

Our ref: FOI ID 4676

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Re: Freedom of Information Request

Please find below the response to your recent Freedom of Information request regarding paediatric continence services within NHS South Sefton CCG.

Request/[Response](#):

In July/August 2014, the Paediatric Continence Forum (PCF) contacted NHS South Sefton CCG, along with other CCGs across England, to request information about the commissioning of paediatric continence services. Since then, we have compiled the responses of 208 responding CCGs and found that only 35% commission all the four continence services (for bedwetting, daytime wetting, constipation/soiling and toilet training) – with just 24% of responding CCGs commissioning services that are fully “joined up”.

We did, however, note that your CCG was one of the few that did commission a joined-up, integrated service covering all four of the main problems (bedwetting, daytime wetting, toilet training, constipation/soiling).

As part of our work with the National Institute of Health and Care Excellence (NICE), we are working with clinical partners from around the country to collect and collate care pathways for paediatric continence which are proven to be effective, with a view to developing a care pathway or set of care pathways which can be used universally across the country.

We kindly request therefore that you provide us with a copy of your care pathway (or pathways) for paediatric continence (bedwetting, daytime wetting, toilet training, constipation/soiling). This will help us to improve the quality of paediatric continence services nationally.

[NHS South Sefton CCG commissions Liverpool Community Health NHS Trust to provide Paediatric Continence Care. Please find attached a copy of the care pathway.](#)

Title	Clinical Policy for Paediatric Continence Care	
Policy reference number	048	
Aim and purpose of Policy	<p>To inform staff on how to undertake an assessment of continence need by using the products and resources available to a child or young person when cared for in the community.</p> <p>To inform staff on the correct procedure for managing a child with delayed toilet training, the issue of products, day and night time wetting and constipation and soiling</p> <p>To inform staff on the correct procedure for intermittent catheterisation, sheath fitting and portable ultrasound bladder scanning</p>	
Author	Continence Advisors and Pediatric Continence Advisor of Liverpool Community Health NHS Trust	
Type	<p>New Policy <input type="checkbox"/></p> <p>Reviewed Policy <input checked="" type="checkbox"/></p>	
Review date	June 2014	
Person/group accountable for review	Continence Service Manager Continence Advisors	
Type of evidence base used	<p>A: Evidence is obtained from systematic reviews /and randomized controlled trials.</p> <p>C: Evidence which includes published and/or unpublished studies and expert opinion.</p>	
Issue Date	JULY 2011	
Authorised by Clinical Policies Group	August 2011 (Virtual Group) / Re-authorised at meeting on 13/4/12	
Impact Assessment Undertaken	<p>Yes <input checked="" type="checkbox"/></p> <p>July 2011</p> <p>No <input type="checkbox"/></p>	<p>Evidence collated <input checked="" type="checkbox"/></p> <p><input type="checkbox"/></p>

Version Control

Version Number:	V2
Ratified by:	Clinical Policies Group
Date of Approval:	August 2011 (Virtual Group)
Name of originator/author:	Continence Advisors of Liverpool Community Health
Approving Body / Committee:	Clinical Policies Group
Date issued:	August 2011
Review date:	June 2014
Target audience:	Health professionals responsible for the assessment and care and children with bladder and bowel dysfunction from the ages 0-16 years
Name of Lead Director / Managing Director:	Helen Lockett Director of Operations/Executive Nurse
Changes / Alterations Made To Previous Version:	Updated to reflect current clinical guidance document framework and current organisational name.

Key individuals involved in developing the document

Name	Designation
Sandra Moran	Continence Advisor
Paula Higgins	Continence Advisor
Debbie Ward	Paediatric continence advisor

This document was circulated to the following individuals for consultation

Name	Designation
Val Ward	Continence service redesign manager
Frank Davidson	Equality and Diversity Advisor

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

Current NICE guidance

Contents:

1. Purpose and Scope of this policy
2. Key Principles
3. Terminology and Definitions
4. Duties and Responsibilities
5. Process and Documentation
6. Training
7. Implementation, monitoring and review
8. Linked areas
9. Appendices

1.0 Introduction

This policy is designed to give clarity and guidance around the assessment, treatment and management of children and young people within the community who have a continence problem, and is based upon the information as outlined on the front-page table.

