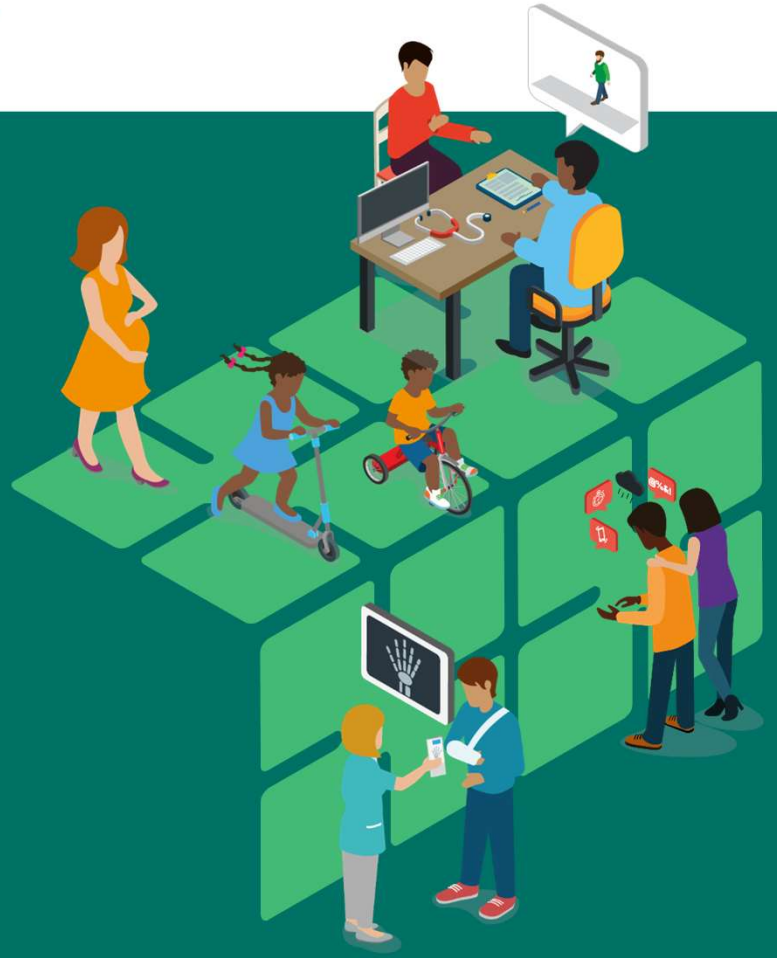
Hertfordshire and West Essex Integrated Care System

Approved Training Provider

NHS
Hertfordshire and West Essex
Integrated Care Board

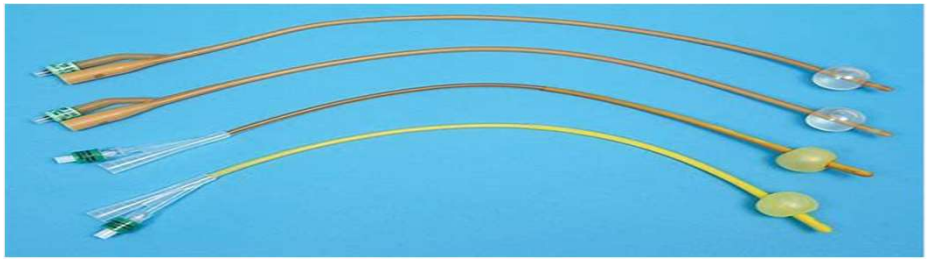
Urinary Catheter Care



Working together
for a healthier future

Urinary Catheters

- What is a catheter and the purpose of a Urinary Catheter?
- Types of Catheters?
- Medical reasons to why a Catheter is inserted?
- To Dip or Not to Dip?
- Tips for Catheter care
- Demonstration



Urinary Catheters

- A urinary catheter is a flexible tube used to empty the bladder and collect urine in a drainage bag
- Urinary catheters are usually inserted by a doctor or nurse
- Catheters can either be inserted through the tube that carries urine out of the bladder (urethral catheter) or through a small opening made in your lower tummy (suprapubic catheter)
- The catheter usually remains in the bladder, allowing urine to flow through it and into a drainage bag

Urinary Catheters

There are 2 main types of urethral urinary catheter:

- Intermittent catheters - temporarily inserted into the bladder and removed once the bladder is empty
- Indwelling catheters - remain in place for many days or weeks, and are held in position by an inflated balloon in the bladder, often known as foley catheters. Usually changed at least every 3 months

Urinary Catheters

Suprapubic catheters:

- A suprapubic catheter is a type of catheter that is left in place, usually changed every 4 to 12 weeks.
- The catheter is inserted through a hole in the tummy (abdomen) and then directly into the bladder. This procedure can be done under general anaesthetic, epidural anaesthetic or local anaesthetic.
- A suprapubic catheter is used when the urethra is damaged or blocked, or when someone is unable to use an intermittent catheter.

