

Policy for the Management and Care of Urinary Catheters in Adults v4

Policy for the Management and Care of Urinary Catheters in Adults

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Executive Lead	Jon Ota, Chief Nurse and Director of Quality and People
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Policy Owner	Continence Nurse Specialist Team Lead
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Equality and Health Inequalities Statement

First Community values diversity, promotes inclusion, and ensures equal opportunities for all. We aim to design and implement services that meet the diverse needs of our population and workforce, ensuring that no one is placed at a disadvantage over others. We take into account the Equality Legislation including the Equalities Act 2010 and embrace the four staff pledges in the NHS Constitution. We use our Equality, Diversity, and Inclusion (EDI) vision and mission statements to help us drive our work.

This document has been assessed to ensure that no employee receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the member of staff has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

First Community are compliant with the requirements of the Accessible Information Standard which aims to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We ensure that we ask people if they have any information or communication needs and ask how we might meet those needs, make sure this is recorded clearly on any records, highlight this so it is clear to other staff, share this as appropriate and make sure that we take the necessary steps so that our patients receive information that they can access and understand and receive communication support as needed.

Sustainability

In October 2020, the NHS became the world's first health service to commit to a target of reaching Net-Zero Carbon emissions by 2040.

As healthcare professionals we have a duty to play our part in tackling the problem of our changing climate. Right across the organisation, in all roles both clinical and non-clinical we can think, and act, more sustainably.

This is why we need to take action to create the change that will protect the environment on which our health depends. We are working to create a greener NHS at First Community as set out in our [Green Plan](#). All of our documents consider sustainability and support our green plan.

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Introduction

This policy has been developed to support nursing staff in First Community in the on-going care and management of patients with an indwelling urinary catheter. Catheterisation is an invasive procedure which should be undertaken with dignity and respect and with patient consent or best interest decision. It should only be carried out following an assessment of need and only after all alternative methods of management have been considered (National Institute for Health and Clinical Excellence (NICE) 2017, Royal College of Nursing (RCN) 2021). The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible (NICE 2017, RCN 2021). In the UK approximately 450,000 people require use of a catheter long term, which accounts for 3% of the community population and an estimated 4% of a District Nurse (DN) caseload (Bardsley 2015).

The majority of patients with a urinary catheter will have had this assessment done whilst in the secondary care setting. However, within the community care setting, there may be occasions where the decision to catheterise may need to be taken following assessment of need and in consultation with the patient and the relevant members of the multi- disciplinary team. Such situations may include: -

- Patient comfort/dignity in end-of-life care
- The patient has open wounds/pressure damage and healing is impaired by urine contamination
- Severe urinary incontinence where all other methods of continence promotion have been unsuccessful, and the insertion of a urinary catheter would promote the patient's dignity and improve quality of life.

Urinary catheterisation should never be used as a first line treatment for continence promotion.

This policy should be read in conjunction with the following First Community documents:

- Consent policy - P-PSQ001
- Waste Policy for Safe Management of Waste - P_HS007
- Record keeping policy - GU_PSQ040
- Infection Prevention and Control policy- P_PSQ029
- Chaperone Policy P_ASMR002
- Corporate and Local Induction Guidelines GU-WF003
- ANTT As per Royal Marsden Manual - <https://www.rmmonline.co.uk/manual/c04-sec-0003>

1. Definitions

Catheter associated urinary tract infection (CAUTI)	A urinary tract infection caused by the presence of an indwelling urinary catheter
Bacteriuria	The presence of bacteria in urine
Urethral Catheter (IDC)	A hollow flexible tube inserted into the bladder via the urethra in order to collect or drain urine
Supra pubic catheter (SPC)	A hollow flexible tube inserted into the bladder via a hole in the abdomen in order to collect or drain urine. It is used if the urethra is damaged or blocked
Aseptic non touch technique (ANTT)	The practice of carrying out a procedure by not touching key elements so that the risk of contaminating a vulnerable area or an invasive device is minimised
Community setting	Patient homes, residential care homes, clinics and Community hospital
Intermittent self-catheter (ISC)	A short hollow flexible tube used to drain urine from bladder and then removed, single use only

2. Purpose

NICE (2017) guidelines state that healthcare professionals working in community and primary care settings “must be trained in catheter insertion, including supra pubic catheter replacement and catheter maintenance”.

