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| <b>Document Title:</b>  | <b>ADULT URETHRAL AND SUPRA-PUBIC CATHETERISATION AND CATHETER CARE, INCLUDING TRIAL WITHOUT CATHETER</b> |  |   |
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| <b>Related Trust Policies</b> (to be read in conjunction with) | 11001 The Mental Capacity Act (2005) policy<br>04071 Policy for standard infection prevention precautions<br>04080 Consent to examination or treatment policy<br>05118 Chaperone policy<br>11037 Adult discharge policy<br>09100 Incident policy<br>08038 Aseptic technique and aseptic non-touch technique<br>09100 Trust incident policy<br>11025 Serious incident policy |
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## **1.0 Purpose**

- 1.1 Urethral catheters are for the purpose of draining urine or instilling fluids into the urinary bladder as part of medical treatment. A catheter misplaced during insertion can result in trauma and false passages within the urethra.
- 1.2 To assist the appropriately trained clinical staff in the insertion of male and female urethral catheterisation and catheter care.
- 1.3 To ensure good practice that should minimise the number of adverse incidents.
- 1.4 To reduce the risk of catheter acquired infections.
- 1.5 To reduce the number of failed urethral catheterisations in males, which can result in trauma and false passages and lead to supra-pubic catheterisation.

## **2.0 Introduction**

- 2.1 Urinary catheterisation is the insertion of a specially designed hollow tube into the bladder using aseptic technique, for the purpose of draining urine, the removal of clots/debris and the instillation of medication.
- 2.2 Urinary catheters may be classified as intermittent, for periodic insertion or indwelling catheters which are retained by inflating an integral balloon within the bladder; they may be inserted urethrally or supra-pubically.
- 2.3 Catheterisation will form part of a holistic assessment based on the patient's diagnosis and nursing needs. The decision to catheterise a patient is made by the nurse / doctor and the patient. Urethral catheterisation should not be encouraged for the purpose of obtaining catheter specimens of urine nor to assess residual urine volume.

## **3.0 Scope**

- 3.1 This guidance applies to the indications, insertion and management of urethral catheters for patients of 16 years plus.

## **4.0 Equality Impact Assessment**

- 4.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.  
(Refer to Appendix 3)

## 5.0 Roles and Responsibilities

- 5.1 **Chief Executive** is responsible for ensuring that systems are in place to guarantee the safe and appropriate insertion and management of urethral catheterisation. This responsibility is delegated to the Clinical Lead.
- 5.2 **Clinical Lead** is responsible for ensuring compliance with systems in place to ensure the correct and safe insertion and management of urethral catheterisation.
- 5.3 **Healthcare professionals**
- 5.3.1 Catheterisation should only be carried out by healthcare professionals who have attended the Trust training course or equivalent, and been assessed as proficient.
- 5.3.2 Healthcare professionals are obligated to adhere to the principles in this policy.
- 5.3.3 Healthcare professionals must ensure that the indications for catheterisation are based on a balanced decision.

## 6.0 Clinical Indications for Catheterisation

### 6.1 Drainage

- Management of intractable incontinence;
- Acute and chronic urinary retention;
- Benign prostatic hyperplasia.

### 6.2 Investigations

- Urodynamic studies;
- X-ray investigation.

### 6.3 Instillations

- Instil medication into the bladder;
- To irrigate the bladder during an episode of haematuria.

### 6.4 Fluid balance monitoring/ resuscitation

- Measure residual volume;
- Monitor urine output hourly;
- If patient diuresing (urine output > 200mls per hour) Administer IV fluids of 0.9% N/Saline to replace 90% of their previous hours diuresis.

6.5 **Antibiotic Use** – Refer to MicroGuide.

## 7.0 **Indications and Contraindications for Supra-pubic Catheterisation (SPC)**

### 7.1 **Indications for SPC**

- SPC should be considered when appropriate; (Refer to Appendix 1)
- Acute urinary retention and failure of urethral catheterisation;
- Severe pelvic trauma;
- Urethral scarring and strictures;
- Pelvic urological surgery.

### 7.2 **Contraindications for SPC**

- Bladder tumours;
- Suspected haematuria;
- Previous abdominal surgery (needs USS guided insertion); (Refer to Appendix 2)
- Anticoagulated patients;
- Inability to aspirate urine.

