Logo, company name

Description automatically generated

Catheter Management Policy

HP108a Homes Policies

November 2024

**Contents**

[1 Introduction 3](#_Toc181867506)

[2 Scope and Purpose 3](#_Toc181867507)

[3 Definitions 4](#_Toc181867508)

[4 Standard Operating Procedures 5](#_Toc181867509)

[5 Assessment (care homes with nursing) 6](#_Toc181867512)

[6 Recording 8](#_Toc181867515)

[7 Catheter Care 10](#_Toc181867517)

[8 Catheter Bags 11](#_Toc181867518)

[9 Roles and Responsibilities 12](#_Toc181867519)

[10 Training and Monitoring 13](#_Toc181867520)

[11 Communication and Dissemination 14](#_Toc181867521)

[12 Impact Assessments (Inc. EDI) 15](#_Toc181867522)

[13 Resources 15](#_Toc181867523)

[14 Appendices 16](#_Toc181867524)

[15 Version Control 20](#_Toc181867525)

1. Introduction
   1. Continence is one of the fundamentals of nursing care and maintaining continence can significantly increase an individual’s quality of life. Many people may need the support of continence products, such as catheters, to help them manage their everyday activities.
   2. This document provides overarching guidance on catheter care including insertion and standard infection control precautions. Throughout the document, all these elements are included under the umbrella term of catheter care and management.
   3. This policy document should be read in association with MHA’s general Continence Management Policy.
2. Scope and Purpose
   1. This document applies to all MHA colleagues who have a responsibility for catheter care, including temporary or agency personnel. The procedures, guidance and information within this document align to national standards and best practice guidance.
   * **Residential Care Homes** – District Nurses or specialist practitioners are responsible for catheterising. Care colleagues must complete continence assessments, support plans and any relevant records in accordance with guidance provided by the District Nurse or specialist practitioner.
   * **Care Homes (Nursing)** – Registered Nurses (RN’s) who are deemed competent and have undergone relevant training can perform catheterisation and must complete assessments, support plans and relevant records, referring to a doctor or specialist practitioner for clinical advice as required.
   1. Catheterisation should only be undertaken after considering alternative methods of management and the person’s clinical need for catheterisation should be reviewed regularly, with the urinary catheter removed as soon as possible (NICE, 2012).
   2. Standards required for registered services include:
   * Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe Care and Treatment
   * The Regulation and Inspection of Social Care (Wales) Act 2016, Regulation 21: Standards of Care and Support
3. Definitions

| Term | Definition |
| --- | --- |
| **Bacteriuria:** | The presence of bacteria in the urine. In the absence of symptoms, this is referred to as asymptomatic bacteriuria, or catheter colonisation if the patient has a catheter in situ. |
| **Catheter Associated Urinary Tract Infection (CAUTI)** | Occurs when pathogens gain access to the bladder via the outer surface of the catheter causing symptoms such as fever and supra pubic tenderness.  A known risk of having a urinary catheter in situ. |
| **Catheter Instillation/Washout:** | A solution which is inserted into the bladder via the catheter. |
| **Closed System** | Aseptic system from catheter tip to drainage bag.  Each time a break is made in the closed system, e.g., changing a catheter bag, it is an opportunity for infection to be introduced |
| **Female Catheterisation** | Insertion of a urinary catheter into a female |
| **Intermittent Catheterisation** | Insertion of a urinary catheter to drain urine or instil solution into the bladder which is immediately removed and not left in situ |
| **Long Term Catheter:** | A catheter which is in situ for longer than 14 days |
| **Male Catheterisation** | Insertion of a urinary catheter into a male |
| **Short Term Catheter** | A catheter which is left in situ for no longer than 14 days |
| **Supra-pubic Catheter** | A urinary catheter inserted via the anterior abdominal wall directly into the bladder |
| **Urinary Catheter** | A specially designed tube passed into the bladder using aseptic technique, for the purposes of draining urine, the removal of clots/debris or the instillation of medication. |
| **Urinary Tract Infection** | Successful invasion, establishment and growth of microbes causing infection. Any factor interfering with the normal flow of urine can increase susceptibility to infection |