This policy aims to aid healthcare professionals working within all First Community care settings in applying best practice for urinary catheterisation, catheter care and management.

Using any form of catheter has associated risks and with the continued risk of urine infections and associated life-threatening complications, such as sepsis, it is of great importance that risk assessment becomes an essential part of clinical decisions and catheter care in all care settings (RCN 2021). (RCN 2021). It is estimated that 75% to 80% of hospital acquired urinary infections are due to catheters. (National Center for Biotechnology Information (Magill et al, 2014). In the community care setting, patients may have a long-term indwelling urinary catheter for an extended period of time. It is essential that First Community staff are competent in providing care that minimises infection risk and prevents complications so as to maintain the comfort and wellbeing of the person receiving care (Nursing & Midwifery Council (NMC) 2018).

The following components of care are all vital in the prevention or reduction of the risk of a catheter associated urinary tract infection (CAUTI):

- Inserting urinary catheters using aseptic non touch technique (ANTT).
- Maintaining urinary catheters based on recommended guidelines.
- Avoiding the unnecessary use of urinary catheters.

Additional supporting information:

- Royal Marsden Manual (available online via First Community intranet)
- NMC Code (2018)

3. Scope

- 3.1 This policy covers the care and management of indwelling urinary catheters - both urethral and supra pubic for any patient aged 18 years old or over requiring care in First Community's services.
- 3.2 This policy covers all clinical staff, registered and unregistered who work within First Community and provide urinary catheter care and management within the community and ward setting. This includes agency staff. NB: all agency staff must have local induction as per Corporate and Local Induction Guidelines GU-WF003.
- 3.3 It is expected that all members of staff who are involved in the care and management of patients with urinary catheters should familiarise themselves with the content of this policy and any related guidance documents.
- 3.4 Urinary catheterisation should only be carried out by registered practitioners who have received appropriate training and assessment as detailed in section 5 and pre-registration student nurses under supervision.
- 3.5 Urinary catheter care and management should only be carried out by staff who have received training, which may be informal as detailed in section 4.

4. Duties and Responsibilities

- 4.1 Registered Nurses are expected to gain proficiency in (male, female and suprapubic) catheterisation during pre-registration training. If not attained during pre-registration training, the nurse must have received an underpinning theory study day relating to urinary catheter insertion and had opportunities to practice under supervision. Registered nurses must only practice if they have been assessed as competent and feel confident to perform the procedure. As registered professionals it is their responsibility to maintain knowledge and competency in this procedure. It is also expected that they will be proficient in carrying out catheter care.

Staff who are new to First Community and have previously completed training and assessment in the above are required to provide evidence of the training and assessment programme they have successfully completed. A team member who is competent in urinary catheterisation will then need to undertake a one-off assessment and keep a record of this in their personal file before the new staff member can be permitted to undertake the task unsupervised.

Staff who are new to First Community and who are unable to produce ~~written~~ evidence of training and competency, must be treated in the same way as staff who have not undertaken this additional training i.e. they cannot carry out this skill until they have attended the training and successfully completed the competency assessment.

Urinary catheterisation should only be carried out by registered practitioners who have received appropriate training and assessment as detailed in section 5. Pre-registration student nurses, whether direct entry students or following a Registered Nurse Degree Apprentice programme, who have completed the relevant theory and simulated practice at their university, may practice male and female catheterisation under the direct supervision of a registered nurse.

Urinary catheterisation is not covered within the Foundation degree programme leading to qualification as a Nurse Associate. Nurse Associates employed by First Community will need to undertake further training and assessment as detailed in section 5 and as required by their line manager in order to perform urinary catheterisation.

Monitoring of practice of urinary catheterisation (female, male and supra pubic) may occur through review of completed competency assessments as part of the annual appraisal process.

There may be circumstances and further training involved for specific specialities relating to catheterisation with further local additional assessments may be required. Urinary catheterisation using specialist catheters such as Tiemann Tip catheters should only be undertaken if specific training has been completed and competency achieved. Catheterisation with specialist catheters should be managed under secondary care as per Appendix 2 where applicable.