Urinary Catheters

- Flip-Flow valve is a tap-like device which fits into the end of catheter tube - urethral or suprapubic, and offers an alternative to a drainage bag
- The bladder continues to store urine and can be emptied intermittently by releasing flip-flow helping to maintain normal function
- The Flip-Flow valve can be opened to empty the bladder whenever there is a feeling to pass urine

Urinary Catheters

Medical reasons to why a Catheter is inserted:

- Usually used when people have difficulty peeing (urinating) naturally
- Can also be used to empty the bladder before or after surgery and to help perform certain tests

Specific reasons a urinary catheter may be used include:

- To allow urine to drain if you have an obstruction in the tube that carries urine out of your bladder (urethra) because of scarring or prostate enlargement
- Allow urinate if have bladder weakness or nerve damage that affects ability to pass urine
- To drain bladder during childbirth if you have an epidural anaesthetic

Urinary Catheters

- To drain bladder before, during or after some types of surgery
- As a last resort treatment for urinary incontinence when other types of treatment have been unsuccessful

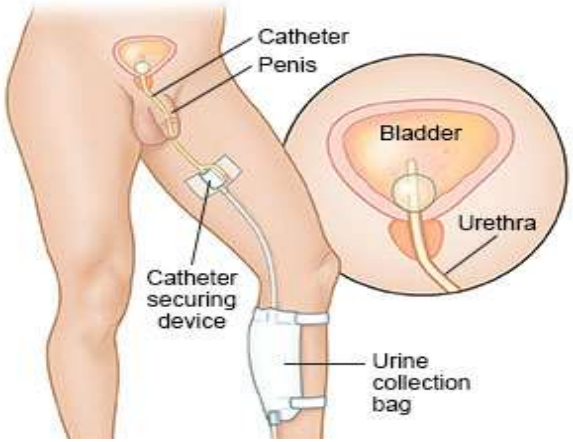
The main problems caused by urinary catheters are infections in the urethra, bladder or, less commonly, the kidneys.

These types of infection are known as urinary tract infections (UTIs) and usually need to be treated with antibiotics. Other problems, such as –

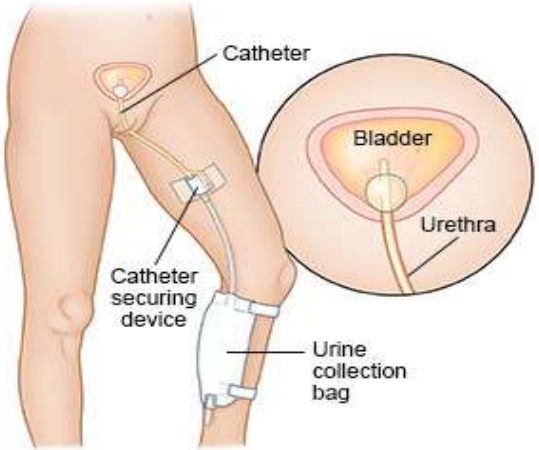
- Bladder spasms (similar to stomach cramps)
- Leakages, blockages - catheter is blocked, check that it's draining
- Damage to the urethra

