Teaching intermittent catheterisation: barriers

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Patients often prefer intermittent catheterisation to an indwelling catheter but the technique must be taught properly to improve the likelihood of ongoing concordance.

In this article...
- Explanation of intermittent catheterisation and its benefits
- Types of catheters
- Factors to consider when teaching patients the procedure

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Abstract

Intermittent catheterisation can be used to empty the bladder, avoiding the need for an indwelling catheter. Patients must be taught the technique by a competent and well-trained health professional, with their individual needs taken into account.

Intermittent catheterisation (IC) is the act of passing a hollow tube or catheter into the bladder to drain urine. The catheter is removed immediately after drainage is complete. This method of bladder drainage is effective for patients with incomplete bladder emptying due to idiopathic or neurogenic bladder dysfunction. As long as it is clinically appropriate and practical for the patient, IC tends to be the long-term preferred option to an indwelling catheter (National Institute for Health and Clinical Excellence, 2012).

Reasons for IC
The reasons why patients may have to have IC are numerous (Box 1) but not everyone will be suitable for, or capable of, it. Children as young as 4-5 years can be taught the technique, as can older people if consideration of their specific needs is taken into account (Association for Continence Advice, 2007). Suitability depends on:
- Symptom profile, renal function and risk assessment, not just residual volume of urine (Royal College of Nursing, 2012);
- An ability to comprehend the technique;
- Dexterity to hold the catheter and mobility to position oneself correctly;
- Motivation and commitment as IC is usually for life (Dougherty and Lister, 2011);
- Willingness of the partner or carer to perform the procedure if the patient cannot do it themselves.

Advantages and benefits
Modern IC has several benefits to patients and healthcare providers, including:
- Improved urinary symptoms including fewer urinary tract infections, no need to wear pads or other products, less chance of being incontinent, less risk of urethral trauma, and protection of patients’ upper tracts from “reflux”;
- Improved sleep;
- No need for drainage bags;
- Ability to remain sexually active;
- Patients and carers being more responsible for their own care, which cuts nursing time (McConville, 2002).

Procedure
Each patient is individually assessed for frequency of IC. Those who are not able to void spontaneously at all will need to undertake IC between four and six times a day but usually no more than every two hours. Sleep should not be disturbed if possible and patients may be advised to use an extra catheter if they know they will not have access to a toilet for a long period of time or before sexual intercourse.

Some patients who start IC because of partial incomplete emptying may only need to undertake IC once a day or even less; a general indication is that the voided volume plus the residual volume should be no more than 500ml (ACA, 2003).

In acute settings, professionals may lack the time and training to adequately teach the technique.

Older people can be taught how to perform IC if their needs are taken into consideration.
Being informed that you need to undertake IC can be embarrassing. Although the procedure is generally considered both simple and safe and is associated with improved quality of life (Cravens and Zweig, 2000), there are reports of some negative effects (Borzyskowski et al, 2004). If a person experiences physical or psychological stress, finds the technique unacceptable or dislikes change, they are more likely to abandon use of the procedure.

Van Achterberg et al (2008) described eight areas that health professionals should discuss with patients to improve their compliance and safety when using IC:

- Patients’ own knowledge of their condition, symptoms, underlying disease aetiology and knowledge of the urinary tract;
- The steps and skills required to complete the procedure – patients often find the procedure complex and struggle to memorise necessary steps;
- Impaired body functions – mobility, hand-motor skills;
- Fears and misconceptions associated with the procedure and the catheter entering the body, where it goes, increased risk of infection and fear of pain;
- Any feelings of shame and stigma that may lead to secrecy;
- The patient’s level of motivation and any past negative experiences with regard to managing continence;
- The timing of the instruction and any feelings around changing role with regard to sickness or impairment;
- Availability of materials and products, especially those associated with patients who live in institutions or in acute settings where policies may limit supply and choice.

The RCN (2012) states that IC should be taught by a competent and experienced specialist nurse, and should take place in an environment with a low infection risk.

Acute setting

Health professionals who work in acute settings, particularly on general wards, may not have been taught the required skills to teach IC effectively and training may not be available in their local areas. Time constraints can also be an issue as patients may need several sessions to master the skill (RCN, 2012). A wide range of intermittent catheter samples need to be available to give patients the best possible outcome; lack of choice and insufficient demonstration in acute care has been identified as a barrier to implementation (RCN, 2012; Van Achterberg et al, 2008).

Patients are less likely to meet the eight determinants identified by Van Achterberg et al (2008) within acute settings and are therefore more likely to abandon the procedure once they have been discharged.

Community

The ideal place for a patient to be taught IC is at home, in their own environment. This provides more privacy and dignity and less risk of cross-infection. Logan et al (2008) identified that patients’ preference to learn the skill at home – their privacy needs are met, the atmosphere is more relaxed and there is less stress due to time constraints, better demonstration of the skill and more frequent follow up. This increases patient concordance and meets Van Achterberg et al’s (2008) eight determinants.

Conclusion

The rationale for patients to undertake and continue to comply with IC is a complex process. There are numerous factors that affect each individual patient and knowledge of these can assist in making the procedure successful. Health professionals need to be skilled in assessment, teaching and communication, but the setting where the instruction takes place can have significant impact on ongoing care and continued concordance.

References

Association for Continence Advice (2007) Notes on Good Practice. Rusch Care. www.aca.uk.com (members area only).