- 4.2 Nurse Apprentices employed by the organisation are not allowed to perform urinary catheterisation independently but may carry out the care of urinary catheters when provided with training (informal training).
- 4.3 Healthcare assistants (bands 2 and 3) are not permitted to undertake any catheterisation procedures but may carry out the care of urinary catheters when provided with training (informal training).
- 4.4 The referrer is responsible for:
 - Ensuring that the patient's community nursing team has been informed of their discharge so that arrangements can be made to visit the patient as soon as possible.
 - Providing comprehensive information regarding the reason for catheter insertion, date of catheter insertion, and type of catheter used including size. Ideally this will be in the form of a catheter care passport.
 - Ensuring that the patient is sent home with a discharge catheter care pack.
 - Ensuring that the community nursing team has been made aware of all known allergies that the patient may have including latex and lidocaine.
 - Providing education and training for the patient and their relatives/carer in the on-going care of the urinary catheter including hand hygiene. The community nursing team should be made aware of any patient/relative/carer that may be unable to care for their urinary catheter appropriately.
 - Identifying those patients who may need a trial without catheter (TWOC) by arranging for this to be done within the secondary care setting. There may be occasion when a TWOC can be undertaken in the community by following the HOUDINI (Adams et al, 2012) Tool for guidance. (see [Appendix 1](#))

- Arranging for those patients with a supra pubic catheter to have their first catheter change done within the secondary care setting by a trained urology nurse. First Community staff should not perform the first catheter change for these patients in the community setting.

4.5 The registered nurse in the community is responsible for:

- Undertaking a holistic patient assessment and the drawing up of a comprehensive care plan in partnership with the patient aimed at meeting their urinary catheter care needs including reducing risk of catheter blockages, encrustations and associated infections.
- Careful documentation of all known patient allergies including latex and lidocaine since this will affect choice of catheter and lubricating gel to be used for routine catheter changes.
- Ensuring that all patients with a urinary catheter have a catheter passport which includes self-care advice.
- Ensuring that all patients with an indwelling urinary catheter are provided with contact details for the community nursing service including the Out of Hours service.
- Reviewing the patient's care plan whilst in their care and amending care as appropriate.
- Ensuring that appropriate catheter care equipment is available in the community care setting.
- To check that the patient has been referred to an appropriate product supplier for catheter consumables. To make the referral where this has not already implemented.
- Demonstrating and maintaining competence in relation to urinary catheterisation (female, male and supra pubic).
- Monitoring and support of skilled non registered staff who may be involved in providing urinary catheter care
- Providing education and training regarding urinary catheter care for patients and their families/carers.

4.6 Service managers and team leads are responsible for:

- Ensuring any safety alert is actioned by their teams.
- Ensuring the implementation of the policy within their teams.
- Facilitating the attendance of those staff needing to attend training regarding urinary catheterisation.
- Ensuring those staff recruited into First Community from elsewhere have produced documented evidence of prior training and assessment of competence in male and supra pubic catheterisation.
- Ensuring competency is addressed in the annual appraisal process.

5. Guidance and Process

The procedure for female, male and supra pubic catheterisation are detailed in the Royal Marsden Manual, which First Community staff have access to via the intranet. The Marsden manual is a professionally respected, up-to-date and detailed source of clinical procedures and First Community staff are expected to follow these when undertaking female, male and supra pubic urinary catheterisation.

The First Community male and supra pubic catheterisation course, which is for staff new to this skill, will cover male and supra pubic urinary catheterisation in detail, with a practical element being included to prepare them for this aspect of practice and to embed the learning.

Wherever possible, catheter changes should be managed in the community setting. However, some patients may require routine catheter changes in the secondary care setting as detailed in [Appendix 2](#).

The longer a catheter is in place the more likely bacteria will be found in the urine, after one month nearly all people with a catheter will have bacteria (NICE 2018). Antibiotic prophylaxis should therefore not be offered prior to routine catheter change in patients with long-term indwelling urinary catheters. This should only be considered for patients who have a history of symptomatic urinary tract infection or have a history of recurrent or severe urinary tract infection. Similarly, prophylactic antibiotics should not be given after catheter change or to patients who experience trauma during catheterisation resulting in frank haematuria (NICE 2018).