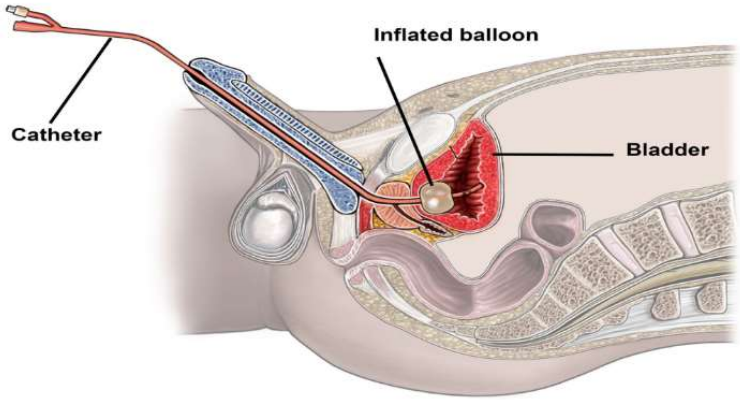
Types of Urinary Catheters

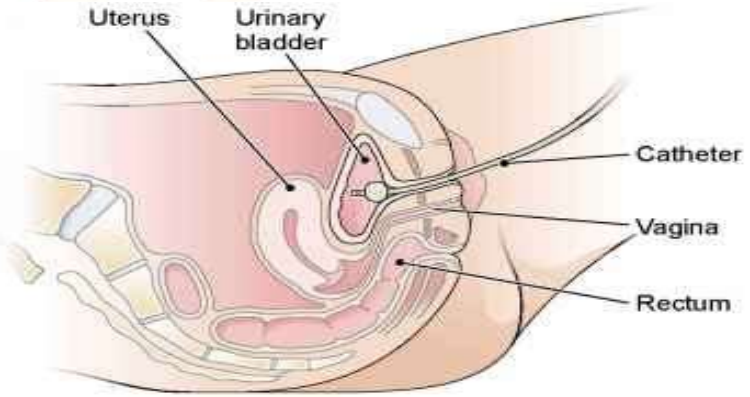
Foley Catheter Male



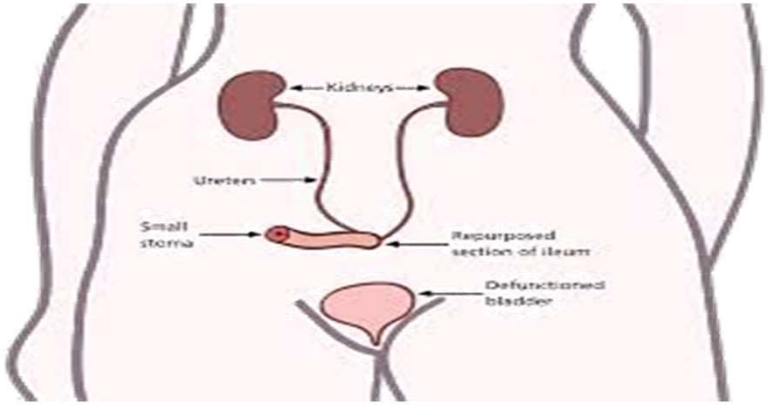
Foley Catheter Female

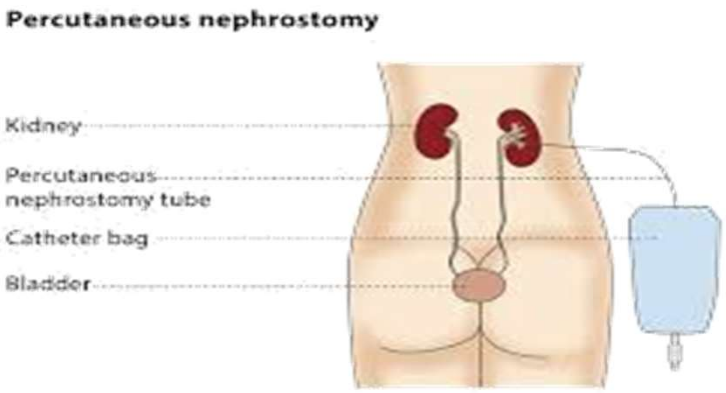






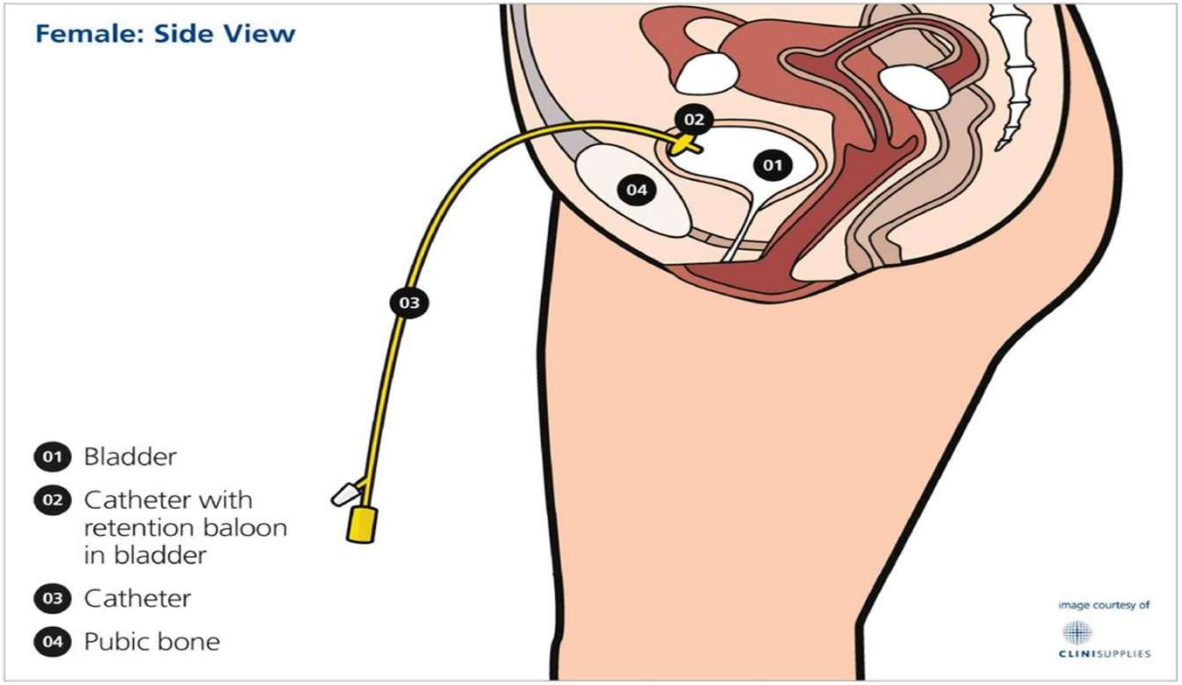
Urinary Catheters

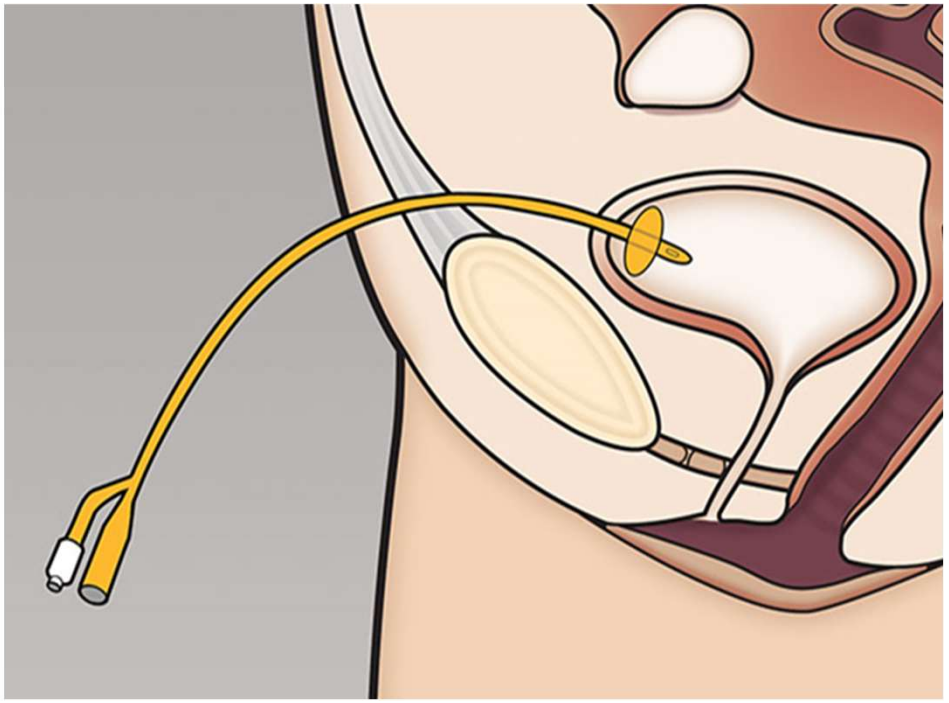




Urostomy a surgical procedure that creates a stoma (opening) for the urinary system Urostomy is made to avail for