Clinical Procedure for the Management of Catheter Problems

For use in:	Wards and A&E
By:	All Medical staff
For:	Junior Doctors / Specialist Nurses / Physician Associates
Division responsible for document:	Surgical Division
Key words:	Catheter, blocked, urethral, suprapubic
Name of document author:	Melissa Gabriel
Job title of document author:	IST Urology Trainee
Name of document author's Line Manager:	Neil Burgess
Job title of author's Line Manager:	Consultant Urologist
Supported by:	Mr Mark Rochester Urology Service Director / Consultant
Assessed and approved by the:	Clinical Guidelines Assessment Panel (CGAP) If approved by committee or Governance Lead Chair's Action; tick here ☑
Date of approval:	27/07/2020
Ratified by or reported as approved to (if applicable)**:**	Clinical Safety and Effectiveness Sub-Board
To be reviewed before: This document remains current after this date but will be under review	05/02/2023
To be reviewed by:	Neil Burgess
Reference and / or Trust Docs ID No:	16926
Version No:	1.1
Compliance links: *(is there any NICE related to guidance)*	N/A
If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

Clinical Procedure for the Management of Catheter Problems

Version and Document Control:

Version Number	Date of Update	Change Description	Author
1.1	27/07/2020	Additional wording on monitoring compliance	Melissa Gabriel

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

Urethral catheter insertion

Objective

To ensure eligible staff safely undertake management of catheter problems.

Rationale

This document was written to enable staff to follow the correct procedure for catheter problems according to current agreed evidence based clinical practice in the urology department.

- Insert under aseptic conditions and request assistance from nursing staff.
- Normally 16Fr size with a 10mL balloon.
- In a male pass the catheter all the way in to avoid inflating balloon in the urethra. If the catheter side arm distends as you are filling the catheter balloon, the balloon may be in urethra. Having filled the balloon it should be possible to withdraw the catheter freely several centimetres (a sign that the balloon is in the bladder and not the urethra).
- Document residual urine volume drained in first 5 minutes.
- Remember to replace foreskin to prevent paraphimosis.
- Send a catheter specimen of urine for C & S if urinary tract infection suspected.
- In retention perform a digital rectal examination: look specifically for faecal loading, prostate size, prostate consistency, malignancy, tenderness and blood on the glove.
- Use 22Fr 3-way catheter if visible haematuria and clots seen (avoid suprapubic catheterisation with visible haematuria).

Difficult catheters

- If difficult some simple tricks include:

- Try 2 tubes of instillagel.
- Try a more rigid (silicone) or larger catheter e.g. if using 12-14Fr try 16Fr.
- Tiemanns tip catheter (need appropriate training to use).
- The following options should only be performed by those with appropriate training:
- Catheter introducer or attempt catheter insertion over a Terumo guide wire.
- Flexible cystoscopy under LA and insert catheter over a guide wire.
- Suprapubic catheter insertion (this should be the last local anaesthetic option and avoided where there is haematuria).
- Cystoscopy and insertion of urethral catheter under general / spinal anaesthesia.

Bypassing catheter

- Either due to blockage or bladder spasm.
- Treat as blocked catheter +/- anticholinergic medication.
- Exclude UTI and treat accordingly.

Monitoring compliance

To ensure that this document is compliant with the above standards any adverse outcomes will be entered onto Datix and reviewed by the Departmental Governance Team who will ensure that these are investigated and are discussed at relevant governance meetings to review the results and make recommendations for further action.

Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this document on behalf of the urology department who have agreed the final content.

This version has been endorsed by the Clinical Guidelines Assessment Panel.

References

No references were applicable.

Blocked catheter

- Often secondary to debris.
- Flush catheter with sterile water / saline or replace catheter.

Blocked suprapubic catheter

- Often secondary to debris.
- Flush catheter with sterile water / saline.
- If catheter remains blocked it may need replacing (NB do not remove suprapubic catheter within 6 weeks of insertion or track may be lost, it may be better to insert a urethral catheter temporarily until suprapubic track has matured).

Suprapubic catheter has fallen out

- Attempt re-insertion, use instillagel via tract, with 14 -16Fr rigid catheter.
- If this fails attempt to insert a urethral catheter.
- If this fails seek senior urological advice.