## 8.0 **Informed Consent**

8.1 The patient's consent must be obtained prior to the procedure.

8.2 The individual has the right to make their own decision and must be assumed to have capacity to do so unless it is proved otherwise.

8.3 In the event of an individual who lacks mental capacity, staff should refer to the Trust's Consent Policy (register number 04080) and Mental Capacity Act Policy (register number 1001). An MCA2 form should be completed in full and a copy submitted to the adult safeguarding team.

## 9.0 **Privacy and Dignity**

9.1 A chaperone will be provided for the patient when requested according to the Trust's chaperone policy (register number 05118).

9.2 The patient's dignity will be respected. A dignity curtain is provided for the patient to part undress behind and a sheet is given to the patient to cover up with once they have undressed.

9.3 A 'Do Not Enter' sign is attached to the outside of the room to stop patients and staff entering the room whilst the procedure is carried out.

## 10.0 Essential Overview of Catheterisation

- 10.1 The insertion of an indwelling urethral catheter should always be carried out using an aseptic non touch technique by a health care professional, to prevent cross infection and the risk of contaminating the catheter.
- 10.2 Female catheterisation can be taught in clinical practice by a competent practitioner, the pre-registration nurse must be **directly supervised** until their own competency is signed off.
- 10.3 Male catheterisation is only permitted by a competent medical professional, registered nurse or healthcare support worker level III (or equivalent), competent healthcare professionals who have attended the Trust's clinical skills/or equivalent catheterisation training session with subsequent competency assessed and signed off in practice.
- 10.4 Lubrication should be instilled directly into the male and female urethra to minimise urethral trauma.
- 10.5 As catheterisation can be painful, anaesthetic gel should be applied and left for the required amount of time prior to catheterisation (as per manufacturer's instructions).
- 10.6 The healthcare professional must have an understanding of the catheter selection including type, material, length and Cherriere (ch) size. They must be able to differentiate between a male and female catheter **and a female catheter is never used for male catheterisation.**
- For initial male catheterisation size 14-16 ch is recommended;
  - For initial female catheterisation size 10-12 ch is recommended;
  - Larger gauge catheters may be necessary if debris or clots are present in the urine;
  - 3 way catheters are often used when haematuria is present in order to carry out bladder irrigation.
- 10.7 The healthcare professional must have an understanding of drainage methods (MEHT continence resource folder for further information).
- 10.8 Following catheterisation the healthcare professional will document a plan of care and instruct the patient in the on-going care and management of the catheter and drainage system according to the manufacturer's guidelines and Royal Marsden Manual of Clinical Procedures.

## 10.9 Documentation

Documentation of the procedure should include:

- Consent;
- Date and time of procedure;
- Adhesive catheter label;
- High impact intervention care bundle 6 label;
- Saving Lives: high impact intervention monitoring tool;
- Record residual volume.

10.10 On discharge from hospital all patients who are using disposable continence products (including pads, catheters, urine drainage bags and flip flow valves) must have a district nurse referral completed and one-week supply of products given to the patients (as per MEHT Discharge Policy; register number 11037).

## 11.0 Equipment Required for Catheterisation

- Sterile catheterisation pack;
- Disposable pad;
- Sterile gloves;
- Appropriate catheters – with syringe and water;
- Sterile anaesthetic lubricating jelly;
- Universal specimen container;
- 0.9% sodium chloride solution;
- Alcohol hand rub;
- Disposable plastic apron;
- Drainage bag and stand or holder or catheter valve – **renewable every 7 days**.

## 12.0 Male Urinary Catheterisation Procedure

- Explain the procedure to the patient and take consent;
- Position patient into supine position. Screen the bed space;
- Wash hands using soap and water and alcohol rub;
- Put on plastic apron;
- Open the outer cover of the catheterisation pack and the side pack onto the top shelf of the trolley;
- Using aseptic technique open the supplementary packs;
- Clean hands with alcohol rub;
- Put on sterile gloves;
- Place sterile towel across patients thighs;
- Wrap a sterile topical swab around the penis. Retract the foreskin , clean the glans penis with 0.9% sodium chloride or an antiseptic solution;
- Insert the anaesthetic gel nozzle into the meatus and squeeze the contents into the urethra. Massage the gel along the urethra;
- Wait approximately 5 minutes for the gel to become effective;