Collection of urine samples should only be performed to confirm urinary tract infection if the patient is symptomatic i.e., has a fever; localised loin or supra pubic pain (NICE 2018). Urine dipsticks should not be used to diagnose urinary tract infection in patients with catheters. Where collection of a urine sample is justified, an aseptic technique must be used as detailed in the Royal Marsden Manual.

First time catheter blockage, where the cause has not been determined, should be treated by removing the catheter (Appendix 3). The catheter tip should be examined for any encrustation, and, if necessary, the catheter should be cut open to ascertain if any debris or crystals are present. Urine pH should be tested – if alkaline (between 6.9 – 9.0) then encrustation is the most likely cause. All findings should be carefully documented in the patient's nursing records.

Long term urethral and supra pubic catheters are licensed for 12 weeks, but routine re-catheterisation may need to be carried out sooner depending on individual patient need. The existing catheter should be removed and examined for encrustations.

6. Catheter Maintenance Solutions

Catheter maintenance solutions have primarily been used extend the life of the catheter when blocking due to encrustation.

All catheter maintenance solutions may increase shredding of epithelial cells within the bladder and should only be used where thorough assessment, including the patient's catheter history, by the registered nurse, has indicated that their use may be beneficial as detailed in [Appendix 4](#).

These solutions are prescribed by the patients GP and recorded on a MAR chart for the nurse/ competent practitioner to sign for once administered.

7. Autonomic Dysreflexia (AD)

Autonomic Dysreflexia is unique to patients with spinal cord injury at the level of the 6th thoracic vertebra or above. It is an abnormal response from the Autonomic Nervous

System to painful or noxious stimuli perceived below the level of the spinal cord injury as detailed in [Appendix 5](#).

Any catheterised patient who has a spinal cord injury and is displaying symptoms of Autonomic Dysreflexia should have their catheter and drainage system reviewed. If the catheter appears blocked it should be changed immediately – any catheter maintenance solution SHOULD NOT be instilled as this will only further distend the bladder with potentially fatal consequences. If infection is suspected seek medical advice for antibiotic therapy immediately.

Information regarding this should be in every relevant patient's clinical records.

8. Monitoring

Monitoring of practice of urinary catheterisation (female, male and supra pubic) occurs through review of completed competency assessments as described.

The EMIS system has a catheter template signposting the need to review at each catheter change. This will be monitored and audited annually and this will be reported through Radar for Clinical Audit and Quality Improvement.

Standards for urinary catheterisation will be monitored and audited annually and this will be reported through the Clinical Audit and Quality Improvement Database.

Hand hygiene audits are conducted 6 monthly or more frequently as required in line with the Infection Prevention and Control Policy P_PSQ029.

9. Training and Development

The Learning and Development team will liaise with the Continence Service to provide training in male and supra pubic catheterisation for all First Community staff who are required to undertake this as part of their role. Service and team leads will support the assessment process and the achievement of competency frameworks to enable safe practice in male and supra pubic catheterisation.

All training completed will be recorded on the electronic record system (ESR) and a copy of competencies will be placed in staff files, to be reviewed as part of annual appraisal.

10. Equality Impact Assessment

All public bodies have a statutory duty under the race Relations Act 2000 to set out arrangements to assess and consult on how policies and functions impact on race equality. All policy documents will be equality impact assessed and this will include equality and human rights with regard to disability, age, and gender. This task will be undertaken by the author.

First Community Health and Care aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It is a requirement that we conduct equality impact assessments on all policies and services within the organisation. Therefore, all policies must have an equality impact assessment.

11. References

Adams D, Bucior H, Day G, Rimmer J. HOUDINI: Make that urinary catheter disappear - nurse led protocol. *Journal of Infection Prevention*. 2012; 13: 44–46

Bardsley A (2015) Safe and effective catheterisation for patients in the community. *British Journal of Community Nursing* Vol 20 issue 4

Cochrane Database of Systematic Reviews 2010; Issue 3.

DH (2006) Essential Steps to safe, clean care: urinary catheter care
Department of Health HMSO London

Hagen S; Sinclair L; Cross S (2012) Washout policies in long-term indwelling urinary catheterisation in adults.

Magill SS, Edwards JR, Bamberg W, Beldavs ZG, Dumyati G, Kainer MA, Lynfield R, Maloney M, McAllister-Hollod L, Nadle J, Ray S, Thompson D, Wilson L, Fridkin S. Multistate Point-Prevalence Survey of Health Care–Associated Infections. *N Engl J Med*. 2014;**370**(13):1198–1208.

