This document has been reviewed in line with the Policy Alignment Process for Liverpool Community Health NHS Trust Services. It is a valid Mersey Care document, however due to organisational change this FRONT COVER has been added so the reader is aware of any changes to their role or to terminology which has now been superseded. When reading this document please take account of the changes highlighted in Part B and C of this form.

Part A – Information about this Document

<table>
<thead>
<tr>
<th>Policy Name</th>
<th>Bladder and Bowel Manual</th>
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<tr>
<td>Policy Type</td>
<td>Board Approved (Trust-wide) ☐ Trust-wide ☐ Divisional / Team / Locality ☒</td>
</tr>
<tr>
<td>Action</td>
<td>No Change ☐ Minor Change ☐ Major Change ☐ New Policy ☒ No Longer Needed ☐</td>
</tr>
<tr>
<td>Approval</td>
<td>As Mersey Care’s Executive Director / Lead for this document, I confirm that this document: a) complies with the latest statutory / regulatory requirements, b) complies with the latest national guidance, c) has been updated to reflect the requirements of clinicians and officers, and d) has been updated to reflect any local contractual requirements</td>
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Part B – Changes in Terminology (used with ‘Minor Change’, ‘Major Changes’ & ‘New Policy’ only)

<table>
<thead>
<tr>
<th>Terminology used in this Document</th>
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Part C – Additional Information Added (to be used with ‘Major Changes’ only)

<table>
<thead>
<tr>
<th>Section / Paragraph No</th>
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Part D – Rationale (to be used with ‘New Policy’ & ‘Policy No Longer Required’ only)

Please explain why this new document needs to be adopted or why this document is no longer required

Part E – Oversight Arrangements (to be used with ‘New Policy’ only)

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SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY’S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, Safeguarding Ambassadors or the trust’s safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of Fairness, Respect, Equality Dignity, and Autonomy
Liverpool Community Health NHS Trust

Bladder and Bowel Manual Policy
<table>
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<tr>
<th><strong>Version Number:</strong></th>
<th>V2</th>
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<td><strong>Date of Approval:</strong></td>
<td>19/12/17</td>
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<td><strong>Name of originator/author:</strong></td>
<td>Bladder and Bowel Service</td>
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<tr>
<td><strong>Approving Body / Committee:</strong></td>
<td>Clinical Standards Group</td>
</tr>
<tr>
<td><strong>Date issued (Current version):</strong></td>
<td>December 2017</td>
</tr>
<tr>
<td><strong>Review date (Current Version):</strong></td>
<td>December 2019</td>
</tr>
<tr>
<td><strong>Target Audience:</strong></td>
<td>This manual applies to all clinical staff involved in the delivery of care in relation to the following,</td>
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| | • Continence Care  
| | • Catheter Care  
| | • Digital Rectal Examination  
| | • Paediatric Continence Care |
| **Name of Lead Director / Managing Director:** | Johanna Reilly  
| | (Director of Operations) |
| **Changes / Alterations Made To Previous Version:** | V1 review December 2017 |
## Contents

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2. Purpose
3. Scope
4. Definitions
5. Roles and Responsibilities
6. Training
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8. Audit
9. Associated Documentation
10. References

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- Appendix B: Catheter Care (p34)
- Appendix C: Digital Rectal Examination (p72)
- Appendix D: Childrens Bladder and Bowel (p89)
1. Introduction

This Bladder and Bowel Manual is designed as a reference point for all Liverpool Community Health Practitioners. The information detailed in the manual will enable the Health Practitioners to either refer into the Bladder and Bowel Service for assessment or specialist professional support; or to enable the practitioner to assess plan, implement and evaluate care for any patient with bladder and bowel dysfunction.

The manual provides detailed information in relation continence care, catheter care, digital rectal examination and paediatric continence care.

The following overarching information will apply to each element of the manual:

The Bladder and Bowel Service is a city wide service. The service has a dedicated Childrens team that sees children from birth to 19 years old with a Liverpool GP. The Adult Bladder and Bowel Service sees patients from 19 years to the end of life who are registered with a Liverpool GP.

The Bladder and Bowel service has an open and direct access for advice and evidence based information. The Bladder and Bowel Service operates Monday to Friday 08:30 - 16:30 excluding bank Holidays.

The Service provides the following:

• Clinics for Adults and Children with complex Bladder and Bowel problems to undertake comprehensive assessments and provide specialist treatment
• Home visits where required when clients are housebound or if there is a clinical need
• Training and education to Liverpool Community Health staff and external sources.
• Acts as a resource for the public and all health care professionals and associated agencies

Referrals to the Service can be made via:

• E Referral from all GP’s
• Written Referral Forms which can be faxed or posted
• Internal Referrals Forms will also be accepted via the Service email address
• Telephone Self Referrals
2. Purpose / Scope

The purpose of this manual is to provide staff with guidance on processes regarding the following,

- Continence Care
- Catheter Care
- Digital Rectal Examination
- Childrens Bladder and Bowel Health Care

3. Scope

This manual applies to all clinical staff involved in the delivery of care in relation to the following,

- Continence Care
- Catheter Care
- Digital Rectal Examination
- Childrens Bladder and Bowel Health Care

4. Definitions

The following definitions have been identified in relation to this manual.

**Urinary Incontinence**: is defined as an involuntary or inappropriate passing of that has an impact on social functioning or hygiene (Department of Health 2002). Faecal incontinence is a sign or symptom not a diagnosis (Department of Health 2007).

**Faecal Incontinence**: is defined as an involuntary or inappropriate passing of that has an impact on social functioning or hygiene (Department of Health 2002). Faecal incontinence is a sign or symptom not a diagnosis (Department of Health 2007).

**Bladder Dysfunction**: is a term used to describe the inability of the bladder to perform to its normal capability to store and empty. Bladder dysfunction can be categorised as being either a storage or voiding problem. This can be the result of detrusor over activity, genuine stress incontinence or voiding difficulties due to outflow obstruction or by detrusor hypo activity.

**Detrusor Muscle**: the third layer of muscle fibres which form the bladder. It is composed of longitudinal and circulate muscle fibres forming an interlacing meshwork.

**Product Matrix**: refers to a list of available containment products from a chosen supplier. This list is available from the Continence Promotion Service.

**Catheterisation**: the insertion of a hollow tube into the urinary bladder for the purpose of drainage of urine or instillation of materials into the bladder.

**Catheter Associated Urinary Tract Infection (CAUTI)**: this refers to a catheter-associated urinary tract infection. Indwelling catheters are the cause of this infection.
**Charrier:** this refers to the external diameter of the catheter 3 charrier is equivalent to 1mm therefore a size 12ch catheter has an external diameter of 4mm

**Hydrophilic/Hydrogel coating:** polymers on the surface of the catheter, which absorb aqueous fluids to produce a slippery surface, which reduces trauma on insertion and removal

**Trial With Out Catheter (TWOC):** is the term used when a catheter which has been inserted via the urethra into the bladder for drainage purposes, is removed for a trial period to determine whether the patient is able to pass urine safely and spontaneously without the need for further.

**HOUDINI:** is an acronym referring to protocol with a list of indicators for reassessing the need for catheterisation (Trovillion et al 2011) in patients. It supports the High impacts actions for the Department of Health. Haematuria, Outflow Obstruction, Urology Surgery, Decubitis Ulcer Sacral or Perineal, Intake and Output, Not for Resuscitation, Immobility.

**Abdominal massage** - Using the back or heel of the hand pressure is applied and released firmly but gently in a continuous progression around the abdomen. Massage is applied to the abdomen following the usual lie of the colon in a clockwise direction.

**Autonomic Dysreflexia** - is a sudden and exaggerated autonomic response to an unpleasant stimuli e.g. a full rectum or digital stimulation of the rectum during bowel evacuation. It occurs in spinal injuries of T6 or above (Athens and Prentice1998). Patients present with marked hypertension and bradycardia.

**Bowel Dysfunction** - term used to describe the inability of the bowel to perform its normal function in relation to the storage and elimination of faeces.

**Bristol stool form scale** - A visual tool for describing stool type in the identification of change in bowel habit, constipation (Heaton 2000)

**Digital Rectal Examination** – the insertion of a non-latex gloved lubricated index finger in to the patient’s rectum to ascertain the presence and consistency of faeces.

**Digital Rectal Stimulation** – this is performed by gently inserting a gloved lubricated finger in to the rectum and slowly rotating the finger in a circular movement against the rectal mucosa promotes peristalsis of the left colon.

**Manual Removal of Faeces** - is the digital removal of faeces from the rectum.

**Vagal stimulation** - stimulation of the parasympathetic vagal nerve originating in the medulla and supply motor and sensory input to upper colon

**Reflex bowel** - individuals with spinal cord injury of T12 and above. Reflex activity and anal sphincter is maintained, allowing the bowel to contract and empty when stimulated

**Idiopathic constipation:** Constipation is the inability to pass stools regularly or empty the bowels completely. It can cause hard, lumpy stools, which may be large or small. Constipation is common in childhood. It is referred to as ‘idiopathic’ if it cannot
be explained by anatomical or physiological abnormalities. The exact cause of idiopathic constipation is not fully understood but factors that may contribute include pain, fever, dehydration, dietary and fluid intake, psychological issues, toilet training, medicines and family history of constipation.

**Impaction:** occurs when faeces is not passed over a period of weeks and causes a build up stretching the bowel and rectum, with a stool they are unable to pass.

**Soiling:** involuntary passage of faeces into underwear, often without the child’s awareness.

**Encopresis:** Voluntary of faeces in inappropriate places in a child 4 years or older after organic causes have been ruled out. It must occur at least once monthly for a duration of 6 months (ICD-10) or 3 months (DSM-IV). *(Neveus 2006)*

**Delayed toilet training:** refers to children over the age of 4 years who have yet to acquire bladder/bowel control.

**Daytime Urinary Incontinence:** Leakage of urine in children over the age of 5 years, which occurs on a regular basis - at least once a week. *(Neveus 2006, Rogers 2002)* Amount of leakage need only be small to be socially unacceptable. Daytime wetting, that is not associated with urinary infection or anatomic abnormalities, is less common than night-time incontinence and tends to disappear much earlier than night-time incontinence. Wetting episodes during the day do not usually become a problem until the child starts school at 5 years because children usually become dry during the day between 2 – 5 years. Wetting that occurs when awake. May also have abnormal elimination habits, the most common being infrequent voiding and constipation. Likely to have an organic association. Most common cause is an overactive bladder. *(NKUDIC 2006)*

**Bladder Dysfunction:** term used to describe the inability of the bladder to perform to its normal capability to store and empty. Can be as a result of detrusor over activity, genuine stress incontinence or voiding difficulties due to outflow obstruction or dysfunctional voiding activity.

**Detrusor Muscle:** the third layer of muscle fibres, which form the bladder. It is composed of longitudinal and circular muscle fibres forming an interlacing meshwork.

**Diurnal Enuresis:** Accidental daytime wetting (see page 12 for further details).

**Nocturnal Enuresis:** (synonymous with enuresis and nocturnal incontinence): wetting the bed at night over the age of 5 years in the absence of any underlying medical conditions/congenital abnormality There is Intermittent incontinence of urine while sleeping.

**Nocturnal polyuria:** large volume of urine in the first few hours of the night.

**Monosymptomatic Nocturnal Enuresis:** Nocturnal enuresis in a child and young person without any (other) lower urinary tract symptoms.
**Nonmonosymptomatic Nocturnal Enuresis:** Nocturnal enuresis in a child and young person with (other) lower urinary tract symptoms, such as daytime incontinence, urgency, etc.

**Primary Nocturnal Enuresis:** Nocturnal enuresis in a child and young person who has previously been dry for less than 6 months.

**Secondary Nocturnal Enuresis:** Nocturnal enuresis in a child and young person who has previously been dry for at least 6 months. This is more likely to be associated with a recognisable psychological or organic cause. (Neveus et al 2006)

**Learning Disability:** ‘A significant lifelong condition which has three facets: reduced ability to understand new or complex information or to learn new skills; reduced ability to cope independently; and a condition which started before adulthood (before the age of 18) with a lasting effect on the individual’s development’. (Scottish Executive 2000b)

In function terms, this would equate to having an I.Q. below 70.

The following conditions may cause children to have learning disability:
- Attention deficits and hyperactivity disorder
- Autistic spectrum disorder
- Down’s syndrome
- Global developmental delay
- Other specific syndromes and genetic conditions

**Developmental Delay:** A child has delayed achievement of one or more developmental milestones.

**Global Developmental Delay:** Implies that the child has delays in the following areas of developmental domains:
- Gross and fine motor
- Cognition
- Activities of daily living
- Speech and language
- Personal and social development

(Scotland Executive 2000a, BIBIC 2006)
Roles and Responsibilities

The following staff groups have been identified as having responsibilities in relation to this manual.

Bladder and Bowel Service

The Bladder and Bowel Service will be responsible for

- Implementing all the processes identified in the manual.
- Participate in reviewing the manual in line with review dates.
- Auditing relevant identified areas of the manual as per audit plan for the service.
- Providing specialist advice and support and guidance to Liverpool Community Health
- Deliver identified training sessions on Continence Promotion, Catheter Care and Digital Rectal Examination to Liverpool Community Health staff

Adult Practitioners

Adults Practitioners will be responsible for

- The implementation of all process identified in the manual relevant to their patients
- Referring to the Bladder and Bowel Service to support complex patient care.
- Identify training needs in relation to the manual via PDR and attend specified training

Children’s Practitioners

Children’s Practitioners will be responsible for

- The implementation of all process identified in the manual relevant to their patients
- Referring to the Bladder and Bowel Service to support complex patient care.
- Identify training needs in relation to the manual via PDR and attend specified training

Infection Control Team

The Infection Control Team will be responsible for
• Ensuring that processes are in place to support the delivery of care detailed within the manual specific to infection control

• Support some elements of auditing in relation to infection control

Please see associated documentation (section 9) below for detail on Infection Control Policies related to this document.

5. Training

Training related to all aspects of this manual is detailed within the Trust Training Needs Analysis.

6. Equality Analysis

An equality analysis has been undertaken and a copy of this is retained by both the manual author and the Equality and Diversity Lead.

7. Audit

The Bladder and Bowel Service undertakes clinical audit on an annual cycle as per clinical audit programme within the organisation. The processes detailed within this manual at Appendices A-D will be considered for clinical audit.

8. Associated Documentation

The following clinical policies should be read in conjunction with this document,

• Hand Hygiene Policy
• Personal Protective Clothing Policy
• Spillage Management Policy
• Standard Precautions Policy
• Guideline for the Management of and Training Needs for Medical Devices and Equipment
10. References


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A. Continence Care

This section of the manual details the following:

A1 Service Provision
A2 Access to Bladder and Bowel Service (including referral)
A3 Assessment of Continence and Management of Incontinence (both by District Nurse Teams and Bladder and Bowel Service)
A4 Treatment
A5 Care Plan
A6 Discharge Process
A7 Intractable Incontinence
A8 Product Information including
   - Delivery
   - Supply
A9 Information Regarding Urinary Sheaths
A10 Bladder Ultrasound and Bladder Scanning Equipment

A.1 Service Provision

The Service provides the following:
- Clinics for adults with complex Bladder and Bowel problems to undertake comprehensive assessments and provide specialist treatment at various locations within the trust (please refer to the intranet Bladder and Bowel page for further details).
- Home visits where required when clients are housebound or if there is a clinical need
- Acting as a resource for the public and all health care professionals and associated agencies

The Bladder and Bowel Service operates Monday to Friday 08:30-1630 excluding Bank Holidays.

A.2 Access to Bladder and Bowel Service (including referral)

Referrals

The Bladder and Bowel Service is a city wide service for patients with a Liverpool GP. The service has an open and direct access for advice and evidence based information. Referrals to the Service can be made via:
- E Referral from GP’s
- Written Referral forms can be faxed or posted
- Internal Written Referrals are accepted via the Service email address
- Telephone Self-Referral

Referrals will be prioritised by the Specialist Nurse using all information provided by the referrer; high priority will be given according to the patient needs. Criteria for referral to the Bladder and Bowel Service:
- Patient must have Liverpool GP
- Have bladder or bowel dysfunction
- May be an existing patient for a review of continence needs
Referral System and Procedure

Comprehensive referral by health care professional received into the service.

Referral is logged onto IT system.

Nurse triage referral (The service aims to see all patients within 28 days upon receipt of the written referral)

Urgent referrals
Including post-prostatectomy patients
End of Life / TWOC

Clinic Visits

Home Visits

Contacted via telephone within 24 hours and visited within 5 days

Patient contacts service and makes appointment

Orders processed immediately patient should receive delivery within 3 working days

If not already booked via E Referral Admin staff will send service opt-in letter

Allocated to appropriate locality sub team

Nurse contacts to arrange visit

Patients who can attend a clinic will be sent self-help information and the choice to opt into a clinic appointment at various locations across the city
A.3 Assessment of Continence and Management of Incontinence (both by District Nurse Teams and Bladder and Bowel Nursing Team)

This policy will ensure that following identification of Bladder and Bowel dysfunction the patient should be referred to the appropriate professional for assessment using the form “Referral to Bladder and Bowel Service” If the patient is under the care of a District Nurse the form should be sent to the DN team who will carry out the continence assessment. If there is no DN involvement, the referral should be sent to the Bladder and Bowel Team or referred by the GP referral using E Referral.

Exclusion Criteria

**Red Flags MALES – for immediate referral to urology secondary care service**
- Haematuria
- Elevated PSA
- Palpable bladder
- Palpable renal mass

**Red Flags FEMALES – for immediate referral to secondary care**
- Micro haematuria 50+yrs
- Recurrent UTI with haematuria 40+yrs
- Suspected mass
- Severe prolapse
- Visible haematuria

**Red flags: bowel dysfunction**
- Persistent rectal bleeding >6 weeks
- Change of bowel habits with looser stool >6weeks
- Iron deficiency anaemia associated with rectal bleeding
- Tenesmus (continued urge, ineffective emptying, pain)
- Palpable rectal mass

The patient will be offered an assessment in order to eliminate any underlying pathology or cause of the incontinence. The assessment is holistic and will take into account patients cultural and religious beliefs (ACA 2003) if the client is ambulant and able to attend a clinic they will be seen in one of the nurse-led Bladder and Bowel clinics throughout the city. Housebound clients and those in residential and nursing homes will receive a home visit.
All patients referred to Liverpool Community Health Bladder and Bowel Service are given a comprehensive; holistic assessments to ensure that their needs are met effectively and with the patients consent may include any or all of the following:
- Urinalysis to exclude underlying pathology
- Ultrasound of the bladder
- Uroflowmetry if indicated
- Abdominal examination,
- Bi manual examination
- Digital rectal examination
- Pelvic floor assessment

Following the individual assessment, the type of incontinence that they are presenting with will be identified and they will then follow a treatment pathway, receiving the correct advice to treat, improve or cure their continence problem where possible. The assessment should also consider any functional or cognitive problems that may be impacting upon the patient’s ability to maintain continence.

A.4 Treatment

This must tailored to meet the individual’s need. This may include:
- Health promotion and education
- Fluid intake and dietary advice
- Bladder training
- Pelvic Floor exercises
- Biofeedback therapy
- Clean intermittent self-catheterisation
- Urethral stricture therapy
- Bowel management
- Medication or appliance in collaboration with medical colleagues
- Referral to other multi-disciplinary agencies to aid independence in achieving continence

A.5 Care Plan

Following assessment the needs of the patient are identified and these are discussed with patient and family and a care plan formulated and agreed upon. The Nurse Specialist will provide:
- Information to empower the patient to contribute to their care and assist them to achieve the goals of their agreed care plan
- Involve where appropriate family, carers and significant others in the care
- Advise General Practitioner on discharge of the patient outcomes within 7 days of discharge.
- Follow up appointments for support and review of care plan will be agreed with the patient
Referrals will be made to other health care professionals and services as identified within the agreed care plan

A.6 When the goal of the agreed care plan has been achieved, the patient will be Discharge Process

- Liverpool Community Health Bladder and Bowel Service reserves the right to discontinue any treatment or management if problems occur with patient’s compliance or personal safety to the staff. If this occurs it will be documented in the patient’s notes, incident form will be completed if required all relevant personnel notified
- Those who fail to attend for their appointment. The referrer, patient and where appropriate the G.P will be informed
- When the goals of the care plan has been achieved , the patient will be discharged
- The G.P and the referrer will be informed of the patient’s discharge

A.7 Intractable Incontinence

Those patients who are found to have an intractable continence problem will be assessed for the most appropriate method of containment and will then receive on-going support to ensure their needs are met (see guidelines for supply of products).