- Grasp the penis behind the glans, raising it until it is totally extended. Maintain the grasp until the procedure is complete;
- Place the receiver containing the catheter between the patient's legs. Insert the chosen catheter for 15-25 cm until urine flows;
- If resistance is felt at the external sphincter, increase the traction of the penis slightly and apply steady, gentle pressure on the catheter. Ask the patient to strain gently as if passing urine;
- When urine begins to flow, advance the catheter almost to its bifurcation;
- Gently inflate the balloon according to the manufacturer's direction, having ensured that the catheter is draining properly beforehand;
- Withdraw the catheter slightly and attach to appropriate drainage system;
- Reposition the foreskin;
- Measure the residual urine and document.

### **13.0 Female Urinary Catheterisation Procedure**

- As per male procedure with following additions;
- Supine position with legs bent, hips flexed and feet resting approximately 60cm apart;
- Using low-linting swabs, separate the labia minora so that the urethral meatus is seen. One hand should be used to maintain labial separation until catheterisation is completed;
- Clean around the urethral orifice with 0.9% solution using single downwards strokes;
- On introducing of the catheter, if there is difficulty in visualising the urethral orifice, due to vaginal atrophy and retraction of the urethral orifice, the index finger of the 'dirty' (non-aseptic) hand may be inserted in the vagina, and the urethral orifice can be palpated on the anterior wall of the vagina. The index finger is then positioned behind the urethral orifice. This acts as a guide;
- Advance the catheter until 5-6cm has been inserted and urine drains;
- Attach appropriate drainage device, e.g. catheter valve, leg bag, urine meter.

### **14.0 Catheter Care and Management**

- 14.1 Clear rationale for on-going usage of catheter device.
- 14.2 Document the date of attachment of the drainage bag and renew every 7 days as per product guidelines.
- 14.3 Patient or healthcare professional to carry out daily catheter care, cleaning around the meatus and along the catheter in a downwards motion.
- 14.4 Healthcare professionals should always wear gloves and aprons when carrying out any catheter care.
- 14.5 Encourage adequate oral intake to ensure free flowing urine, reduce infection rate and avoid constipation.

- 14.6 The patient and healthcare professional should ensure that the drainage system is correctly situated on the appropriate stand and the device should not come in contact with the floor at any time.
- 14.7 The healthcare professional should monitor fluid input/output as required and Document appropriately.
- 14.8 Patients at end of life require daily catheter care and management of catheter, remove uro-meter if insitu and replace with a catheter bag, catheter bags should remain in place and are renewed every 7 days as per product guidelines.
- 14.9 Consider removal of catheter for patients at end of life if the catheter is causing distress and minimal urine is draining.
- 14.10 Consider anticholinergics if the patient appears to have bladder spasms.

## **15.0 Manual Bladder Washout**

- 15.1 Establish rationale for bladder washout. This is required when the catheter appears blocked with debris or clots following surgery or bladder sediment.
- 15.2 Explain rationale and procedure to patient, obtaining verbal consent.
- 15.3 Prepare bladder washout equipment on sterile field – washout /catheter pack, sterile gloves, 50ml catheter syringe, large galley pot/sterile kidney dish for sterile solution, large clean jug for washout contents.
- 15.4 Pour sterile saline solution 0.9% for irrigating into a sterile kidney dish/galley pot. Draw up the solution into a 50ml catheter tip syringe.
- 15.5 Wash hands. Put on sterile gloves. Place absorbent sheet under the catheter junction and remove the catheter drainage bag and discard.
- 15.6 Clean around the end of the catheter with antiseptic wipe/solution.
- 15.7 Draw up the irrigating fluid into the bladder syringe and insert nozzle into the end of the catheter. Gently insert part/all of the sterile saline into the bladder, trying not to inject air.
- 15.8 Remove the syringe and allow the bladder contents to drain by gravity into a receiver placed on the sterile towel.
- 15.9 Repeat steps 15.7 and 15.8 of the procedure until the washout is complete or the fluid is running clear.
- 15.10 Manual suction with the catheter tip syringe may be required in order to remove large bladder clots in the event of haematuria.
- 15.11 Reattach a new drainage bag or catheter valve.