NICE (2017) Infection: Prevention and control of Healthcare associated infections in primary and community care: Clinical Guideline 139 National Institute of Healthcare and Clinical Excellence

NICE (2018) Urinary tract infection (catheter-associated): antimicrobial prescribing: Nice Guideline (NG) 113

NMC (2018) The Code Nursing and Midwifery Council

RCN (2021) Catheter Care: RCN guidance for Nurses Royal College of Nursing Second edition RCN London

Yates, A (2018) Using patency solutions to manage urinary catheter blockage. *Nurse Times*. 2018;114(5):18-21.

Appendix One - HOUDINI protocol

Unless one of the conditions listed below is present, the catheter may not be necessary, and a TWOC should be considered.

Haematuria – severe, blood clots
Obstruction – leading to retention
Urology or gynaecology surgery
Decubitus ulcer – to aid healing of severe pressure ulcers
Input/Output recording
Nursing in end of life for comfort and dignity
Immobility – i.e. bone fracture, neurological deficit

- Assess the patient for self-care ability or confirm a carer will be present.
- Discuss with patient/carers about the intention to TWOC at the next catheter change, agree a date and explain process as several contacts on the day may be required. Advise patient should be well and not constipated.
- Ensure catheter supplies available for the day of TWOC
- For male patients, discuss with GP and consider Tamsulosin 400mcg for 4 days (unless contra-indicated) prior to TWOC.
- If patient is able to use a catheter flip-flow valve this should be present. Advise patient to open valve at 06:00 (if possible) and then keep closed until visit.

TWOC – Catheter removal

1. Plan an early morning visit and remove catheter. If on ward this may be carried out earlier. Encourage the patient to void and then carry out a bladder scan. Commence fluid chart, fluid intake and output must be recorded and ensure contact details left should any discomfort occur. Remind patient to drink at least 200mls per hour.
2. 4 hours later - contact patient to ascertain all well and assess input and output.
3. During the afternoon, visit patient to re-assess input and output and carry out a post-void bladder scan.
4. If there is any discomfort, output significantly less than input and scanner reveals more than 300ml – re-catheterise. Inform referrer and GP.
5. If patient appears to be voiding well and scan is less than 100mls then TWOC successful. If scan 100mls - 300mls, arrange another scan 48 hours later. Should patient continue to be voiding adequately arrange a follow-up in 2 weeks.
6. Refer to continence service if necessary.
7. Document all results and amend schedules. Inform relevant organisations.