Methods of managing containment should include consideration of:
- Sheaths
- Penile pouch’s
- Urinals (male and female)
- urethral female inserts
- Commode
- Referral to other agencies/physiotherapy/occupational health
- Intermittent self-catheterisation
- discharged
Flow Chart for assessment by District Nursing Teams

1. Patient presents with continence problem

   Urinalysis

   Positive Sample:
   - Sample to GP and await results
   - Give advice re fluids, voiding

   Nothing detected

   Patient referred to secondary care identified:
   - Red flag
     - Post void residual
   - Signs of obstructed outflow
   - Evidence of prolapse

   Assessment to identify incontinence type

   Incontinence can be improved

   - Put on to correct care pathway as indicated by symptoms
   - NB patients with neurological involvement – consider bladder scan

   Review as determined by care pathway

   Patient improved: discharge

   Incontinence cannot be improved i.e. palliative care patient

   Select appropriate appliance or containment products and forward paperwork to Continence Service

   No improvement: Refer to Continence Promotion Service
Flow Chart for assessment by Bladder and Bowel Teams

1. Patient presents with continence problem
   - Urinalysis
     - Positive Sample:
       - Sample to GP and await results
       - Give advice re fluids, voiding
     - Nothing detected
       - Patient referred to secondary care
         identified:
           - Red flag
           - ↑Post void residual
           - Signs of obstructed outflow
           - Evidence of prolapse
       - Incontinence cannot be improved i.e. palliative care patient
         - Select appropriate appliance or containment products.
         - For on-going review.
     - Assessment to identify incontinence type
       - Incontinence can be improved
         - Put on to correct care pathway as indicated by symptoms
         - Review as determined by care pathway
     - Patient improved: discharge
     - No improvement: Refer to Secondary Care Services
A.8 Product Information

Delivery
The purpose of using ring-back for containment product deliveries is:

- To ensure that each delivery received by the client meets their changing requirements.
- To prevent over-stocking of products.

New clients will have one initial delivery and will be sent a ring-back letter advising them how long their delivery should last for and how to arrange future deliveries.

During office hours a clerical officer will operate the ring-back phone line. Outside office hours or in the absence of the clerical officer an answer machine system will operate and the clerical officer will call the client back as soon as possible.

When clients request their usual prescription and they are not ringing too early a delivery will be inputted on the computer and they will be told the date of that delivery. If the client states that their needs have changed or they are ringing too early, a nursing review from a healthcare assistant will be arranged. This will be performed via telephone unless a home visit is necessary to fully discuss changing requirements.

It is the client’s/carer’s responsibility to reorder products when they have two weeks supply remaining this will ensure they do not run out of products. If the client is then found to be an unsuitable candidate for the ring-back system they will be placed on regular deliveries.

If the client remains on ring-back but subsequently fails to use ring-back correctly and runs out of products, it is their own responsibility to purchase containment products.

Any complaints that cannot be resolved by the continence team will be referred to the line manager.
Guidelines for Supply of Products

Emergency Supply

Circumstances that warrant an emergency supply of incontinence pads are:

- Terminally ill clients – District nurses should complete the palliative care pathway which includes demographics of the patient and a management plan with rationale for choice and fax to the service. This is available on the intranet.
- The District Nurse can then arrange for a collection of a packet of containment products from Baylis Suite 2, Liverpool Innovation Park, Digital Way, Liverpool, L7 9NJ. This is an emergency measure until a home delivery is arranged via the Bladder and Bowel service within 3 working days
- New cases of severe incontinence (including patients new to the area) where skin integrity is at risk, or carers are unable to cope without clients whose regular delivery has failed to arrive on the due date because of an error by the delivery service.

Disposable products

Disposable products should only be prescribed on completion of a continence care pathway when incontinence proves to be intractable. Clinical assessment will determine what product is the most appropriate from the product matrix.

Alternative methods of containment should always be considered.

Staff should consider the most cost effective use of products available to the patient. The maximum issue of products is 4 pads in 24 hours. The use/fitting of the products should be explained fully to the patient/carer in order for products to be used effectively.

Should a patient be found on assessment, to have a clinical need for a greater number of pads, this will be considered by the continence nursing team.

The Product Matrix is available on the intranet
**Reusable Products**
Reusable products should only be issued to patients who have undergone a thorough assessment of their needs and are assessed as being suitable for reusable products.

They are the first choice of product for light to moderate incontinence providing the patient has suitable washing and drying facilities.

They should **not** be considered for patients with faecal leakage.

The patient will be supplied with 6 pairs of pants and or 2 bed sheets.

Patients should also be given full instructions on the laundering of these products in order to achieve the maximum benefit of the product.

A reusable product matrix is available on the intranet

**A.9 Information Regarding Urinary Sheaths**

**Assessment**

A full continence assessment should be carried out by a trained health care professional using the integrated continence care pathway. Determining the cause of the incontinence may require specialist investigations such as ultrasonic bladder scan or uroflowmetry. Relevant treatments and advice should be given before reaching the decision on management of incontinence.

Sheaths can be used with male patients who have moderate to severe urinary incontinence. Each patient should be individually assessed, as there is no single product that will meet all patients’ needs.

Patients must have sufficient penile length and girth, and they or their identified carer must be competent and willing to use the device.

Sheath system should be used with caution in patients with cognitive impairment, confusion, skin breakdown or if sexual gratification is obtained from the procedure.

If a sheath system is required the should obtain the consent from the patient explain its usage to the patient and any carers, including skin care advice. The patient should be shown samples and offered the choice of product style from the urology formulary.

They should be measured using the appropriate manufacturers guide.
Choices to offer the patient:
- Sheath
- Leg bag
- Night bag
- Leg bag straps or sleeve
- Night stand for bag

Each sheath can be left in place for a maximum of 24 hours. Leg and night bags are available in a wide variety of sizes and tap styles. Leg bags should be replaced after 5 – 7 days use, non-drainable night bags should be replaced each night. Please refer to the urology formulary for choice of products.

Once the patient has made their choice the nurse should help them to fit their first sheath and attach the leg bag correctly. A follow-up appointment should be made to check the suitability of the chosen system, to observe carers fitting as appropriate and to prescribe or request a prescription from the G.P. once the correct system is known.

Correct measuring is essential to ensure success and comfort. To ensure correct fitting measure the penis by placing the tape around the mid shaft of the penis. Consideration that the penis may vary in size during the day according to blood supply, temperature and sexual responses should be taken into account. If size falls between sheath sizes, choose the larger size.

Always refer to individual manufacturer’s instructions for application of the product. For advice regarding products - sheaths and drainage bags, please refer to the Hub Formulary or Continence Promotion Team on 0151 295 3994.

**Fitting of Urinary Sheath System**

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>Obtain the patient's consent and co-operation.</td>
</tr>
<tr>
<td>2. Offer Chaperone and document name of chaperone if present. As RCN (2004</td>
<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000)</td>
</tr>
<tr>
<td>4. Assist the patient into a semi recumbent position. Ensure the patient is not unduly exposed.</td>
<td>Maintain dignity and comfort.</td>
</tr>
<tr>
<td>5. Wash and dry hands, put on apron and gloves.</td>
<td>Personal protective equipment and to reduce risk of cross infection.</td>
</tr>
<tr>
<td>6. Prepare equipment on a clean field.</td>
<td>To assist in the application of sheath and</td>
</tr>
</tbody>
</table>
**Method** | **Rationale**
--- | ---
7. The genital area should be washed and dried. Ensure that the foreskin is returned to its natural position Place a piece of tissue around the penis to absorb extra moisture Encourage the patient/carer to perform this procedure if possible. Creams talc or lotions should not be used. | To prepare skin surface for the application of the sheath. To prevent phimosis To maintain patient independence. To ensure skin surface is ready for the adhesive.

8. If discussed and agreed with the patient trim the pubic hairs. Alternately a piece of tissue or a hair guard can be put over the penis to push back the pubic hair. This can then be removed once the sheath is in place. | Keep pubic hair out of the way and prevent discomfort.

9. Leave a small gap between the tip of the sheath and the end of the penis, or adhere to manufactures | To prevent backflow of urine.

10. Ensure the foreskin is not retracted and roll the sheath onto the penis. | To allow application of the sheath.

11. Gently squeeze the sheath around the penis, encourage the patient/carer to perform this procedure if possible | To ensure adhesion, To encourage patient independence

12. Attach sheath to closed drainage system or catheter valve. | Maintain patient comfort and allow for collection of urine

**Removal of Urinary Sheath System**

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
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<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>4. Assist the patient into a semi recumbent position. Ensure the patient is not unduly exposed.</td>
<td>Maintain dignity and comfort.</td>
</tr>
</tbody>
</table>
5. Wash and dry hands, put on apron and gloves.  
   Personal protective equipment and to reduce risk of cross infection.

6. Apply warm soapy a flannel or disposable cloth to the shaft of the penis. Working from the base work the soap under the sheath gently rolling the sheath off the penis. Dispose of waste products in household waste. 
   Warm soapy water will deactivate the adhesive. Rolling the sheath gently will help protect the skin when removing the sheath. To comply with infection control and environmental health.

7. Monitor the skin for signs of soreness or irritation. This is especially important for patients with neurological deficits who may be unable to feel any restriction or soreness. 
   To ensure skin integrity is maintained.

### A.10 Bladder Ultrasound and Bladder Scanning Equipment

Bladder Ultrasound is a non-invasive and reliable method to detect this and to estimate bladder volume. This procedure is a standard part of a continence assessment and most specialist nurses in urology or continence care perform ultrasound. (Addison 1999).

**INDICATIONS FOR ULTRASOUND BLADDER SCAN**

Patients will have a bladder scan performed for:
- As indicated by continence assessment i.e neurological diseases, incomplete emptying, palpable bladder or recurrent urinary tract infections.
- Following a referral to the continence service for an estimation of residual urine
- To assess the degree of retention prior to catheterisation
- To assess volume of urine in the bladder if a catheter is failing to drain
- Following trial without catheter to eliminate residual urine (please refer to catheter care policy 2015)
- Prior to teaching ISC to determine if the procedure is necessary
- To monitor the action of medication – anti cholinergic therapy

**BENEFITS OF USING ULTRASOUND BLADDER SCANNING EQUIPMENT**

- Non-invasive technique
- Reduces risk of infection due to an alternative method of catheterisation
- It is a quick and easy procedure to perform
- Reduces patient anxiety
- It is easy to use with children
- Equipment is portable for the procedure to take place in the patients home or clinic setting
- Reduces inappropriate catheterisation and prescribing costs
- Enhances the practice of the continence promotion team
- Gives the patient bio feed back
WHO CAN CARRY OUT AN ULTRASOUND BLADDER SCAN
- A competent registered nurse, doctor or health care professional
- Competency should be acquired through education session followed by observation in the clinical setting and completion of competency framework. The practitioner must feel both confident and be competent in the clinical procedure and take into account their own professional accountability.

CONSENT FOR ULTRASOUND SCANNING OF THE BLADDER
- To gain consent and co-operation for the procedure to take place. It is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2014). Document consent has been given.
- Offer Chaperone and document name of chaperone if present. As RCN (2004) This can reduce patient anxiety maintain dignity of patient and protect both staff and patient from improper behaviour.

EXCLUSIONS AND PRECAUTIONS
- Do not perform the procedure without patient consent
- Do not perform the procedure if you are not competent or confident in doing so
- Care should be taken with patients who have retention of urine, they may find it uncomfortable when gentle pressure is applied
- If a patient has a wound on the scanning site, please utilise protective sheath (contact continence Promotion service if the benefits of performing the procedure outweighs the risks of not performing it.
- The probe head has been damaged or dropped
- Not intended for use in pregnant patients to monitor fetal progress

FALSE READINGS
The following factors may result in false readings when using a bladder ultrasound:
- Volumes over 1,000ml may not show up and those under 100ml may not be accurate
- If a Foley catheter is in situ, or there is an intravesical mass, the bladder will not be standard shape
- If there is a fluid filled cyst in the bladder area
- Obesity or advanced pregnancy and lower abdominal scarring over the scanning area
- Possible altered shape of the bladder following surgery or if there are blood clots or stones in the bladder

CARE OF EQUIPMENT
- Store in cool dry place in supplied carry case
- Equipment must be handled with care.
- Calibration of equipment is to be completed on a six monthly rota in conjunction with manufactures guidance
- All machines will have a valid warranty
- Place on a steady surface during use.
- Ensure battery is charged on a regular basis.
- Use the transportation trolleys supplied to prevent injury to staff
- Always place portable ultrasound scan machine in the boot of the vehicle when travelling.
- Never leave in unattended vehicle
- If a fault is detected the unit should be taken out of circulation, manufacturer should be alerted and return process followed.

**PERFORMING BLADDER ULTRASOUND PROCEDURE – using the Bard Bladder Scan or Mediwatch Portascan**

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient if pre void the patient should present with a full bladder. If a post void scan is required, the procedure is to be done within 10 -15 minutes</td>
<td>Obtain the patients consent and co-operation Empty bladder</td>
</tr>
<tr>
<td>2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)</td>
<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place, it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000)</td>
</tr>
<tr>
<td>4. Assist the patient to a supine position supported by pillows. Expose the supra pubic area and protect the patients clothing from the transmission gel</td>
<td>Maintain dignity and comfort</td>
</tr>
<tr>
<td>5. Apply transmission gel to the probe head</td>
<td>To act as ultrasound wave conductor as the probe transmits a beam into the patient and detects echoes</td>
</tr>
<tr>
<td>6. To start- (Bard) press orange button (Mediwatch) Black button at back of machine This will take 30 seconds to install scan mode</td>
<td>To start up the scanner</td>
</tr>
<tr>
<td>7. Place the probe approx 3cm above the pubis bone with the ridge and alignment label towards the right hand side of the patient (BARD) for mediwatch position the blue spot facing towards the patients head.</td>
<td>To perform a transverse scan</td>
</tr>
<tr>
<td>8. Press the start/stop button to start scanning (BARD) Mediwatch press either the blue button or the freeze button on the</td>
<td></td>
</tr>
<tr>
<td>Method</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Touch screen. Adjust the position of the probe to obtain largest image</td>
<td></td>
</tr>
<tr>
<td>9. Press the scan button again to obtain a reading for bladder volume, press print to obtain reading</td>
<td>Evidence of scan with result</td>
</tr>
<tr>
<td>10. Re align the probe with the ridge and alignment label towards the head of the patient. For mediwatch position the blue spot facing towards the patients left hand side</td>
<td>To perform Sagittal Scan</td>
</tr>
<tr>
<td>11. Press the sagittal scan button to start sagittal scan. Adjust the probe for best image</td>
<td></td>
</tr>
<tr>
<td>12. Press the sagittal scan button again to obtain a combined volume reading. Press print to obtain printout of result</td>
<td>To obtain total bladder volume</td>
</tr>
<tr>
<td></td>
<td>Evidence of scan for patients records</td>
</tr>
<tr>
<td>13. Remove any excess transmission gel from the patient.</td>
<td>Patient comfort</td>
</tr>
<tr>
<td>14. Turn the machine off and remove the battery or electrical supply</td>
<td>To preserve the battery and ensure safety when cleaning.</td>
</tr>
<tr>
<td>15. Remove excess transmission gel from the probe head.</td>
<td>To prevent risk of cross infection</td>
</tr>
<tr>
<td>16. Clean the probe head, and lead with the recommended cleansing solution according to local infection control policy and manufactures guidance Wash hands</td>
<td>To prevent risk of cross infection and prepare machine for the next use</td>
</tr>
<tr>
<td>17. Place the machine back into the protective carry case and restock with necessary equipment: gel/protective tissues and transept cleansing spray</td>
<td>To protect the machine</td>
</tr>
<tr>
<td></td>
<td>Prepare the machine for the next use</td>
</tr>
<tr>
<td>18. Thermal printout should be photocopied and both copies placed into the patient’s notes and document outcome of investigation.</td>
<td>Thermal prints can fade within approximately 12 weeks of printing therefore photocopy of the print will ensure a copy is available in the patient notes. To comply with record keeping.</td>
</tr>
</tbody>
</table>
B. Catheter Care

This section of the manual details the following:

B1 Procedure for the Catheterisation of the Urinary Bladder
B2 Recommended Products
B3 Catheter Stability and Drainage Systems
B4 Lubricants
B5 Choice of Catheter, Size Length and Balloon Size
B6 Supra-pubic catheterisation
B7 Intermittent Catheterisation
B8 Catheter Maintenance Solutions
B9 Management of Suspected Bacterial (CAUTI)
B10 Autonomic Dysreflexia
B11 Equipment required for Urethral Catheterisation
B12 Catheter Removal Prior to Repeat Catheter
B13 Procedure for indwelling catheterisation for Male
B14 Procedure for indwelling catheterisation for Female
B15 Procedure for supra pubic catheterisation
B16 Procedure for intermittent urethral catheterisation male
B17 Procedure for intermittent catheterisation female
B18 Trail without Catheter
B19 Algorithm: Trail without Catheter
B20
B21 Catheter Blockage pathway

B.1 Procedure for the Catheterisation of the Urinary Bladder

B.1.1 Background

Urinary catheters are used frequently in healthcare and can lead to serious life-threatening complications. Urinary catheters cause urinary tract infections and are the second leading cause of blood stream infections. Complications arise directly from their use and in particular if the care is sub-optimal.

The risk of infection complication with a urinary catheter is high because:

- The urinary catheter bypasses the body’s defence mechanism of micturition when organisms are naturally flushed from the lower urinary tract;
- The urinary catheter enables micro-organisms to gain direct entry to the bladder along the external catheter surface;
- The urinary catheter drainage system allows micro-organisms to gain entry from any of the connection points if they are disconnected or opened;
- Once organisms have entered the urinary catheter, biofilm forms on the lumen surface and can lead to infection and potentially to complete blockage of the catheter.
The risk of complications from a urinary catheter increases the longer the urinary catheter remains in situ. Because the risk of infectious complications is so high, indwelling urinary catheters must only be used after considering all the alternatives.

Only use indwelling urinary catheters after alternative methods of management have been considered e.g. intermittent catheterisation). The trained health care practitioner (HCP) should consider alternative measures to avoid urinary catheterisation where possible and understand the high level of risk associated with short and long-term catheterisation (EPIC3 Guidelines, NICE 2012).

**Paediatric Catheterisation**

Children / young people (0-19 years) who have bladder problems may need to be catheterised to maintain a healthy bladder or to achieve continence. Children diagnosed with an inability to empty their bladder are at an increased risk of infection.

The insertion of a catheter into the urethra or catheterisable channel ie Mitrovanof or urostomy, to empty urine from the bladder, reduces this risk when undertaken appropriately.

There is a risk of cross infection when using intermittent catheterisation. Prevention of cross infection is therefore important. Catheterisation should be taught using an aseptic non-touch technique (ANTT).

Children / young people and adults with the need for intermittent catheterisation are attending special or mainstream schools, short break services and residential care settings. Trained Healthcare Professionals are being asked to undertake this task and also to train care staff from Health, Education and Social Services in this procedure. Assistant practitioners employed by the trust may also undertake this task within their role.

