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Care and management of indwelling urinary catheters

Penny Tremayne and Jillian Pawlyn jillian.pawlyn@open.ac.uk

Abstract

The insertion of an indwelling urethral catheter is a considered, invasive intervention which places the patient in a position of increased vulnerability. It requires the nurse to have the knowledge, skills and understanding to prepare and perform the procedure whilst supporting the patient. Such a procedure may evoke a range of emotions and responses in a person with an intellectual disability (ID). It is important that nurses address the needs of the individual tailoring the care to their needs in a sensitive and respectful manner.

Key words

Indwelling, Catheter, care, management, learning disability, intellectual disability, urinary continence

Aim and intended learning outcomes

This article aims to raise awareness of issues relating to indwelling urinary catheter care and management for people with an Intellectual disability (ID).

It outlines what a catheter is and the different types available alongside consideration of influencing factors regarding the choice of catheter; an overview of the insertion procedure will be presented, and everyday catheter management and ongoing care will be discussed.

After reading this article and completing the time out activities, you should be able to:

- Define what urinary catheterisation is.
- Identify the types of catheter available.
- Outline principles of informed consent and make reasonable adjustments for the patient with an ID
- Describe the ongoing care that promotes safety and wellbeing for the patient with a catheter in situ.
- Reflect on the psychosocial impact that an indwelling catheter can have on a person with an ID.

Introduction

It is well established that people with an ID are at greater risk of having unmet health needs and untimely death (Mencap 2007; Mencap 2012; Heslop et.al 2013; PHE 2016).

Appropriate interventions delivered by skilled and experienced nursing staff in partnership with the person with an ID are important in reducing associated risks. Assisting people in their elimination needs is a fundamental role of all nurses (NHS England, 2018). Urinary catheterisation is an invasive procedure that can lead to several complications. It is imperative that nurses are equipped with the knowledge and understanding to effectively care and support people with an ID and facilitate their holistic health and wellbeing

The production of urine which is controlled by the kidneys is essential in maintaining blood pressure homeostasis (RCN, 2012). A urinary catheter may be considered where a person (with an ID) is acutely unwell, has intractable incontinence, their skin integrity is compromised due to urine, as part of a treatment regime, during or following surgery, retention of urine or has severe incontinence and where an externally worn continence product is ineffective (Tremayne 2012; Burkhard et al, 2018).

A urinary catheter is a hollow tube which drains urine from the bladder. In the community long – term urinary catheterisation (longer than 28 days) is estimated to be used for 450,000 people in the UK (Prinjha and Chapple, 2013). It is difficult to accurately determine catheter usage by people who have an ID across the UK. In a meta-analysis of the health or healthcare of people with learning disabilities, Kinnear et al (2018) indicated there are significant gaps in research on physical health conditions among people with an ID. Public Health England (2016) estimate 2015 there were 1,087,100 people with learning disabilities living in England, equivalent to 2.16% of the English population; for the same period only 252,446 were registered with a GP. This ‘hidden majority’ (Hatton 2016), an estimated 77% of the population remain invisible to services and health needs go un-recognised. This lack of accurate data makes it difficult to identify how many people with ID experience continence problems; estimates indicate a prevalence from 47% (Lennox et al 2003), 59% (Bland et al 2003) 72% (Chapman et al 2008). More accurate figures are being collated through the NHS Digital (2018) GP Hub; figures report on the prevalence of health conditions of people with learning disabilities residing in England and are patients recorded on the GP ID register; unfortunately, these figures do not represent the full population of people with an ID and, as yet, does not report incidence of urinary incontinence.

The NMC (2018) highlight that those receiving care are treated with dignity and respect, that their privacy is maintained, that their rights are upheld and that any discriminatory attitudes and behaviours are challenged. This is important when considering urinary catheterisation for people with an ID, in addition it also highlights that the nurse should practise in line with the best available evidence adhering to relevant laws and policies while protecting and caring for vulnerable people.

The involvement, where clinically necessary, of a family member or paid carer needs to be achieved in partnership with the person who has an ID (RCN 2012, NMC 2018). It is essential that the nurse seeks consent for the procedure respecting, supporting and documenting the person's right to accept or refuse care and treatment while balancing the need to act in the person's 'best interest' (NMC 2018).