urinary diversion in cases where drainage of urine through the bladder and urethra is not possible, e.g. after extensive surgery or in case of obstruction	**Nephrostomy is an opening between the kidney and the skin.** Allows for the urinary diversion directly from the upper part of the urinary system

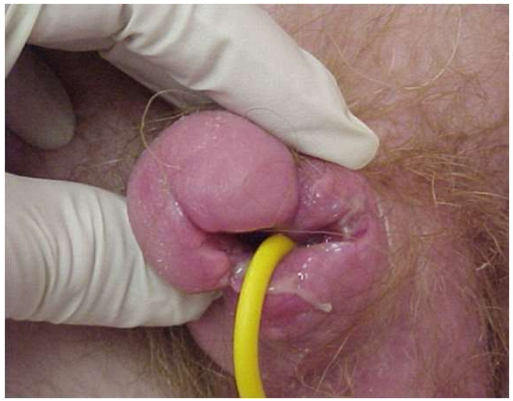
Suprapubic Catheter





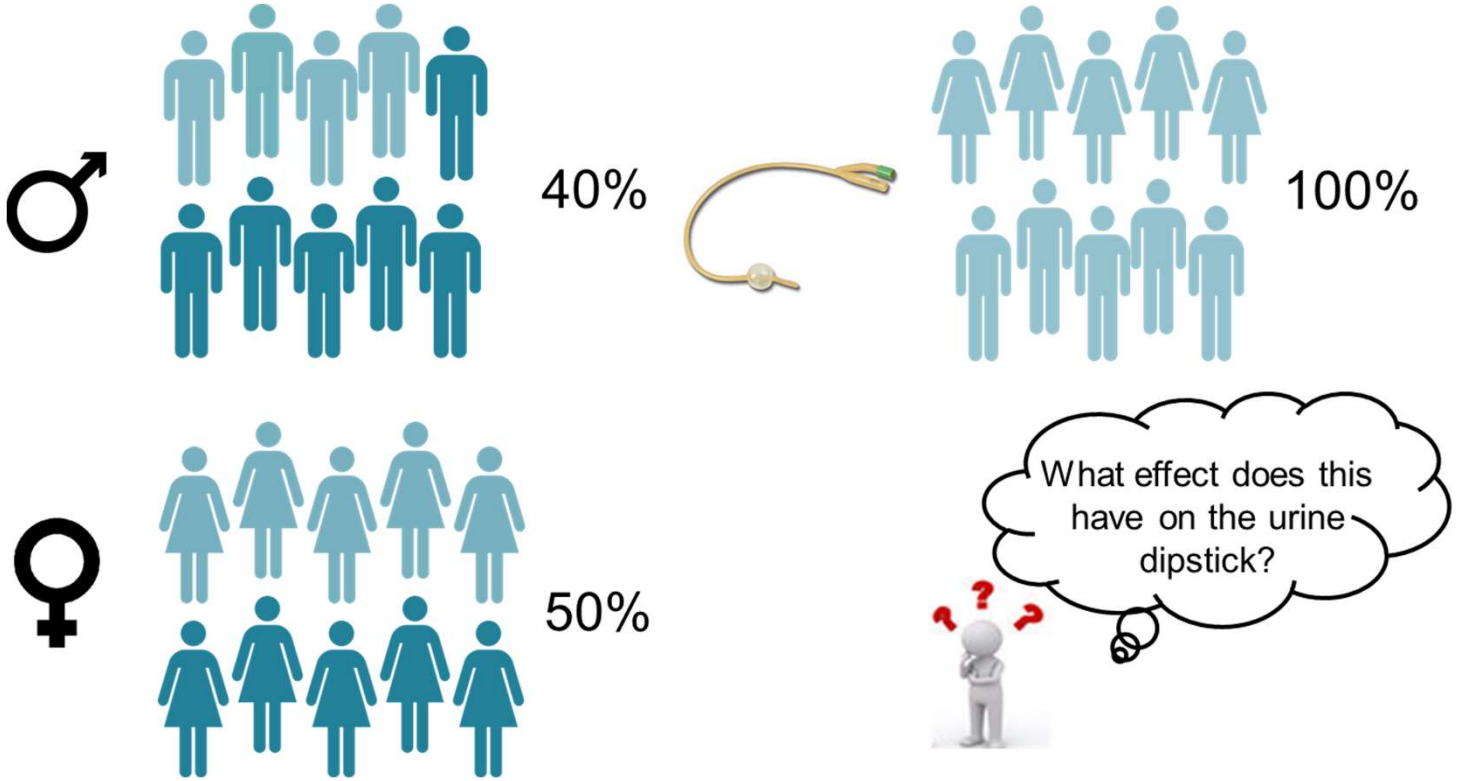
Complications associated with Urinary Catheters?

