South Tees Hospitals NHS
NHS Foundation Trust

Competency document to support urinary catheter insertion for a female adult patient

Competency document to support the care of an adult patient requiring urinary catheter insertion.

The practitioner will be able to fully demonstrate the knowledge and skills required for the safe insertion and management of a urinary catheter.

Each practice area has speciality competencies particular to the care of their patients. Urinary catheterisation is considered a speciality competency as it is not carried out in all areas of the Trust.

Working through this competency document will support you in the provision of evidence of your learning and development to become proficient in the performance of female urinary catheterisation.

This competency package is designed for you to provide evidence of continuing competence and ongoing development required for your professional portfolio, revalidation and staff development review. Once the competencies are completed, evidence can be added periodically to demonstrate how you are keeping your skills and knowledge up to date and maintaining your competence.

Competence

The Nursing and Midwifery Council (NMC, 2018) - The Code requires that you must:

- *keep your knowledge and skills up to date*
- *have the knowledge and skills for safe and effective practice when working without direct supervision*
- *recognise and work within the limits of your competence*
- *keep your knowledge and skills up to date throughout your working life*
- *take part in appropriate learning and practice activities that maintain and develop your competence and improve performance*
- *complete the necessary training before carrying out a new role*
- *maintain the knowledge and skills you need for safe and effective practice*

The Health and Care Professional Council (HCPC, 2024) - Standards of conduct, performance and ethics for allied health professional (AHP) states that duties as a registrant you must:

- *provide (to us and any relevant regulators) any important information about your conduct and competence.*
- *keep your professional knowledge and skills up to date.*
- *act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner*
- *effectively supervise tasks that you have asked other people to carry out.*

Competence is therefore a combination of skills, knowledge and the ability to apply these principles to practice in diverse situations and circumstances, the evidence you produce as you work through this pack and in the future should reflect this. As skill minus knowledge / understanding / appropriate attitude **does not** equate with competent practice.

Assessment of practice
You should seek support from a practitioner already competent in female urinary catheterisation. The competency assessment framework below should be completed, and the chosen assessor should work through all the elements with you until you both deem that you are proficient in female urinary catheterisation.

Reflective Practice
Continuous Professional Development (HCPC, 2024) and Revalidation (NMC, 2019) are essential elements of lifelong learning. It enables you to review your practice, improve standards of care and maintain your registration. It is expected that you prepare reflective accounts of your learning in practice and identify your future learning needs. Different models of reflection maybe used one suggested format is from the NMC:

- *what was the nature of the CPD activity?*
- *what did you learn from the development of competence in female catheterisation?*
- *how did this change or improve your practice as a result?*
- *how is this relevant to the Code? (NMC, 2018)*
- *how is this relevant to the Standards? (HCPC, 2024)*

You and your assessor should discuss these accounts and develop any action plans required to meet the learning needs identified through the reflective process.

How will I be assessed?

This document contains competency elements that must be attained in order that you show overall achievement of proficiency. This competency package represents the minimum standard expected for a healthcare worker in the organisation. Completion of these competencies along with your reflective accounts of learning in practice will provide evidence for demonstrating the achievement of the required knowledge and skill framework domains.

The WASP framework has been used to host the required competencies, identifying the process of achievement of proficiency for every skill through measuring competency for each individual element of the skill. It uses the scoring system below to provide a robust assessment of each element at every stage of learning. All steps may be revisited as necessary until proficiency is achieved and agreed by the assessor. To ensure that staff assess at the same standard, each competency has specific criteria that must be met.

Witnessed – Observe or witness the competency prior to being supervised.

Assimilated – Demonstrate sound knowledge base for the competency, evidenced by knowledge of Trust Policies, the Nursing & Midwifery Strategy and professional and legal issues relating to the competency elements. Assimilation of knowledge can be assessed through observation of practice, questioning and/or discussion and/or simulation of situations relating to the competency elements.

Score is as follows-:

1 = Demonstrates fundamental knowledge and understanding of this element of the competency.
2 = Demonstrates broad knowledge and understanding
3 = Demonstrates an in-depth knowledge and understanding of the issues supporting the element of the competency / skill.