Prinjha et al (2016) highlight that the information needs of person with an ID could be better in relation to; technical information about it, information to prevent catheter – related physical problems, sexual and intimate relationships and the management of the catheter in social situations. To meet the persons information needs while seeking informed consent it is essential the nurse communicates effectively.

“When you're communicating with someone with a learning disability, think about your tone of voice and your body language, as well as the words you use” (Mencap 2018).

Effective communication can be achieved by using the persons preferred mode of communication when explaining what to expect during the catheter insertion and while it remains in position, including discomfort and pain, meatal cleansing, body position, pushing sensation, fixation devices and the sensations/ urges to pass urine. Communication may be verbal or non-verbal or both, use accessible language, avoiding jargon and long words, be creative and be prepared to use a variety of communication tools, ensure you communicate at the persons pace, following their lead, and always check your and their understanding (Mencap 2018). Resources which may be beneficial may include: peer/mutual support (Keyes and Brandon 2011) from a person who lives with a catheter in situ, desensitisation/familiarisation with equipment, demonstration/simulation of the insertion of the catheter on a mannequin, provision of mixed media resources (e.g. video, printed material; access to apps for mobile devices) providing information about catheter, insertion and aftercare; the person with an ID may also find it beneficial to invite a familiar person to join the conversation.

The combination of the intrusive nature of the procedure, the increased likelihood that the indwelling catheter will be long term and the co-morbidities of the person with an ID the risk of complications is considerable, introducing an indwelling catheter should be avoided wherever possible. “It is recognised that indwelling urinary catheterisation is associated with infection which can lead to illness, hospital admission and even death. People living with a long-term catheter may find them distressing, uncomfortable and undignified. However, for others they may promote independence and prevent kidney damage” (NHS England 2018: 13). These risks can be minimised if catheter care and maintenance is undertaken by those who have received training (NICE, 2014b), this included the person with an ID and carers. According to Bardsley (2015) a holistic assessment of the patient or whether there are carers available to manage the devices should inform the choice of catheter material, drainage system and securement device. It is important to clearly explain to the person the clinical need for the catheter, seek informed consent, identify those at risk

of self-extraction of the indwelling catheter and apply a range of measures to reduce self-extraction (Box 1) (Leslie and Shenot 2018).

Box 1 Measures to reduce self-extraction

- Identify the person at risk of self-extraction;
- Clearly explain the procedure;
- Be suspicious of possible malposition catheter;
- Increase monitoring and observation of the person identified as being at risk;
- Use standard securing and fixation devices correctly, an appropriate fixation device suited to the individual is important as it can reduce the anxiety that can be associated with the catheter being pulled or dislodged. Such devices prevent excessive traction, can anchor the catheter and prevent excessive movement (Yates 2018);
- Reposition the indwelling catheter under the thigh, tape it and cover it, securing with a wide elastic strap;
- Encourage the person to also wear mesh underpants or a full continence pad with taped panels and clothing which cover and protect the catheter;
- Add a decoy catheter tube;
- Implement additional preventative measures of supervision; distraction activities; ensuring these are the 'least restrictive';
- Removal of the indwelling catheter and use of intermittent catheter if clinically appropriate.

Adapted from: Leslie and Shenot (2018)

Time Out 1:

Refer to the 'Catheter Care: RCN guidance for Nurses' (RCN, 2012), <https://www.rcn.org.uk/professional-development/publications/pub-003237> sections 6 and 7 and read the reasons for, and decisions influencing, catheterisation.

Compare the guidance with your local policy and identify any contradictions which need to be discussed. Ensure these are discussed with the appropriate person

Catheter types

There are three types of urinary catheter but only two are indwelling; urethral and suprapubic, the third is Intermittent Self – Catheterisation (ISC) also known as Clean Intermittent Catheterisation (CIC) [Figure 1].

Figure 1 Catheter Types (Top to bottom: standard length balloon inflated, Long length, Standard length balloon deflated, Intermittent Self Catheter).

Urethral catheters

A urethral catheter is inserted via the urethral meatus and advanced up the urethra and secured in the bladder by a balloon filled with fluid advised by the manufacturer.

There are many issues to consider when catheterising a person with a ID with a urethral catheter. Take some time to familiarise yourself with what the procedure involves [See Box 2].