**B.1.2 Indications for catheterisation are as follows:**

- Haematuria: post-surgery
- Outflow Obstruction: prostatic hyperplasia; chronic retention; hypotonic bladder;
- Decubitis ulcer sacral or perineal: sacral/perineal wounds (stage 3 or 4)
- Intake and output: Investigations – e.g. urodynamics; measurement of residual volumes (less invasively achieved by a portable bladder scanner)
- Not for resuscitation: end of life comfort;
- Immobility: Long-term care - intractable incontinence, that hasn’t responded to alternative methods of care;

However, the use of indwelling catheterisation should not be considered routine in any of these situations.
**B.1.3 Training**

Nurses are accountable for possessing knowledge, skills and competency (NMC 2008) and it is advisable, if they have not already done so, that staff attend one of the catheter workshops run by the Bladder and Bowel (see intranet Organisational development). Healthcare Professionals who are catheterising should also be signed off as competent and complete both theory and practical sign off.

Any healthcare professional who feels both confident and competent in this clinical procedure should be able to catheterise both males and females. To gain competence the practitioner should attend theoretical training followed by evidence of catheter competency. They should only undertake this procedure after the patient gives informed consent and with the full approval of the person with continuing responsibility for the patient. In some instances, a carer or relative may undertake re-catheterisation. It is important that the nurse responsible for the patient ensures the knowledge and competence of the carer.

Healthcare Professionals should consult the patients G.P. when considering catheterisation. The patient should be reviewed at each catheter change to ascertain if catheterisation is still the most appropriate treatment for them.

The Healthcare Professional is responsible for undertaking a full assessment of need with each individual patient, ensuring that all other alternatives to catheterisation have been explored including a trial without catheter, assessment should identify clinical need considering HOUDINI, suitability and contraindications to the catheterisation procedure. Sexual activity should be discussed when considering catheterisation. Benefits, disadvantages and risks should be clearly discussed with the patient and documented when gaining consent from the patient.

The Healthcare Professional must also consider the patients religious beliefs when selecting catheter products. The Association for Continence Advice (ACA) Notes on Good Practice suggest that Muslim patients requiring a catheter should be offered a catheter valve wherever possible to allow them to conform to their religious beliefs and practices (ACA 2007).

Male catheterisation can be undertaken by any healthcare professional who is clinically competent to do (ACA 2007, RCN 2012, Map of Medicine 2010, NICE 2010). Extra caution should be taken when catheterising men with cancer of the prostate or with enlarged prostate who experienced difficulties during initial catheterisation. Support from the continence team should be sought.

**B.1.4 Antimicrobial Prophylaxis**

In line with NICE guidelines (NICE 2012) antibiotic prophylaxis for catheterisation should only be used for patients with a history of catheter-associated urinary tract infection following catheter change.

Has antimicrobial prophylaxis been considered for patients who have:
• Reoccurring CAUTI
• Where severe infections impact on function and wellbeing (SIGN 88 Management of suspected bacterial urinary tract infections in adults 2012).

**B.1.5 Documentation**

An individualised care plan should be commenced and reviewed at each catheter change.

The catheter care bundle checklist should be used in conjunction with core care plan, it should be and completed at every nursing intervention and as a minimum once a week, to ensure best practice of catheter care for the patient between planned catheter changes.

**Please access the following on the intranet:**
- **Core Clinical care plans**
- **Catheter record**
- **Catheter care bundle checklist**

A link to the Catheter Care Bundle is located in section B20.

After each catheterisation the catheter record form should be completed for that patient.

• Patients who have a heart valve lesion, septal defect, patent ductus or prosthetic valve only require antibiotics if they too have a history of catheter associated infection.

As referenced in section B1.5 please follow the link below to access the Catheter Care Bundle Template:

B.2 Recommended Products

Liverpool Community Health Trust subscribe to NHS SBS Commercial Procurement Solutions. By using a shared services business model, we aim to achieve cost savings and demonstrate both innovation and best practice.

A recommended formulary has been produced and it is advised that products are chosen from the formulary.

You can still access products that are not listed but with a justified rationale for choice.

The formulary can be accessed from the Bladder and Bowel Service
B.3 Catheter Stability and Drainage Systems

B. 3.1 Fixation Aids  
To avoid frictional movement of an indwelling catheter causing trauma, a catheter securing system should be fitted on the thigh or abdomen to keep the catheter securely anchored in place.

B. 3.2 Drainage Bags  
A closed drainage system for urinary catheters is one of the most important steps in the prevention of urinary tract infections in patients with indwelling catheters. They have non return valves to prevent back flow of urine and an outlet tap, which enables the bag to be emptied without disconnection from the catheter thus reducing the incidence of urinary tract infection.

• Patients with indwelling catheters should be encouraged to choose a drainage system that suits them.
• Leg bags are available in different volumes, shapes and types of tap.
• All leg bags should be replaced after 5 – 7 days use (as per Drug Tariff 2013). They should not be washed out.
• The leg bag should be secured in place with the elasticated / Velcro straps supplied with the bags. These should be woven through the back of the bag, never across the front, as this will interfere with the free flow of urine into the bag. If the straps are uncomfortable then the patient may use a urine bag holder made of soft fabric, which is applied like a stocking with a sleeve to hold the leg bag
• 2-litre non-drainable night drainage bags are available in either single use
• Drainable bags are available for patients using sheath system.
• Single use night drainage bags should be used for catheterised patients, using a new bag each night and tearing / cutting the bag to drain it in the morning then dispose of it. Night bags should be supported on a suitable night bag stand (available from community equipment stores) below the level of the bladder, to avoid contact with the floor.
• Drainage bags need to be positioned below the level of the bladder to avoid hydrostatic suction, which can cause damage to the bladder mucosa. Higher rates of bacteriuria have been linked to incorrect positioning.

B.2.3 Bag Emptying  
• Patients should be encouraged to empty their own drainage bag. If this is not possible, the Health Care Professional (HCP) or carer should wear an apron and non-sterile gloves. Eye goggles may need to be considered when there is a risk of splashing.
• To avoid contamination of the tap or the environment by spillage. When drainage bags are three-quarters full, they should be emptied to avoid traction on the bladder.
• The closed system should not be broken more than is necessary.
• It is reported that decontamination of outlet spouts with an alcohol wipe is ineffective. Clean tissue should be used to clean the outlets

B.2.4 Link Drainage System  
The drainage bag should not be disconnected from the catheter; the night bag should be is connected to the drainage tap and ensure the leg bag tap is opened to allow drainage.
**B.3.3 Catheter Valves**

Consideration of a catheter valve should be discussed with the patient at the point of assessment. The patient must be fully aware of the need to drain these on a regular basis to avoid over-distension of the bladder. A catheter valve will help maintain bladder tone during a relatively short period of catheterisation, or to eliminate the need for a drainage bag, cognisant patients may choose to use a catheter valve to manage catheter drainage.
**B.4 Lubricants**

Urinary catheterisation in male or female patients should never be performed without the use of an appropriate lubricant. Urethral trauma and discomfort will be minimised by using an appropriate sterile single use lubricant or anaesthesia gel, this will minimise trauma discomfort and the potential for catheter associated infection.

Cautions: epilepsy, hepatic or respiratory impairment, impaired cardiac conduction, bradycardia, porphyria, (NICE 2012) Reduce dose in elderly or debilitated. Contra-indications: hypovolaemia, complete heart block – (See BNF for further details). The product is available in male or female application pack.

**B.5 Choice of Catheter, Size Length and Balloon Size**

**B.5.1 Charriere Size**
The external diameter of a catheter is measured in Charriere – one Ch equals 0.3mm, therefore 12 Charriere will equal 4mm. The smallest Charriere size allows mucus produced by paraurethral glands in the urethra to drain away possible. Larger sizes can cause block these glands and cause irritation and bypassing of urine around the catheter. If 16 Ch or larger is currently used, seek advice from the patients urology specialist or the Continence Service

**Paediatric Catheterisation**
- 6-12 Ch are appropriate for use. The smallest diameter catheter should be used that will effectively empty the bladder, which should be chosen according to the experienced practitioner’s judgment.

As a guide for the urethral route:
- Female 12 – 14 Ch
- Male 12 – 14 Ch

For suprapubic use,
- 16ch is recommended to allow for maintenance of a good tract between the abdominal wall and bladder

**B.5.2 Balloon Size**

**Paediatric Balloon size**
- Routine 5ml in paediatric catheters
**Adult Balloon Size**

- 10ml balloons should always be used for both urethral and suprapubic routes.
- 30ml balloons are reserved for use in specific situations, mainly for post-prostatic surgery. They can cause bladder spasm and trigone irritation (Pomfret 1996).
- Pre-filled balloons or pre-packed syringes filled with sterile water are preferable. Failing this, sterile water only should be used to fill the balloon. The exact stated amount should be instilled as over or under inflation of the balloon will cause bladder irritation.
- Balloons should always be filled with sterile water, never air (will float above the urine, preventing drainage), or tap water (contains soluble salts that can cause osmosis), or saline (crystals of salt may prevent deflation of balloon).
- Balloons should never be under or over filled, as misshaping of the balloon will interfere with drainage.
- Do not withdraw fluid and refill as a management option for bypassing as this is not in line with manufacturer’s instructions.
- **Always follow the manufacturer’s instructions.**

**B. 5.3 Length of Catheter**

**Urethral**

(Male) 43cm Standard – used for males or for females who prefer a longer length (E.g. wheelchair bound females and obese females may find extra catheter length beneficial for the drainage system).

Female 26cm – **used for females only. Not to be used for males.**

Suprapubic route: a standard length is the most usual, but patient preference may decide the most suitable length.

**| B.5.4 Material**

For long-term catheterisation (maximum catheter life 12 weeks) a hydrogel-coated catheter is recommended. If a patient has a known latex allergy a hydrogel coated silicone catheter or an all silicone catheter should be used, along with sterile non-latex gloves for the procedure.

**B.6 Supra-pubic Catheterisation**

Supra-pubic catheterisation may be considered as an alternative to urethral catheterisation for the following patients:
- Unable to have a urethral catheter due to anatomical difficulty
- Before or after surgical procedures where urethral catheterisation is not appropriate
- Persistent problems with urethral catheterisation
Life-long use of a catheter (E.g. spinal injuries)
- Sexually active
- Informed patient choice

Supra-pubic catheters are not an option for patients with:
- carcinoma of the bladder
- those who are very obese
- those presenting with unexplained haematuria
- Ascites
- Suspicion of ovarian cyst
- Unable to fill bladder to a minimum of 300 ml

The initial catheterisation and the first catheter change should be performed in hospital.

Size 16 Ch
Length Standard (male) 43cm for both males and females.
Balloon Adult 10ml

Pre-filled balloons are preferable. Failing this, sterile water only should be used to fill the balloon. The exact stated amount should be instilled as over or under inflation of the balloon will cause bladder irritation.

Material For long-term catheterisation (maximum catheter life 12 weeks) a hydrogel-coated catheter is recommended. If a patient has a known latex allergy a hydrogel coated silicone catheter or an all silicone catheter should be used, along with sterile non-latex gloves for the procedure. Only certain catheters are licensed for supra-pubic use. See product information sheet.

B.7 Intermittent Catheterisation

Following insertion of the catheter, the catheter is not retained – it is removed following drainage of the bladder or instillation of fluid.

Intermittent self-catheterisation: The patient performs the procedure. This is a clinically clean technique undertaken by the patient on himself or herself.

Intermittent catheterisation: A relative or carer performs the procedure. This is a clinically clean procedure.

Intermittent catheterisation by Healthcare Professionals must always be a sterile procedure.
B.7.1 Reasons for Intermittent Catheterisation
- Where the bladder does not empty completely, resulting in a residual volume. Often due to neuropathic conditions such as:
  - Spina bifida
  - Multiple sclerosis
  - Cerebral palsy
  - Nerve damage
  - Outflow obstruction
- Measurement of residual post-micturition bladder volume (ultrasound bladder scan is a non-invasive alternative, available from the continence service).
- Instillation of medicines into the bladder
- Prevention of urethral stricture recurrence
- As an alternative to indwelling catheterisation

B.7.2 How often does the patient need to catheterise?
The frequency of ISC is very individual and is dependent upon assessment of individual needs.

Paediatrics
In paediatric practice the frequency is determined by experienced paediatric practitioners within the continence service supported by the urology specialist nurses at Alder Hey

Adults
A useful guide is based upon the measurement of voided volumes and residual urine. It is desirable that the voided urinary volume + residual urine is less than 500mls. (BAUN 2000)

It is advisable not to exceed a residual of 250mls as this potentially leads to recurring urine infections.

Although this type of management is very individualised, ISC is usually not beneficial to the patient if the bladder capacity is lower than 100mls and residuals are lower than 50mls as catheterisation would be required too frequently.

If a patient is wet between catheterisations they may require catheterisation more frequently. If they also have some detrusor instability (urgency) they may require ISC plus antimuscarinic/anticholinergic medication

B.7.3 Stricture Dilatation
Stricture dilatation usually commences with three catheter insertions a day, reducing to weekly dilation with a size 18Ch where possible. Stricture programmes can differ with each individual – always check with the urologist. ACA 2007, RCN, 2012)

B.7.4 Teaching a Patient or Carer the Procedure
Only a competent healthcare professional should instruct / teach a patient to carry out the catheterisation procedure.
When a healthcare professional is teaching a patient or carer the procedure it must be incorporated as part of a teaching package with supporting information provided (booklets and videos are available from the bladder and bowel service).

Following the initial teaching of the procedure the patient should be followed up within 2 days, then reviewed at 2 weeks, 3, 6, 12 months subsequently. Factors to be taken into consideration when teaching ISC or IC:

<table>
<thead>
<tr>
<th>Patient selection</th>
<th>Well motivated, good cognitive skills, manual dexterity, physical ability, carer availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient discussion</td>
<td>Knowledge regarding anatomy and reasons for ISC, type of bladder problem</td>
</tr>
<tr>
<td>General discussion</td>
<td>Personal hygiene, hand washing, storage and disposal of catheters, travel, life styles, obtaining future supplies of catheters, who to contact for advice</td>
</tr>
<tr>
<td>Health issues</td>
<td>ISC problem solving, diet, sexual activity, exercise</td>
</tr>
<tr>
<td>Observations</td>
<td>Observe technique</td>
</tr>
</tbody>
</table>

**B.7.5 Catheter Selection**

Hydrophilic catheters are pre-coated catheters, which allow for ease of insertion and removal reducing the risk of urethral trauma. They are for single use only. Catheters should be used in accordance with manufacturer’s instructions and the correct literature given relating to the product selected. Selection should be from the Urology formulary unless justified clinical rationale is provided for choosing an alternative.

**Size**

**Paediatric**
- 6-12 Ch are appropriate for use. The smallest diameter catheter should be used that will effectively empty the bladder, which should be chosen according to the experienced practitioner’s judgment.

**Adult**
- 12 Ch – 14 Ch.

If doing I.C. for dilatation of stricture, larger sizes are used (16 Ch – 18 Ch).

**Length**

Standard (Male) 43cm – used for males or for females who prefer a longer length or in female patients were drainage would be affected by their size (E.g. wheelchair bound females and obese females may find extra catheter length beneficial for the drainage system).

Female 26cm for women.
Material Hydrophilic coated catheters reduce urethral trauma (BAUN 2000); some are ready for use, and others require the addition of water. Manufacturer’s instructions should be followed.

**B.8 Catheter Maintenance Solutions**

The use of catheter maintenance solutions continues to be a contentious issue. They are not required routinely for patients with an indwelling urinary catheter but evidence supports their use in certain circumstances. Routine use of these should be avoided due to the risk of damage to the epithelial lining of the bladder and risk of infection from disrupting the closed drainage system. They should not be used to prevent CAUTI (NICE 2012)

1. Assess if the catheter is still required
2. Carry out a full patient assessment as catheters can block for a variety of reasons including constipation, the patient’s position in the bed or chair, bladder spasm, the drainage system being kinked or raised above the level of the bladder. If the problem remains unresolved then consider the following
3. Always record the reasons for the catheter changes in the care plan and the patient’s notes, both paper and electronic. By recording details correctly patterns of blockage can be clearly identified and action can be taken at an early stage to ensure that the catheter remains patent.
4. For persistent blockers history of 3 catheter lives should form assessment for planned catheter changes to prevent blockage
5. Catheter maintenance solutions are prescription only medications. As such they should only be used on the patient they are prescribed for. Patients must give informed consent to their use (ACA 2007).

**B.8.1 Preventing Catheter Blockage**

Blocked catheters should be examined on removal:
- If catheters are blocking with pus, blood clots or debris normal saline can be used to gently wash out the lumen of the catheter.
- If encrustation is seen around the catheter balloon & eyes Solution G can be used to prevent this recurring in the new catheter (Solution R can be used if this is not effective at dissolving severe encrustation). Encrustation only occurs if the urine is alkaline, so the nurse should check the PH of the urine. Best practice indicates that with problem catheters, urine should be tested weekly to monitor the PH and catheter maintenance solutions should only be used when the PH is above 7. Patients with a high PH should have a sample of urine sent for investigation, as there is an increased likelihood of infection being present. Bacteria such as Proteus Mirabilis and Pseudomonas are more likely to cause a rise in the urines PH level.
B.8.2 Catheter Maintenance Solutions in current use

<table>
<thead>
<tr>
<th>Recommended Solutions</th>
<th>Product Licence</th>
<th>Practice Notes/Cautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Saline</td>
<td>Used to irrigate catheters that block with pus, blood clots or debris and it is very effective for clients with reconstructed bladders where there is a large amount of mucous produced.</td>
<td>It will not dissolve encrustation but works by gently washing out the lumen of the catheter.</td>
</tr>
<tr>
<td>Solution G or Suby G (3.23% citric acid)</td>
<td>For the dissolution of struvite crystals which form on the catheter tip under alkaline conditions (pH 7.5 – 9.5)</td>
<td>Charting of urinary pH over time will allow development of an individual catheter care plan</td>
</tr>
<tr>
<td>Solution R (6% citric acid)</td>
<td>Effective at dissolving severe encrustation due to its acidic nature. Should only be used after Solution G has been tried and has not been effective. It can also be used just prior to catheter removal to dissolve any crystals on the tip of the catheter, which may cause trauma on catheter removal</td>
<td>Strongly acidic – potential mucosal irritation</td>
</tr>
</tbody>
</table>

B.8.3 Catheter Maintenance Solutions used only under the direction of a microbiologist

**Mandelic Acid 1 %**
An acidic solution aimed at preventing growths of urease producing bacteria such as pseudomonas and proteus. However, it contains no magnesium. As magnesium appears to minimize tissue irritation then its use needs to be carefully monitored. (Alderman 1988) There is little evidence to suggest that this solution is effective. It should only be used under the direction of a microbiologist.

B.8.4 Procedure for using a catheter maintenance solution

**Equipment**
- Sterile dressing pack
- Drainage Bag
- Prescribed maintenance solution on a community nursing medicines administration chart (chart must be reviewed at least six monthly or earlier if the patient’s clinical needs change)
- Protection for the patient if required in case of leakage
- Disposable single use apron, non-sterile gloves

Check the expiry date of the solution and that its packaging is intact and sterile
Always warm the solution to body temperature (37°C) prior to instilling. To warm the solution it is suggested that the container be placed in a jug of warm water to bring it up to body temperature. This is to prevent the bladder going into spasm if the solution is too cold.