Supervised – Practice under supervision to demonstrate understanding and competence. Score as follows-:

1 = Needs further practice
2 = Shows aptitude
3 = Demonstrates skilled and professional practice

Understanding and competence as part of “Supervised” can be assessed through observation of practice, or through questioning / discussion / simulation of situations relating to the competency if these situations have not arisen within the supervisory period. The “Supervision” element of

the competency may be continuous observation by the assessor until he or she is confident that skilled, professional practice has been achieved by the candidate and can be signed off as “Proficient”.

Proficient - Competent in both knowledge and skill elements of the competency

Both the “Assimilated” and “Supervised” aspects of the competency can be scored more than once as necessary, and the combination of in-depth knowledge and understanding, coupled with skilled professional practice equals proficiency.

On the title page of the WASP framework, it is documented how the competency links to:

1. *Knowledge and Skills Framework*
2. *Nursing and Midwifery Strategy Key Performance Indicators*
3. *NMC Code (2018)*
4. *HCPC Standards (2024)*
5. *South Tees Accredited Quality Care Standards (STAQC)*

These links have been provided to facilitate understanding of how all these elements combine to ensure competence, and consequently the high standard of patient care and patient safety that the organisation expects. It is strongly advised that you use the links to help you fulfil your competencies.

The use of the competency framework is designed to highlight areas to help you monitor your progress and identify areas for further development. You will be encouraged and supported to work on these key areas.

On completion, please complete the final meeting form on page 21, getting this signed by your assessor, and send a copy to:

Education and Practice Development Team. Murray Building
South Tees NHS Foundation Trust
The James Cook University Hospital **OR**
Email: stees.clinicalskills@nhs.net

Links to Nursing & Midwifery Strategy Key Performance Indicators	3,4,11,12,13,16,17,18,19,21.
Links to the NMC Code (2018)	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 19, 20, 23, 25.
Links to HCPC Standards (2024)	1, 2, 3, 5, 6, 7, 8, 9, 10.
South Tees Accredited Quality Care (STAQC)	D1: 10,13,17,18, 22, 23 D2, 1, 2, 7, 21, 22, 25, 37, 39, 41, 47, 48, 57 D3: 5, 26, 29, 38, 51, 52, 53, 58, 65, 91, 92, 93, 99, 101 D4: 3, 27, 28, 29, 41

Competency Standard Statement		The learner will be able to demonstrate knowledge and skills in performing **female urinary catheterisation** in a safe and competent manner.
Rationale		To fulfil the requirements for safe and accountable practice in accordance with Trust Policy for the skill of female urinary catheterisation.
W	WITNESSED	Observe or witness the skill– it is considered good practice that the learner will have had the opportunity to observe the procedure prior to being supervised.
A	ASSIMILATED	Understands the underpinning knowledge associated with each element of the competency: 1 = Demonstrates fundamental knowledge and understanding 2 = Demonstrates broad knowledge and understanding 3 = Demonstrates in depth knowledge and understanding of the issues supporting the element of the competency/skill
S	SUPERVISED	Practice under supervision to demonstrate understanding: score as follows: 1 = Needs further practice 2 = Shows aptitude 3 = Demonstrates skilled professional practice

P	PROFICIENT	Competent in both knowledge and skill elements of the competency (level 3).

Competency element	**Rationale**	**W**	**A** Score	**S** Score	**P**

Demonstrate awareness of accountability issues and patient safety regarding catheterisation.	To ensure that practitioner is working within the scope of practice (NMC Code 2018; HCPC 2024).				
Demonstrate knowledge of the anatomy and physiology of the female urinary tract, psychological issues and incorporating its relevance to the catheterisation procedure.	To minimise patient harm and improve patient experience				
Demonstrate adequate knowledge and understanding of the types of catheterisations as listed below: a) intermittent, b) urethral and c) suprapubic and recognise the appropriate situations for their use.	To deliver the patient care in an efficient and precise manner depending on their need through effective assessment.				
Demonstrate an understanding of the need for patient consent and the mental capacity act.	To ensure that patient receives adequate information to make an informed choice and gives valid consent. (Policy G38; NMC 2018).				
Demonstrate a thorough understanding of the indications and contraindications for catheterisation.	To decrease unnecessary urinary catheterisation and ensure appropriate selection of urinary catheter (Policy HIC 21).				
Demonstrate knowledge of the types and sizes of catheters and drainage bags available and the correct situations for their use.	To aid appropriate assessment for urinary catheterisation (Policy HIC21).				
Demonstrate the knowledge in infection control and aseptic non-touch technique (ANTT) in relation to catheterisation, taking note of: a) Key parts – catheter tip, syringe tip etc, b) Key site – the urethral orifice	To reduce the risk of introducing infection into the bladder (Policies HIC1, HIC14, HIC19, HIC21).				