	Warn the patient before instilling prescribed anaesthetic lubricating gel.	
	Remove gloves. Perform hand hygiene and put on sterile gloves.	
	Expose tip of catheter and place the drainage port of the catheter and syringe of sterile water into the sterile receiver.	
	Connect sterile drainage bag to catheter and place the between patient's legs.	
	Used ANTT to insert catheter.	
Use sterile gauze to retract labia and inserted tip of catheter into urethra.		Warn the patient and hold penis upwards.
Gradually remove packaging from catheter while advancing.		Ask the patient to cough or strain as catheter pass external sphincter.
	Ensure catheter fully insert before inflating balloon.	
	Attach catheter drainage bag and secure so catheter not pulling.	

When urine began to flow, advance catheter to bifurcation and inflate balloon.

→
Clean residual gel and retract foreskin.
←

Gently withdrew catheter until it stopped.

Connect drainage bag.

Remove paper sheet and cover patient.

Position catheter and bag so it could drain freely without pulling on catheter.

Discard all equipment and remove gloves.

Attach drainage bag to stand and check catheter draining freely.

Made sure the patient was comfortable and assist with dressing as required. Where applicable ensure the bed/chair is clean and dry.

Discard gloves and equipment safely.

Retain adhesive catheter label.

Remove apron and perform hand hygiene.

Document catheterisation and retain label according to local policy.

Report volume and appearance of urine.

If patient's condition allows, encourage oral fluids.

Provide aftercare in accordance with local policy and procedures

Adapted from:

Cronin P and Faulds S. (2012) Chapter 8.15 Female Catheterisation. In: Nichol, M (et.al) (Eds) Essential Nursing Skills. 4th Edition. Edinburgh: Mosby Limited. p.p.251-254.

Cronin P (2012) Chapter 8.16 Male Catheterisation. In: Nichol, M (et.al) (Eds) Essential Nursing Skills. 4th Edition. Edinburgh: Mosby Limited. p.p.255-259.

Suprapubic catheters

A suprapubic catheter is inserted through a tract created from the bladder to the anterior abdominal wall (Rigby, 2009). It may be implemented as a short-term intervention where urethral catheterisation is not possible to relieve urinary retention in acute and chronic conditions or is contraindicated (Kumar and Pati, 2005). A suprapubic catheter may be preferable as the lumen of the catheter is bigger and therefore may reduce the risk of blockage (Bardsley, 2015). Further benefits of suprapubic catheterisation include no risk of catheter induced urethritis, urethral trauma or necrosis and there is greater comfort, particularly for patients who are wheelchair users (RCN 2012).

Intermittent Clean Self – Catheterisation (ISC) / Clean Intermittent Catheterisation (CIC).

As the name indicates these are catheters which are used in an intermittent technique, therefore they are not 'indwelling' [Figure 2 & 3].

Figure 2 Intermittent catheter (cover intact)

Figure 3 Intermittent catheter (cover removed)

For some people an indwelling catheter may not be appropriate and intermittent catheterisation may be clinically indicated [Box 3]. ISC/CIC is when a sterile lubricated catheter is passed down the urethra, urine drained, and the catheter removed. A person with an ID may lack manual dexterity or mental capacity to safely perform this technique the nurse, may need to perform, assist or offer verbal prompts with this procedure [Box 4] (Stafford, 2017).

Box 3 indicators for intermittent Catheterisation

Indicators for Intermittent catheterisation:

- Detrusor Dysfunction/ detrusor hypotonicity or failure;
- Bladder outlet obstruction, failure of the bladder outlet to open sufficiently to allow the passage of urine through it;
- Post-operative procedures or drugs affecting the contractility of the detrusor;
- Instilling drugs into the bladder;
- Managing urethral stricture.