1. Standard Operating Procedures

New Admission – Catheter in situ (all service settings)

| **Action** |
| --- |
| Complete Preadmission Assessment to gather the following information:   * Reason for catheterisation * Date when the catheter was inserted and by who * Type of catheter * Medical history including any urinary infections * Support needs, i.e., can the person independently empty the bag or requires full support * Mobility * Fluid intake, is the individual able to manage their own fluid intake * Any concerns * Make sure there are sufficient supplies of equipment prior to moving in   **On Moving in (Day 1)**   * Make contact with doctor or specialist practitioner for further information * Nursing Only - Complete Catheterisation Risk assessment and Continence Assessment * Residential – complete Continence Assessment * Complete Nutrition Assessment (MUST) * Ensure Critical Information is reflective that a catheter is in situ and the type * Develop continence, diet and fluid support plans based on the results of the assessments, including all Catheter interactions as linked interactions on the support plan * Determine and record if fluid intake monitoring is required and for how long to ensure adequate hydration and reduce risk of infections – if required the Daily Fluid Intake [interaction] should be personalised to include a fluid target * Record frequency of assessment and review * Effectively communicate individual support needs with all colleagues |

1. Assessment (care homes with nursing)
   * 1. A urinary catheter is an invasive procedure and should not be undertaken without full consideration of the benefits and risks. The presence of a catheter can be a traumatic experience for individuals and have huge implications for body image, mobility, pain, and comfort.
     2. A nurse must ensure, in consultation with a doctor or specialist practitioner, the individual and their representative that the decision to catheterise is made for the right clinical reasons following a clinical assessment, completed with the doctor or specialist practitioner. Complete Multidisciplinary [interaction] following any discussions with healthcare professionals
     3. Inform the individual of the reasons and necessity for the procedure and determine whether there are any contra‐indications and ensure that verbal consent and agreement is reached, and the relevant information is recorded in the individual’s records.

Individuals Lacking Capacity

* + 1. Sometimes it will be necessary to provide care and treatment to individuals who lack the capacity to make decisions. In these situations, colleagues must adhere to the Mental Capacity Act 2005 (MCA 2005) in partnership with the doctor or specialist practitioner
    2. Further information can be located in MHA’s policies, Mental Capacity and Deprivation of Liberty Safeguard and Consent Policy

Catheter Insertion

* + 1. Catheter insertion should only be undertaken by a practitioner or nurse who has received training in the procedure and is deemed to be competent.
    2. In conjunction with the doctor or specialist practitioner select the type and gauge of catheter to be inserted based on the individual’s clinical history, age, gender, and preferences
    3. Always comply with standards Infection Control Precautions (SICP’s)
  + Clean hands and wear appropriate PPE, e.g., gloves (sterile for catheterisation, non-sterile for catheter care), disposable apron, when dealing with all aspects of catheter care. Facial protection should be worn when there is a risk of splashing to the face.
  + Dispose of all catheter care items as offensive waste if there is no confirmed or suspected infection or as infectious waste if there a confirmed or suspected infection.
  + Clean hands after removing and disposing of PPE
    1. Catheterisation is an aseptic procedure and, therefore, sterile equipment (including a sterile syringe to inflate the balloon) and an aseptic technique must be used.
  1. The perineum will require cleansing with soap and warm water before commencing the aseptic technique.
  2. To minimise introduction of bacteria during catheterisation, the urethral meatus (opening) should be cleaned using sterile normal saline prior to catheter insertion.
  3. For both male and female residents, a lubricant or anaesthetic gel from a single use container must be used and inserted directly into the urethra.

Anaesthetic gels should be left for the recommended time.

* 1. A new catheter should be used after each unsuccessful attempt.
  2. Catheter balloons must only be filled with sterile water.
  3. Attach the catheter to a sterile closed drainage bag.
  4. Intermittent self-catheterisation is always an aseptic technique when undertaken with support from colleagues. When undertaken by an individual, it is a clean technique (where gloves are not required, but strict hand hygiene should be used).
  5. Do not change catheters unnecessarily, but if the catheter is frequently blocking, bypassing, etc., discuss with your local Specialist practitioner or the individuals GP.