Can you think of any catheter related problems? UTI, bladder spasms (similar to stomach cramps), leakages, blockages - catheter is blocked, check that it's draining, catheter falls out.



Bacteria in the urine of older people

Bacteria can harmlessly live in the bladder of an older person



Causes of UTIs

- Poor hygiene – not wiping from front to back
- Constipation
- Poor Hydration
- Not emptying the bladder properly
- Urine staying in the bladder too long, holding onto urine
- Catheter in-situ
- Weakened immune system - people with diabetes or people having chemotherapy

Causes of UTIs

- Conditions that obstruct your urinary tract, such as kidney stones*
- Women have a shorter urethra than men, bacteria are more likely to reach the bladder or kidneys and cause an infection
- An enlarged prostate gland* in men

Possible symptoms in a dementia resident

- Agitated /Restless – or more than usual
- Poor concentration/ Dazed
- Hallucinations/ Delusions
- Becoming sleepy/ withdrawn
- Refuses diet and fluids

Symptoms of a UTI associated with using a Catheter

Can include:

- Pain low down in your tummy or around your groin
- A high temperature
- Feeling cold and shivery
- Confusion

To Dip or Not to Dip?

The presence of bacteria in the urine in older people does not necessarily mean there is an infection that requires antibiotics. Bacteria can live harmlessly in the urine of older people.

In fact, around 50% of older people have bacteria in the urine without causing any symptoms. In those with a long-term urinary catheter, this rises to 100%.

Often, if a resident has a positive dipstick result and has non specific symptoms, such as had a fall or is drowsy, they are inappropriately diagnosed with a UTI.

To Dip or Not to Dip Pathway

In the pathway, urine dipsticks are not used, instead care home staff use a UTI Assessment Tool which focuses on the signs and symptoms of the resident and what actions to take.

UTI PROFORMA

Hertfordshire and West Essex Integrated Care System

Resident:.....

DOB:.....

Care Home:.....

Date:.....

Carer:.....

Older Residents (>65) with Suspected UTI (Urinary Tract Infection)

Guidance for Care Home staff:

NHS Hertfordshire and West Essex Integrated Care Board

- Complete sections **1** to **4** and **residents details** and fax to GP
- Add the original form to the residents notes
- **DO NOT PERFORM URINE DIPSTICK** – NOT recommended in patients >65 years
- **CLEAR URINE** – UTI highly unlikely
- **Send MSU** if treatment failure or ≥ 2 signs of infection (especially dysuria, fever or **new** incontinence)

1) Catheter: **N / Y** Reason for catheter:.....

2) Signs of any other infection source? **N / Y** **Circle any NEW symptoms:**

*Cough *Shortness of Breath *Sputum Production *Nausea/Vomiting *Diarrhoea *Abdominal Pain *Red/warm/swollen area of skin

3) Can the resident communicate symptoms? **N / Y**

4) Tick the signs and symptoms present in the two tables below:

NEW ONSET - Sign/Symptom	What does this mean?	Tick if present
Dysuria	Pain on urinating	
Urgency	Need to pass urine urgently/new incontinence	
Frequency	Need to urinate more often than usual	
Suprapubic tenderness	Pain in lower tummy/above pubic area	
Haematuria	Visible blood in urine	
Polyuria	Passing bigger volumes of urine than usual	
Loin pain	Pain either side of spine between ribs & pelvis	

Sign/Symptom	Tick if present
New onset or worsening confusion or agitation	
Temperature above 37.9°C or 1.5°C above baseline ontwo occasions during 12 hours (if able to measure)	
Heart Rate >90 beats/min (if able to measure)	
Respiratory rate >20 breaths/min (if able to measure)	
Diabetic ? Y / N (if able to measure) If N - Blood glucose >7.7 mmol/L	
Bloods taken? N / Y If Y - WCC >12/μL or < 4/μL	

Any other information:.....

5) GP Management Decision - <u>circle all</u> which apply and notify home of decision made:

(a) Review in .....hours

(b) Mid Stream Urine specimen (MSU) – particularly if ≥ 2 symptoms

(c) Give person specific hydration advice

(d) Arrange trial without catheter

(e) Antibiotic Prescribed:.....