(Geng, Cobussen-Boekhorst Farrell J et al 2012; Colpman 2018)

Box 4 Procedures for intermittent catheterisation

Procedures for intermittent catheterisation:

Recommendations for IC undertaken by a healthcare professional -

- prior to its initiation, a comprehensive history should be taken (NICE, 2012b).;
- Gain consent from the individual, explain the procedure, audio-visual aids may assist with this;
- Ensure local guidance is followed for the procedure;
- Follow the principles of clean technique (Davies and Rantell 2018);
- Use an appropriate sized single-use catheter; where the individual has sufficient dexterity then self-lubricating hydrophilic coated with polymer, or uncoated with a gel reservoir catheter may be considered, suitability of the catheter may require some trials.;
- Cross check for any known allergy to lubricants that may contain lidocaine and chlorhexidine*;
- Single-use lubricant jelly can be used, when inserting a non-coated urethral catheter*;
- Instil 10ml of lubricating gel within the male urethra, 6 ml in the urethral meatus of female patients (Bardsley 2005) when inserting a non-coated urethral catheter*;
- The routine use of antiseptic lubricants for catheter insertion is unnecessary*;
- In an individual who can pass urine carry out IC after they have passed urine*;
- Document fluid intake and output in a voiding diary to identify patterns*;

The above recommendations with an asterisk (*) should also be included in the patient / caregiver education on intermittent (self) catheterisation

Adapted from: Vahr et al. (2013) Catheterisation Urethral Intermittent in adults.

Infection control

Catheter associated urinary tracts infections (CAUTIs) are serious and can escalate to acute kidney injury or septicaemia if unrecognised. Other indicative signs and symptoms, may include; pyrexia, lower abdominal, lower back, groin pain, nausea, vomiting, fatigue, dehydration, restlessness and sometimes confusion. Unfortunately, CAUTIs are not uncommon (Mantle 2015) and are the most frequent cause of Hospital Care Associated Infection (HCAI) (Holmes et al 2015; Mantle 2015).

There are several potential sources of infection (Box 5) that should be considered:

Box 5 Sources of infection (RCN, 2012)

- During catheter insertion;
- Gap between the catheter and urethra;
- Catheter lumen;
- Catheter connection to the valve / bag;
- Sample port [Figure 4];
- Reflux from the bag;
- Tap on the valve / bag;
- Self- infection and
- Cross infection by the person, nurse, others involved in care of the catheter.

(RCN 2012: 45)

Figure 4 Sample port for specimen collection

NICE (2012a) advocate that the person and their carers are educated about and trained in techniques of hand decontamination, insertion of intermittent catheters where applicable, and catheter management before discharge from hospital. A Recent report from the Learning Disabilities Mortality Review (LeDeR) (2017) offers several significant points in relation to the inadequacies in healthcare provision for people with a ID. In the report it details an example of a patient called Nick who was discharged home with a catheter in situ but the carers who supported him were not provided with any training in relation to the care of a catheter. Nick was subsequently re-admitted with urinary sepsis. It is essential therefore to be proactive in identifying the prior knowledge, skills and understanding not only of the person but those caring / supporting them.

Prior to handling a catheter hands should be decontaminated, and non-sterile single use gloves used, after handling then hands should again be decontaminated after removal and disposal of gloves (W.H.O 2009; Yates, 2012; NICE 2012a, 2014a).

Time Out 2:

Visit this website to remind yourself on handwashing technique.

<https://www.nhs.uk/Livewell/homehygiene/Pages/how-to-wash-your-hands-properly.aspx>

Identify how you could assist the person to include hand hygiene within their personal care/ catheter care routine.

Influencing factors include duration of insertion and unnecessary delay in removing the catheter (NICE, 2014b). Meatal observation and cleansing with soap and water should be undertaken daily during personal cleansing (RCN, 2012, Yates, 2012 and NICE, 2014). The appearance and odour of urine should be monitored and changes such as cloudy dark urine, blood, pus or malodorous urine documented and acted upon. Urinalysis should be undertaken and if a CAUTI is suspected (leucocytes, haematuria may be present) an aseptic catheter specimen of urine taken from a catheter port (NICE, 2014b).

An important aspect in reducing infection during catheter care is establishing one of two drainage systems; closed or link.

A closed drainage system [Figure 5] is an indwelling catheter which is attached to either a sterile valve / bag. The seal between the catheter and the valve / bag should only be broken when the valve / bag is changed which is usually 5-7 days or as recommended by the manufacturer (Woodward 2013; NICE, 2014b and Wilson 2015). Leg bags are often used to collect urine, but they have a capacity limitation which means at night a link system [Figure 6] of a large capacity drainage bag is required. The large capacity drainage bag is attached to the outlet tap of the leg bag and the leg-bag tap opened (Wilson, 2015). Depending on the brand, the large capacity drainage bag may be single use; or it may come equipped with a drainage tap for reuse. Reusable drainage bags may be used for around 5-7 nights before replacing, always ensure that manufacturers recommendations are followed (ICI and ICS 2018a).