Competency element	**Rationale**	**W**	**A** Score	**S** Score	**P**
Demonstrate an understanding of the possible risks when performing the procedure.	To minimise risk, harm and trauma to the patient, (Policies HIC1, HIC14, HIC19, HIC21).				
Demonstrate an understanding of the possible risks in relation to gender reassignment surgery.	To minimise risk, harm and trauma to the patient, (Policies HIC1, HIC14, HIC19, HIC21).				
Demonstrate knowledge and understanding of the care of the catheter to patient and carers appropriately (*if indicated*)	To ensure patient/carers are aware of measures of infection prevention, signs and symptoms of CAUTI and to access expert help when difficulties arise. NICE 2012, policy HIC21.				
Pre-procedure					
Wash/gel hands, introduce self: explain procedure to patient.	To ensure the patient fully understands the reason for the procedure and what it involves. To enable the patient, make an informed decision (NMC 2013, policies HIC1, HIC14, HIC 21, G13).				
Obtain verbal consent ***or*** act in the patient's best interest *(as appropriate)* by following Trust Policy on consent, clearly document decisions in the healthcare records and if appropriate complete MCA and DoLS forms. Consider chaperone if required.	To ensure the patient understands the procedure and its potential side effects to make an informed decision (NMC 2018, NMC 2013, policy G13, Mental capacity act 2005).				
Check for any allergies e.g. latex or anaesthetic gel. Any previous catheterisation and problems (*if any*).	To reduce risk of anaphylaxis.				
Clean the procedure trolley with disinfectant wipes from top to bottom. Collect all the necessary equipment, ensure it is in date and place on the bottom shelf of a clean trolley.	To minimise risk of contamination (Policy HIC19).				

Perform the procedure in a clinical treatment room or bed area with appropriate use of screens/curtains.	To ensure the patient's privacy, dignity and improve the patient's experience. (NMC 2018).				

Competency element	**Rationale**	**W**	**A Score**	**S Score**	**P**
Assist patient into the supine position with both legs flexed and place disposable pad/bed protector under patient's buttock. Ensure that the patient is comfortable.	To ensure ease of access to perform the procedure and that the patient's abdominal muscles are relaxed.				
Uncover patient but do not overexpose them, ensure they socially clean or assist with a wash to the genital areas and dry prior to conducting procedure. Assess for signs of abnormality i.e. discharge	To reduce the risk of contamination & infection. (Policies HIC1, HIC 14, HIC 21).				
Wash hands using soap and water and don disposable plastic apron.	To reduce the risk of transfer of transient micro-organisms on health care workers hands and uniform. (Policies HIC1, HIC 14, HIC 21).				
Procedure					
Wash hands using soap and water, open and drop catheterisation pack on the top shelf of trolley and prepare the sterile field as follows: • open the pack using ANNT, • organise contents, • pour cleaning solution into gallipot and • drop Cath gel onto the sterile field. Decontaminate hands and wear first pair of sterile gloves	To maintain asepsis and prevent contamination of sterile equipment. (Policies HIC1, HIC 14, HIC 19, HIC 21.)				
Separate labia and using gauze swab soaked in cleaning solution • clean vulva area from top to bottom, • identify the urethral meatus Repeat the above process as necessary	To ensure adequate decontamination of the area and to minimise the risk of introducing bacteria to the urinary tract. (Loveday et al., 2014).				