NB. Urine should be sent in case of suspicion of complicated infection, symptoms suggestive of pyelonephritis, failure to respond to initial therapy or recurrent symptoms after treatment of previous UTI.

Other action:..... **Name:**..... **Signed:**..... **Designation:**..... **Date:**.....

ENHCCG Prescribing Guidance (follow link)

HVCCG Prescribing Guidance (follow link)

Download the Herts Antibiotic Guidelines App by visiting the appropriate app store for your device and searching for 'Herts Antibiotic'.

Version: December 2017

Adapted from 'To Dip or Not To Dip' BaNES CCG

Prevention is better than cure

Ensure residents are drinking 1.5 – 2 litres of fluids per day*

*Some residents may have been advised to restrict fluid intake if they have a heart or kidney condition. Discuss with GP or Matron if unsure.

Blockages: what can we do?

Can be caused by debris or encrustation but also because of kinking of the catheter, catheter resting against the bladder wall or constipation.

Debris will increase with more concentrated urine. It is important to encourage fluid intake. Fluid intake needs to be gradually through the day to maintain consistent urine output.

It can be caused by poor urine flow. Make sure catheter tubing is not kinked and bag is emptied regularly. A bag that is 2/3 full will decrease urine flow.

No urine drainage or a leaking catheter. Try mobilising the resident/changing their position to see if this helps the catheter to drain. Inform SN/DN.

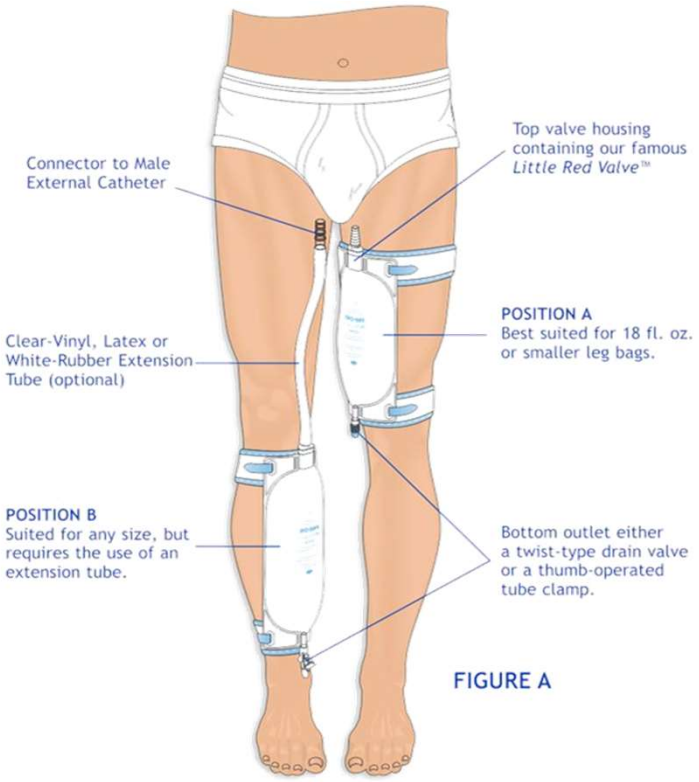
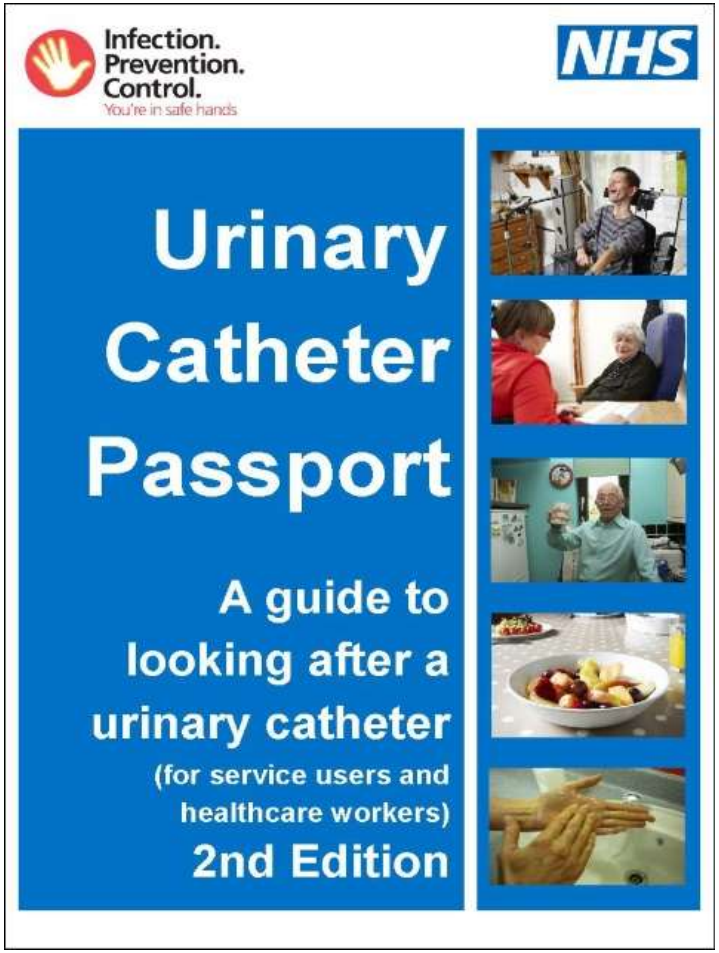