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbally check name of patient, by asking for name and date of birth, or</td>
<td>Reduce error by ensuring correct patient</td>
</tr>
<tr>
<td>with carer if necessary</td>
<td></td>
</tr>
<tr>
<td>Explain the procedure to the service user and gain valid consent,</td>
<td>To actively involve patient in health care decisions</td>
</tr>
<tr>
<td>explaining risks and benefits to procedure.</td>
<td>Gain patient consent and follow trust chaperone policy</td>
</tr>
<tr>
<td>Check for any known allergies</td>
<td>To reduce allergic reaction</td>
</tr>
<tr>
<td>Ensure privacy within the environment where care is being delivered</td>
<td>To promote dignity and respect for the patient</td>
</tr>
<tr>
<td>Help the patient into a supine or sitting position, protect the bed and</td>
<td>To maintain patient’s privacy and dignity</td>
</tr>
<tr>
<td>ensure privacy</td>
<td></td>
</tr>
<tr>
<td>Assist if necessary to remove clothing from the waist down to facilitate</td>
<td>Maintain dignity of patient</td>
</tr>
<tr>
<td>observation</td>
<td></td>
</tr>
<tr>
<td>Decontaminate hands, put on apron and apply non sterile gloves</td>
<td>Reduce the risk of transfer of transient organisms on the healthcare</td>
</tr>
<tr>
<td>Drain bladder or empty urine bag before starting the procedure.</td>
<td>workers hands to the patient</td>
</tr>
<tr>
<td>Remove straps, and lay leg bag on the bed (if in use) or flat surface</td>
<td>To accurately determine volume of fluid to be instilled</td>
</tr>
<tr>
<td>Check solution has been stored at room temperature, whilst in the patient’s</td>
<td>This is to prevent the bladder going into spasm if the solution is too</td>
</tr>
<tr>
<td>environment</td>
<td>cold</td>
</tr>
<tr>
<td>Prepare a maintenance solution as manufactures guideline checking expiry</td>
<td>To reduce any errors</td>
</tr>
<tr>
<td>date and cross checking against prescription chart. To ensure the correct</td>
<td></td>
</tr>
<tr>
<td>administration of the solution.</td>
<td></td>
</tr>
<tr>
<td>Open sterile dressing pack– place dressing towel under catheter and put</td>
<td>Procedure must be sterile</td>
</tr>
<tr>
<td>on sterile gloves and apron.</td>
<td></td>
</tr>
<tr>
<td>Insert catheter maintenance solution into catheter and administer</td>
<td>A catheter holds little more than 4mls and therefore only very small</td>
</tr>
<tr>
<td>according to manufactures instruction</td>
<td>amounts of solution should be necessary to fill the lumen of the</td>
</tr>
<tr>
<td></td>
<td>catheter and bathe the tip. The use of two sequential washes using</td>
</tr>
<tr>
<td></td>
<td>50ml of fluid could dissolve more</td>
</tr>
</tbody>
</table>
If the solution is to be retained in the bladder close the clip for the specified period.

The use of containers that allow gentle agitation may be more effective than instilling the product for a long period of time as agitation appears to dissolve the encrustation (Getcliffe, 2000)

When the solution is to be removed, ensure the bag is below the level of the bladder, open the clip and allow the solution to drain back.

For gravity to help facilitate drainage

Disconnect the solution bag and connect a new sterile urinary drainage bag/valve.

To maintain closed circuit system and reduce risk of infections

Attach straps, if required, or other suspension accessory.

For comfort of patient

Dispose of equipment following waste disposal policy; remove gloves and decontaminate hands.

To reduce risk of cross-infection

Document the procedure:-
- including consent
- batch number
- manufacturer of solution
- record results, including any complications encountered in care plan

To recognise patterns and identifying the length of time an individual catheter will remain functional, planned catheter changes can be performed prior to blockage occurring (Getliffe 2001)

As the bladder size decreases on catheterisation, it is better to use a smaller volume of maintenance solution. Solutions are available in two volumes – 50ml and 100ml; however evidence has shown that administering two 50ml solutions sequential is more effective than administering 100 ml as a total volume (Getliffe, 2002). They come in two types of containers – gravity feed or agitation.

Therefore when choosing a catheter maintenance solution consideration should be given to:

- The type of solution
- Delivery method – gravity feed or agitation
- Volume of solution to be used

During the procedure the nurse should observe for:

- Bypassing around the catheter
- Discomfort, pain, distress
- Bleeding
- Shock and collapse
- Autonomic dysreflexia in spinal injury patients

The procedure should be discontinued if:

- The patient becomes distressed
- The solution cannot be administered because of catheter blockage

Dispose of equipment following waste disposal policy; remove gloves and decontaminate hands.

To reduce risk of cross-infection

Document the procedure:-
- including consent
- batch number
- manufacturer of solution
- record results, including any complications encountered in care plan

To recognise patterns and identifying the length of time an individual catheter will remain functional, planned catheter changes can be performed prior to blockage occurring (Getliffe 2001)
• Severe bladder spasm
• Shock and collapse
• Bleeding becomes of concern
• Signs of Dysreflexia in spinal injury patients such as headache, flushing, sweating, blurring of vision

B.9 Management of Suspected Bacterial Infection (CAUTI)

This guidance provides recommendations based on current evidence for best practice in the management of adults with community acquired urinary tract infection (SIGN 88 2012, Map of medicine 2010). Urinary tract infection is the most common hospital acquired infection in the UK, accounting for 23% of all infections and the majority of these are associated with catheters.

Catheter-associated UTI is the source for 8% of hospital acquired bacteraemia. Patients who have catheter insertion, up to 98% of catheters will have bacteriuria present after 28 days. The most effective way to reduce Catheter acquired urinary tract infection (CAUTI) is to:

• Avoid of catheter insertion
• Ensure indwelling catheter is appropriate
• Maintain Sterility
• Early removal of catheter

B.9.1 Diagnosis

Between two and seven per cent of patients with indwelling urethral catheters acquire bacteriuria each day, even with the application of best practice for insertion and care of the catheter. All patients with a long term indwelling catheter are bacteriuric, often with two or more organisms. The catheter provides a focus for bacterial biofilm formation.

Duration of catheterisation is strongly associated with the risk of infection. The longer the catheter is in place the greater the likelihood of infection. The presence of a short- or long term indwelling catheter is associated with a greater incidence of fever of urinary tract origin. Fever without any localising signs is a common occurrence in catheterised patients and urinary tract infection accounts for about a third of these episodes.
The correct identifying criteria to diagnose UTI

**DO NOT PERFORM DIPSTICK URINALYSIS**

At least 1 of the following present with no other recognised cause AND has and correctly taken positive urine culture (= or > than $10^5$ microorganisms per ml of urine):

Fever (>38°C), suprapubic tenderness, altered mental status, malaise, lethargy, tenderness over the kidneys, pelvic pain, acute haematuria

Or

At least 2 of the following present with no other recognised cause and a diagnosis of UTI has been made:

Fever (>38°C), suprapubic tenderness, altered mental status, malaise, lethargy, tenderness over the kidneys, pelvic pain, acute haematuria

**B.9.2 Treatment of CAUTI**

- Relieve symptoms with paracetamol or ibuprofen
- Send urine for culture and microscopy before starting antibiotics
- Please follow Pan Mersey Microbiological recommendation for treatment

**Use of Antibiotics**

- Antibiotic prophylaxis is not recommended for cardiac malfunction/stents/valves according to NICE Guidelines (NICE 2008). For any further information on when antibiotics may be required, please consult with Clinical Microbiology.
- For those with symptomatic catheter associated urinary tract infection, the catheter should be changed at the start of antibiotic therapy (SIGN 2012)

Choice of empirical treatment should be guided by symptoms and follow local antibiotic policy:

- treat with antibiotics for 7 days
- follow local Pan Mersey guidelines, if available
- if symptoms are mild, consider withholding antibiotics until culture results are available
- if symptoms are severe, prescribe empirical antibiotics
**Antibiotic choice**

**Women over 65 years and ALL men**

First Line

Nitrofurantoin:

- 100mg orally twice daily (modified-release) for 7 days

Second Line

- Trimethoprim 200mg orally twice daily for 7 days

*Cefalexin 500mg bd for 7 days in penicillin allergy and renal impairment only*

**Women UNDER 65 years**

First Line

Nitrofurantoin:

- 100mg orally twice daily (modified-release) for 3 days

Second Line

- Trimethoprim 200mg orally twice daily for 3 days

*Cefalexin 500mg bd for 3 days in penicillin allergy and renal impairment only*

*Please refer to Pan Mersey Microbiological recommendation for full guidance*

24 hours following removal of catheter

The patient should be treated as per CAUTI guidance above if they present with the following within 24 hours of removal, assuming no other recognised cause; Supra-pubic tenderness, fever (>38C), urinary urgency, urinary frequency, dysuria
CAUTI
Catheter Associated Urinary Tract Infection

Treat the **PATIENT** not the urine!

**DO NOT** perform dipstick urinalysis

The **CORRECT** identifying criteria to diagnose a CAUTI:

- At least 1 of the following present with no other recognised cause:
  - Fever (>38°C), suprapubic tenderness, altered mental status, malaise, lethargy, tachycardia, or tachypnoea.
  - Pelvic pain, acute haematuria.
  - Correctly taken positive urine culture.

- **OR**

- At least 2 of the following present with no other recognised cause:
  - Fever (>38°C), suprapubic tenderness, altered mental status, malaise, lethargy, tenderness over the kidneys, pelvic pain, acute haematuria.

CSU is **ASEPTIC** procedure. Utilise the needle free sampling port on the drainage bag.

**24** hours following removal of catheter

- The patient should be treated as per above CAUTI guidance if they present with the following within 24 hours of removal, assuming no other recognised cause:
  - Suprapubic tenderness, fever (>38°C), urinary urgency, urinary frequency, dysuria.

**Pan Mersey APC** guidance

- Please follow Pan Mersey microbiological recommendation for treatment:
  - Do not treat catheterised patients with asymptomatic bacteriuria.
  - Do not routinely prescribe antibiotics on changing catheters.

Ensure that the patient has a completed **CATHETER PASSPORT**
B10. Autonomic Dysreflexia

Autonomic dysreflexia can occur in spinal injury patients (injury T5 and above). It is triggered by stimulation of sensory nerves in the body below the level of the injury causing over-activity of the autonomic nervous system, resulting in a rapid increase in blood pressure.

B.10.1 Possible Causes

- Over filling / stretching of the bladder
- Indwelling catheter – blocked, infection,
- Kinked tubing
- Bladder irrigation
- Digital rectal examination

B.10.2 Symptoms

- Pounding headache
- Slow pulse
- Sweating above the injury
- Goose bumps
- Blotching of skin
- Nasal congestion
B.10.3 Treatment
Where there is a history of autonomic dysreflexia if the catheter appears to be blocked, change it immediately to prevent an attack. If this is their first episode, it must be treated as an emergency and medical attention gained immediately. Patients who have had episodes previously will have been informed of the warning sign and treatments and will have nifedipine for future attacks.

If an episode occurs:
- Raise the patient’s head
- Feel for a distended bladder
- Change the catheter immediately
- Check blood pressure
- If B.P. continues to increase, the patient is prescribed nifedipine 5-10mg

Once a patient has had an episode of autonomic dysreflexia, it may be a recurrent problem for life.

B.11 Equipment required for Urethral Catheterisation

- Sterile dressing pack or similar alternative
- 2 pairs sterile gloves, 1 pair non-sterile gloves
- Disposable plastic apron
- An appropriate urinary catheter
- Cleaning solution (0.9% saline)
- Hand washing kit
- Alcohol based hand wash solution
- Soap, water and towel if genitalia area is soiled
- Patient’s notes to record procedure and catheter details

For indwelling catheters you will also need
- Sterile lubricant gel
- Sterile water for injection 10ml (if non-prefilled catheter is to be used)
- Sterile syringes 10ml x 2. Needle to draw-up sterile water if required
- Catheter bag of choice with 2 bag straps
- Catheter securement system.
Cost effectiveness and Management of Stock
Initial stock levels should be advised by the district nurse, GP or continence nurse and should reflect the patients chosen delivery system. It then becomes the patient’s responsibility to restock items to the following items.

- x Catheters
- 1 box of anaesthetic gel
- 1 box of urine drainage legs bags
- 30 disposable urine night drainage bag
- 1 box of catheter securement system
- If utilising catheter valve system then 1 box

If not using prefilled catheter then the following stock levels are advised

- 1 box of sterile water
- 10 x 10ml syringes
- 10 x needles for drawing up
- SHARPS BOX NOT to be left in patient's house if only utilised for catheterisation

Storage of Catheters

- Catheters must be stored CAREFULLY – they can be easily damaged;
- It is best to store catheters in a box. Do not pack tightly into drawers or cupboards, or use elastic bands, which can cause potential damage to the product;
- Catheters should be stored away from direct sunlight and direct heat.

B.12 Catheter Removal Prior to Repeat Catheter

The patient, carer or healthcare professional should ensure that the patient is socially clean by washing the insertion areas with soap and water.

Wearing non-sterile gloves deflate the catheter balloon and remove the catheter. It is vital that the catheter is removed slowly and gently to avoid urethral trauma from the irregular shape of the deflated balloon, which is the main cause of haematuria at catheterisation. With supra-pubic changes, check the angle of the tract and length of catheter required on removal, for reference when inserting the new catheter. If difficulty is experienced on removing a supra-pubic catheter, apply lubricating gel around the insertion site and rotate catheter, applying gentle pressure, using a twisting motion whilst removing the catheter.

If the catheter will still not come out, refer to hospital.

Dispose of the old catheter and leg bag before commencing the new procedure. If bleeding is encountered at any stage during removal of the old catheter or insertion of the new catheter then the patients GP should be informed and antibiotic cover given. If any problems are experienced on re-catheterisation, contact either the patient's hospital specialist or local bladder and bowel team.
B.13 Procedure for Indwelling Catheterisation for Male

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>To ensure patient understands procedure and rationale</td>
</tr>
<tr>
<td>4. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. It is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>4. Ensure privacy</td>
<td>Maintain dignity and comfort</td>
</tr>
<tr>
<td>5. Assist the patient into a semi recumbent position. Ensure the patient is not unduly exposed.</td>
<td>Maintain dignity and comfort.</td>
</tr>
<tr>
<td>6. Place protective sheeting below the patient’s buttocks.</td>
<td>To maintain patient comfort and protect work area Reduce risk of cross infection</td>
</tr>
<tr>
<td>7. Wash and dry hands, put on apron and open the pack to receive sterile equipment</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>8. Put on sterile gloves and arrange sterile field.</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>9. Retract the foreskin (if present). Thoroughly cleanse shaft, glans and urethral meatus with saline. Swab away from the urethral orifice. Dry thoroughly.</td>
<td>Reduce infection.</td>
</tr>
<tr>
<td>10. Arrange the sterile drape and place so that penis passes through hole in the drape. Using gauze hold the penis gently and laterally behind glans.</td>
<td>Create sterile field and help prevent contamination</td>
</tr>
<tr>
<td>11. Anaesthetise the urethra with 11ml of local anaesthetic gel by instilling it slowly and evenly into the urethra. Warn the patient slight stinging may be experienced.</td>
<td>Prevent urethral trauma, minimize discomfort, aids lubrication, anesthetises and reduce the introduction of infection</td>
</tr>
<tr>
<td>12. Allow at least 5 minutes to elapse before attempting to pass the catheter.</td>
<td>Allow the anaesthetic and antimicrobial properties to take effect.</td>
</tr>
<tr>
<td>14. Position the sterile receiver to catch urine. Open the inner cover of the catheter.</td>
<td>To expose the catheter tip To ensure a non-touch technique</td>
</tr>
<tr>
<td>13. Using a gauze swab grasp penis with the left or non-dominant hand and hold it up.</td>
<td>This manoeuvre straightens the urethra. Resistance may be felt as the catheter moves through the urethra.</td>
</tr>
<tr>
<td>Method</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ask the patient to take deep breaths during insertion. Coughing or</td>
<td>passes through the prostate. Deep breaths may ease discomfort. Advancing</td>
</tr>
<tr>
<td>straining as though trying to void can also help. The catheter</td>
<td>catheter fully will ensure it is correctly positioned. If resistance is</td>
</tr>
<tr>
<td>should go in easily up to its bifurcation point and urine should be</td>
<td>still felt, withdraw catheter and abandon procedure.</td>
</tr>
<tr>
<td>seen to flow within a few seconds.</td>
<td></td>
</tr>
<tr>
<td>14. Steady catheter in place and inflate the balloon with the stated</td>
<td>Over inflation of the balloon may cause irritation to the bladder trigone</td>
</tr>
<tr>
<td>amount of sterile water.</td>
<td>inducing bladder spasm, which in turn causes “bypassing” of urine around</td>
</tr>
<tr>
<td></td>
<td>the urethral meatus.</td>
</tr>
<tr>
<td>15. Once the balloon is inflated, withdraw the catheter gently until</td>
<td>Check the catheter is positioned in the bladder and not the urethra.</td>
</tr>
<tr>
<td>slight resistance is felt.</td>
<td></td>
</tr>
<tr>
<td>16. If appropriate a urine specimen can be collected for bacteriological</td>
<td>First urine flow will have irrigated away any contaminants.</td>
</tr>
<tr>
<td>examination at this point.</td>
<td></td>
</tr>
<tr>
<td>17. Attach catheter to closed drainage system or catheter valve.</td>
<td>Maintain patient comfort and allow for collection of urine</td>
</tr>
<tr>
<td>or catheter valve. Attach strapping and secure in place.</td>
<td></td>
</tr>
<tr>
<td>18. Ensure that you retract the foreskin back into its original</td>
<td>To prevent damage or trauma to the penis</td>
</tr>
<tr>
<td>position.</td>
<td></td>
</tr>
<tr>
<td>19. Make the patient comfortable and ensure that the area is dry.</td>
<td>If the area is left wet or moist secondary infection and skin irritation</td>
</tr>
<tr>
<td></td>
<td>may occur.</td>
</tr>
<tr>
<td>20. Measure and chart urinary output if necessary.</td>
<td>To obtain baseline information</td>
</tr>
<tr>
<td>21. Clear away equipment and dispose of clinical waste and personal</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>protective equipment as per trust policy. Wash and dry hands.</td>
<td></td>
</tr>
<tr>
<td>22. Record insertion date, size of catheter and balloon volume, reason</td>
<td>Legal requirement.</td>
</tr>
<tr>
<td>for catheterization and gel used in patient’s nursing documentation.</td>
<td></td>
</tr>
<tr>
<td>23. Persistent post catheterization haemorrhage should be reported</td>
<td>To maintain patient safety and care</td>
</tr>
</tbody>
</table>
### B.14 Procedure for Indwelling Urethral Catheterisation Female

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>Obtain the patient’s consent and co-operation.</td>
</tr>
<tr>
<td>2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)</td>
<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>4. Ensure privacy</td>
<td>To maintain dignity and comfort</td>
</tr>
<tr>
<td>3. Assist the patient into a semi recumbent position. Ensure the patient is not unduly exposed.</td>
<td>Maintain dignity and comfort.</td>
</tr>
<tr>
<td>4. Place protective sheeting below the patient’s buttocks.</td>
<td>To maintain patient comfort and protect work area Reduce risk of cross infection</td>
</tr>
<tr>
<td>5. Wash and dry hands, put on apron and open the pack to receive sterile equipment</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>6. Put on sterile gloves and arrange sterile field.</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>7. Thoroughly cleanse the vulval area with saline, swabbing from above downwards. Cleanse labia minora, vestibule in turn. At this point identify the urethral meatus.</td>
<td>Reduce infection.</td>
</tr>
<tr>
<td>8. Arrange the sterile drapes.</td>
<td>Create sterile field and help prevent contamination</td>
</tr>
<tr>
<td>9. Anaesthetise the urethra with 6ml of local anaesthetic gel by instilling it slowly and evenly. Warn the patient slight stinging may be experienced.</td>
<td>Prevent urethral trauma, minimize discomfort aid lubrication reduce the introduction of infection.</td>
</tr>
<tr>
<td>10. Allow 5 minutes to elapse before</td>
<td>Allow the anaesthetic to take effect.</td>
</tr>
<tr>
<td>Method</td>
<td>Rationale</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>attempting to pass the catheter</td>
<td></td>
</tr>
<tr>
<td>11. Discard gloves apply alcohol gel to hands and put on another pair of sterile gloves.</td>
<td>Maintain sterility</td>
</tr>
<tr>
<td>12. Position the sterile receiver to catch urine. Open the inner cover of the catheter.</td>
<td>Lubricate the tip of the catheter using a sterile swab covered with remaining anaesthetic gel</td>
</tr>
<tr>
<td></td>
<td>Over inflation of the balloon may cause irritation to the bladder trigone inducing bladder spasm, which in turn causes “bypassing” of urine around the urethral meatus.</td>
</tr>
<tr>
<td>13. Insert catheter into the urethral orifice for 6-8cm until urine flows. Labial separation should be maintained with one hand using sterile swabs (do not touch any part of the vulva with the catheter).</td>
<td>Check the catheter is positioned in the bladder and not the urethra.</td>
</tr>
<tr>
<td>14. Steady catheter in place and inflate the balloon with the stated amount of sterile water.</td>
<td>First urine flow will have irrigated away any contaminants.</td>
</tr>
<tr>
<td>15. Once the balloon is inflated, withdraw the catheter gently until slight resistance is felt</td>
<td></td>
</tr>
<tr>
<td>16. If appropriate a urine specimen can be collected for bacteriological examination at this point.</td>
<td></td>
</tr>
<tr>
<td>17. Attach catheter to closed drainage system or catheter valve</td>
<td>Maintain patient comfort and allow for collection of urine</td>
</tr>
<tr>
<td>18. Make the patient comfortable and ensure that the area is dry.</td>
<td>If the area is left wet or moist secondary infection and skin irritation may occur.</td>
</tr>
<tr>
<td>19. Measure and chart urinary output if necessary.</td>
<td>To obtain baseline information</td>
</tr>
<tr>
<td>20. Clear away equipment and dispose of clinical waste and personal protective equipment as per trust policy. Wash and dry hands.</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>21. Record insertion date, size of catheter and balloon volume, reason for catheterization and gel used in patient’s nursing documentation.</td>
<td>Legal requirement.</td>
</tr>
<tr>
<td>22. Persistent post catheterization haemorrhage should be reported to medical staff.</td>
<td>To maintain patient safety and care</td>
</tr>
</tbody>
</table>
### B.15 Procedure for Supra Pubic Catheterisation, Male or Female Patients.