Competency element	**Rationale**	**W**	**A** Score	**S** Score	**P**
Gently place an appropriate amount of anaesthetic lubricating gel (according to BNF) around the urethral orifice. Wait for 3-5 minutes to take effect.	To prevent urethral trauma and promote comfort (Ghaffary et al., 2014, Policy HIC 21).				
Discard used gloves, gel hands and prepare for the catheter insertion phase as follows: • open catheter and drop don onto the sterile field • partially open the drainage bag and have it ready • decontaminate hands and • don a second pair of sterile gloves. • have the solution ready for use,	To maintain aseptic technique and prepare for catheterisation (NICE 2012).				
Place a sterile towel between the legs, under the genital area and the other over the abdomen ensuring not to contaminate the sterile gloves.	To prevent contamination of the catheter.				
Place the sterile receiver onto the sterile field in between the patient's legs. Get hold of the catheter, expose the tip and have the remaining catheter resting in the sterile receiver.	To prevent contamination of the catheter and provide a temporary container for urine as it drains				
Separate the labia identify the urethral orifice and slowly insert the catheter using ANTT inserting 2-3cm at a time to the bifurcation (where the catheter balloon valve is located). Observe for urine output	To ensure the catheter is correctly inserted into the bladder				
Inflate the balloon with the required amount using push and pause technique. Observe for signs of pain or inform patient to alert you if they feel any discomfort or pain.	To ensure the catheter is correctly inserted into the bladder and to prevent trauma, pain and infection.				
Gently withdraw the catheter until there is a slight resistance while observing the patient's response. Attach the appropriate drainage bag to the catheter using ANTT	To ensure inflated balloon sits in the neck of the bladder which encourages optimal drainage of urine. (Dougherty, 2015).				

Competency element	Rationale	W	A Score	S Score	P
Secure the correct drainage bag i.e. leg bag, hourly urine bag or free drainage bag, by using designed support. If patient is bed bound, attach the drainage bag and hang below patient's waist on the bedside. **Best practice** – *Use of catheter fixator. Continued tension on catheters due to heavy unsupported drainage bags can cause pressure necrosis (LeBlanc & Christensen, 2005). Effective support is enhanced by securing tubing to the thigh using a catheter fixator (Getliffe & Dolman, 2007).*	To maintain patient comfort and to reduce risk of urethral and bladder neck trauma (Yates, 2018)				
Ensure the patient is left clean, dry and comfortable, thank patient.	To promote patient comfort and improve the patient's experience.				
Post procedure					
Dispose of clinical waste according to Trust Policy	To maintain patient and staff safety policy HS12.				
Remove gloves, wash hands with soap and water and clean trolley	To minimise the risk of spreading infection (NICE 2012 Policies HIC1, HIC14, HIC19, HIC21).				
Position drainage bags below bladder level and above the floor and put the date on back of the bag (leg and urometer).	To ensure that urine output is drained freely and to prevent Intraluminal contamination (Loveday et al 2014), To ensure the collection bag is changed as appropriate				
Monitor patient's bladder capacity and the renal function and record fluid balance on a fluid balance chart.	To ensure patient safety and reduce the risk of unrecognised deterioration.				
Provide education to patient / carers on the techniques used to prevent infection and safely manage the device.	To ensure patient safety and to promote patient and carers confidence in the maintenance of the device to minimise risk of infection. (HIC21)				

Competency element		**Rationale**	**W**	**A** Score	**S** Score	**P**
Documentation The practitioner must acknowledge the importance of documentation and complete the appropriate documentation after the procedure, including the following: • Consent obtained • Urinary sticker record, • Urinary observation chart • Fluid balance chart-measure and record urine output • Catheter care pathway and care plan • Health care records • Catheter batch and expiry date • Use of local anaesthetic • Balloon size and volume of fluid inserted • Any complications • Planned catheter change /removal		To ensure patient safety and continuity of care through written communication and handover. (NICE 2012; NMC 2018; Policy G80)				
Staff Member (Print Name)	**NMC or HCPC Number**	**Staff Member (Signature)**				
Assessor (Print Name)	**NMC or HCPC Number**	**Assessor (Signature)**				
		Competency Achieved				**Yes/No**

Evidence of attainment of competences

Aim: In order to be deemed competent in female catheterisation: the staff member **must continue to perform catheterisation procedure under strict supervision until deemed competent**.

Please note: Both staff member and assessor must adhere to the Trust urinary catheterisation guidelines and Policy HIC21

Date	Evidence of learning	Staff member Signature	Assessor Signature	Remarks

To be completed by Ward manager

I can confirm that _____ (staff member name) is competent to perform female catheterisation independently.