FIGURE A

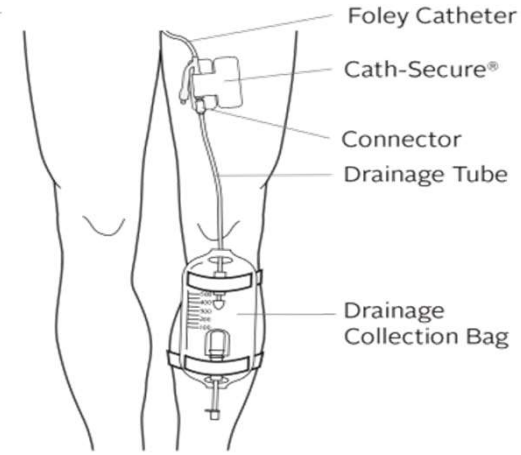
Tips for Top Catheter Care?

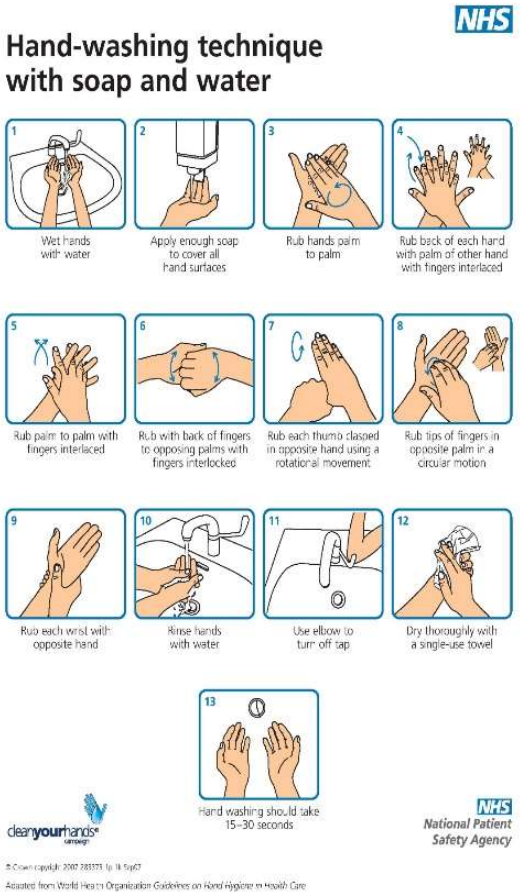
- Wash Hands, use PPE
- Avoid Back flow
- Keep System Closed
- Keep catheter off the floor
- Promote Free Flow
- Hygiene - Cleanse the catheter insertion site daily
- Record keeping
- Individual care plan
- Monitoring Fluid Intake
- Empty drainage bag when 2 thirds full



Tips for Top Catheter Care?

- Inspection
- Encourage Self care
- Change Leg Bag every 7th day - alternate leg
- Secure Catheter - prevent falling out
- Monitoring Bowels - avoid constipation
- Avoid kinks or bends in the catheter
- Drainage collection bag below the level of bladder
- Attach single use night bag at night, place on a stand next to bed





Indwelling Urinary Catheter

- Accurate fluid input and urine out put recorded and documented on fluid chart and notes, recommended fluid input is up to 2 L per day, if there are not on fluid restrictions
- Regular checks for catheter to be positioned correctly, check the catheter tube for kinks, not be twisted or bent, not to pull, flip flow catheter valve to be closed in order to avoid leakage from tube
- Would help if there is a Gstrap attached on resident's thigh to fix and keep catheter tube in place; If none in place please ask DNs for Gstrap; (Gstrap is a strap aimed to hold and fix the catheter, placed on thigh)
- Encourage resident to mobilise and change position
- Hygiene performed, if resident is self caring encourage to perform own hygiene, wiping front to back, clean around catheter insertion area

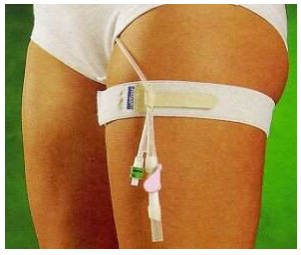
Indwelling Urinary Catheter

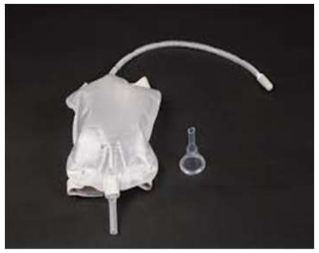
- Monitor bowel movement, record and document on charts and notes, prevent and avoid constipation as this can lead to leakages or bypassing
- Catheter care plan completed and updated
- If any details needed or concerns please address to DN when visiting resident
- Remember, document and record in the notes

Demonstration

Practical demonstrations and practice of No touch techniques:

- Emptying catheter bag or releasing valve
- Attaching and removing a night drainage bag
- Changing a leg bag or catheter valve
- Taking a sample of urine from a catheter port
- Cleaning the catheter tube