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>Obtain the patient’s consent and cooperation.</td>
</tr>
<tr>
<td>2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)</td>
<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. It is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>4. Place protective sheeting below the patient’s buttocks.</td>
<td>To maintain patient comfort and protect work area Reduce risk of cross infection</td>
</tr>
<tr>
<td>5. Wash and dry hands, put on apron and open the pack to receive sterile equipment</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>6. Put on sterile gloves and arrange sterile field.</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>7. Thoroughly cleanse the area around the insertion site with saline.</td>
<td>Reduce infection.</td>
</tr>
<tr>
<td>8. Arrange the sterile drapes.</td>
<td>Create sterile field and help prevent contamination</td>
</tr>
<tr>
<td>9. Deflate the balloon with 10ml syringe and leave for 5 minutes</td>
<td>To allow the balloon to re conform its shape and minimise trauma on removal</td>
</tr>
<tr>
<td>10. Remove catheter from the tract observing catheter length and angle from the abdominal wall. A twisting motion may be required to remove the catheter Change gloves and wash hands</td>
<td>To ensure new catheter is inserted to the same position. To allow easier removal as a result of cuffing of the balloon To minimise infection</td>
</tr>
<tr>
<td>11. Anaesthetise the insertion tract with local anesthetic gel by instilling it slowly and evenly. Warn the patient slight stinging may be experienced.</td>
<td>Prevent urethral trauma, minimize discomfort and reduce the introduction of infection.</td>
</tr>
<tr>
<td>12. Allow 5 minutes to elapse before attempting to pass the catheter.</td>
<td>Allow the anaesthetic to take effect.</td>
</tr>
</tbody>
</table>
13. Position the sterile receiver to catch urine. Open the inner cover of the catheter. Lubricate the tip of the catheter using a sterile swab covered with remaining anaesthetic gel.

14. Insert catheter into the insertion site, remembering the angle of the tract and the length of catheter required, until urine flows. Insert the catheter a further 3cm. Insertion past the point of urine flow ensures the balloon is through the musculature before inflation.

15. Steady catheter in place and inflate the 10ml balloon with the stated amount of sterile water. Over inflation of the balloon may cause irritation to the bladder trigone inducing bladder spasm, which in turn causes “bypassing” of urine.

16. Once the balloon is inflated, withdraw the catheter gently until slight resistance is felt. Check the catheter is positioned in the bladder and not the urethra.

17. If appropriate a urine specimen can be collected for bacteriological examination at this point. First urine flow will have irrigated away any contaminants.

18. Attach catheter to closed drainage system or catheter valve. Maintain patient comfort and allow for collection of urine.

19. Make the patient comfortable and ensure that the area is dry. If the area is left wet or moist secondary infection and skin irritation may occur.

20. Measure and chart urinary output if necessary. To obtain baseline information.

21. Clear away equipment and dispose of clinical waste and personal protective equipment as per trust policy. Wash and dry hands. To reduce risk of cross infection.

22. Record insertion date, size of catheter and balloon volume, reason for catheterisation and gel used in patient’s nursing documentation. Legal requirement.

23. Urine drainage may be a little blood-stained. Persistent post catheterisation haemorrhage should be reported to medical staff. To maintain patient safety and care.
### B.16 Procedure for Intermittent Urethral Catheterisation Male

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>Obtain the patient’s consent and co-operation.</td>
</tr>
<tr>
<td>3. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>4. Place protective sheeting below the patient’s buttocks.</td>
<td>To maintain patient comfort and protect work area Reduce risk of cross infection.</td>
</tr>
<tr>
<td>5. Wash and dry hands, put on apron and open the pack to receive sterile equipment</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>6. Put on sterile gloves and arrange sterile field.</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>7. Retract the foreskin (if present). Thoroughly cleanse shaft, glans and urethral meatus. Swab away from the urethral orifice. Dry thoroughly.</td>
<td>Reduce infection.</td>
</tr>
<tr>
<td>8. Arrange the sterile drape and place so that penis passes through hole in the drape. Using gauze hold the penis gently and laterally behind glans.</td>
<td>Create sterile field and help prevent contamination</td>
</tr>
<tr>
<td>9. Lubricate intermittent catheter according to manufacturer’s instructions.</td>
<td>Prevent urethral trauma, minimize discomfort and reduce the introduction of infection.</td>
</tr>
<tr>
<td>10. Discard gloves wash hand or apply alcohol gel and put on another pair of sterile gloves.</td>
<td>Maintain sterility.</td>
</tr>
<tr>
<td>11. Position the sterile receiver to catch urine. Open the inner cover of the catheter.</td>
<td></td>
</tr>
</tbody>
</table>


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<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Using a gauze swab grasp penis with the left or non-dominant hand and hold it up. Ask the patient to take deep breaths during insertion. The catheter should go in easily and urine should be seen to flow within a few seconds. Hold it in position until urine flow stops.</td>
<td>This manoeuvre straightens the urethra. Resistance may be felt as the catheter passes through the prostate. Deep breaths may ease discomfort. Advancing catheter fully will ensure it is correctly positioned. If resistance is still felt, withdraw catheter and abandon procedure.</td>
</tr>
<tr>
<td>13. Remove the catheter slowly.</td>
<td>Maximise bladder drainage, minimise trauma.</td>
</tr>
<tr>
<td>14. Make the patient comfortable and ensure that the area is dry.</td>
<td>If the area is left wet or moist secondary infection and skin irritation may occur.</td>
</tr>
<tr>
<td>15. Measure and chart urinary output if necessary.</td>
<td>To obtain baseline information</td>
</tr>
<tr>
<td>16. Clear away equipment and dispose of clinical waste and personal protective equipment as per trust policy. Wash and dry hands.</td>
<td>To reduce risk of cross infection</td>
</tr>
<tr>
<td>17. Record date, size, type and batch number of catheter, residual urine volume, care advised and time of next catheterisation in patient’s nursing documentation.</td>
<td>Legal requirement.</td>
</tr>
</tbody>
</table>
### B.16 Procedure for Intermittent Catheterisation Female

<table>
<thead>
<tr>
<th>Method</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the procedure to the patient</td>
<td>Obtain the patient’s consent and co-operation.</td>
</tr>
<tr>
<td>2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)</td>
<td>Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour</td>
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<td>3. Document consent has been given</td>
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<td>4. Place protective sheeting below the patient’s buttocks.</td>
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</tr>
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<td>5. Wash and dry hands, put on apron and open the pack to receive sterile equipment</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>6. Put on sterile gloves and arrange sterile field.</td>
<td>Reduce risk of cross infection.</td>
</tr>
<tr>
<td>7. Thoroughly cleanse the vulval area with saline, swabbing from above downwards. Cleanse labia minora, vestibule in turn. At this point identify the urethral meatus.</td>
<td>Reduce infection.</td>
</tr>
<tr>
<td>8. Arrange the sterile drapes.</td>
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<td>9. Lubricate intermittent catheter according to manufacturer’s instructions.</td>
<td>Prevent urethral trauma, minimize discomfort and reduce the introduction of infection.</td>
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<tr>
<td>10. Discard gloves wash hands or apply alcohol gel and put on another pair of sterile gloves.</td>
<td>Maintain sterility</td>
</tr>
<tr>
<td>11. Position the sterile receiver to catch urine.</td>
<td></td>
</tr>
<tr>
<td>12. Insert catheter into the urethral orifice for 6-8cm until urine flows. Hold it in position until urine flow stops. Labial separation should be maintained with one hand using sterile swabs (do not touch any part of the vulva with the catheter).</td>
<td>Maximise bladder drainage, minimise trauma.</td>
</tr>
<tr>
<td>13. Remove the catheter slowly.</td>
<td></td>
</tr>
<tr>
<td>14. Make the patient comfortable and ensure that the area is dry.</td>
<td>If the area is left wet or moist secondary infection and skin irritation may occur.</td>
</tr>
<tr>
<td>15. Measure and chart urinary output if necessary.</td>
<td>To obtain baseline information</td>
</tr>
</tbody>
</table>
16. Clear away equipment and dispose of clinical waste and personal protective equipment as per trust policy. Wash and dry hands. To reduce risk of cross infection

17. Record date, size, type and batch number of catheter, residual urine volume, care advised and time of next catheterisation in patient’s nursing documentation. Legal requirement.

B.17 Trial without Catheter

B.18.1 Indications for trial without catheter (TWOC)
- To ascertain voiding function
- To prevent continued catheter usage when it is no longer needed
- Patient choice
- A risk assessment should be undertaken prior to a trial without catheter. This should include medical status, infection history, antibiotic indications, skin integrity, diabetes, cardiac status, history of nocturnal polyuria, cognitive status, mobility and dexterity status and social status.
- The patient's ability to consent/co-operate is an important factor when planning a TWOC.

B.18.2 Extra Consideration
- Symptomatic Urinary Tract Infection (must have symptoms not just positive urinalysis). Treat infection, ensure treated and then arrange community TWOC.
- Bladder and Prostate Carcinoma should only be considered a relative contraindication if the prostate or bladder cancer caused that specific catheterisation to be DIFFICULT. In this situation discussion with the Urology Department or GP is advised and a community TWOC may still be appropriate.
- A community TWOC is appropriate if the patient only has a history of prostate or bladder cancer and the catheterisation was straightforward.
- Unless the patient has an absolute contraindication (please see below) and the patient history does not indicate any problems with the catheterisation then a TWOC in the community is highly likely to be appropriate.
- Constipation: Patients who are constipated / no bowel movement for 3 days, require treatment for constipation prior to community TWOC.
Housebound Patient in the Community

TWOC referral form can be accessed on the trust service intranet page

Visit 1: Healthcare Professional Protocol for TWOC

- Explain procedure and obtain verbal consent
- Document a care plan for the TWOC
- Discuss potential risks and discuss patient information leaflet
- Highlight procedure should the TWOC be unsuccessful, including the potential for being re-catheterised
- Check medication to ensure that those on diuretics are aware of the need to take medication on the morning of the procedure
- Check that the patient is on an Alpha blocker if indicated (See BNF)
- Check patient not constipated (will need to rearrange if constipated >3 days, once constipation resolved)
- Ensure plastic jug for measuring output is available
- Ensure equipment for re-catheterisation is available
- Ensure correct documentation is available
- Provide team / nurse contact details - day & evening/night numbers

Visit 2: Day of TWOC

- Only remove the catheter if no signs or symptoms of infection e.g. pain or fever.
- Ensure patient has had a normal (for the patient) bowel movement in last 24 hours
- Ensure patient has washed perineum prior to catheter removal
- Remove catheter early morning using clean technique
- Ask patient to record fluid intake and urine output on chart
- Explain to the patient that the first void may sting and they may see a little blood, due to trauma removing the catheter
- Advise on fluid intake, no more than 1 -1.2 litres in 6 hours
- Give patient the District Nurse’s contact number for any problems
- Phone contact after 3-4 hours (maximum) to monitor progress and check fluid intake
- At any time if the patient becomes uncomfortable and unable to void RECATHETERISE

Consider as per algorithm appendix 19 to refer back to Urology outcome to be documented

Visit 3 or Telephone: 6 hours post TWOC (Performed by a member of the bladder and bowel team)

- Visit patient to assess progress and review charts to check passing urine of at least 100mls at each void.
- Perform post void bladder scan to ensure there is no urinary retention
Option 1: If patient is passing urine safely, TWOC has been achieved.
Option 2: If residual higher than 200mls is identified via portable bladder scan: consider
- Double void and repeat bladder scan
- Teach ISC (to reduce CAUTI)
- Re-catheterisation using aseptic technique with a further planned TWOC

If unable to re-catheterise the patient will have to be admitted to Accident and Emergency.

Consider referral to Urology as per TWOC pathway Appendix 19 if TWOC unsuccessful

Ensure discharge documentation is completed to:
- District nursing team
- Gp
- Urology
- Patient
B.19 Algorithm: Trial without Catheter

Criteria for TWOC at home: (Following Urology input/advice)

- Failed TWOC following surgery (other than urology)
- Acute urinary retention
- Chronic urinary retention
- Dementia
- Bed bound/immobile
- Unable to get to hospital
- Immunosuppressed
- To ascertain if voiding is possible
- Patient choice
- Post-acute urinary retention (after commencement of medication)
- Chronic Retention for voiding function

Discharge from secondary care to community district nursing team detailing length of time to TWOC.

Copy of referral to be sent to Bladder and Bowel Service as additional safety netting management

DN’s refer to Bladder and Bowel Service

Joint date arranged for TWOC between DN/ Bladder and Bowel service and patient

Information regarding ISC to be sent to the patient in preparation for a failed TWOC (if clinically appropriate)

DN will visit approx. 3 days before planned TWOC and commence valve to encourage bladder retraining

DN visits in am and removes the catheter provides advice on fluid intake and monitoring, voiding and contact numbers made available

Bladder and Bowel Service will visit 4-6 hours later to perform bladder scan and re-catheterise if indicated as per below guidance

If residual higher than 200ml detected (dependant on individual patient):

- Double void and repeat bladder scan
- Teach ISC (to reduce CAUTI)
- Re-catheterisation with a further planned TWOC
- If unable to re-catheterise the patient will have to be admitted to A and E
As per B.17 Trial Without Catheter please follow the link below to access the TWOC Referral Pathway

B.20 Catheter Blockage Pathway

Long Term Management:

- Review last 3 catheter changes and establish pattern. Plan subsequent changes to happen before bypassing/blocking.
- For indwelling urethral catheter – ensure smallest calibre size is in place for adequate drainage 12-14ch 10ml balloon.
- If suprapubic catheter consider increasing the lumen size by one at each change to a maximum of 18ch.
- Consider planning change of catheter earlier than 12/52.
- If catheter blocks with evidence of debris/encrustation consider introducing catheter maintenance solution to extend catheter life (see Continence Manual for support).
- Consider use of anti-cholinergic.

For further support or patient review contact the Bladder and Bowel Service for advice. T. 0151 295 3993 E. Bladder&Bowel.Service@liverpoolch.nhs.uk
C. Digital Rectal Examination

This section of the manual details the following:
C1 Offering a Chaperone
C2 Procedure for Rectal Examination
C3 Procedure for Digital Ano-rectal Stimulation
C4 Procedure for Abdominal Massage
C5 Procedure for Manual Removal of Faeces
C6 Neurogenic Bowel Management
C7 Autonomic Dysreflexia
C8 Rectal Irrigation
C9 Record Keeping
C10 Bristol Stool Chart

C.1 Offering a Chaperone

All patients should be made aware a chaperone can be made available for any consultation or procedure involving a health professional. It is not always clear ahead of the consultation that an intimate examination or procedure is required. It is therefore prudent to offer a chaperone at the time of the examination or treatment. In every case the health professional should be able to demonstrate, if challenged, that they have taken all reasonable steps to protect themselves and the patient from allegations of improper behaviour.

Many patients will not take up the offer of a chaperone, especially where a relationship of trust has been built up or where the examiner is the same gender as them. If the patient is offered and does not want a chaperone it is important to record this in their health record, that the offer was made and declined.

Where a chaperone is requested but not available
If the patient has requested a chaperone and none is available at that time the patient must be given the opportunity to reschedule their appointment.

If the seriousness of the condition means that a delay is inappropriate then this should be explained to the patient and recorded in their notes. A decision to continue or otherwise should be jointly reached. It is acceptable for a health professional to perform an intimate examination without a chaperone if the situation is life threatening or speed is essential in the care or treatment of the patient. This should be recorded in the patient’s health record.

C.2 Procedure for Rectal Examination

Digital rectal examination is to be used as part of a healthcare professional’s assessment, providing the healthcare professional has received suitable training to do so. Training is provided by LCH and can be accessed via Learning and development.

Indications for DRE are to establish:

- The presence of faecal matter in the rectum, amount and consistency
• Anal tone and the ability to initiate a voluntary contraction and to what degree
• Anal/rectum sensation
• The need for the effects of rectal medication in certain circumstances
• The need for manual removal of faeces and evaluating bowel emptiness
• The outcome of rectal/colonic washout/irrigation if appropriate
• The need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex (RCN 2012)

IMPORTANT: it is vital to check for allergies, including allergies to latex, soap(lanolin), phosphate and peanut (present in arachas oil enemas) before proceeding with these procedures.

Considerations
DRE and manual removal of faeces are invasive procedures and should only be performed when necessary, and after an individual assessment. Cultural and religious beliefs need to be considered before performing these procedures

Consent
Valid Consent should be obtained in adherence to Liverpool Community HealthTrust policy on consent.

Observation of the perineal and perianal area
Before these procedures can be performed, abnormalities of the perineal and perianal areas should be observed, documented and reported. You should observe for the following abnormalities:
• Rectal prolapse –degree, ulceration
• Haemorrhoids –number, position, grade, prolapse
• Anal skin tags-number, position, condition
• Wounds, dressings, discharge present
• Anal lesions (malignancy)
• Skin conditions, broken areas, pressure sores of all grades
• Bleeding and colour of blood
• Faecal matter
• Infestation
• Foreign bodies

Presence of any abnormality would indicate that DRE or Manual removal of faeces should not be performed until advice has been sought from a specialist nurse or medical practitioner (RCN 2012).

