfortable and safe position

No.	Action	Rationale
4.	If the catheter is not pre-lubricated, follow manufacturers guidelines e.g. fill pouch containing catheter with water.	Adequate lubrication helps reduce urethral trauma and minimises the discomfort experienced by the patient (Cochran, 2007).
5.	Ask the patent to place the opened catheter packaging near to where they can reach and without the catheter contained to become contaminated	If there is risk of the contained catheter being contaminated dispose of and acquire a new sealed catheter to minimise risk of infection
6.	Advise patient/carer to wash hands & genitalia with soap and water (Rantell, 2012)	To minimise risk of infection
7.	Female patients – Ensure enough time is given to educate the patient in their anatomy by the use of a mirror If a carer is performing the ISC the nurse should help identify the urethral meatus of the patient.	To assist in the identification of urethral meatus
8.	Advise the patient/carer to remove catheter from packaging using a no touch technique i.e. by holding the catheter by the drainage attachment	To minimise risk of infection.
09.	Male patients - Advise the patient/carer to retract any foreskin and to raise the penis into an upright position. Female patients – ask the patient to position mirror to enable good visibility of genitalia If the catheter has a gripper or sleeve instruct patient to only touch the gripper or sleeve to hold the catheter (Non touch technique) If the catheter does not have a gripper or sleeve instruct the patient to hold the catheter near to the drainage (Clean technique) Advise the patient to insert the intermittent catheter into the urethra until urine flows.	Retraction of the foreskin prevents contamination. Raising the penis in an upright position straightens the penile urethra.
10.	Male patients - Advise the patient that he might feel some resistance at the external sphincter; ask him to cough or to strain as if passing urine and advise to continue inserting the catheter gently. All patients/carers - If unable to insert the catheter, stop the procedure. A referral to Secondary care for investigations may be required if a stricture is suspected.	Some resistance may be due to spasm of the external sphincter. To avoid trauma to the urethra.

No.	Action	Rationale
11.	If the amount of urine drained is required and an intermittent catheter without a drainage bag attached is not used ask the patient/carer or carer to place a measuring jug in between the patient's legs or on a closed toilet lid.	To ascertain amount of catheterisations required
12.	When urine begins to flow, advise to advance the catheter another 1 - 2 cm.	To ensure catheter is in the bladder
13.	When urinary drainage stops instruct the patient/carer to slowly remove intermittent catheter in stages – Urine may start to flow again	To ensure a good drainage of the bladder
14.	Male patients - Advise the patient/carer to dry the glans penis and to return any foreskin to its normal position.	Reduces the risk of infection, irritation and paraphimosis. If patient/carer or nurse is unable to return the foreskin to its normal position seek medical advice.
15.	Dispose of catheter in household rubbish, advise patient/carer not to flush it down the toilet.	To prevent environment contamination
16.	Advise patient/carer to wash hands with soap and water	To minimise risk of infection
17.	Inform patient/carer of any potential complications post ISC – Stinging sensation at next void, Haematuria, Signs & symptoms of UTI.	To allow for prompt remedial intervention
18.	Supply contact numbers to the patient/carer. - The relevant Community Care Team - Community Continence & Urology Service 0151 488 8230	To enable the patient/carer to have access to advice and support
19.	Record information using catheter EMIS template as per (CP3 Health Records Policy); this should include: • consent • reasons for catheterisation • residual volume • date and time of catheterisation • catheter type and size • colour and odour of urine • problems negotiated during the procedure • patient experience and problems	To provide a point of reference to ensure accurate record keeping.

Appendix 1 - Competency document – For Registered Nurses or Nursing Associate/Assistant Practitioner to perform Female / Male intermittent urethral catheterisation (IC)

Prior to completing this document the Registered Nurses or Nursing Associate/Assistant Practitioner must have completed the CWP catheterisation training or provide evidence of IC training in the previous 3 years. The practical procedure should be carried out as directed per Clinical guideline for insertion and removal of an intermittent urethral catheter (IC) (Section 11.1) In order to complete this document the Registered Nurse or Nursing Associate/Assistant Practitioner will need to undertake a minimum of 1 - 3 supervised practices in urethral intermittent catheterisation or until the practitioner feels confident and competent to carry out the procedure.

Please note if the Registered Nurse or Nursing Associate/Assistant Practitioner has completed the competency document in female or male indwelling urethral catheterisation, only 1 supervised practice is required if they feel confident and competent. It is the Registered Nurse or Nursing Associate/Assistant Practitioners responsibility to keep up to date by completing the CWP catheterisation training Community Continence every 3 years. On completion of this competency document retain it in your professional portfolio as evidence.

Name & Designation of Registered Nurse or Nursing Associate/Practitioner						
Registered Nurses or Nursing Associate / Nursing Associate should be able to demonstrate competency in the following elements and work within CWP guidelines and policies	**Date**	**Initial**	**Date**	**Initial**	**Date**	**Initial**
- Assess and review the need for catheterisation – Consider alternatives						
- Assess if the patient could carry out the procedure her/himself (Section 11.2)						
- Identifies medical/surgical history and any known allergies						
- Explain procedure and associate risks to the patient						
- Gain informed consent as per (MH13 Consent to treatment)						
- Work within CWP's Infection Prevention & Control policies						
- Check equipment and materials to ensure they are safe and fit for purpose before usage. Check type, size, expiry date of catheter						
- Prepare patient for procedure						
- Prepare environment and equipment						

- Describe when not to proceed or abandon intermittent catheterisation and what actions to take						
- Demonstrate an aseptic technique throughout						
- Insert and remove intermittent catheter as per (Section 11.1)						
- Dispose of clinical waste appropriately as per (HR1 Waste management policy) -						
- Record information as per (CP3 – Health records policy) and supply contact numbers						

On completion of this competency document retain it in your professional portfolio as evidence.