The policy is designed to ensure that all staff working for, on behalf of the Trust, provides an optimal level of service delivery to this specific patient population. The advice and guidance contained within this policy is based upon the latest research – based evidence, and has been agreed by a number of professionals.

1.1 Status

This is a clinical policy document for the use in Liverpool Community health

1.2 Purpose

This policy is designed to ensure quality and consistency in the delivery of clinical care to children and young people with bladder or bowel dysfunction within the Primary Care Setting.

The child will receive a holistic assessment of their problem and will be offered appropriate treatment and management of that problem.

The policy is also designed to ensure quality and consistency in the delivery of clinical care to children with nocturnal enuresis, day time wetting, delayed toileting and use of intermittent catheters and the management of children with constipation and soiling

The provision of enuretic alarms, including subsequent follow up, maintenance, cleaning and decommissioning in conjunction with Medical devices Policy 2011

1.3 Scope

This policy applies to all staff employed by Liverpool Community health. The assessment, treatment and management of all children up to the age of 16 years with continence needs within the Primary Care setting irrespective of their place of residence e.g. own home, residential school, children' home It will apply to the following staff groups:

- Paediatric Continence Nursing Team
- Community nursing staff including school nurses and health visitors

2. General Policy Statement

Liverpool Community Health has developed this policy (in collaboration with the Liverpool Integrated Continence Stakeholder group) to fulfill the requirements of children and young people receiving continence advice from staff employed by Liverpool Community Health who are committed to ensuring that all staff are trained and equipped to perform their role effectively.

3. Definitions

The following definitions have been agreed and adopted as workable definitions for use within LCH.

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

Constipation – difficulty or delay in the passage of stools (< 3 stools per week)

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

Day time wetting – refers to children over the age of 5 years who have wetting episodes during the day

Nocturnal enuresis - wetting the bed at night over the age of 5 years in the absence of any underlying medical conditions/congenital abnormality

Nocturnal polyuria – large volume of urine in the first few hours of the night

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

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

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.

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

4. Duties and Responsibilities

The following general statutory duties apply:

All Liverpool Community Health staff are responsible for cooperating with the development and implementation of Liverpool Community Health policies as part of their normal duties and responsibilities.

All other personnel will be expected to comply with requirements of all relevant Liverpool Community Health policies applicable to their area of operation.

All potential adverse incidents should be reported in line with the Liverpool community Health Accident and Incident Reporting and Management Policy (Including Serious Untoward Incidents).

5. Process and Documentation

This policy was adopted by the Clinical Policies Group following approval.

The policy will be available to all staff via the Trust intranet site and will form the basis of training provided by the Continence Service.

6. Training Requirements

Training to support use of this policy will be available as per local training needs analysis

All Community nurses involved with children and young people, including School Health Practitioners, Health Visitors, and Paediatric Continence Team staff should attend the workshops facilitated by the Paediatric Continence Promotion Service that are available via the Learning and Development Bureau. Staff should attend within the first 12 months of coming into post to ensure they have theoretical underpinning knowledge to support policy in practice.

Training packages are reviewed on an annual basis by the Paediatric Continence Advisor to ensure evidence continues to include best practice.

All staff responsible for the issue of an alarm should undergo appropriate training. All public health and community nurses involved with children with nocturnal enuresis should

attend the workshops facilitated by the Paediatric Continence Promotion Service that are available via the Learning and Development Bureau.

This training will be carried out in conjunction with the Nurse Lead for School Health Enuresis Service and include yearly updates with link nurse forum to be disseminated to teams

7. Implementation, Monitoring and Review

7.1 The Director of Operations/Executive Nurse is responsible for implementing this policy.

This process is delegated to the Paediatric Continence Advisor

7.2 The Director of Operations/Executive Nurse is responsible for ensuring that this policy is reviewed and, if required revised in the light of legislative, guidance or organisational change. This process is delegated to the Paediatric Continence Advisor and the authors of the policy.