Ward Manager's Signature _____ Staff member's signature _____ Date _____

Record of Learning & Achievement (ROLA) - Evidence Log Sheets

Date	***Competency element-female urinary catheterisation.*** Use these ROLA sheets to keep an ongoing record of your learning and development. Record each attempt at Male urinary catheterisation and reflect upon anything you see as relevant or significant. Where possible use a reflective approach in your entries and refer to current evidence to underpin your work.

Date	***Competency element- female urinary catheterisation*** Use these ROLA sheets to keep an ongoing record of your learning and development. Record each attempt at Male urinary cathete and reflect upon anything you see as relevant or significant. Where possible use a reflective approach in your entries and refer to current evidence to underpin your work.

Reflection on Learning in Practice

You should now reflect on what you have learnt ***or*** any episode of catheterisation by completing this competency and identify any future learning needs.

Describe the learning activity?
How many hours was the session?
What have you learnt?
How will this influence your practice?
What further learning needs has this identified?

Associated policies and references

Hospital Infection Control Policies

HIC 01 Standard Principles of Infection Control policy

HIC14 Hand hygiene policy

HIC 19 Decontamination policy

HIC 21 Preventing Infections Associated with Short-Term Indwelling Urethral Catheters.

General Policies

G 13 Consent to examination and treatment policy

G 38 Policy and Procedure for the Positive Identification of Patients

G 80 Healthcare Records Standards Policy

Health and Safety Policies

HS12 Waste management policy

Clinical Guideline 5, Urinary catheterisation.

References

Bardsley, A. (2013) Use of Lubricant gels in urinary catheterisation (updated). **Nursing standard,** 20 (8): 41-6.

Department of Health (2006). *Essential steps to safe, clean care: reducing Healthcare Associated Infection* (Online) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136212 (Accessed, 01/08/2024)

Ghaffary, C., Yohannes, A., Villanueva, C. and Leslie, S.W. (2013). A Practical Approach to Difficult Urinary Catheterizations. *Current Urology Reports*, [online] 14(6), pp.565–579. doi:https://doi.org/10.1007/s11934-013-0364-3.

Getliffe, K. & Dolman, M. (2007). *Promoting continence, a clinical and research resource*, Bailliere Tindall, London

Health and Care Professional Council (2016) Standards of conduct, performance and ethics (online) https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/ (Accessed 10/12/2024)

LeBlanc, K. & Christensen, D. (2005). Addressing the challenge of providing nursing care for elderly men suffering from urethral erosion. **Journal of Wound, Ostomy & Continence Nursing**, 32(2): 131-4

Lister, S., Hofland, J., Grafton, H. and Wilson, C. eds., (2021). Urinary catheterization: female. *www.rmmonline.co.uk*, [online] (10). Available at: https://www.rmmonline.co.uk/manual/c06-fea-0006?resultNumber=1&start=0&totalResults=275&q=catheterization&resultsPageSize=10&rows=10 (Accessed 01/08/2024).

Loveday, H.P., Wilson, J.A., Pratt, R.J., Golsorkhi, M., Tingle, A., Bak, A., Browne, J.,

Prieto, J. and Wilcox, M. (2014). National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection*, [online] 86(1), pp. S1–S70. doi:https://doi.org/10.1016/S0195-6701(13)60012-2. (Accessed 01/08/2024).

Nursing and Midwifery Council (2013) Determining Capacity to Consent to Treatment (online) https://www.nursingtimes.net/roles/mental-health-nurses/determining-capacity-to-consent-to-treatment-25-10-2013/ (accessed 01/08/2024)

Nursing and Midwifery Council (2018). *The Code*. [online] The Nursing and Midwifery Council. Available at: https://www.nmc.org.uk/standards/code/read-the-code-online/.(accessed 01/08/2024)

Loveday, H.P., Wilson, J.A., Pratt, R.J., Golsorkhi, M., Tingle, A., Bak, A., Browne, J., Prieto, J., Wilcox, M. (2014). Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England, **Journal of Hospital Infection** 86S1 (2014) S1–S70

National Institute for Care and Excellence, (2017) Infection Prevention and Control of Healthcare Associated Infections In Primary and Community Care, CG 139. (online) https://www.nice.org.uk/Guidance/CG139 (accessed 01/08/2024).

Nursing and Midwifery Council (2018). *The Code*. [online] The Nursing and Midwifery Council. Available at: https://www.nmc.org.uk/standards/code/read-the-code-online/.(accessed 01/08/2024).

