

CCSG REPORT: THE RISKS ASSOCIATED WITH URINARY CATHETERISATION

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The Clinical Continence Supervision Group (CCSG) was founded in 2002 after the initiative was proposed by Anne Winder, Senior Continence Clinical Nurse Specialist for east and north Hertfordshire. The idea of the group is to look at continence issues in the form of a national clinical governance-style meeting. There are currently 10 members of the group:

- ▶ Anne Winder, Chairman,
- ▶ Rona Mackenzie, Secretary
- ▶ Ian Pomfret, Treasurer
- ▶ Wendy Colley, Deputy Treasurer
- ▶ Valerie Bayliss
- ▶ Liz Bonner
- ▶ Sharon Eustice
- ▶ Karen Irwin
- ▶ Mandy Wells
- ▶ Katherine Wilkinson.

The aims of the CCSG's meetings are to:

- ▶ Provide a confidential forum for the clinical supervision of senior clinical continence nurse specialists and enable discussion and evaluation of patient-focused care
- ▶ Discuss clinical, managerial and ethical issues surrounding the care of patients with bladder and/or bowel dysfunction
- ▶ Review and discuss NHS directives and guidelines that potentially change nursing boundaries
- ▶ Share knowledge with other professionals by producing articles for publication in professional peer-reviewed journals

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- ▶ Review and discuss present clinical research in relation to clinical practice
- ▶ Address unsafe professional practice.

The group meets four times a year at venues around the UK. They have commented on a variety of national initiatives, including the recent Department of Health consultation on the provision of appliances in primary and secondary care. They have published articles on catheter care (CCSG, 2004) and on the issues that surround the provision of continence products (CCSG, 2005a,b).

Urinary catheterisation

One of the key issues that continence services have to address is that of urinary catheterisation. This is a highly emotive subject affecting patients and their families in both acute and primary care. Urinary catheterisation has many advantages for patient

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care and is an essential tool for the provision of medical and nursing treatment. Indications for urinary catheterisation include (Pomfret, 1999):

- ▶ Relief of urinary tract obstruction
- ▶ Prostatic hyperplasia
- ▶ Acute or chronic retention
- ▶ Drainage of hypotonic bladder
- ▶ Neurogenic bladder and suprasacral transection
- ▶ Pre and post-pelvic surgery

- ▶ Accurate measurement of urinary output
- ▶ To obtain an uncontaminated specimen of urine
- ▶ Emptying the bladder during labour
- ▶ Irrigation of the bladder
- ▶ Clot retention
- ▶ Chemotherapy intervention
- ▶ Cytotoxic therapy for papillary carcinoma
- ▶ Urodynamic investigation
- ▶ Cystometry
- ▶ X-ray investigation
- ▶ Video cystourethrography
- ▶ Management of urinary incontinence when all other methods are not applicable.

However, catheters can present serious risks to patients and their use should be always be questioned and limited to essential circumstances.

Risks associated with catheterisation

The risks of catheterisation include urinary tract infection (UTI) and as Pratt et al (2006) note: 'Catheterising patients places them in significant danger of acquiring a UTI. The longer the catheter is in place, the greater the danger.'

Despite this, 15–25% of hospitalised patients are catheterised sometimes unnecessarily (Tenke et al, 2004; Saint et al, 2005). Indeed, patients who have catheters inserted in nursing homes are three times more likely to need antibiotics, three times more likely to be admitted to hospital and three times more likely to die within 12 months (Kunin et al, 1992).

Other risks associated with catheters include (Stickler and Zimakoff, 1994; Lowthian, 1998):

- ▶▶ Urethral trauma
- ▶▶ Stricture formation
- ▶▶ Encrustation and bladder calculi
- ▶▶ Urethral perforation
- ▶▶ Increased risk of carcinoma of the bladder.

All of these risk factors should be well known to healthcare professionals and there is no excuse for the 'catheter apathy' that is apparent in some healthcare professionals who regard UTI as an acceptable consequence of urinary catheterisation, believing it to be relatively harmless and easy to treat (Tew et al, 2005).

A relative's perspective

In 2001 at the age of 70 years the mother of one of the CCSG members (who prefers to remain anonymous) was diagnosed with early onset dementia. Soon afterwards she underwent surgery for bowel cancer and it was also discovered that she had an aortic stenosis. The board member wrote the following reflection, outlining her experience of her mother's treatment:

'My mother was a smart, organised and intelligent woman and to witness the sharp decline in her physical and mental health was extremely distressing for my father and the rest of the family. My father struggled to cope but it became clear that my mother required 24-hour nursing care. Soon after being admitted to a care home, my mother became incontinent as she was not able to find the toilet and was often uncooperative when attempts were made to take her.

My mother then started to suffer with recurrent anaemia. This was investigated and no obvious cause could be found. It was decided that in view of her poor physical and mental state, the best option was to monitor her haemoglobin levels every week and admit her for a blood transfusion when necessary, which was about every 3 weeks. Because of the aortic stenosis as soon as she became anaemic she had a tendency to collapse and underwent many emergency admissions as a result.

It was during the last such admission to hospital that I noticed that my mother

had been catheterised. As a nurse I am only too aware of the risk of urinary catheterisation, especially to an older frail person. I asked the nurse in charge why my mother had been catheterised and she was not able to give a good reason. 'Perhaps it is so we can monitor her urine output,' she said. However, I pointed out that the catheter drainage bag had not been emptied all day and the urine output had not been recorded. I expressed my concern that my mother would receive a UTI as a result of the catheterisation and requested that the catheter be removed.

The catheter was removed after being in situ for approximately 24 hours. I noticed the next morning after my mother had been transfused that she appeared flushed. A nurse checked her temperature and discovered that she had low-grade pyrexia. I again expressed my concern that she was at risk of a UTI and a course of antibiotics was prescribed.

Soon afterwards my mother was discharged to the care home but during the next few days her condition deteriorated and she died peacefully a week later. However, it was with great reluctance that my father showed me the death certificate. The cause of death was septicaemia secondary to UTI.'

In the CCSG member's view, the main issues surrounding her mother's catheterisation were:

- ▶▶ Why was the catheter inserted in the first place? Could it have been simply because her mother was incontinent?
- ▶▶ Whose decision was it to catheterise? Was it a nursing or medical decision?
- ▶▶ Was a risk assessment undertaken before the catheterisation?
- ▶▶ Were alternatives considered, i.e. manage the incontinence with pads?
- ▶▶ How was consent obtained? The CCSG member's mother had advanced dementia and could not have given her consent and none of the family members were informed.

Having reflected on these events the CCSG member has decided to

address these issues with the hospital concerned to try and prevent this happening again.

Conclusion

There is overwhelming evidence that urinary catheters can cause harm (Tew et al, 2005), even, as demonstrated here, fatalities. However, many healthcare professionals accept urinary catheters as being necessary. However, as healthcare professionals we have a duty to ensure that we always act in patients' best interests and do not cause them any harm through our actions (NMC, 2002). **CUK**

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