7.3 The implementation of this policy will be undertaken by paediatric Continence advisor and staff employed by LCH

7.4 The monitoring of this the use of this policy should be undertaken by the service lead of the area were this policy is in use.

The Paediatric Continence Service will audit the effectiveness of the continence care pathways in relation to treatment outcomes and continence product provision to ensure continued best practice and effective use of resources. Information from audits will be forwarded to senior management teams (including Patient Services, School Health, Continence Service) via local governance arrangements

7.5 Review shall be 1 year unless new evidence to support changes in practice become available. It is the responsibility of the Continence Service Manager to initiate this process. Others involved in the process will be:

- Paediatric Continence Advisor located within LCH

8. Impact Assessment

This has been updated and the evidence retained by the person responsible for the update and the Equality & Diversity Lead of LCH

9. Linked areas / information

Consent www.nmc-uk.org

Record keeping www.nmc-uk.org

RCN Clinical Guidelines www.rcn.org.uk/resources/guidelines

National Patient Safety Agency www.npsa.nhs.uk

Education and Resources for Improving Childhood continence (ERIC)

http://www.eric.org.uk/InformationZone/information_zone

Cochrane review -

http://www.medisurf.com/DB_Gateway/Cochrane/ccab0303/AB002911.htm

10. Relevant legislation /Statutory Requirements

This document should be read in conjunction with:

Good Practice in Continence Services

www.continence-foundation.org.uk/campaigns/goodpracticecontinence.pdf

Children's' NSF Standard 6

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAndGBrowsableDocument/fs/en?CONTENT_ID=4094571&MULTIPAGE_ID=4867894&chk=I2SYw6

Good Practice in Paediatric Continence Services - Benchmarking in Action

www.cgsupport.nhs.uk/PDFs/articles/good_practice_paediatric_continence_services.pdf

11.0 List of Appendices

Please see document paediatric appendices

Paediatric Continence Promotion

This guidance will ensure that following identification of a continence problem the patient should be referred to the appropriate professional for assessment using the form “Referral to Paediatric continence promotion service”.

If the patient attends a special school the form should be sent to the school nurse who will carry out the continence assessment. If there is no school nurse involvement, the referral should be sent to the Paediatric Continence Promotion Team or referred by the GP referral using choose and book.

Red Flags Urinary symptoms – for immediate referral to urology secondary care service

3 or more urinary tract infections

Dysuria

Gential pain

Straining to urinate

Motor Sensory Loss

Haematuria

Palpable bladder

Palpable renal mass

Red flags: bowel dysfunction

Rectal pain

Rectal discahrge

Rectal bleeding

Change of bowel habits with looser stool >6weeks

Tenesmus (continued urge, ineffective emptying, and pain)