Figure 5 Closed drainage system

Figure 6 Link drainage system

For those with a suprapubic catheter there is also the risk of a wound infection. Observation of the cystostomy (insertion site) should be daily; initially cleansing should be via strict aseptic technique and once the insertion site has healed the catheter and site can be cleaned daily with soap, water and a clean cloth (Geng et al 2012; RCN 2012). Davey (2015) considers how over-granulation of the insertion site occurs and suggests that one of the solutions to this can be changing the angle at which the catheter lies against the abdomen and to tape it accordingly.

To reduce the risk of infection, when emptying the drainage bag the drainage outlet should be cleansed with an alcohol wipe [Figure 7] (Fraise & Bradley 2009), urine should be collected into a sterile container [Figure 8] or a container that is used solely for that person and the outlet tap should be clear of the unsterile surface (Gould, 2015).

Figure 7 Cleanse drainage outlet

Figure 8 Emptying into sterile single use container

Drainage

Positioning of the catheter is something always to be mindful of and the drainage bag should always be below the bladder to ensure that there is no backflow that may be caused by kinking. Davey (2015) highlights that wheelchair users may require extra tubing if they are using bags that cannot be placed below the bladder. The support of the drainage bag is important to prevent urethral trauma and traction (Geng et al 2012; Nazarko 2014; Woodward, 2014). There are various stabilisation devices that can secure and offer support; E.g. Adhesive devices, these provide an anchor holding the catheter in position, however care needs to be given to avoid lumen occlusion (Wilson 2015), it is important to consider contraindications to the adhesive on the device. Leg straps [Figure 9] are another alternative, these are fitted around the leg and the catheter secured to the strap to reduce tension (Woodward, 2014), however caution on the level of tension used and other contraindications need to be considered; for example, oedematous legs, poor circulation, phlebitis and diabetes. Wilson (2015) considers leg sleeves, these elasticated – mesh bag sleeves can be worn either upper or lower leg and often have an integral pocket that the

bag fits into; there is an opening for the outlet tap. Various catheter stands [Figure 6] are available, all of which should ensure the outlet tap is clear from an unsterile service.

Figure 9 Leg strap securing leg bag

It is especially important to monitor bowel movements to ensure that constipation is not inhibiting drainage and that fluids are encouraged to prevent dehydration (Geng et al 2012; Vahr 2013). The Bladder and Bowel foundation (B&BC 2016) advocate that the person should drink 'at least 12 cups (4 pints) per 24 hours. This will dilute their urine and possibly reduce the risk of infection and help flush out any debris in the bladder. The B&BC provide a 'Fluid Matrix' table which indicates the amount of fluid the person should drink for their weight).

Pain is something that tends to be unacknowledged and can be present in nearly a quarter of people who have a long-term indwelling catheter in place (Wilde et al, 2013).

Time Out 3:

How do you know when the person supporting you is in pain? Read this document and view the resources referred to at the end of the guidance. Discuss this information with your colleagues.

PHE (2017) Pain management: supporting people with learning disabilities.

<https://www.gov.uk/government/publications/improving-healthcare-access-for-people-with-learning-disabilities>

Nazarko (2014) considers some troubleshooting measures including; explore whether ISC/CIC is possible, review catheter length, size of material to reduce the risk of tissue trauma. A smaller lumen of catheter can promote greater comfort and whilst a silicone catheter reduces encrustation and therefore blocking they can cause friction because they are more rigid and because they are uncoated the lumen is larger (Bardsley, 2015). Friction can be relieved between the catheter tip and bladder tissue by lifting the bladder tissue from the catheter tips (Woodward, 2013). Security of the catheter needs to be ensured, the catheter tip being secured by a balloon in the neck of the bladder. For adults, a 10ml balloon is generally recommended as standard and 2.5ml to 5ml for children (ICI and ICS 2018b). Manufacturers will recommend the volume of water required to ensure the balloon is inflated [Figure 10] however the larger balloon the more direct contact it will have with the bladder tissue and cause potential irritation (Gould, 2015), it is therefore recommended that the smallest balloon size is used (ICI and ICS 2018a).

