Is Documentation of Urethral Catheterisation Important? An Experience in a District General Hospital, UK

Introduction and Objectives: Urethral catheterisation is a common procedure performed in every hospital worldwide. Documentation of this procedure is of utmost importance as it can influence the decision for further management especially the record of residual volume of urine. This procedure although simple, can be associated with high morbidity such as urosepsis. We want to evaluate our hospital practice with published guidelines. Aim: One day snapshot to assess the quality of documentation of urethral catheterisation in our district general hospital.
Materials and Methods: We collected the data prospectively as a snapshot of one day. All patients who had catheter in situ on the specific day were included. Total of 44 patients had catheter in situ. Standards were selected form Royal College of Nursing Guidelines on catheterisation. We collected data regarding patients' demographics, catheter size, type, indication and residual urine volume. Catheter insertion was performed by doctors and nurses in 28:16 ratios.
Results: Our results showed that in 18 patients (40.90%) indication of catheterisation was documented. Date of catheterisation and type of catheter was recorded in 29 (65.90%), 20 (45.45%) patients respectively. However in 31 patients (70.45 %), there was no record of residual urine, which is important for further management.
Conclusion: Overall we concluded poor documentation of urethral catheterisation in our hospital. We suggest developing a universal proforma for urethral documentation in line with British Association of Urological Surgeons (BAUS) consent forms. We also suggest aggressive teaching sessions for junior doctors and nurses to improve documentation regarding catheterisation and regular auditing, as it will improve our practice.