Appendix Two - Referrals

Patients who should be referred to secondary care for routine catheter changes

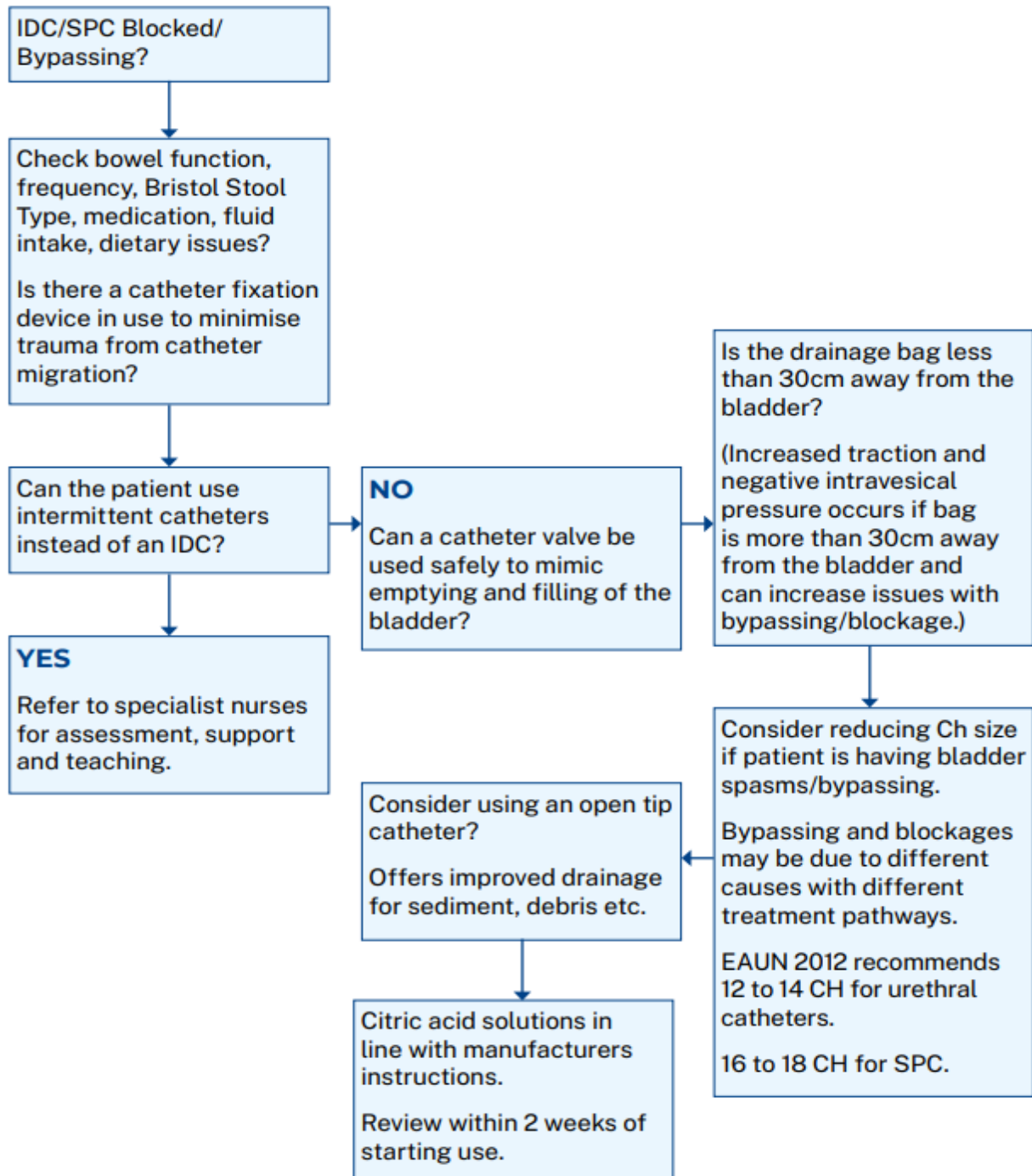
CONDITION	ACTION/REASON
First presentation of urine retention	Catheterisation should be done by a medical practitioner if cause of retention is unknown
Cancer of the prostate/penis/bladder – unless tract is viable	Possible complications requiring Urology nurse or medical supervision
Paraplegics – unstable autonomic dysreflexia Patients with spinal injury at T6 known condition	Will be known to suffer from autonomic dysreflexia. Can be managed but unstable patients need medical supervision
Hypospadias Congenital abnormality of the urethra affecting position of meatus on penis	Medical supervision due to unknown and abnormal tract
Traumatic injury	Unknown problems and anatomy arising from injury – medical supervision
Urology post-op	Known to urology team and deemed to require hospital supervision due to surgical procedures
History of gross haematuria/acute clot retention	Possibility of shock/infection. Clot retention requiring 3-way catheter drainage supervised in hospital
Known list of patients selected for Urology nurse re-catheterisation	Patients referred to Urology nurse due to complications and seen for planned changes until deemed suitable for community
New supra pubic catheters before first scheduled change	Urology guidelines, early first change by medical staff

These patients should be reviewed by the Medical/Urology team to see if they can transfer to community for routine re-catheterisation.

Appendix Three – Catheter Blockages Flowchart – (RCN, 2021)

Generally, catheter blockages fall into 2 groups (Yates,2018):

- Luminal blockages - the catheter drainage lumen is occluded, usually by encrustation:
- Blockages due to a mechanical dysfunction – there is a problem with the drainage system but the lumen remains clear.



Appendix Four – Catheter Maintenance Solutions

There is limited evidence for the use of catheter maintenance solutions; however, they are available on prescription for use in treating specific conditions. The cause of catheter blockage should be determined so that the appropriate catheter maintenance solution can be prescribed, and to formulate an individualised maintenance programme which should be regularly reviewed by the registered nurse.