Circumstances when extra care is required
You should exercise particular caution when performing these procedures with patients who have the following diseases and conditions:
• Active inflammation of the bowel, including Crohns disease, ulcerative colitis and diverticulitis
• Recent radiotherapy to the pelvic area
• Rectal pain
• Rectal surgery/trauma to the anal/rectal/area
• Tissue fragility due to age, radiation, loss of muscle tone in neurological disease of malnourishment
• Obvious rectal bleeding
• If the patient has a known history of abuse
• In spinal injury patients because of autonomic dysreflexia
• If patients have a known history of allergies

Exclusions and contra-indications
Healthcare Professionals should not undertake these procedures when:
• There is a lack of consent from the patient – either written, verbal or implied
• The patients doctor has given specific instructions that these procedures are not to take place
• The patient has recently undergone rectal/anal surgery or trauma
• If the patient gains sexual satisfaction from the procedure. In this case consultation with the doctor is advised, involving the patient in the consultation. You may consider a chaperone in some circumstances.
• In the presence of abnormalities of the perineal and perianal area is observed
C.2.1 PROCEDURE - Digital Rectal Examination

**Equipment required**
- Disposable gloves
- Water soluble lubricant or anaesthetic gel
- Disposable underpad
- Tissues/wipes
- Waste bag
- Access to toilet/commode/bedpan
- Hand cleansing equipment

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete bowel assessment with the patient</td>
<td>To ascertain need for digital rectal examination</td>
</tr>
<tr>
<td>2. Explain the procedure</td>
<td>Patient information reduces anxiety</td>
</tr>
<tr>
<td>4. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. it is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>5. Assess risk for autonomic dysreflexia of those spinal injury patients T6 and above</td>
<td>Autonomic dysreflexia is a sudden and exaggerated autonomic response to unpleasant stimuli e.g. full rectum or DRE may trigger this response</td>
</tr>
</tbody>
</table>

Record BP if patient has SCI at T6 or above

Has recently had an autonomic response

Does the patient have symptoms of constipation

If yes, signifies risk of autonomic dysreflexia, this risk must be balanced against secondary risk of constipation leading to dysreflexia by not emptying
<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Ask the patient if they wish to use the toilet prior to undertaking the procedure</td>
<td>to undertake the bowel</td>
</tr>
<tr>
<td>7 Position the patient, left lateral side with knees flexed, ensuring privacy at all times</td>
<td>To expose anus and allow easy insertion of finger</td>
</tr>
<tr>
<td>8 Place protective sheet under the patient</td>
<td>To protect bedding from faecal matter</td>
</tr>
<tr>
<td>9 Observe the perineal and perianal area, document and report any abnormalities</td>
<td>If abnormalities present DRE and manual removal of faeces should not be undertaken and advice sought</td>
</tr>
<tr>
<td>10 Wash hands put on disposable apron and non-latex gloves</td>
<td>To minimise cross infection</td>
</tr>
<tr>
<td>11 Lubricate gloved index finger</td>
<td>To facilitate easier insertion of the index finger and prevent trauma to the anal and rectal mucosa by reducing surface friction. To alleviate discomfort for the patient</td>
</tr>
<tr>
<td>12 Inform patient of start of procedure and insert the finger slowly into the anus then rectum.</td>
<td>To ensure dignity, relaxation and awareness of the examination is about to begin and to minimise discomfort</td>
</tr>
<tr>
<td>13 Undertake assessment of: Anal tone and sensation of anal sphincter Presence of faecal matter, amount and consistency: referencing to the Bristol Stool Chart</td>
<td>To ensure that the nurse examination is in guidance to the indications as identified in the RCN /trust guidelines (RCN, 2005)</td>
</tr>
<tr>
<td>14 Slowly withdraw the finger from the rectum when assessment/examination is complete</td>
<td>To minimise patient discomfort</td>
</tr>
<tr>
<td>If the patient requires manual removal of faeces the nurse must refer to separate procedure guidelines</td>
<td>To reduce anxiety of patient waiting subsequently procedure</td>
</tr>
<tr>
<td>15 Remove any residual lubricating gel from the anal area.</td>
<td>For patient comfort and reduce irritation or soreness</td>
</tr>
<tr>
<td>16 Remove gloves, dispose of equipment as per trust guidance and wash hands</td>
<td>To minimise cross infection</td>
</tr>
<tr>
<td>17 Make the patient comfortable. Offer toilet/commode/bed pan as appropriate. Gently wash and dry area if required</td>
<td>Examination can stimulate ano-rectal reflex and urge to defecate. To prevent skin excoriation and promote patient comfort</td>
</tr>
<tr>
<td>18 Record outcome of examination by documenting: Consent Stool type/findings on examination Nursing intervention and outcome Referral to G. P.(where indicated)</td>
<td>Documentation should provide clear guidance to evidence based care planned, decisions made and treatment given. To comply with NMC (2008) and trust guidance on record keeping. To improve communication between</td>
</tr>
</tbody>
</table>
### C.3 Procedure for Digital Ano-rectal Stimulation

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete bowel assessment with the patient</td>
<td>To ascertain need for digital rectal examination</td>
</tr>
<tr>
<td>2. Explain the procedure</td>
<td>Patient information reduces anxiety</td>
</tr>
<tr>
<td>3. Offer chaperone to be present, document chaperone name if present. As RCN (2000), NMC (2008)</td>
<td>To reduce patient anxiety and maintain dignity. To protect nurse and patient from improper behaviour</td>
</tr>
<tr>
<td>4. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. It is a legal means by which the patient gives valid authorisation for treatment or care (RCN 2000)</td>
</tr>
<tr>
<td>5. Assess risk for autonomic dysreflexia of those spinal injury patients T6 and above</td>
<td>Autonomic dysreflexia is a sudden and exaggerated autonomic response to unpleasant stimuli e.g. full rectum or DRE may trigger this response</td>
</tr>
<tr>
<td>Record BP if patient has SCI at T6 or above</td>
<td>To obtain baseline BP</td>
</tr>
<tr>
<td>Has recently had an autonomic response Does the patient have symptoms of constipation</td>
<td>If yes, signifies risk of autonomic dysreflexia, this risk must be balanced against secondary risk of constipation leading to dysreflexia by not emptying the bowel</td>
</tr>
<tr>
<td>6. Ask the patient if they wish to use the toilet prior to undertaking the procedure</td>
<td>Dignity and comfort of the patient during this procedure</td>
</tr>
<tr>
<td>7. Position the patient, left lateral side with knees flexed, ensuring privacy at all times</td>
<td>To expose anus and aloe easy insertion of finger</td>
</tr>
<tr>
<td>To prevent over stretching of the anal sphincter and discomfort to the patient</td>
<td></td>
</tr>
<tr>
<td>8. Place protective sheet under the patient</td>
<td>To protect bedding from faecal matter</td>
</tr>
<tr>
<td>9. Observe the perineal and perianal area. Document and report any abnormalities</td>
<td>If abnormalities present DRE and manual removal of faeces should not be undertaken and advice sought</td>
</tr>
<tr>
<td>10. Wash hands put on disposable apron and non-latex gloves</td>
<td>To minimise cross infection</td>
</tr>
<tr>
<td>11. Lubricate gloved index finger</td>
<td>To facilitate easier insertion of the index finger and prevent trauma to the anal and rectal mucosa by reducing surface friction. To alleviate discomfort for the patient</td>
</tr>
<tr>
<td>12. Inform patient of start of procedure and insert the finger slowly into the anus</td>
<td>To ensure dignity, relaxation and awareness of the examination is about...</td>
</tr>
</tbody>
</table>
then rectum. Encouraging the patient to relax to begin and to minimise discomfort

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Digital ano-rectal stimulation should last 20 seconds, and stimulate no longer than 1 minute if necessary. Stimulation can be repeated every 5 to 10 minutes until evacuation is complete, or no stool has been passed following 2 stimulations</td>
<td>To stimulate reflex emptying</td>
</tr>
<tr>
<td>14. Ensure the padded inferior surface of the finger is in contact with the bowel wall and slowly rotating the finger in circular movements against the rectal mucosa. Rotation is continued until relaxation of the bowel is felt, flatus passes, stool passes, or the internal anal sphincter contracts</td>
<td>To stimulate reflex emptying of the bowel</td>
</tr>
<tr>
<td>15. Remove any residual lubricating gel from the anal area.</td>
<td>For patient comfort and reduce irritation or soreness</td>
</tr>
<tr>
<td>16. Remove glove, dispose of equipment and wash hands</td>
<td>To minimise cross infection</td>
</tr>
<tr>
<td>17 Make the patient comfortable. Offer toilet/commode/bed pan as appropriate. Gently wash and dry area if required</td>
<td>Examination can stimulate ano-rectal reflex and urge to defecate. To prevent skin excoriation and promote patient comfort</td>
</tr>
<tr>
<td>18. Record outcome of examination by documenting:</td>
<td>Documentation should provide clear guidance to evidence based care planned, decisions made and treatment given. To comply with NMC (2008) and trust guidance on record keeping. To improve communication between health professionals</td>
</tr>
<tr>
<td>- Consent</td>
<td></td>
</tr>
<tr>
<td>- Stool type/findings on examination</td>
<td></td>
</tr>
<tr>
<td>- Nursing intervention and outcome</td>
<td></td>
</tr>
<tr>
<td>- Referral to G. P.(where indicated)</td>
<td></td>
</tr>
</tbody>
</table>

**C.4 Procedure for Abdominal Massage**

Massage may be used before and after digital rectal stimulation, insertion of stimulants or digital removal of faeces to aid evacuation (Coggrave 2005).

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the procedure to the individual (if necessary) and obtain consent. Even if the individual consents to the procedure, if they request you to stop at any time, you must do so.</td>
<td>As per Liverpool community Health Trust consent policy (2008)</td>
</tr>
<tr>
<td>The individual should be offered an chaperone</td>
<td>As per chaperone guidelines (RCN 2006)</td>
</tr>
<tr>
<td>The patient should be assisted into in a</td>
<td>To ensure comfort</td>
</tr>
<tr>
<td>ACTION</td>
<td>RATIONALE</td>
</tr>
<tr>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>supine position, with head and shoulders supported on their left side.</td>
<td></td>
</tr>
<tr>
<td>Effleurage: Stroke for the direction of the ascending colon across the transverse colon and down the descending colon increasing the pressure gradually</td>
<td>Effleurage stimulates the austral and segmental contractions of the large intestine may also be used, which may trigger somato-visceral reflexes. The aim is to propel the faecal matter along the intestine</td>
</tr>
<tr>
<td>Palmar kneading, Using the back or heel of the hand apply and release pressure firmly but gently in a continuous progression down the descending colon, up the ascending colon, and down the descending colon once again</td>
<td>Kneading helps to propel the faecal matter along the gut to load the rectum (McClurg et al 2010)</td>
</tr>
</tbody>
</table>

**C.5 Procedure for Manual Removal of Faeces**

**Equipment required**
- Disposable gloves
- Water soluble lubricant or anaesthetic gel
- Disposable under pad
- Tissues/wipes
- Waste bag
- Access to toilet/commode/bedpan
- Hand cleansing equipment(hand cleansing gel does not kill clostridium difficile spores)

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete bowel assessment with the patient</td>
<td>To ascertain need for digital rectal examination</td>
</tr>
<tr>
<td>2. Explain the procedure</td>
<td>Patient information reduces anxiety</td>
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<tr>
<td>4. Document consent has been given</td>
<td>To gain consent and co-operation for the procedure to take place. It is a legal means by which the patient gives valid authorisation for treatment or care RCN (2000) NHS Liverpool Community Health (2008)</td>
</tr>
<tr>
<td>5. Assess risk for autonomic dysreflexia of those spinal injury patients T6 and above</td>
<td>Autonomic dysreflexia is a sudden and exaggerated autonomic response to unpleasant stimuli e.g. full rectum or DRE may trigger this response</td>
</tr>
<tr>
<td>record BP if patient has SCI at T6 or above</td>
<td>To obtain baseline BP</td>
</tr>
<tr>
<td>ACTION</td>
<td>RATIONALE</td>
</tr>
<tr>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>Has recently had an autonomic response</td>
<td>If yes, signifies risk of autonomic dysreflexia, this risk must be balanced against secondary risk of constipation leading to dysreflexia by not emptying the bowel</td>
</tr>
<tr>
<td>Does the patient have symptoms of constipation</td>
<td></td>
</tr>
<tr>
<td>6. Ask the patient if they wish to use the toilet prior to undertaking the procedure</td>
<td>Dignity and comfort of the patient during this procedure</td>
</tr>
<tr>
<td>7. Position the patient , left lateral side with knees flexed, ensuring privacy at all times</td>
<td>To expose anus and aloe easy insertion of finger, To prevent over stretching of the anal sphincter and discomfort to the patient</td>
</tr>
<tr>
<td>8. Place protective sheet under the patient</td>
<td>To protect bedding from faecal matter</td>
</tr>
<tr>
<td>9. Observe the perineal and perianal area. Document and report any abnormalities</td>
<td>If abnormalities present DRE and manual removal of faeces should not be undertaken and advice sought</td>
</tr>
<tr>
<td>10. Wash hands put on disposable apron and non-latex gloves</td>
<td>To minimise cross infection</td>
</tr>
<tr>
<td>11. Lubricate gloved index finger</td>
<td>To facilitate easier insertion of the index finger and prevent trauma to the anal and rectal mucosa by reducing surface friction, To alleviate discomfort for the patient</td>
</tr>
<tr>
<td>12. Inform patient of start of procedure and insert the finger slowly into the anus then rectum. Encouraging the patient to relax</td>
<td>To ensure dignity, relaxation and awareness of the examination is about to begin and to minimise discomfort</td>
</tr>
<tr>
<td>13. In scabala type stool (Bristol stool type 1) remove one lump at a time until no more faecal matter can be felt</td>
<td>To relieve patient discomfort</td>
</tr>
<tr>
<td>In a solid faecal mass, push finger into the middle of the mass, split it and remove small pieces with a hooked finger until no more faecal matter can be felt</td>
<td>To relieve patient comfort</td>
</tr>
<tr>
<td>If the faecal mass is too hard or larger than 4cm across and unable to break it up STOP the procedure and refer to medical team</td>
<td>To avoid pain and trauma to anal sphincter</td>
</tr>
<tr>
<td>Proceed with caution for spinal cord injury patients: those with a reflex bowel may require further rectal stimulant</td>
<td>Most spinal cord injury patients will not experience pain</td>
</tr>
<tr>
<td>14. As faecal matter is removed it should be placed in a appropriate receiver</td>
<td>To facilitate appropriate disposable of faecal matter</td>
</tr>
<tr>
<td>15. Continue to observe the patient throughout the procedure STOP: if there is rectal bleeding,</td>
<td>To note signs of distress, pain general discomfort</td>
</tr>
</tbody>
</table>

Version2 Bladder and Bowel Policy 30.11.2017
<table>
<thead>
<tr>
<th>ACTION</th>
<th>RATIONALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>persistent pain, or the patient requests to do so</td>
<td></td>
</tr>
<tr>
<td>16. Check patients pulse&lt;br&gt;STOP: if heart rate drops or rhythm changes</td>
<td>Vagal stimulation can slow heart rate and alter heart rhythm</td>
</tr>
<tr>
<td>17. STOP if signs of autonomic dysreflexia</td>
<td>To prevent onset of dysreflexia remove stimuli-stop procedure</td>
</tr>
<tr>
<td>18. Slowly withdraw the finger from the rectum when assessment/examination is complete</td>
<td>To minimise patient discomfort</td>
</tr>
<tr>
<td>19. Remove any residual lubricating gel from the anal area.</td>
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<td>20. Remove gloves, dispose of equipment and wash hands</td>
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</tr>
<tr>
<td>21. Make the patient comfortable. Offer toilet/commode/bed pan as appropriate. Gently wash and dry area if required</td>
<td>Examination can stimulate ano-rectal reflex and urge to defecate. To prevent skin excoriation and promote patient comfort</td>
</tr>
<tr>
<td>22. Record outcome of examination by documenting:&lt;br&gt;Consent&lt;br&gt;Stool type/findings on examination&lt;br&gt;Nursing intervention and outcome&lt;br&gt;Referral to G. P. (where indicated)</td>
<td>Documentation should provide clear guidance to evidence based care planned, decisions made and treatment given. To comply with NMC (2008) and trust guidance on record keeping. To improve communication between health professionals</td>
</tr>
</tbody>
</table>

**C.6 Neurogenic Bowel Management**

Neurogenic bowel dysfunction is impaired sensory and motor control of the ano rectum leaving the individual with reduced or absent voluntarily control of the process of defecation.

Stool transit through the bowel may be slowed placing the individual at high risk of constipation and or faecal incontinence.

The function of the large bowel must be actively managed to allow the individual some degree of continence and to minimise associated quality of life and health problems.

**Motor Function**

<table>
<thead>
<tr>
<th>Reflex bowel function</th>
<th>Areflexic (Flaccid)bowel function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive anal reflex (anal reflex) visible contraction of anus in response to pinprick of surrounding skin</td>
<td>No anal reflex</td>
</tr>
<tr>
<td>Positive bulbo-anal reflex- contraction of anus in response to pressure on the glans penis/clitoris</td>
<td>Absent bulbo- anal reflex</td>
</tr>
</tbody>
</table>
### Injury/damage to spinal cord/brain at or above twelfth thoracic vertabra, reflex or spastic paralysis

<table>
<thead>
<tr>
<th>Reflex bowel function</th>
<th>Areflexic (flaccid bowel) function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily or alternate days</td>
<td>Once or more a day</td>
</tr>
<tr>
<td>(Aim for a Bristol stool scale 4) Stimulant laxative 8-12 hours before planned care if necessary</td>
<td>(Aim for Bristol stool scale 4) Stimulant laxative 8-12 hours before planned care</td>
</tr>
<tr>
<td>Gastro colic reflex</td>
<td>Gastro colic reflex</td>
</tr>
<tr>
<td>DRE check for presence of faeces remove plug of faeces if possible</td>
<td>Abdominal massage</td>
</tr>
<tr>
<td>Rectal stimulant suppository/micro enema</td>
<td>Digital removal of faeces</td>
</tr>
<tr>
<td>Abdominal massage</td>
<td>Single digital check to ensure rectum is empty 5-10 minutes after last stool is passed</td>
</tr>
<tr>
<td>Digital rectal stimulation</td>
<td></td>
</tr>
<tr>
<td>Digital removal of faeces if reflex evacuation incomplete</td>
<td></td>
</tr>
<tr>
<td>Single digital check to ensure rectum is empty 5-10 minutes after last stool is passed</td>
<td></td>
</tr>
</tbody>
</table>

### C.7 Autonomic Dysreflexia

Autonomic dysreflexia can occur in spinal injury patients (injury T5 and above). It is triggered by stimulation of sensory nerves in the body below the level of the injury causing over-activity of the autonomic nervous system, resulting in a rapid increase in blood pressure.

#### Possible causes

- Over filling / stretching of the bladder
- Indwelling catheter – blocked, infection,
- Kinked tubing
- Bladder irrigation
- Digital rectal examination

#### Symptoms

- Pounding headache
- Slow pulse
- Sweating above the injury
- Goose bumps
• Blotching of skin
• Nasal congestion

**Treatment**
Where there is a history of autonomic dysreflexia if the catheter appears to be blocked, change it immediately to prevent an attack. If autonomic dysreflexia response has been triggered by DRE procedure, stop the procedure immediately. If this is their first episode, it must be treated as an emergency and medical attention gained immediately. Patients who have had episodes previously will have been informed of the warning sign and treatments and should have nifedipine (sub lingual administration) for future attacks.

If an episode occurs:
• Raise the patient’s head
• Feel for a distended bladder
• Change the catheter immediately
• Stop DRE manual removal of faeces procedure
• Check blood pressure Under normal circumstances a tetraplegic person may have a low blood pressure (e.g. 90/60.mmHg). A rise to “normal” level of 120/80mm.Hg may represent a significant elevation.
• Regular monitoring of blood pressure is essential as changes can occur very quickly
• Monitor blood pressure every five minutes until blood pressure control is achieved
• If B.P. continues to increase, the patient is prescribed nifedipine 5-10mg
• If medication is not effective or not available then contact 999 as it is an EMERGECYSITUATION.