1. Recording
   1. The following details should be recorded in the individual’s personal records following catheterisation, take a photograph of the label if provided by manufacturer (Use Catheterisation Interaction Record interaction).
   * Individual consent.
   * Catheter Bag Emptied (interaction) - Amount of urine drained with description and colour.
   * Specimens and Investigation (interaction) - Specimen collected (if required) and the reason why.
   * Any problems or discomfort, the number of attempts.
   * Catheterisation Record (interaction) - Reason for catheterisation or Record of Catheter Change
   * Catheterisation Record (interaction) - Date of insertion, catheter brand, size, type
   * Balloon size, batch number, expiry date.
   * Lubricant used - lot number and expiry date.
   * In men, was any obstruction felt at prostatic area.
   * No pain related to balloon inflation, free movement of the catheter once balloon inflated.
   * Type of cleansing lotion used, where applicable
   * Name of person catheterising
   * Support plan update including fluid monitoring frequency, if assessed as required – Catheter Fluid Intake and Output – Senior/Nurse Check must be completed daily where intake and output are being monitored.
   * Continence support plan must include links to applicable Catheter care interactions (Catheter Bag Change / Catheter Bag Emptied / Catheter Change / Catheter Site Cleaning / Catheterisation Record (nursing)/ Catheterisation Risk Assessment (nursing)/Catheter Fluid Intake and Output – Senior/Nurse Check.

Fluid output and intake monitoring

* + 1. Residential homes must refer any concerns to the district nurse or equivalent clinical professional and action follow advice regarding frequency of monitoring.
    2. If first-time catheterisation takes place, it is safe practice to monitor and make note of urine output for **four hours** after catheterisation.
    3. If the individual passes more than 200mls per hour after initial drainage, they need to be referred to the accident and emergency unit for fluid replacement as they are in risk of hypovolemic shock' and to note hourly urine output in critically ill patients
    4. It may be necessary to record fluid intake balanced against urinary output and, in some cases, this may be ongoing (for example, renal function and or failure). [Daily Fluid intake and Catheter Bag emptied interaction/Catheter Fluid Intake and Output – Senior/Nurse Check].
    5. Always review the 24-hour urine output, urine colour, visual sediment etc. using the interaction logs attached to the continence support plan and complete Catheter Fluid Intake and Output – Senior/Nurse Check, record twice daily (2pm/midnight) to confirm fluid intake/output has been checked and if applicable: Action to be taken by staff where input / output is below an acceptable level.
    6. Where an individual has been in hospital or there are any indications of poor fluid intake, fluid intake and output monitoring must continue for at least 2 weeks
    7. If a catheter is in situ, the continence interaction should be personalised to remove questions relating to urine output as this should be recorded in Catheter Bag Emptied.
    8. Link to guide [How to add and remove parameters](https://intranet.mha.org.uk/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=16.+How+to+add+and+remove+parameters+from+an+interaction.docx&fileguid=5e557774-03d3-4a0f-88e7-8b766ce8f343)

1. Catheter Care
   1. Residential care homes should seek advice from the district nurse or specialist practitioner, complete assessments and support plans clearly indicating the support required, i.e., frequency of urine bag changes, if fluid monitoring is required, how and when to report any concerns.
   2. Use a catheter anchoring device and two leg straps to prevent pulling and damage to the urethra.
   3. Move the catheter anchoring device daily, from leg to leg, to avoid pressure damage to the skin and bladder opening.
   4. Inspect the urethral opening daily for signs of pressure damage. If damage noted, record in the individual’s records and inform the resident’s GP.
2. Catheter Bags
   1. Catheter drainage bags may be body-worn, i.e., leg bag, or free standing.
   2. If an individual is independently mobile, a leg bag should always be used, held in place with an anchoring device and two leg straps to reduce the risk of damage to the urethra/bladder by the catheter/catheter drainage bag being pulled.
   3. Position the urine drainage bag below the level of the bladder to allow good drainage. Incorrect positioning, even for a short time, is linked to back flow (urine in the tube or bag flowing back into the bladder) and higher rates of infection.

* 1. Body worn (leg bag) systems should be changed weekly (or in line with manufacturer’s instructions). Each change should be documented in the Catheter Bag Change interaction
  2. When opening the closed system to fit a new bag, a rigorous non-touch clean technique is essential. The tip of the new drainage tube must not be touched before inserting into the catheter.
  3. Single use 2 litre night bags should be added for overnight drainage in residents with body worn (leg bag) systems, using a non-touch clean technique.
  4. Catheter bags must be kept off the floor (attach to a stand/hanger).

1. Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| **Registered Nurses (RN’s)** | * Remain accountable and responsible for all aspects of their practice, providing a high standard of care and support * Make appropriate and timely referrals to external clinical professionals * All RNs must have read and understood this guidance, received appropriate training, and be deemed competent. * Complete all records as described within this policy and procedures * RNs will be expected to update their competency by reflection on practice and keep this in their portfolio for revalidation purposes. * Support, guide, and mentor colleagues in promoting best practice in catheter care aligned to their role and responsibilities * Effectively communicate any changes to the care team and manager, as appropriate |
| **Care Teams (residential)** | * Adhere to all aspects of this policy and associated documents * Complete and review assessments and support plans for continence care * Refer to District Nurse or specialist practitioners for guidance and advice * Report any concerns relating to catheter care, including skin integrity and fluid intake * Attend relevant training * Effectively communicate any changes to the care team and manager, as appropriate |
| **Home or Scheme Managers** | * Assess training requirements and skills required ensure the service can support with catheter care * Responsible for promoting a culture of excellence in supporting continence and catheter care * Responsible for ensuring all colleagues involved in delivering continence and catheter care are aware of this policy and have the required knowledge and skills to deliver the standards expected * Ensure improvements are made where any concerns are identified through audits, monitoring, complaints, and investigations. * Digital records, support plans, risk assessment reviews and audits are completed in accordance with MHA’s internal auditing schedules * Support team members to attend relevant training * Engage with external professionals, communicating any recommendations to the relevant care teams * Support teams to attend relevant training * Report all incidents on RADAR * Submit regulatory notifications as required including safeguarding * Report outcomes of any investigation within Duty of Candour code of practice |
| **Area Managers** | * Responsible for monitoring compliance with this policy and associated procedures during prescribed audits and visits * Action, and report, poor performance and non-compliance * Review concerns with Managers to identify trends, patterns and any action required to manage risks * Work with operational colleagues to promote and deliver best practice * Disseminate any policy or procedural changes to respective teams * Monitor all medical or equipment alerts have been received, recorded, and disseminated to the teams * Monitor external reporting i.e., Safeguarding/Adult protection and regulatory bodies |

1. Training and Monitoring
   1. All colleagues undertaking catheter management must undertake appropriate training and signed off as competent.
   2. Nursing Colleagues must attend all relevant training and undertake competency assessments to remain qualified in delivering high standards of care and support in accordance with legislation and best practice guidance.
   3. The Nursing and Midwifery Council (NMC 2008b), states that nurses performing urinary catheterisation should have:
   * A good knowledge of the urinary tract anatomy and physiology
   * A sound knowledge of the principles of aseptic technique
   * A knowledge of equipment and devices available
   * Awareness of infection control practice and legislation
   * Practice within the limits of competence and be able to recognise when they need to seek help from more experienced staff
   * Understanding of the issues of informed consent and a knowledge of the Mental Capacity Act
   * The ability to deliver care based on the best available evidence or best practice.
   1. Training compliance will be monitored through MHA’s internal People Development system (Learning Zone); training data reports are available to all managers
   2. Compliance with this policy and associated procedures will be monitored during prescribed audits and visits in accordance with MHA’s governance framework.
2. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Each colleague’s line manager must ensure that all teams are aware of their roles, responsibilities.
   3. This policy will be available to the people we support and their representatives in alternate formats, as required.
   4. Any review of this policy will include consultation with our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.
   5. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)
3. Impact Assessments (Inc. EDI)
   1. Equality, Diversity, and Impact Assessment to be confirmed.
4. Resources
   1. MHA policy documents, guidance, and Nourish Interactions
   * Catheter and Suprapubic Catheter Competencies
   * Continence Management Policy
   * Nutrition and Hydration Policy
   * Mental capacity and Deprivation of Liberty Standards
   * Consent
   * Standard Infection Control Precautions
   1. Nourish Interactions
   * Continence Assessment
   * Constipation Risk Assessment
   * Catheterisation Risk Assessment (nursing only)
   * Catheter Change
   * Catheter Site Cleaning
   * Catheter Bag Change
   * Catheter Bag Emptied (fluid output)
   * Daily Fluid interaction (for fluid monitoring – personalised to include a target)
   * Catheterisation Record (including photograph of batch label)
   * Catheter Fluid Intake and Output – Senior/Nurse Check
   1. External Resources
   * [Royal College of Nursing; Catheter care for Health Care Professionals, 2021](https://www.rcn.org.uk/Professional-Development/publications/catheter-care-guidance-for-health-care-professionals-uk-pub-009-915)
   * [National Institute for Health and Care Excellence (NICE); Urinary Tract Infections in Adults (QS90)](https://www.nice.org.uk/search?q=urinary+tract+infections)