There is insufficient evidence to guide clinical practice in their use with long term urinary catheter care and management (Hagen et al, 2010). In addition, there is the potential to increase the risk of urinary tract infection as the drainage bag will need to be disconnected from the catheter to enable instillation of the catheter maintenance solution (NICE 2017).

Solution	Purpose
Sodium Chloride 0.9% (Opti-Flo S)	Neutral solution - recommended for flushing of debris and small clots
Solution G (Opti-Flo G; Twin Suby G)	Citric Acid 3.23% - for dissolving crystal encrustation
Solution R (Opti-Flo R; Twin Solution R)	Citric Acid 6% - for dissolving more persistent crystal encrustation – to be used with caution

Mandelic Acid 1% and Chlorhexidine 0.02% catheter maintenance solutions are not recommended, and guidance from a Microbiologist should be sought prior to their use.

All catheter maintenance solutions should be administered in accordance with manufacturer’s guidelines. It must be remembered they are for the catheter and not the bladder and must be allowed to drain immediately after insertion.

- Catheter maintenance solutions should not be used to prevent catheter associated infections (NICE 2017).
- Catheter maintenance solutions should not be used to unblock a blocked catheter. A blocked catheter should be replaced.
- Any patient on regular catheter maintenance solutions should be regularly reviewed and, if the solution does not appear to be extending the catheter life, it should be stopped.

Appendix Five – Autonomic Dysreflexia (AD)

Due to spinal cord damage, normal nerve signals are unable to pass to the brain. The body therefore produces exaggerated nerve signals resulting in problems above and below the spinal cord injury. Blood vessels below the injury go into spasm causing blood pressure to rise, whilst above the level of injury the body senses the high blood pressure and tries to relax the blood vessels. Symptoms of AD may be mild or severe and the patient may present with one or more of the following:

- Pounding headache
- Flushing and/or blotching above the level of spinal cord injury
- Pallor below the level of spinal cord injury
- Slowed heart rate
- Profuse sweating (above level of injury)
- Palpitations
- Goosebumps
- Blurred vision or seeing spots before the eyes
- Stuffy nose
- Feeling of doom and gloom, anxiety, apprehension
- Elevated blood pressure

NB: Under normal circumstances a tetraplegic person may have a low blood pressure (e.g., 90/60). A rise of 20mmHg can be quite significant; therefore, if the BP rises to 120/80 mmHg it could become an emergency situation. Hypertension may be severe enough to lead to seizures, strokes or ultimately death.

Autonomic Dysreflexia is commonly caused by:

- Overfull bladder
- Kidney or bladder stones
- High pressure voiding
- Urinary tract infection
- Blocked catheter
- Defective drainage system e.g., kinked tubing, overfull drainage bag

Treatment

Identify the source of the noxious stimulus. Removing the stimulus will cause the symptoms to settle. Reduce the blood pressure by returning the patient to bed and place in a sitting position. (If bladder problems suspected only sit patient to 45 degrees. Sitting at 90 degrees may cause increased pressure on the full bladder). The patient will likely have a supply of Nifedipine for use.

Appendix A: Version control

Version Number	Status	DATE	Name and job title of person making amendments	Comments / summary of changes
0.1	Draft	July 2015	Annette Steadman, Practice Educator	Amendments made following feedback from those in consultation District Nurses District Nurse Team Leaders Clinical Lead for Community Services Quality Improvement Facilitator Rapid Assessment Clinic Continence Nurse Advisor
1	Final	Sept 2015	Annette Steadman, Practice Educator	Final Version
1.1	Draft	Nov 2018	Tembie Nyoni Continence Nurse Specialist	Reviewed - Some word changes across document, updated references, Houdini Tool inclusion, RAC operational hours. Sent to Clinical Practice Group for approval – approved subject to review by Health Protection Specialist
1.2	Draft	Dec 2018	Tembie Nyoni Continence Nurse Specialist	Reviewed by Mary Brown, Health Protection Specialist. No further changes
2	Final	Jan 2019	Tembie Nyoni Continence Nurse Specialist	Final Version
2.1	Final	June 2019	Sarah Buxton	Appx 5 Catheter Passport added
2.2	Draft	Jan 20221	Linda West, Continence Nurse Specialist	Policy reviewed. References updated Catheter Blockage flowchart added Band 4 and pre-reg students included
2.3	Draft	May 2021	Linda West, Continence Nurse Specialist	Sent to CPG for approval. Approved subject to changes
2.4	Draft	Aug 2021	Linda West, Continence Nurse Specialist	Amendments made following recommendations from CPG review. Some word changes across the document. Audit process linked into updated catheter template on emis
2.5	Draft	Sept 2021	Chris Garner, Continence Nurse Specialist	RCN guideline reference updated and monitoring process clarified. Final approval by CPG chair. For IGC ratification
3	Final	Sept 2021	Emma Marcroft, Head of Patient Safety and	Added reference to Corporate and Local Induction Guidelines