## **16.0 Trial without Catheter (TWOC)**

- 16.1 Clarification for the catheter removal. Establish appropriate time: early daytime with increased fluid intake.
- 16.2 Position patient in the prone position. Do not remove catheter with patient in sitting position as this is extremely painful
- 16.3 Observe the volume in balloon from catheter port prior to deflation. Ensure that balloon is fully deflated before removal of catheter and document accordingly.
- 16.4 Consider removal by gently pulling the catheter out or allowing the patient to void it out if a flip flow valve had been used, thus the bladder being full.
- 16.5 Abandon the catheter removal if painful, or if bleeding is a concern. Inform the Nurse in Charge who will assess and call medical/surgical team if required.
- 16.6 Encourage the patient to drink normally in the following 4 hours and monitor the input and output. Perform bladder scan if competent. If nil urine is voided consider re - catheterization, intermittent self-catheterization.

## **17.0 Transfer of Care to the Community**

- 17.1 The healthcare professional should discuss the impact of the catheter on the patient's lifestyle and quality of life. Self-Intermittent Catheterisation should be considered at this point.
- 17.2 The patient's level of ability to self-care and dependence status must be considered by the healthcare professional.
- 17.3 The patient and carer should be adequately educated with catheter care and be provided with the appropriate equipment and documentation to carry out this management and safe disposal of the equipment.
- 17.4 The healthcare professional should refer patient to the District Nurse for review of catheter management or awareness.
- 17.5 Provide patient with a catheter passport to ensure continuity of care.

## **18.0 Breach of Policy**

- 18.1 Any incidents related to breach of policy causing serious harm should be reported as a Serious Incident in accordance with the Trust incident policy (register number 09100) and Serious incident policy (register number 11025).
- 18.2 All incidents related to a breach of policy must be reported on Datix Web.

## 19.0 Auditing and Monitoring

- 19.1 An annual audit of compliance with this policy will be undertaken by the Urology Centre.
- 19.2 Findings of the audit will be presented at the Urethral Catheterisation core skills teaching session, carried out monthly by the Urology Clinical Nurse Specialist.

## 20.0 References

British Journal of Urology (2010) The British Association of Urological Surgeons supra-pubic catheter practice guidelines

Available at –

[https://baus.org.uk/professionals/baus\\_business/publications/10/baus\\_suprapubic\\_catheter\\_practice\\_guidelines](https://baus.org.uk/professionals/baus_business/publications/10/baus_suprapubic_catheter_practice_guidelines)

Royal College of Nursing (2012) Catheter Care – RCN guidance for health care professionals

Available at – <https://www.rcn.org.uk/professional-development/publications/007-313>

Royal Marsden Online Procedures (available via MEHT intranet)

European Association of Urology Nurses (2012) Catheterisation indwelling catheters in adults – Urethral and Suprapubic

Available at – <https://nurses.uroweb.org/guideline/catheterisation-indwelling-catheters-in-adults-urethral> and suprapubic

National Institute for Health and Care Excellence (2010) NICE Guidelines

National Institute for Health and Care Excellence (2012) Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline (CG139)

Available at – <https://www.nice.org.uk/guidance/cg139>

Morris N.S., Stickler D.J. (2001) Does drinking cranberry juice produce urine inhibitory to the development of crystalline, catheter blocking *Proteus mirabilis* bio films BJU International 88 (3); 192-197

Nursing and Midwifery Council (2018) The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates NMC Portland Place: London

Available at – <https://www.nmc.org.uk/standards/code>

Pomfret I. (2000) Urinary catheters: selection, management and prevention of infection. British Journal of Community Nursing. 5 (1): 6-13

## **Appendix 1**

### **Summary of recommendations for supra pubic catheter (SPC) practice BAUS 2010**

#### **General considerations**

Clinicians who are involved in the management of patients with long-term catheters should consider in each case whether an SPC would offer advantages to the patient over the use of a urethral catheter.

Patients in whom an SPC is felt to be appropriate should have access to an efficient and expert service for SPC insertion.

Patients who are undergoing SPC placement either as an isolated or as a combined procedure should undergo an appropriate consent procedure with best practice including the provision of both verbal and written information.