Appendix 2 - Competency document – For patients carers to perform Female / Male intermittent catheterisation

Only carers employed in an official capacity (paid or voluntary) are required to complete this competency document. It is however, good practice to use this competency document as a guide when a Registered Nurse or Nursing Associate/Assistant Practitioner are teaching ISC to a patient.

Prior to performing IC/ISC an initial assessment must be completed by a Registered Nurse competent in IC and teaching ISC. Once an assessment has been completed and the intermittent catheters are prescribed as part of bladder management the task can be delegated to a carer. It is the Registered Nurse's responsibility to ensure a review of the carer's skills is undertaken.

- A certificate of indemnity insurance must be produced by the carer and uploaded to patient's EMIS Records.

- Training must only be performed on a named patient – named carer basis as part of the individual patient's bladder management. Carers, cannot transfer this skill to other patients and have to be reassessed per patient.
- All named carers must receive the appropriate training and be deemed confident and competent under supervised practice before undertaking this procedure independently
- Contact details of the relevant Community Care Team must be given to the patient and carer.

In order to complete this document the carer will need to undertake between 2 – 3 supervised practices until the carer feels confident and competent to carry out the procedure. It is the carers responsibility to maintain skills and knowledge and to report any limitations in knowledge or reduction in skills to the patients Community Care Team for further training & support.

Patient name		**D.O.B & NHS Number**					
Address							
Name of carer & employing agency (If employed)							
Name & Designation of Assessor/Assessors							
The carer must demonstrate competencies in the following procedures		**Date**	**Initial**	**Date**	**Initial**	**Date**	**Initial**
Prior to undertaking the procedure the carer should ask the patient if they have are experiencing any of the following;							

• Discomfort or burning sensation in or around the intermittent catheter insertion site or has symptoms of UTI; • Has symptoms of constipation; • Has concerns about the procedure being performed. If the answer to any of these is **YES** the procedure **SHOULD NOT** be undertaken & discussion with Community Care Team required.						
Explains procedure to patient and gains verbal consent from the patient						
Ensures working area is free of clutter or obstruction						
Ensures patient is lying down on their back and comfortable Covers the patient to maintain dignity						
Checks intermittent catheter packaging for expiry date						
Identifies when to abandon procedure						
Is aware that if blood is seen in urine drained or if urine is not draining to contact the appropriate Community Care Team for advice.						
Demonstrates safe and correct insertion/removal of intermittent catheter						
Disposes of waste appropriately in a closed/sealed bag Ensures patient is comfortable						
Records the following information in the patient's appropriate records; Batch number and expiry date of catheter – reports the colour of urine drained and notes if there is any debris or blood seen.						

On completion of this competency document the carer should retain it as evidence.

Appendix 3 Information on Autonomic Dysreflexia

Patients with spinal cord injuries at T6 and above are particularly susceptible to autonomic dysreflexia. Spinal injury patients are usually aware of this condition and have experienced it prior to hospital discharge. However health care professionals need to be aware that a small proportion of patients who have severe forms of Parkinson's disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke may also develop Autonomic Dysreflexia.

Autonomic Dysreflexia is a sudden and potentially lethal surge of blood pressure often triggered without warning by acute pain or a harmful stimulus. This occurs because the body is unable to lower the blood pressure therefore the blood pressure will continue to rise until the offending stimulus is removed.

Factors that can trigger Autonomic Dysreflexia:

- Full bladder / insertion of urinary catheter;
- Constipation;
- Skin i.e. cuts, bites, burns;
- Sexual activity / menstruation/Labour.

Symptoms of Autonomic Dysreflexia may be mild or severe. Patients can present with one or more of the following:

- Cool, clammy skin;
- Flushed face;
- Blotchiness;
- Sweating above level of injury;
- Pounding headache;
- Seeing spots or blurred vision;
- Nausea;
- Feeling Anxious;
- Increased blood pressure.

Treatment for Autonomic Dysreflexia:

- Remove intermittent catheter;
- Sit the patient up;
- Give prescribed medication for Autonomic Dysreflexia;
- Monitor blood pressure;
- Contact 999 if the hypertension cannot be controlled.

If you suspect the symptoms of Autonomic Dysreflexia in a patient who has not been diagnosed with it previously, i.e. patients who have severe forms of Parkinsons disease, Multiple Sclerosis, Cerebral Palsy or Spina Bifida or had a severe stroke;

- Contact 999;
- Sit the patient up;
- Monitor blood pressure.

Appendix 4 – Public Health England

Guide to donning and doffing standard Personal Protective Equipment (PPE) for health and social care.

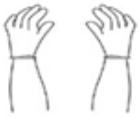
Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose make sure it is extended to cover your and chin.

3. Put on your eye protection if there is a risk of splashing

4. Put on non-sterile nitrile gloves.

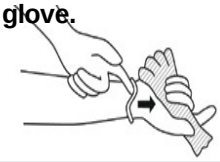


5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.



2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Wash your hands with soap and water.