Figure 10 Syringe in position for balloon inflation/ deflation

Spasms and contractions can be caused by essentially a foreign object being placed in the bladder; if these persist despite any reduction in balloon size then antimuscarinic medication can be prescribed and can abate irritation but if this persists referral to a urologist may be required (Joint Formulary Committee 2018).

Blockage

One of the complications that can occur in long-term use of an indwelling catheter is blockage due to encrustation. According to Stickler (2014) and Holdroyd (2017) crystals form in the presence of bacteria, bacteria facilitate the production of an enzyme called urease which leads to the urine pH increasing and crystals being formed. Alongside this the bacteria colonise the surface of the catheter and forms a bacterial biofilm, this continues until there is a blockage in the flow of urine (Stickler 2014; Holdroyd 2017). To have an awareness that this could be a risk it may be useful to maintain a catheter diary/passport which can identify a catheter 'lifetime' so that proactive measures can be taken to prevent to minimise complications (Gibney, 2016). Urine pH and specifically its alkalinity will indicate a risk of blockage and Gibney (2016) recommends that it will be useful at the same time every week

the same time that the drainage bag is changed that this is monitored. Trying to reduce the pH, Stickler (2014) and Gibney (2016) considers that an increase in oral fluids and citrate intake may be a useful non-invasive intervention. According to Yates (2012) and Davey (2015) to dilute the urine and thereby reduce the risk of encrustation and blockage a daily fluid intake of 1.5 – 2litres (water preferably) should be encouraged and monitored; furthermore, Wilde et al (2016) highlights that those who require more help with eating and are more disabled are more likely to have more blockages. In addition to dietary interventions it may also be beneficial to contemplate prescribed catheter maintenance solutions, these can be used to reduce the occurrence of blockage, they are citric based and can dissolve encrustations (Joint National Formulary 2018). However, they must never be used to attempt to clear a blockage and there is increased infection risk because the 'closed system' is broken (Turner and Dickens, 2011).

Removing an indwelling urethral catheter

Bardsley (2017) reminds us of the importance of understanding the reasons why a catheter needs to be removed. Although removal is not a complex procedure it is important that it is explained in a way the person with an ID can understand. Plans to manage urinary retention should be put in place prior to commencing catheter removal.

The catheter bag should be emptied prior to catheter removal [Figure 11 and 12]. There are a number of things to be particularly mindful of when deflating the balloon; the first is that the syringe will be inserted into the same port through which the balloon was inflated (the port near to where the drainage bag was attached) [Figure 10], the syringe is inserted and the water left to drain naturally, [Refer to Box 6 for clarification on what to do if the balloon does not deflate.] Osmosis may mean that the volume of water drained may not be the same as the amount inserted. Creases and ridges can form as can a cuff in silicone catheters and therefore gentle squeezing of the length of the catheter tubing may displace any blockage. It is important that after removal that the urinary output is monitored and fluids encouraged.

Figure 11 Tap in closed position

Figure 12 Tap in open position

Box 6 Steps to take if the catheter balloon does not inflate' (Bardsley 2017)

Steps to take if the catheter balloon does not deflate:

- Avoid bursting the catheter balloon by overinflating it.
- Never cut the catheter or the inflation arm.
- Leave the syringe attached to the catheter valve and allow the water to seep out slowly. This can take up to 20 minutes.
- Establish if the individual is constipated as this can cause lead to pressure on the urethra and subsequently the catheter, preventing it from draining.
- Troubleshoot by changing the syringe, as the other syringe may be defective.
- Instil 1-2mL of sterile water into the inflation channel and draw back on the syringe. This demonstrates the patency of the inflation channel and indicates if water has been lost from the balloon ([Association for Continence Advice \(ACA\) 2007](#)).
- Gently squeeze along the catheter tubing. This may move agitate any blockage and enable the water to drain from the inflation channel ([ACA 2007](#)).
- Insert approximately 3mL of air and draw back using the syringe. This can create a vacuum, which may facilitate deflation of the balloon.
- As a last resort, attach a 25-gauge (orange) needle to the syringe and pierce the catheter below the valve, insert he needle into the inflation channel, and draw back the water from the balloon using the syringe. This method bypasses the faulty catheter valve ([ACA 2007](#)).
- If the balloon still does not deflate then, seek medical advice and escalate appropriately.