Once a patient has had an episode of autonomic dysreflexia, it may be a recurrent problem for life.

**C.8 Rectal Irrigation**

Rectal irrigation should not be a first choice treatment option for patients and is usually instigated by secondary care or specialist nurses within the Bladder and Bowel Service

Digital Rectal Examination should also be performed prior to the first irrigation and documented to check there is no obstruction, that the anus is not stenosed and that there are not any painful ano-rectal conditions (such as anal fissure).

**Contraindications**
It is important to be aware that Rectal Irrigation is not suitable for all patients and there are certain conditions that may contraindicate or prohibit its use.

**Absolute contraindications (irrigation should not be used)**
• Acute active inflammatory bowel disease
• Known obstructing rectal or colonic mass
• Rectal or colonic surgical anastomosis within the last 6 months
• Severe cognitive impairment (unless carer available to supervise/administer)

Additional care and close monitoring
Some types of patients may require additional supervision or monitoring; at least until it is clear that irrigation is not producing any problems. This will depend on the judgement of the assessing professional, but may include; Spinal cord injury at or above T6. Monitor for autonomic dysreflexia until it is clear that the technique is well tolerated and does not provoke autonomic dysreflexia.

• Unstable metabolic conditions (frail, renal or liver disease, electrolytes will need to be monitored and the possible use of saline instead of water for irrigation.
• Inability to perform the procedure independently or comply with then protocol in the absence of close involvement of carers (E.g due to physical disability, cognitive impairment, major impairment major mental/emotional disorder

Relative contra-indications (Use only after careful discussion with a relevant medical practitioner)
• Pregnant or planning pregnancy (women)
• Active perianal sepsis
• Diarrhoea
• Anal Fissure
• Large Haemorrhoids that bleed easily
• Faecal impaction (clear if possible before starting irrigation)
• Past pelvic radiotherapy which has caused bowel symptoms
• Known severe diverticular disease
• Use of rectal medications for other diseases
• Congestive cardiac failure
• Anal surgery within the last 6 months.

Using Rectal Irrigation
The patient should be taught to perform his/her own irrigation independently; however, carers can be taught how to do this procedure for patients. The procedure should be fully explained to the patient before it is carried out for the first time.

An educational information which would inform the use of rectal irrigation for patients and staff is available to view prior tocommencing the procedure (from the Bladder and Bowel service).

If the patient is taking laxatives before the procedure, it is usual to continue these until the irrigation routine is established. Once established the Health Professional can review the success of rectal irrigation continuation of oral laxatives may be required long term but should be reviewed at least 6 monthly.

All spinal cord injured patients with an injury at or above T6 MUST be commenced in secondary care.
C.9 Record Keeping

- Date, time
- Valid consent
- Reason for performing DRE/DRS/MRF
- Discussions held with the patients about risks and benefits
- What did you observe (DRE)
- What did you feel (DRE/DRS)
- Presence of faecal matter (DRE)
- Anal tone (DRE)
- Administration of any medications
- Result from any intervention/medications
- Inform doctor of findings

For Rectal irrigation also record

- Type of irrigation, the make
- Expiry date, batch number of the rectal catheter used,
- The result of the irrigation
- Any complications.
- Plans for follow-up and monitoring (suggested to be 6 monthly clinical contact if patient performing procedure themselves)
# Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. <strong>Entirely Liquid</strong></td>
</tr>
</tbody>
</table>
Appendix One

Bladder and Bowel Service

DRE Audit

*Please ensure you this form is printed, do not photocopy*

---

1. **Bowel assessment documented**

<table>
<thead>
<tr>
<th></th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stool type using Bristol Stool Chart</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>Associated pain or strain</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>Presence of blood or mucus</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>Any bowel medications or current bowel regimes</td>
<td>Yes □</td>
<td>No □</td>
</tr>
</tbody>
</table>

2. **Chaperone offered?**

<table>
<thead>
<tr>
<th></th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
</table>

3. **Documentation relating to DRE**

<table>
<thead>
<tr>
<th></th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>If Yes Verbal □ Written □ Implied □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes of examination</td>
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<td>No □</td>
</tr>
<tr>
<td>Observation of perineal area</td>
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<td>No □</td>
</tr>
<tr>
<td>Stool type</td>
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</tr>
<tr>
<td>Nursing intervention</td>
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<td>No □</td>
</tr>
<tr>
<td>Outcome</td>
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<td>No □</td>
</tr>
<tr>
<td>Complications documented</td>
<td>Yes □</td>
<td>No □</td>
</tr>
<tr>
<td>Specific care plan for bowel management</td>
<td>Yes □</td>
<td>No □</td>
</tr>
</tbody>
</table>

---

This form was designed by the Continence Promotion Service in conjunction with Trust Governance Team for Liverpool Community Health NHS

---

Version2 Bladder and Bowel Policy 30.11.2017
Appendix Two - This chart is to be utilised for patients who are on a regular prescribed bowel routine.

<table>
<thead>
<tr>
<th>Date</th>
<th>Changes to regime</th>
<th>Signature</th>
<th>Date</th>
<th>Changes to regime</th>
<th>Signature</th>
<th>Established regime: Bowel function reflex/flaccid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Aperient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rectal stimulant</td>
</tr>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Assistance required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apperient</th>
<th>Rectal Stimulant</th>
<th>Bowel result</th>
<th>Unplanned results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Time</td>
<td>Apperient/Bulking Agent</td>
<td>Time</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
<td>------------------------</td>
<td>------</td>
</tr>
</tbody>
</table>


Childrens Bladder and Bowel Service

This section of the manual details the following:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Access to the Service</td>
</tr>
<tr>
<td>D2</td>
<td>Referral Criteria</td>
</tr>
<tr>
<td>D3</td>
<td>Constipation</td>
</tr>
<tr>
<td>D4</td>
<td>Delayed Toilet Training</td>
</tr>
<tr>
<td>D5</td>
<td>Nocturnal Enuresis</td>
</tr>
<tr>
<td>D6</td>
<td>Catheterisation</td>
</tr>
</tbody>
</table>

**D.1 Access to the Service**

The childrens Bladder and Bowel Service will provide open access support, advice and information to all children (0 to 19 years) and their families and carers in accordance to Nice Guildlines [https://www.nice.org.uk/Guidance/CG111](https://www.nice.org.uk/Guidance/CG111).

The patient will be offered an assessment in order to eliminate any underlying pathology or cause of the incontinence. The assessment is holistic and will take into account patients cultural and religious beliefs (ACA 2003). Children are assessed in the most appropriate setting; this may be in one of the nurse-led continence promotion clinics throughout the city or in school or preschool. Home visits are offered if children or parents have difficulty with mobility or children have difficulty with new environments.

Internally the childrens Bladder and Bowel Service within Liverpool has a transition letter for internal referral to the Bladder and Bowel Service. The Children’s Service within Liverpool operate with a transfer form to adult continence services.

Following the individual assessment, the type of incontinence that they are presenting with will be identified and they will then follow a treatment pathway, receiving the correct advice to treat, improve or cure their continence problem where possible. The assessment should also consider any functional or cognitive problems that may be impacting upon the patient’s ability to maintain continence. Those patients who are found to have an intractable continence problem will be assessed for the most appropriate method of containment and will then receive ongoing support to ensure their needs are met (see guidelines for supply of products).

**D.2 Referral Criteria**

Following identification of a continence problem, the patient should be referred to the appropriate professional for assessment using the form “Referral to childrens bladder and bowel health Service”

**D.2.1 Special School**

If the patient attends a special school, the form should be sent to the school nurse who will carry out the continence assessment.
D.2.2 Red Flag Referral
The following should be considered.

**Red flags: bowel dysfunction**
- Rectal pain
- Rectal discharge
- Rectal bleeding
- Change of bowel habits with looser stool >6 weeks
- Tenesmus (continued urge, ineffective emptying, and pain)
- Palpable rectal mass
- Motor Sensory Loss

**Red Flags Urinary symptoms – for immediate referral to urology secondary care service**
- 3 or more urinary tract infections
- Dysuria
- Genital pain
- Straining to urinate
- Motor Sensory Loss
- Haematuria
- Palpable bladder
- Palpable renal mass

D.3 Constipation

Constipation is common in childhood. It affects around 5–30% of the child population, depending on the criteria used for diagnosis. Symptoms may become chronic in more than one third of patients, and can be a common reason for referral to secondary care.

A full assessment is completed by all health care professionals to identify idiopathic constipation. Maintenance therapy of oral macrogol is commenced and the child and or parent is given written information. The child is reviewed within 6 weeks by a health care professional.

If there is no response within 3 months the health care professional should refer into the paediatric continence service.

Children who are impacted should be commenced on macrogols, disimpaction regime, written information given and referred to paediatric continence service. Review is to be done within 1 week.

Treatment and care should take into account patients’ individual needs and preferences. Good communication is essential, supported by evidence-based
information, to allow patients to reach informed decisions about their care. Families and carer’s should have the opportunity to be involved in decisions about treatment and care. Where appropriate, for example for older children, this should be with the child's agreement.

**Do not use dietary interventions alone as first line treatment**

**D.3.1 Treat Constipation with Oral Macrogols as First Line Treatment.**

- Negotiated and non-punitive behavioural interventions suited to the child or young person’s stage of development. This could include scheduled toileting and support to establish a regular bowel habit, maintenance and discussion of a bowel diary, information on constipation, and use of encouragement and rewards systems.
- Dietary modifications to ensure a balanced diet and sufficient fluids are consumed.

Advise parents and children or young people (if appropriate) that a balanced diet should include:

- Adequate fluid intake.
- Adequate fibre. Recommend including foods with high fibre content (such as fruit, vegetables, high-fibre bread, baked beans and wholegrain breakfast cereals) (not applicable to exclusively breastfed infants). Do not recommend unprocessed bran, which can cause bloating and flatulence and reduce the absorption of micronutrients.

Give written information about diet and fluid intake to children and young people and their families.

Start a cows' milk exclusion diet only on the advice of the relevant specialist services.

Advise daily physical activity that is tailored to the child or young person’s stage of development and individual ability as part of ongoing maintenance.

**D.3.2 Information and Support**

Provide tailored follow-up to children and young people and their parents or carers according to the child or young person’s response to treatment, measured by frequency, amount and consistency of stools (using the Bristol Stool Form scale).

This could include:

- Telephoning or face-to-face talks
- Giving detailed information about their condition and its management, which is available from the continence service

Offer children and young people with idiopathic constipation and their families a point of contact with specialist healthcare professionals, including Paediatric Continence Advisor and school nurses, who can give ongoing support.
Liaise with school nurses to provide information and support, and to help them raise awareness of the issues surrounding constipation with pupils and school staff.

Refer children and young people with idiopathic constipation that does not respond to initial treatment within 3 months to the Peadiatric Continence Advisor. See appendix 2

**D.4 Delayed Toilet Training**

Children identified by health visitors as having delayed toilet training should be given meaningful advice and information by the health visiting team to support them to achieve success in this.

They should be followed up after 3 months see appendix 9

Children with additional needs should be identified early and their assessment should be carried out with School Nurse, Health Visitor, Nursery Nurse or Paediatric Continence Specialist to plan and review the child’s progress.

Where possible, the preschool placement and staff are also involved with the child’s plan and educated how to develop the child’s toileting skills see appendix 5

**D.5 Nocturnal Enuresis**

Each child should be assessed as an individual, and only the most appropriate management, which can be carried out successfully within the family dynamics for that child should be used.

**Enuresis policy for all age groups should aim to:**
- Exclude pathology / medical problems
- Social/emotional problems
- Reassure and support
- Give helpful advice on coping with and managing bedwetting
- Address associated bowel/bladder problems, e.g. constipation, day-time wetting

Following a school entry any child who is noted to be a “bed wetter” should be given appropriate advice by the school nurse. This will ensure that:
- Appropriate advice is given on the first encounter
- This advice should be uniform and non-conflicting
- Basic background work, such as fluid intake correction and identification of underlying problems can be done early on
- The level of motivation and environmental problems are identified early
- Treatment can be considered from age 5 years

**Enuresis policy for children aged 5 years and over**
The child is to have a documented assessment.
- Exclude pathology/social/emotional factors
• Ask child and parent to record instances of wetting over a period of 1-2 weeks before introducing any programme.
• An input / output chart (including bowels) should be completed, ideally over the same 1-2 week period, but in any case, for a minimum of 3 days (appendix 2)
• First, address any underlying problems such as constipation or daytime wetting

D.5.1 Initial Treatment
Please see Appendices for further detail.

D.5.1.1 Alarm
Offer an alarm as the first-line treatment to children and young people whose bedwetting has not responded to advice on fluids, toileting or an appropriate reward system, unless:
• An alarm is considered undesirable to the child or young person or their parents and carers or
• An alarm is considered inappropriate, particularly if:
  o bedwetting is very infrequent (that is, less than 1–2 wet beds per week)
  o the parents or carers are having emotional difficulty coping with the burden of bedwetting
  o the parents or carers are expressing anger, negativity or blame towards the child or young person

Offer desmopressin to children and young people over 5 years, if:
• rapid-onset and/or short-term improvement in bedwetting is the priority of treatment or
• an alarm is inappropriate or undesirable (see recommendation 1.8.1).

D.5.1.1.1 The issue and use of enuresis alarms
When offering an alarm, consider alarm treatment tailored to the needs and/or abilities of children and young people with:
• hearing impairments (for example, consider a vibrating alarm)
• learning difficulties and/or physical disabilities.

Do not exclude alarm treatment as an option for children and young people with:
• daytime symptoms as well as bedwetting
• secondary onset bedwetting.

D.5.1.1.2 Issuing of Alarms
The following must be followed when issuing an alarm:
• When a brand new alarm is being commissioned it must have a log number tag on it. If there is not one on the alarm then it should be assigned with a log number and all relevant documentation completed (See appendix 3 and registered with the School Health Enuresis service.
• When an alarm is reissued to a new patient it is to have a new sensor and batteries checked.
• The alarm must be checked that it is in full working order before it is issued.
• The child and carer must be given a practical demonstration of the alarm, and written instructions also given.
• The alarm must be logged with its identification code and date of issue.
• The carer must sign a enuresis alarm form saying that they agree to the terms (appendix 3)

D.5.1.1.3 Follow up
The first follow up must be within 2 weeks of the alarm being issued.

Throughout the time the child has an enuretic alarm they must be reviewed 4 weekly or more frequently if required as per care pathway.

When using the alarm improvement can occur after the first three weeks, but are usually effective between the sixth and tenth week. If after 12 weeks there has been no improvement consider discontinuation.

Use can be discontinued after 14 consecutively dry nights. Alarm may be employed again should the child relapse.

If a child fails to attend two follow-up appointments the parents must be contacted and advised that if they do not attend the follow up appointment the alarm will have to be returned to the service - this is a compliance issue.

D.5.1.1.4 Exclusions and Contra-indications
Alarms should not be issued to a child where there is intolerance to the bed wetting in the home when the use of the alarm would increase this intolerance.

Caution must be taken where there is multi-occupancy in the home, as an alarm can cause disruption and wake everyone in the household and this must be discussed with the child and family.

Alarms should not be issued if there is poor family dynamics or lots of family stress.

Where there is poor compliance to treatments alarms should not be issued, as there is likely to be poor compliance with the alarm and it is unlikely to be of any benefit.

D.5.1.1.5 Return of equipment to continence service
When an alarm is returned, the following must be followed,

• A return slip is to be completed indicating length of treatment time
• Check alarm is in full working order
• Replace batteries
• Body worn and bed sensors are only used by one child as per manufacturer’s instructions. On return sensors are disposed of in clinical waste.
• Log alarms returned
• Clean and store following Medical Devices Policy

D.5.2 Reward systems
Explain that reward systems with positive rewards for agreed behaviour rather than dry nights should be used either alone or in conjunction with other treatments for bedwetting.
For example, rewards may be given for:
- drinking recommended levels of fluid during the day
- using the toilet to pass urine before sleep
- engaging in management (for example, taking medication or helping to change sheets)

**D.5.2.1 Using alarms with reward systems**
Inform children and young people and parents or carers about the benefits of combining alarm treatment with a reward system using rewards for desired behaviour (for example, waking up when the alarm goes off, going to the toilet, returning to bed and resetting the alarm).

Encourage children and young people and their parents or carers to discuss and agree their roles and responsibilities for using alarms and rewards.

**D.5.3 Lack of response to initial treatment options**
Refer children and young people with bedwetting that has not responded to courses of treatment with an alarm and/or desmopressin to secondary care for further review and assessment of factors that may be associated with a poor response, such as an overactive bladder, an underlying disease or social and emotional factors.

**D.5.4 Information, advice and support**
Ensure that advice and support for using an alarm are available, and agree with the child or young person and their parents or carers how this should be obtained. They may need a considerable amount of help when learning how to use the alarm.

Inform the child or young person and parents or carers:
- of the aims of alarm treatment
- that alarms have a high long-term success rate
- that using an alarm needs sustained commitment, involvement and effort
- that using an alarm can disrupt sleep, and that parents or carers may need to help the child or young person to wake to the alarm
- that they are not suitable for all families
- that they will need to record their progress
- about what to do when the alarm goes off, how to set, use and maintain the alarm, and how to manage problems
- that it may take a few weeks before the alarm starts to have an effect, and it may take weeks before dry nights are achieved
- that they can restart using the alarm immediately, without consulting a healthcare professional, if bedwetting starts again after stopping treatment
- how to return the alarm when they no longer need it.

**D.6 Catheterisation**

Please refer to Appendices and the Catheter Care Policy for further information.

**D.6.1 Provision of Products**
Please see Appendix 4 for further detail.
The Childrens Bladder and Bowel Service would expect that children and young people referred to the service will have undertaken a basic toileting programme which has then identified a continence problem. They also anticipate that an ethos of promoting healthy bladders and bowels is part of our culture. Not all children will achieve continence but every child is to be given the opportunity.

All children should have a documented assessment and trial of toilet training (if appropriate) prior to the issue of any product. It could be considered as active discrimination in relation to the child’s disability if we do not offer these children the same continence promotion service as any other child presenting with a wetting/soiling problem.

Children who have achieved day-time control, regardless of any ‘special need’ would not normally be considered for provision for night time products only, without prior consultation with the Paediatric Continence Advisor.

Products will not be supplied as ‘containment’ for a treatable condition e.g. soiling in relation to constipation.

**D.6.2 Procedure for provision of continence products**

Continence must be promoted at all times.

A copy of the completed toilet skills chart and care pathway must accompany all requests for products for new patients. Failure to do so will result in delays in product requests being authorised by the Childrens Bladder and Bowel Team.

No child to be issued with continence products without having a prior written continence assessment which includes diet/fluid intake/output/bowel actions/dip stick urine test and physical examination if indicated and trial of potty/toilet training if appropriate.

The number of disposable products supplied per 24 hours will depend on the individual child’s needs but would normally not exceed 4 products per day without exceptional circumstances and prior consultation with the Paediatric Continence Advisor.

Children under the age of 4 are not eligible for products. Any request for products should be detailed on the childrens bladder and bowel health referral form. The family will be given information regarding the home delivery service including when to expect their first order and contact details.

**D.6.3 Supply of re-usable products**

Following assessment some children may be considered more suitable for the supply of washable products such as absorbent pants for day time and bed pads for the night time.
The number of washable pants issued will depend on the individual child’s needs but would not normally exceed 12 pairs per year.

The number of washable absorbent bed pads issued would not normally exceed 2 every 12 months.

Prior to issuing the full supply of washable products the child should be issued with a trial product to ensure its suitability.

Once considered suitable the child can then be provided with their full supply.

D.6.4 Review of products
Following issue of products the child should be reviewed by the professional who initiated the product request after 2 weeks and thereafter at no more than 12 monthly intervals.

Regardless of any change in need a reassessment checklist ( appendix 3 ) should be completed and sent to the Paediatric Continence Service at least 12 monthly as a record that the child’s needs have been reassessed.