			Quality	GU_WF003. Chairs approval given for ratification at QSIAC
3.1	Draft	Oct 2023	Chris Garner, Continence Nurse Specialist	Reviewed and updated. Submitted to CPG for approval. Approved by CPG subject to changes
3.2	Draft	Nov 2023	Chris Garner, Continence Nurse Specialist	Changes made and submitted to Quality Committee for ratification
3.3	Draft	Mar 2024	Diane Winchester, Clinical Team Lead for Long Term Conditions	Clarification on Tiemann catheters and consultation with clinical team leads. Send to Quality Committee Chair for virtual ratification
4	Final	Apr 2024	Emma Marcroft, Head of Patient Safety and Quality	Ratified by Chair for Quality Committee

Appendix B: Equality Impact Assessment Screening Tool

For help and guidance see GU_WF015 EIA Guidance or contact fchc.edi@nhs.net

Once complete please send the whole document to fchc.edi@nhs.net

Equality Impact Assessment Screening Tool

EIA No: <i>(To be inserted by EDI Lead)</i>	Approved by Zenia Squires Jamison 02/05/24	
What is being assessed? (Name of Policy, process, procedure, decision, guidance, change etc.)	Policy	
Owner/Author:	Continence Nurse Specialist Team Lead	
What are the main aims and objectives of the Policy/Document/project/programme/guidance/change	Clinical guidance policy	
Date EIA screening tool Commenced	April 2023	
Person leading the EIA	Name Job Title	Chris Garner Continence Nurse Specialist Team Lead
	Date Completed	30/04/2024

The Equality Act (2010) defines a range of protected characteristics we must think about when doing an EIA. These are age, disability, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex and sexual orientation. In relation to marriage and civil partnership only the discrimination aim applies, not advance equality of opportunity or foster good relations. Please consider these protected characteristics groups, along with other relevant groups such as carers when completing the EIA.

Section 1: SCREENING:

Do any of the following apply? (If so complete a full impact assessment):

Criteria*	Yes	No
Could or does the policy, process, procedure, decision, guidance, change, etc affect one or more equality target group(s) in a different way to other groups?	<input type="checkbox"/>	X
Could or do different equality groups have different needs in relation to the policy, process, procedure, decision, guidance, change, etc?	<input type="checkbox"/>	X
Does the policy, process, procedure, decision, guidance, change, etc actually or potentially contribute to or hinder equality of opportunity?	<input type="checkbox"/>	X
Does the policy, process, procedure, decision, guidance, change, etc offer unique opportunities to promote equality?	<input type="checkbox"/>	X

If all answers to the above are NO, a full assessment is not required. Please make reference to the fact that EIA Screening has taken place and forward the document to the EDI Lead at fchc.edi@nhs.net.

If you have answered YES to any of the questions above, please complete the full Equality Impact Assessment template in appendix c.

Further Information and Feedback

If you would like to find out more about our services, please visit our website at:

www.firstcommunityhealthcare.co.uk

If you would like this information in another format, for example large print or easy read, or if you need help communicating with us, please contact:

First Community (Head Office)

Call: **01737 775450**

Email: **fhc.enquiries@nhs.net**

Text: **07814 639034**

Address: First Community Health and Care, Orchard House, Unit 8a, Orchard Business Centre, Bonehurst Road, Redhill RH1 5EL

Twitter: **@1stchatter**

Facebook: **@firstcommunityhcNHS**

Instagram: **firstcommunityhealthandcare**

LinkedIn: **www.linkedin.com/company/first-community-health-&-care-c-i-c-/**

TikTok: **www.tiktok.com/@firstcommunityhc NHS**