(Bardsley 2017: 43)

For people with a suprapubic catheter in place it is slightly different. Deflation of the balloon is similar but post removal slight pressure on the site with a sterile dressing will be required followed by application of a waterproof sterile dressing if a catheter is not going to be passed immediately post removal.

Trial without catheter (TWOC) may be undertaken to prevent unnecessary continued catheter usage. There may be a local policy and it is advisable to read this. There are several issues that need to be considered with TWOC for the wellbeing and safety of the patient.

Box 7 Trial without catheter (TWOC)

- Suitability for a TWOC;
- Cautions:
- How to minimise discomfort during a TWOC:
- Indications to abandon a TWOC:
- Where to perform a TWOC and why;
- Where a TWOC is unsuccessful, reasons why intermittent bladder drainage is the appropriate option.

RCN (2012)

Psychosocial issues

It is imperative that the nurse is aware of the psychosocial implications of having an indwelling urinary catheter. Darbyshire et al (2015) identify that some people find having a catheter embarrassing and lead to sexual problems, it can also have an impact on the person's body image (De Jaeger, 2011), therefore nurses need to recognise how they can offer support and empower the person with an ID. This includes addressing subjects such as sexual intercourse (sex); something that Prinjha et al (2016) considers is seldom addressed by healthcare professionals. Mencap (n.d.) emphasise that love doesn't discriminate, and like everyone else, many people with an ID want loving relationships and sex. When discussing the clinical need for a catheter, it is important that the location of where the catheter will be placed is clearly communicated; it is beneficial that the catheter insertion, personal hygiene, and 'taping' the catheter into position, or condom application for men; are demonstrated on a mannequin with opportunity for the person to observe and practice the techniques; with further supplemental information provided in the person's preferred format. If the positioning and aftercare has not been clearly explained, then the women may be concerned that the urethral catheter is placed so close to the vagina it prevents sexual intercourse; whilst men may question the practicalities of having sexual intercourse with a urethral catheter in place.

Time Out 4:

Go to the website Bladder and Bowel Community and read the 'sexual relationships' [<https://www.bladderandbowel.org/help-information/sexual-relationships>] section focusing on what needs to be considered before, during and after sexual intercourse.

Document the key considerations and discuss sex and intimate relationships with the person with an ID.

We recommend the following further reading to widen your understanding:

Mencap (n.d.) Relationships and Sex. [online] <https://www.mencap.org.uk/advice-and-support/relationships-and-sex> read the about 'what we think' and the 'FAQs' about relationships and sex.

Healthtalk.org (DIPEX (2018) Sex and intimate relationships. [online] <http://www.healthtalk.org/peoples-experiences/long-term-conditions/living-urinary-catheter/sex-and-intimate-relationships> and listen to peoples experiences of sex and intimate relationships while living with a urinary catheter.

Conclusion

Supporting a person through 'enabling them' to eliminate is an essential role of the nurse. Being able to pass urine without help or assistance or an aid such as a urinary catheter may be taken for granted. It is therefore not surprising that people can find this both intrusive and embarrassing. The role of the nurse is to ensure that the person is fully prepared and informed of the risks and benefits of a urinary catheter and that they are appropriately cared for and supported with dignity, respect and compassion at all times.

People with an ID may need the support of a catheter, but require careful and clear explanation of their role, purpose and what it will feel like to have one in situ. There are different catheterisation strategies, the right one will depend on patient circumstances as well as clinical indications. Intermittent catheterisation for example assumes quite a rich resource of support. Catheter hygiene and monitoring for infections and complications is imperative. Inattention can cause CAUTIs which are serious and can escalate to acute kidney injury, septicaemia and untimely death if unrecognised and untreated

It is evident that caring for and managing an indwelling urinary catheter is multidimensional and can be complex for all people and more so for a person with an ID. ~~The health and wellbeing of the person with an ID who requires a urinary catheter is important.~~ It is imperative that the care and management is person centred and holistic as well as being underpinned by contemporary evidence-based practice. Nurses must ensure that they maintain their knowledge, skills and understanding. In doing so they will be able to deliver effective care and will be able to minimise potential complications and troubleshoot issues promptly.

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