Palpable rectal mass

Motor Sensory Loss

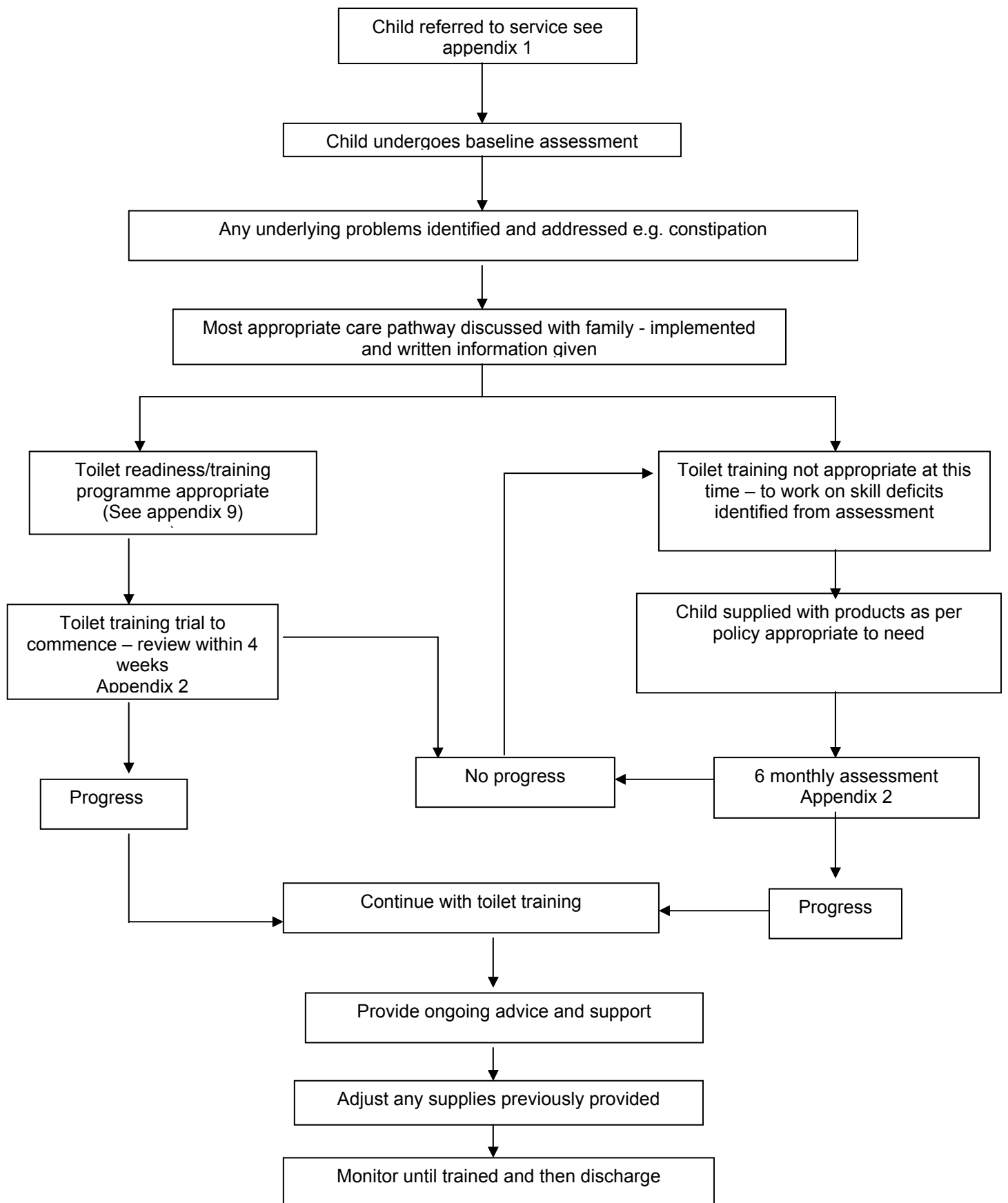
Paediatric continence promotion service will provide open access support, advice and information to all children (0 -16 years) and their families. The patient will be offered an assessment in order to eliminate any underlying pathology or cause of the incontinence. The assessment is holistic and will 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 continence promotion clinics throughout the city. Housebound clients will receive a home visit

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).

The Continence Service within LCH is also actively working towards a transition service for young people between 16-19 years within the continence service and from secondary care.

Supply of Paediatric Continence Products

Paediatric Policy for Continence Care v2
Paediatric Continence Promotion Service
LCH
July 2011



Provision of continence products for children

Paediatric Continence 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.

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.

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 Paediatric Continence 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 prior consultation with the Paediatric Continence Advisor
- Children under the age of 4 are not eligible for products
- A product request form should be complete at time of assessment and sent to the Paediatric continence service
- Please inform the family regarding the home delivery service including when to expect their first order and contact details.

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

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
- All professionals (e.g. Special School Nurse) who initiated the supply of products are to keep the children on their active caseload unless formally transferred over to another professional
- 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

Procedure for ring-back pad delivery service

The purpose of using ring-back for pad 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. A home visit may be necessary to fully discuss changing requirements.

It is the client's/carers' 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.

Paediatric Continence Promotion

Toilet Training skills

The assessment should commence in the child's second year and establish if they have the skills required in order to be trained and to identify any skill deficits and any underlying pathology. The toilet skills assessment checklist forms part of a holistic assessment.