[Urinary Catheter Care Policy for Care Home Settings](https://www.infectionpreventioncontrol.co.uk/resources/urinary-catheterisation-policy-for-care-home-settings/)

* + [Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12: Safe Care and Treatment](https://www.cqc.org.uk/guidance-providers/regulations/regulation-12-safe-care-treatment)
  + [The Regulation and Inspection of Social Care (Wales) Act 2016: Regulation 21 Standards of Care and Support](https://www.gov.wales/sites/default/files/publications/2024-03/guidance-for-care-home-and-domiciliary-suppliers-2024.pdf)

1. Appendices
   * Appendix 1 – Catheter Problem Solving
   * Appendix 2 – Urinary Catheter Care Quick Reference Guide

Appendix 1 - **Catheter Problem Solving**

| Problem | Possible Reasons to take action |
| --- | --- |
| **Urine does not drain** | * Check for mechanical obstruction – kinked tubing; occlusion by leg straps; bag higher than level of bladder * Check for constipation * Occlusion of catheter eyes by anaesthetic gel or bladder mucosa – gently instil sterile water/saline to clear eyes; check that leg bag is not too low down on the leg * Consider that the individual maybe dehydrated or in renal failure * If new catheter doesn’t drain – check that it’s in the urethra; that the catheter is correct length and that eyelets are in the bladder |
| **Encrustation** | Main cause is struvite formation (calcium phosphate and magnesium ammonium phosphate salts); struvite forms as a result of precipitation of these salts from the urine when it becomes alkaline because of urease forming bacteria  Encourage fluid intake, which include citrate-based drinks |
| **Haematuria** | May be caused by trauma, infection, renal/bladder pathology; if severe, seek medical help urgently.  Treat for shock and monitor for clots and blockages |
| **Urine bypassing** | Check for tube kinking and/or constipation  If due to bladder spasm or irritation: consider anticholinergic medication; consider a smaller catheter size; check balloon size; consider catheter material (latex allergy)  If due to encrustation: change and inspect catheter |
| **Urethral discharge** | During normal micturition a mucus substance is produced by the para-urethral glands (which line the urethra) to protect against ascending infection and is usually flushed away.  However, in the catheterised patient, the mucus drains away through peristaltic action and gravity rather than being flushed away and can result in presence of mucus outside the urethra and on the catheter surface |
| **Urethral discomfort** | This should subside after 24 hours of initial insertion, if it persists refer to doctor or specialist practitioner for advice |
| **Non-deflating balloon** | Check that syringe is not faulty; leave syringe for a few minutes to allow water to drain spontaneously – not forcibly as a vacuum may result in the inflation channel.  If unsuccessful, discuss with doctor regarding a urological opinion. NEVER cut the valve off |
| **Difficulty in removing catheter** | Expert opinion suggests that inflating and deflating balloon about four times and then leaving for five minutes before catheter removal can assist in easier extraction of catheter.   * If the catheter cannot be removed, stop, and refer to the doctor or specialist practitioner * All silicone catheters should be left for 3-5 minutes after deflating the balloon before removing. * This allows the balloon to completely deflate. |

Appendix 2 - Urinary Catheter Care Quick Reference Guide

1. Version Control

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Version Date | Revision Description / Summary of Changes | Author | Next Review Date |
| 8 | December 2023 | Full review of policy and procedures, new template, revised external links to latest guidance  Interim review – continence related documents to be reviewed and revised to align with best practice  Policy amended to align with digital support planning | Head of Standards & Policy  Senior Nurse Advisor  Clinical Nurse Advisors | March 2025 |
| 9 | November 2024 | Addition of Catheter Fluid Intake and Output – Senior/Nurse Check interaction in sections 6.1/6.2  Additional monitoring for intake and output  Updated for transfer to BAU  England and Wales regulations included | Head of Standards & Policy  Head of Quality Improvement  Clinical Nurse Advisor  Operational Project Lead | November 2026 |