#### **The supra-pubic catheterisation procedure**

If appropriate expertise for SPC insertion is not available at a particular time, supra-pubic aspiration of urine using a needle of up to 21 gauge can be used as a means of temporarily relieving the patient's symptoms.

A general or regional anaesthetic should be used if the bladder cannot be comfortably filled with at least 300 ml of fluid and in spinal cord injury patients with an injury level of T6 or above.

The use of antibiotic prophylaxis is recommended for patients where the urine is likely to be colonized with bacteria despite there being a lack of published data addressing this issue.

The different catheter insertion techniques and kits have not been compared in adequate clinical trials; the choice of technique is therefore a matter of individual preference. All of the closed (abdominal puncture) techniques run the risk of injury to intra-abdominal organs and the operator must have received training that allows the level of risk to be appreciated.

Ultrasonographic examination of the abdomen may be used as an adjunct to SPC insertion. However, the practitioner involved must have appropriate training and experience. Ultrasonography should only be used to look for interposing bowel loops along the planned catheter track by individuals who have received specific training and are experienced in this task.

In the patient with a readily palpable bladder and no history of lower abdominal surgery, it is considered reasonable to insert a SPC using a closed technique providing that urine can be easily aspirated from the bladder using a needle passed along the planned catheter track.

In the patient with no history of lower abdominal surgery but where the distended (over 300 ml) bladder cannot be palpated because of obesity, it is considered that blind insertion should not be undertaken. In such circumstances, ultrasonography may be used to identify the distended bladder or cystoscopy may be used to ensure that an aspirating needle on

the planned catheter track is entering the bladder at an appropriate point on the anterior bladder wall.

In the patient with either a history of lower abdominal surgery or a bladder that cannot be adequately distended, the SPC should either be inserted using an open technique or with the adjunct of imaging that can reliably exclude the presence of bowel loops on the intended catheter track. An open procedure must be performed in a manner that will reliably identify the bladder and allow mobilization of any interposing intestine away from the catheter track. Imaging to support a closed procedure would include the use of ultrasonography in skilled hands (see above) or CT scanning.

### **Postoperative complications**

Patients, carers and clinical staff must be made aware that urgent medical attention is needed if there are symptoms present that might suggest the presence of a catheter insertion-related visceral injury. Symptoms would include the persistence or worsening of lower abdominal pain or pain that is spreading away from the catheter insertion site

Written instructions covering contact details and indications for seeking medical assistance should be given to patients and carers immediately after catheter insertion.

### **Long-term SPC management**

The use of a catheter valve as an alternative to continuous free drainage should always be considered where the bladder is known to provide safe urinary storage.

The patient should have prompt and easy access to catheter change services and be offered the option of either them or their immediate carers being taught to change the catheter.

Immediate access to a urology unit should be provided in the event of a failed catheter change.

Antibiotic administration is indicated where there is evidence of cellulitis in the catheter site area or where there is evidence of symptomatic urinary tract infection.

Systemic antibiotics should not be used to treat uncomplicated peri-catheter discharge or asymptomatic bacteruria.

Regular catheter bypassing or blockage should prompt referral to the local urology department for further investigation and management.