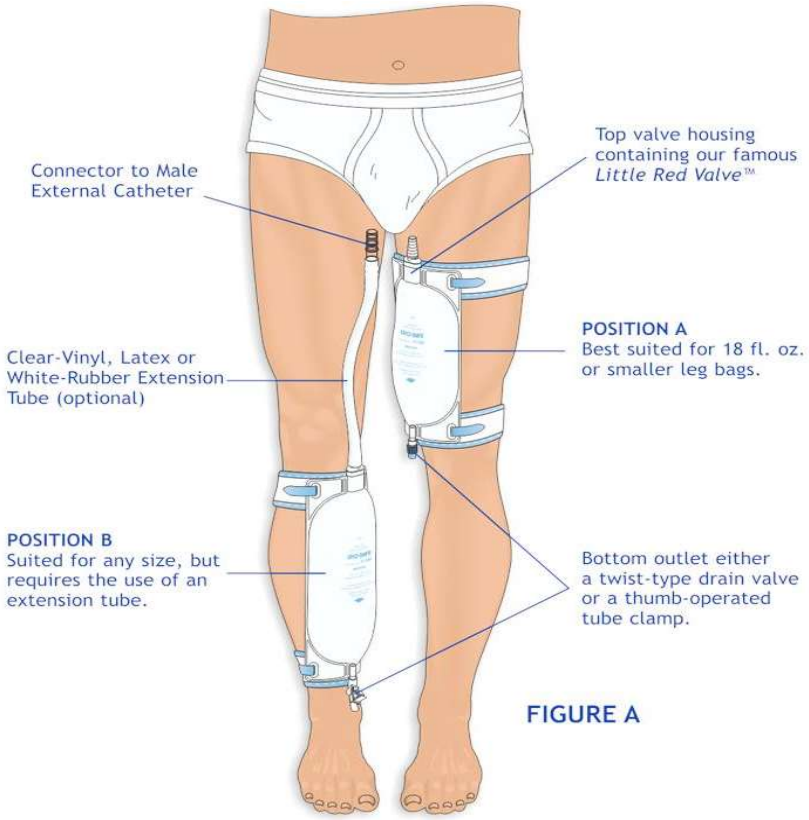


FIGURE A

SBAR tool - to support you to structure your conversations when discussing your residents with professional colleagues

S	SITUATION • Your name and Care home name • Name of patient , age, DOB • What is the concern, what has happened? Describe symptoms which are different than normal. Does the patient have capacity to tell you what is wrong?	**Examples of symptoms you might describe:** • Falls – are there injuries? • Confused, disorientated, dizzy, unsteady • Drowsy or hard to rouse • Hot / flushed /sweating. Cold / clammy / shivering / pale • Breathing harder or faster, slower or shallower • Complaining of pain, grimacing, posture indicating pain if unable to communicate - describe where pain is • Weakness in legs or arms / facial differences • Coughing / bringing up phlegm / wheezing • Vomiting / nausea - how long for • Change in urinary continence / Smelly urine, blocked or problem with catheter • Change in bowel habit /Diarrhoea • Not eating or drinking / loss of appetite • Bleeding from what area?
B	BACKGROUND • How long have symptoms been present? • Did they come on suddenly? • Does the person have any other long term illness? • Have they already been seen by the GP for this change? If so was any medications started? What instructions were given to the home? • Have you got a list of their current medication? • Has the patient recently been into hospital? If so what for? • Does the patient have a current DNAR in place? If yes be clear why you are ringing	
A	ASSESSMENT • What actions have you already taken? Is the patient in a safe place? • Has the person lost consciousness? Be very clear is it a true loss of consciousness? If yes how long for in minutes. • Are there any obvious signs of injury or bleeding?	**Examples of assessment actions you might describe:** • First aid options used /Recovery position • Pressure on bleeding area • BP, Pulse, respiration rate, temperature, urine analysis - give results
R	RECOMMENDATION • Explain what you need - be specific about the request and timeframe • Make suggestions i.e. ECP or Dr or advice only • Clarify expectations **Note: an ambulance can take from 9 – 60 minutes depending on urgency**	**Examples of recommendations you might describe:** • Review by GP urgently • Ambulance • Call back from Clinical Advisor • Clarify what is happening as a result of call – when you can expect a visit or ambulance

SBAR COMMUNICATION TOOL- AIDE MEMOIRE

FINAL

If an ambulance is sent these are suggestions of what do whilst waiting for the ambulance to arrive?

Reassure the resident and stay with them, continue to monitor for signs of deterioration which may mean a further call to the service. Ask another staff member to follow the check list. Do you need an escort? Do you need to ask senior management to attend the home?

In no particular order:-

1. Inform relatives.

2. Prepare the RED BAG; Photocopy medication charts and bag all medication. Is there any in the fridge, room or cupboards?

3. Photocopy main care plan details or grab sheet making sure the details are up to date. Especially where you have allergies or special instructions around other medical conditions. Include copy of DNAR form. Is there any special information which may help staff to communicate or deliver care for the resident, (i.e. strategies to adopt when the patient is anxious especially with dementia residents)? Are there any triggers which are not recorded?

4. Prepare an overnight bag for the resident. Remember to take items that may offer reassurance. Maintaining the residents' dignity is paramount so having their own belongings may help.

SBAR link to assist in e-learning

SBAR Communication in Care Homes - e-Learning for Healthcare (e-lfh.org.uk)

Any Questions?

Hertfordshire and
West Essex Integrated
Care System