South Tees Catheter Working Group (2020) Urinary Catheter Pathway

South Tees NHS Foundation Trust (2020) South Tees accreditation for quality of care (STAQC) Standards

Yates, A. (2018). Catheter Securing and Fixation devices: Their Role in Preventing Complications. *British Journal of Nursing*, [online] 27(6), pp.290–294. doi:https://doi.org/10.12968/bjon.2018.27.6.290.

Final Meeting: Female Catheterisation

Staff members name: ……..

Job title: ……..

Ward/Department: ……

Email address where certificate should be forwarded: ……

Assessor Name: ……

Date of workshop attended : ……/……/…… **Course Tutor…….....**

Date of competency completion: ……/……/……

Discussion between ward manager & the staff member completing to identify and agree that the:

- Workshop has been attended
- The competency packs has been completed and the staff member has meet the criteria to carry out female urinary catheterisation
- Adheres to ANTT principle.
- The staff member will carry out this clinical skill frequently enough to remain competent.

Comments from the assessor:

Comments from the staff member after completion:

Signatures: Staff members signature……PIN……

Assessors signature: ……..PIN……

Assessor print name/designation……..

On completion of this form please retain a copy in your portfolio, file a copy in your personnel file and send a copy to:
stees.clinicalskills@nhs.net or
Education and Practice Development Team, Second Floor, Murray Building, JCUH.

Entered in ESR date: By who

Guideline for Female Catheterisation

Elements of Performance
Approach patient, introduce self, positively identify patient and confirm by checking patient's four identifiers (*first and second name, DOB, Hospital/ NHS number / first line of the address*). These should be cross referenced verbally with the patient/relative/carer, health care records (HCRs), and wristband worn by the patient.
Explain the procedure to the patient, then either obtain informed verbal consent, or act in their best interest (Mental Capacity Act 2005). Consider a chaperone.
Clean trolley from top to bottom using *S* technique, wait to air dry for 30 seconds. Collect all the necessary equipment *(catheter pack, catheter, urinary bag/tap, anaesthetic gel, cleaning solution, spare pair of sterile gloves, apron* **if not** *in pack, procedure towels*), check expiry date and place on the bottom shelf of trolley. Wash hands and apply apron.
Using an aseptic non-touch technique (ANTT), open and drop catheter pack on the top shelf and open pack. Open and drop anaesthetic gel on the sterile field. Pour the cleaning solution into the galipot.
Ensure privacy, assist the patient in semi recumbent position, and place procedure towels under patient's bottom. Expose patient and make sure patient is socially clean, assess for any signs of infection and abnormality. Decontaminate hands, put on first pair of sterile gloves.
Organise the equipment on the sterile field. Separate labia, clean vulva area from top to bottom, identify the urethral meatus. Apply small amount of anaesthetic gel around the urethral orifice slowly, warn patient that gel will sting temporarily, and wait for 3-5 mins.
Remove gloves away from the sterile field, wash hands, open catheter onto the sterile field, decontaminate hands and put on second pair sterile gloves.
Place the sterile towels underneath patient's bottom and over the abdomen *(ensure not to contaminate the sterile gloves)*; place a collecting tray near patient to collect urine.
Partially remove the catheter from inner sterile pack, separate labia with your non dominant hand. With the catheter in the dominant hand, slowly insert into the urethra –taking care not to touch the vulva or perineum with the catheter cover, (*if there is difficulty advancing or if there is pain–seek assistance before continuing*), continue to advance the catheter completely to the bifurcation.
Inflate the balloon slowly with designated amount (using prefilled syringe) of sterile water, observe for signs of pain or discomfort; withdraw the catheter until a slight resistance is felt, attach a drainage bag to catheter, place below patient's waist securely or on catheter stand or side of bed (**bag should not be in contact with the floor).**
4. After care
Clear area and discard all the rubbish in the appropriate bin. Remove apron and gloves, wash hands, ensure the patient is comfortable, measure the residue urine, enter on fluid balance chart.
Document reason for catheterisation (complete a catheter passport if patient is to be discharged), document date of insertion, and write the date on back of the catheter bag. Document the type and size of catheter, expiry date and batch no. Put a sticker from catheter packaging into the patient's notes or catheter pathway and the date for reassessment and/ removal. Document local anaesthetic used and balloon size and indicate if urine sample was taken.