Families are to be informed that they can request a reassessment for a change in need at any time and provided with appropriate contact numbers.

D.6.5 Procedure for ring-back pad delivery service
The purpose for using ring-back for pad deliveries is:
- To ensure that each delivery received by the clients meets their changing requirements
- To prevent over-stocking of products

New clients will have one initial delivery and will be sent a ring-back letter advising them how long their delivery should last for and how to arrange future deliveries.

During office hours a clerical officer will operate the ring-back phone line. Outside office hours or in the absence of the clerical officer an answer machine system will operate and the clerical officer will call the client back as soon as possible.

When clients request their usual prescription and they are not ringing too early a delivery will be inputted on the computer and they will be told the date of that delivery. If the client states that their needs have changed or they are ringing too early, a nursing review from a healthcare assistant will be arranged. A home visit may be necessary to fully discuss changing requirements.

It is the client’s/carer’s responsibility to ensure they do not run out of products.

If the client is then found to be an unsuitable candidate for the ring-back system they will be placed on regular deliveries.

If the client remains on ring-back but subsequently fails to use ring-back correctly
and runs out of products, it is their own responsibility to purchase containment products.

Any complaints that cannot be resolved by the continence team will be referred to the line manager.
Appendix One

Constipation: History taking and physical examination

Establish constipation
Two or more symptoms from table 1 (pg 29)
Complete bowel record (appendix 4)

Establish idiopathic constipation and exclude underlying causes
Take a history to exclude or identify any red flags from table 2
Do a physical examination to exclude or identify any red flags from table 3

Red flag found
Go to ‘Investigate possible underlying causes’ (pg 26)

No red or amber Flags found
Inform about diagnosis of idiopathic constipation
Inform the child or young person and his or her parents or carers that underlying causes have been excluded by the history and/or physical exam.
Reassure them that there is a suitable treatment but it may take several months for the condition to be resolved

Amber flag found
Go to investigate possible underlying cause (pg 26)

No significant findings from red flags
Assess for faecal impaction
Assess all children and young people with idiopathic constipation for faecal impaction, including those originally referred for red flags but in whom there were no significant findings (see tables 2 and 3).
Use a combination of history-taking and physical examination to diagnose faecal impaction – look for overflow soiling and/or faecal mass palpable abdominally and/or rectally if indicated

Go to ‘Clinical management’ (Appendix 2)
Investigate possible underlying causes

**Red flags found**
Do not treat for constipation. Refer urgently for tests to a healthcare professional experienced in the specific aspect of child health that is causing concern

**Faltering growth (amber flag)**
If the history-taking or physical examination shows evidence of faltering growth, treat for constipation and refer for test for coeliac disease and hypothyroidism if indicated

**Possible maltreatment (amber flag)**
If the history-taking or physical examination shows evidence of possible child maltreatment, treat for constipation and refer to *When to suspect child maltreatment*, NICE clinical guideline 89 and Refer to Safeguarding Children

**Digital rectal examination**
Do not perform digital rectal examination in children or young people older than 1 year with a 'red flag' Refer to GP urgently.
Refer to GP urgently, or a healthcare professional competent to perform a digital rectal examination:
To interpret features of anatomical abnormalities
Hirschsprung’s disease,
Children younger than 1 year with idiopathic constipation that does not respond to optimum treatment within 4 weeks
Appendix Two

Constipation: Clinical Management

Does the child or young person have faecal impaction? (See history taking and physical examination pg 25)

Yes

Disimpaction

Offer the following oral medication regimen:–
Polyethylene glycol 3350 + electrolytes1 using an escalating dose regimen (see table 4) as the first-line treatment. Polyethylene glycol 3350 + electrolytes can be mixed with a cold drink

Add a stimulant laxative (see table 4) if polyethylene glycol 3350 + electrolytes does not lead to disimpaction after 2 weeks

- Substitute a stimulant laxative singly or in combination with an osmotic laxative such as lactulose (see table 4) if polyethylene glycol 3350 + electrolytes is not tolerated
- Inform families that disimpaction treatment can initially increase symptoms of soiling and abdominal pain.

Refer to Paediatric Continence advisor if treatment fails.

Maintenance therapy

Start maintenance therapy as soon as the child or young person's bowel is disimpacted

Reassess the child or young person frequently during maintenance treatment to ensure they do not become reimpacted and assess issues in maintaining treatment such as taking medicine and toileting.

Offer the following regimen for ongoing treatment or maintenance therapy:

- Polyethylene glycol 3350 + electrolytes as the first-line treatment1
- Adjust the dose of polyethylene glycol 3350 + electrolytes according to symptoms, response and using the Bristol chart.
- As a guide for children and young people who have had disimpaction the starting maintenance dose might be half the disimpaction dose
- Add a stimulant laxative (see table 4) if polyethylene glycol 3350 + electrolytes does not work
- Substitute a stimulant laxative if polyethylene glycol 3350 + electrolytes is not tolerated by the child or young person. Add another laxative such as lactulose or docusate if stools are hard.

Continue medication at maintenance dose for several weeks after regular bowel habit is established. Children who are toilet training should remain on laxatives until toilet training is well established. Do not stop medication abruptly: gradually reduce the dose over a period of months in response to...
stool consistency and frequency. Some children and young people may require laxative therapy for several years. A minority may require ongoing laxative therapy.
### Table 1 Key components of history taking to diagnose constipation

<table>
<thead>
<tr>
<th>Key components</th>
<th>Potential findings in a child younger than 1 year</th>
<th>Potential findings in a child/young person older than 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stool patterns</strong></td>
<td>Fewer than 3 complete stools a week type 3 or 4 (this does not to apply exclusively to breast feed babies of 6 weeks of age). Hard large Stool Bristol stool type 1</td>
<td>Fewer than three complete stools per week (Bristol Stool type 3 or 4, Overflow soiling (commonly very loose [no form], very smelly [smells more unpleasant than normal stools], Stool passed without sensation. Bristol Stool Form 1 Large, infrequent stools that can block the toilet</td>
</tr>
<tr>
<td><strong>Symptoms associated with defecation</strong></td>
<td>Distressed on stooling Bleeding associated with hard stool Straining</td>
<td>Poor appetite that improves with passage of large stool Waxing and waning of abdominal pain with passage of stool Evidence of retentive posturing: typical straight legged, tiptoed, back arching posture Straining Anal pain</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td>Previous episode of constipation Previous or current anal fissure</td>
<td>Previous episode(s) of constipation Previous or current anal fissure Painful bowel movements and bleeding associated with hard stools</td>
</tr>
<tr>
<td>Key components</td>
<td>Findings and diagnostic clues that indicate idiopathic constipation</td>
<td>‘Red flag’ findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Timing of onset of constipation and potential precipitating factors</td>
<td><strong>In a child younger than 1 year:</strong> Starts after a few weeks of life. Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, infections.</td>
<td>Reported from birth or first few weeks of life.</td>
</tr>
<tr>
<td></td>
<td><strong>In a child/young person older than 1 year:</strong> Starts after a few weeks of life. Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, timing of potty/toilet training or acute events such as infections, moving house, starting nursery/school, fears and phobias, major change in family, taking medicines.</td>
<td></td>
</tr>
<tr>
<td>Passage of meconium</td>
<td>Normal (within 48 hours after birth, in term baby)</td>
<td>Failure to pass meconium/delay (more than 48 hours after birth, in term baby)</td>
</tr>
<tr>
<td>Stool patterns</td>
<td></td>
<td>‘Ribbon stools’ (more likely in a child younger than 1 year)</td>
</tr>
<tr>
<td>Growth and general wellbeing</td>
<td><strong>In a child younger than 1 year:</strong> Generally well, weight and height within normal limits.</td>
<td>No ‘red flag’, but see ‘amber flag’. Go to Investigate possible underlying causes</td>
</tr>
<tr>
<td></td>
<td><strong>In a child/young person older than 1 year:</strong> Generally well, weight and height within normal limits, fit and active</td>
<td></td>
</tr>
<tr>
<td>Symptoms in legs/locomotor development</td>
<td>No neurological problems in legs (such as falling over in a child/young person older than 1 year),</td>
<td>Previously unknown or undiagnosed weakness in legs.</td>
</tr>
<tr>
<td>normal locomotor development</td>
<td>locomotor delay</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Abdominal distension with vomiting</td>
<td></td>
</tr>
<tr>
<td>Diet and fluid intake</td>
<td>In a child younger than 1 year: Changes in infant formula, weaning, insufficient fluid intake</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a child/young person older than 1 year: History of poor diet and/or insufficient fluid intake</td>
<td></td>
</tr>
<tr>
<td>Key components</td>
<td>Findings and diagnostic clues that indicate idiopathic constipation</td>
<td>‘Red flag’ findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Inspection of perianal area: appearance, position, patency, etc</td>
<td>Normal appearance of anus and surrounding area</td>
<td>Abnormal appearance/position/patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus, absent anal wink</td>
</tr>
<tr>
<td>Abdominal examination</td>
<td>Soft abdomen. Flat or distension that can be explained because of age or excess weight</td>
<td>Gross abdominal distension</td>
</tr>
<tr>
<td>Spine/lumbosacral region/gluteal examination</td>
<td>Normal appearance of the skin and anatomical structures of lumbosacral/gluteal regions</td>
<td>Abnormal: asymmetry or flattening of the gluteal muscles, evidence of sacral agenesis, discoloured skin, naevi or sinus, hairy patch, lipoma, central pit (dimple that you can’t see the bottom of), scoliosis</td>
</tr>
<tr>
<td>Lower limb neuromuscular examination including tone and strength</td>
<td>Normal gait. Normal tone and strength in lower limbs</td>
<td>Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy</td>
</tr>
<tr>
<td>Laxatives</td>
<td>Recommended doses</td>
<td></td>
</tr>
<tr>
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<tr>
<td><strong>Macrogols</strong></td>
<td><strong>Paediatric formula:</strong> Oral powder: macrogol 3350 (polyethylene glycol 3350) 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet (unflavoured).</td>
<td></td>
</tr>
</tbody>
</table>
| Polyethylene glycol 3350 electrolytes | **Disimpaction** Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose)  
Child 1–5 years: 2 sachets on 1st day, then 4 sachets daily for 2 days, then 6 sachets daily for 2 days, then 8 sachets daily (non-BNFC recommended dose)  
Child 5–12 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 12 sachets daily (non-BNFC recommended schedule)  
**Ongoing maintenance** (chronic constipation, prevention of faecal impaction)  
Child under 1 year: ½–1 sachet daily (non-BNFC recommended dose)  
Child 1–6 years: 1 sachet daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) (for children under 2, non-BNFC recommended dose)  
Child 6–12 years: 2 sachets daily; adjust dose to produce regular soft stools (maximum 4 sachets daily) |
|                                  | **Adult formula:** Oral powder: macrogol 3350 (polyethylene glycol 3350) 13.125 g; sodium bicarbonate 178.5 mg; sodium chloride 350.7 mg; potassium chloride 46.6 mg/sachet (unflavoured). |
|                                  | **Disimpaction** Child/young person 12–18 years: 4 sachets on 1st day, then increased in steps of 2 sachets daily to maximum of 8 sachets daily (non-BNFC recommended dose)  
**Ongoing maintenance** (chronic constipation, prevention of faecal impaction)  
Child/young person 12–18 years: 1–3 sachets daily in divided doses adjusted according to response; maintenance, 1–2 sachets daily |
| Osmotic laxatives Lactulose       | Child 1 month to 1 year: 2.5 ml twice daily, adjusted according to response  
Child 1–5 years: 2.5–10 ml twice daily, adjusted according to response (non-BNFC recommended dose)  
Child/young person 5–18 years: 5–20 ml twice daily, adjusted according to response (non-BNFC recommended dose) |
**Table 4 Laxatives: recommended doses continued**

<table>
<thead>
<tr>
<th>Laxatives</th>
<th>Recommended doses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stimulant laxatives</strong></td>
<td></td>
</tr>
<tr>
<td>Sodium picosulfate (c)</td>
<td>Non-BNFC recommended doses Elixir (5 mg/5 ml)</td>
</tr>
<tr>
<td></td>
<td>Child 1 month to 4 years: 2.5–10 mg once a day</td>
</tr>
<tr>
<td></td>
<td>Child/young person 4–18 years: 2.5–20 mg once a day</td>
</tr>
<tr>
<td></td>
<td>Non-BNFC recommended dose Perles (d) (1 tablet = 2.5mg)</td>
</tr>
<tr>
<td></td>
<td>Child/young person 4–18 years: 2.5–20 mg once a day</td>
</tr>
<tr>
<td>Bisacodyl</td>
<td>Non-BNFC recommended doses</td>
</tr>
<tr>
<td></td>
<td>By mouth Child/young person 4–18 years: 5–20 mg once daily</td>
</tr>
<tr>
<td></td>
<td>By rectum (suppository) Child/young person 2–18 years: 5–10 mg once daily</td>
</tr>
<tr>
<td>Senna (E)</td>
<td>Senna syrup (7.5 mg/5 ml)</td>
</tr>
<tr>
<td></td>
<td>Child 1 month to 4 years: 2.5–10 ml once daily</td>
</tr>
<tr>
<td></td>
<td>Child/young person 4–18 years: 2.5–20 ml once daily</td>
</tr>
<tr>
<td></td>
<td>Senna (non-proprietary) (1 tablet = 7.5 mg)</td>
</tr>
<tr>
<td></td>
<td>Child 2–4 years: ½–2 tablets once daily</td>
</tr>
<tr>
<td></td>
<td>Child 4–6 years: ½–4 tablets once daily</td>
</tr>
<tr>
<td></td>
<td>Child/young person 6–18 years: 1–4 tablets once daily</td>
</tr>
<tr>
<td>Docusate sodium (F)</td>
<td>Child 6 months–2 years: 12.5 mg times daily (use paediatric oral solution)</td>
</tr>
<tr>
<td></td>
<td>Child 2–12 years: 12.5–25 mg times daily (use paediatric oral solution)</td>
</tr>
<tr>
<td></td>
<td>Child/young person 12–18 years: up to 500 mg daily in divided doses</td>
</tr>
</tbody>
</table>

a. All drugs listed above are given by mouth unless stated otherwise. Unless stated otherwise, doses are those recommended by the British National Formulary for Children (BNFC) 2017. Informed consent should be obtained whenever medications/doses are prescribed that are different from those recommended by the BNFC.

b At the time of publication Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that includes electrolytes. It does not have UK marketing authorisation for use in faecal impaction in children under 5 years, or for chronic constipation in children under 2 years. Informed consent should be obtained and documented. Movicol Paediatric Plain is the only macrogol licensed for children under 12 years that is also unflavoured.
Elixir, licensed for use in children (age range not specified by manufacturer). Perles not licensed for use in children under 4 years. Informed consent should be obtained and documented.

d Perles produced by Dulcolax should not be confused with Dulcolax tablets which contain bisacodyl as the active ingredient.

e Syrup not licensed for use in children under 2 years. Informed consent should be obtained and documented.

f Adult oral solution and capsules not licensed for use in children under 12 years. Informed consent should be obtained and documented.
Appendix Four

Supply of Paediatric Continence Products

Child referred to service see appendix 1

Child undergoes baseline assessment

Any underlying problems identified and addressed e.g. constipation

Toilet training trial to commence – review within 4 weeks

Progress

No progress

6-12 assessment
Appendix 2

Child supplied with products as per policy appropriate to need

Continue with toilet training

Provide ongoing advice and support

Adjust any supplies previously provided
Appendix Five
Initial treatments Nocturnal Enuresis

Child or young person with bedwetting
- Advise on fluid intake, diet and toileting behaviour
- Address excessive or insufficient fluid intake and abnormal toileting patterns before starting other treatments (see page 10)
- Advise on using a reward system (see page 11)
- Suggest a trial without nappies or pull-ups for children and young people wearing them at night. Offer advice on alternative bed protection
- Consider whether alarm or drug treatment is appropriate, depending on the age, maturity and abilities of the child or young person, the frequency of bedwetting and the motivation and needs of the family
- Assess the ability of the family to cope with an alarm

Advice

Alarm Treatment

Drug Treatment

Young child who has some dry nights

Bedwetting has not responded to advice on fluids, toileting and an appropriate reward system and
- Alarm treatment is desirable and appropriate

Offer an alarm as first-line treatment
- Consider an alarm for children under 7 years

Offer desmopressin for children and young people over 5 years
- Consider desmopressin for children aged 5 years if treatment is required

Advertise parents or carers to try a reward system alone

Rapid-onset and/or short-term dryness is a priority or
- Alarm treatment is undesirable or
- Alarm treatment is inappropriate (particularly if parents or carers are having emotional difficulty coping or are expressing anger, negativity or blame)

See 'Reward systems' page

See 'Alarm treatment' page

See 'Desmopressin treatment'
Appendix Six

Alarm Treatment

Start alarm treatment
Assess response by 4 weeks – early signs of response?

Yes

Assess progress at 3 months
Is bedwetting improving and the child and parents or carers motivated?

No

Continue with alarm
2 weeks uninterrupted dry nights achieved?

Yes

Stop alarm treatment

No

Continue with alarm

Stop alarm treatment

Reoccura

alarm treatment if the child starts regularly bedwetting again

Offer desmopressin combined with an alarm
See ‘Desmopressin treatment’

Stop treatment with alarm alone
Is alarm treatment still acceptable?

Yes

No

Repeated Reoccura

Offer desmopressin alone
See ‘Desmopressin treatment’
Appendix Seven

Desmopressin Treatment

Signs of a response to desmopressin may include smaller wet patches, fewer wetting episodes per night and fewer wet nights.

Start desmopressin Treatment (Appendix 8)
Is complete dryness achieved after 1–2 weeks?

- Assess response at 4 weeks
  - Signs of response?

- Consider increasing dose
  - (to 400 micrograms for Desmotabs or 240 micrograms for DesmoMelt)

- Consider advising that desmopressin is taken 1–2 hours before bedtime, instead of at bedtime, if the child can comply with fluid restriction

- Continue treatment for 3 months

- Consider continuing Desmopressin treatment (up to 6 months)

- Stop desmopressin treatment

- Restart desmopressin and consider repeated courses of desmopressin for repeated recurrences
  - Withdraw every 3 months for 1 week to assess response
  - Withdraw gradually if using repeated courses

- Consider stopping desmopressin treatment

- Refer for further review and assessment of factors associated with poor response (e.g., overactive bladder, underlying disease or social and emotional factors)
### Appendix Eight

**Desmopressin combined with an Anticholinergic**

Consider desmopressin combined with an anticholinergic for young people with:
- bedwetting that has partially responded to desmopressin alone
- bedwetting that has not responded to desmopressin alone
- bedwetting that has not responded to an alarm combined with desmopressin
- Who have daytime symptoms and bedwetting.

Do not use an anticholinergic:
- alone for children and young people with bedwetting without daytime symptoms.
- combined with imipramine.

**Partial response**
- Consider continuing treatment for bedwetting that has partially responded to desmopressin combined

**Repeated recurrence**
- Consider repeated courses of desmopressin combined with an anticholinergic for bedwetting that recurs repeatedly after successful treatment with desmopressin combined with an anticholinergic.

**Information and advice**
Inform the child and young person and parents or carers:
- that success rates are difficult to predict, but more children and young people are drier with a combination of desmopressin and an anticholinergic than with desmopressin alone
- that the combination can be taken together at bedtime
- that treatment should be continued for 3 months
- that repeated courses can be used.
Appendix Nine

Daytime Wetting

Child < 5 years
if Toilet training programme
failed refer to continence
service

Child >5 years refer to continence
service

Child to have an assessment to include:
- Physical examination including spine and reflexes
- Dip stick urine test
- Investigation of UTI according to NICE and local
guidelines
- Pre-Post ultrasound scan of bladder

Complete care pathway

Underlying pathology is
detected

Yes

Refer to secondary care

No

Treat in community.