

# Urinary Catheter Care

## Statement of Best Practice

*Patients with a urinary catheter in situ will have insertion and care delivered safely, optimising their comfort and minimising adverse affects.*

## Introduction

Urinary tract infections (UTIs) are one of the most common types of healthcare – associated infections. Virtually all healthcare-associated UTIs are caused by the instrumentation of the urinary tract.

## Risk Assessment

Using any form of catheter has a number of associated risks. These risks are becoming more serious with the continued development of a wide range of multi-resistant bacteria which cause catheter associated urinary tract infections and associated life threatening complications. Risk assessment is an important part of catheter care.

## Reasons for catheter insertion

- Urine output monitoring of critically ill patients (haemodynamic monitoring)
- Bladder outlet obstruction – retention
- Open wounds / pressure damage where healing is impaired due to the contamination of urine
- Disability makes moving/ changing very painful
- Allow bladder irrigation
- Introduce cytotoxic drugs to the bladder
- Bladder function tests
- Surgical procedure of post operatively if required
- Empty the bladder before childbirth.

## Pre-insertion

**Consent** – consent should be gained from the patient if mental capacity allows. If the patient is not able to consent this should be documented as procedure done in the best interest of the patient.

**Allergies** – ensure no Latex allergies or use latex free catheter.

**Equipment** - ensure that the equipment is available in the correct size and length. (Female catheters are not licensed for male patients or children).

## Insertion

- Prepare the patient giving full explanation of what is happening ensuring their privacy and dignity is maintained.
- Using strict Aseptic Non Touch Technique insert the catheter following Trust policy.

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- Collect Urine specimen for Culture and Sensitivity.
- Secure catheter and bag so that it has no tension on the tube (consider using a securing device if available) and the drainage bag is lower than the patient but not touching the floor.
- Ensure the patient is comfortable and the catheter is patent and draining.
- Document procedure, ensure catheter used is recorded.

### Daily Care

- Record fluid balance as per patients' condition.
- Catheter toilet performed at least 12 hourly following Trust policy.
- Check catheter patent and draining.
- Check bag is lower than the patient and not touching the floor and that there is no tension on the tube.
- Follow Trust policy regarding collection of samples, maintaining the closed system.
- Assess the need for catheter – can it be removed?

**If NO drainage** – check tube is not kinked / clamped. Perform bladder scan if equipment available. Inform medical staff as may be necessary to remove catheter and insert a new one. Bladder washouts are not advised unless ordered by the medical staff.

### Removal

- Prepare the patient giving full explanation of what is happening ensuring their privacy and dignity is maintained.
- Administer antibiotics as per protocol prior to removal.
- Monitor fluid balance following removal.
- Ensure there is a **documented care** plan if the patient fails to pass urine.
- Consider when you remove the catheter; late in the day is not the best time as the patient may be up all night at the toilet.

### References:

Royal College of Nursing (2012) **Catheter Care**. London RCN

**Chart adapted from Queen Elizabeth Hospital, Gateshead**