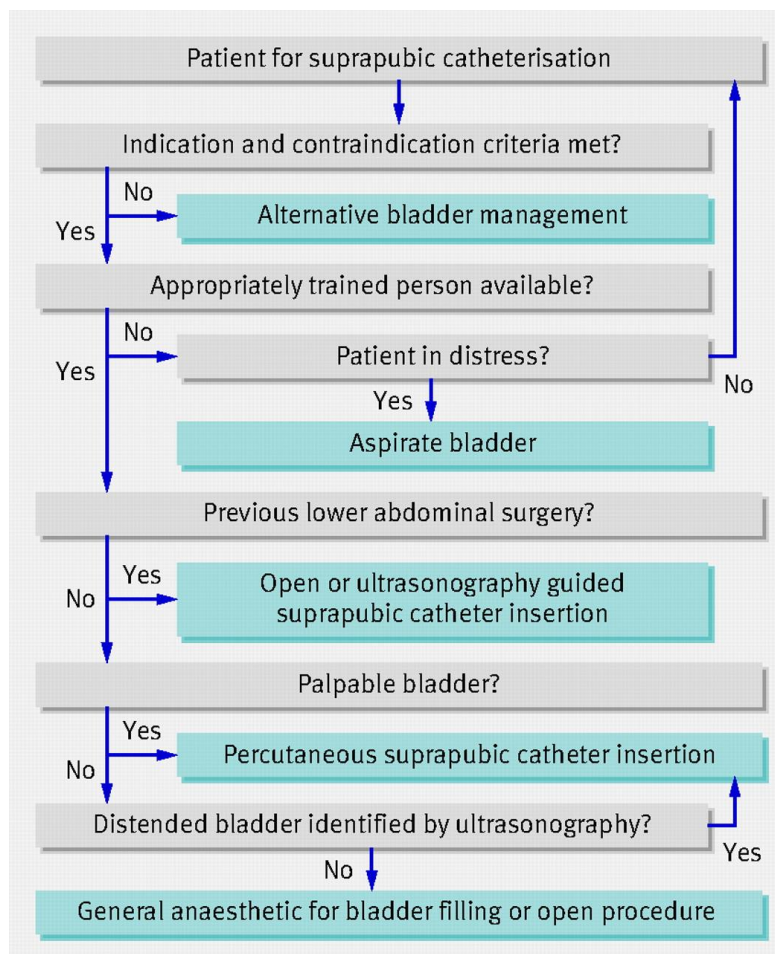
Cystoscopy should be undertaken if repeated catheter blockages are occurring.

## Appendix 2

### Safer insertion of supra-pubic catheters: summary of a report from the National Patient Safety Agency

There are new recommendations making changes to the way supra-pubic catheters are to be inserted. These have been issued from the National Patient Safety Agency and the British Association of Urological Surgeons [1, 2].

All NHS organisations were given until April 2010 to implement the actions and according to the recent BMJ article 13% of NHS organisations had not completed actions. A decision guide has been issued (see below) [3].



### Key points

1 If the bladder is not palpable (e.g. in an obese patient), USS should be used to identify it before proceeding.

2 Supra-pubic catheters can no longer be inserted blindly in patients with previous lower abdominal surgery due to the risk of bowel injury, **even if the bladder is easily palpable**. These catheters must be inserted under USS guidance.

## References

- 1 Harrison SCW, Lawrence WT, Morley R, Pearce I, Taylor J. British Association of Urological Surgeons' Supra-pubic catheter practice guidelines. *BJU Int* 2010; 107:77-85
- 2 National Patient Safety Agency. Minimising risks of supra-pubic catheter insertion (adults only). NPSA/2009/RRR005. NPSA, 2010. [www.nrls.npsa.nhs.uk/alerts/?entryid45=61917](http://www.nrls.npsa.nhs.uk/alerts/?entryid45=61917)
- 3 Lamont T, Harrison S, Panesar S, Surkitt-Parr M. Safer insertion of supra-pubic catheters: summary of a safety report from the National Patient Safety Agency. *BMJ* 2011;342:d924



### Appendix 3: Preliminary Equality Analysis

This assessment relates to: 05101 Urethral Catheterisation

| A change in a service to patients  |  | A change to an existing policy          | <b>X</b> | A change to the way staff work |  |
|--|--|---|----------|--------------------------------|--|
| A new policy   |  | Something else<br>(please give details) |          |                                |  |
| Questions  |  | Answers                                 |          |                                |  |
| 1. What are you proposing to change?   |  | Full policy review                      |          |                                |  |
| 2. Why are you making this change?<br>(What will the change achieve?)  |  | 3 year review                           |          |                                |  |
| 3. Who benefits from this change and how?  |  | Clinicians & patients                   |          |                                |  |
| 4. Is anyone likely to suffer any negative impact as a result of this change? If no, please record reasons here and sign and date this assessment. If yes, please complete a full EIA. |  | No                                      |          |                                |  |
| 5. a) Will you be undertaking any consultation as part of this change?<br>b) If so, with whom?   |  | Yes<br>Refer to pages 1 & 2             |          |                                |  |

Preliminary analysis completed by:

|             |                |                  |                          |             |          |
|-------------|----------------|------------------|--------------------------|-------------|----------|
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|-------------|----------------|------------------|--------------------------|-------------|----------|