A baseline assessment is to be taken of bowel and bladder habits to identify the child's normal micturition cycle by completion of the toileting training chart

They are to pick a number of days when they will be at home and either put cotton pants on the child with the nappy on top or place inside the nappy a folded kitchen towel that does not disintegrate when wet. The mum then checks the child's nappy at least every hour and records whether the child is wet or dry.

When assessing a child's cognitive level of awareness for toilet training for a child with poor communication and apparent lack of awareness a formal assessment may be beneficial in their own home using 'unobtrusive observational assessment' (UOA) has been found beneficial in assessing a child's level of understanding and co-operation.

The family given an agreed management plan to implement with the support of the assessing health professional

The child would be re-assessed every 3 months.

A formal toilet training programme will be put in place once the child is achieving the physical skills to enable training to take place.

For example:

- Maturing bladder that can hold urine for around 1½ - 2 hours
- Bowel that is not constipated
- Ability to sit on toilet/potty for sufficient time

Children who will not sit on a potty or toilet the following strategies should be used

- Engage the child in a pleasurable activity encourages the child to sit for an increasing length of time
- If the child was unable to sit because of lack of balance etc the referral to an O/T should be made for assessment for a potty chair/toileting aid.

References

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2. Van Gool J D, Vijverberg M A W, de Jong T P Functional Daytime Incontinence: clinical and urodynamic assessment. Scandinavian Journal of Urology and Nephrology 1992, 141, 58-69.
3. Hellstrom A.L, Hjalmas K, Jodal U. Rehabilitation of the dysfunctional bladder in children: method and 3 year follow-up. The Journal of Urology 1987, 138, 847-849
4. Berger R, Maizels M, Morgan G, Conway J, Firlit C, Bladder capacity equals age plus 2 predicts normal bladder capacity and aids in diagnosis of abnormal voiding patterns. The Journal of Urology 1983, 129, 347-349
5. Hellstrom A.L, Hansson E, Hannson S, Hjalmas K, Hodal U, Association between urinary symptoms at 7 years old and previous urinary infection. Archives of Diseases of Childhood 1991. 66, 232-234

NOCTURNAL ENURESIS

MANAGEMENT POLICIES

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

1. Explore social/emotional problems
2. Reassure and support
3. Give helpful advice on coping with and managing bedwetting
4. Address associated bowel/bladder problems, e.g. constipation, day-time wetting

Following a school nurse health interview (age 4-5 years) any child who is noted to be a “bed wetter” should be given appropriate advice by the school nurse.

This ensures that:

1. Appropriate advice is given on the first encounter
2. This advice should be uniform and non-conflicting
3. Basic background work, such as fluid intake correction and identification of underlying problems can be done early on
4. The level of motivation and environmental problems are identified early
5. Treatment can be considered from age 5 years

Enuresis policy for children aged 5 years and over:

Child to have a documented assessment

1. Exclude pathology/social/emotional factors
2. Ask child and parent to record instances of wetting over a period of 1-2 weeks before introducing any programme.
3. 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)
4. First, address any underlying problems such as constipation or daytime wetting

Initial treatment

- 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:

- bedwetting is very infrequent (that is, less than 1–2 wet beds per week)
- the parents or carers are having emotional difficulty coping with the burden of bedwetting
- the parents or carers are expressing anger, negativity or blame towards the child or young person.

Offer desmopressin to children and young people over 7 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).

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)

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 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.

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.

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.

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.

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 must 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.

Issuing of Alarms

- 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 5) 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
- If possible the child/family should be given a choice of alarm (e.g. bed or body worn) 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 5)

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.

Return of equipment to continence service

- When the alarm is returned 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 manufacturers instructions. On return sensors are disposed of in clinical waste.
- Log alarms returned.
- Clean and store following medical devices policy.

The Paediatric Continence Service will audit the effectiveness of the nocturnal enuresis care pathways in relation to treatment outcomes and use of the enuresis alarm to ensure continued best practice and effective use of resources.

Information from audits will be forwarded to the audit department and senior management teams via local governance arrangements.

12. References/Bibliography

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Education and Resources for Improving Childhood continence (ERIC)
www.eric.org.uk/prof/literature.html

Cochrane review - <http://www.mediscope.ch/cochrane-abstracts/ab002911.htm>

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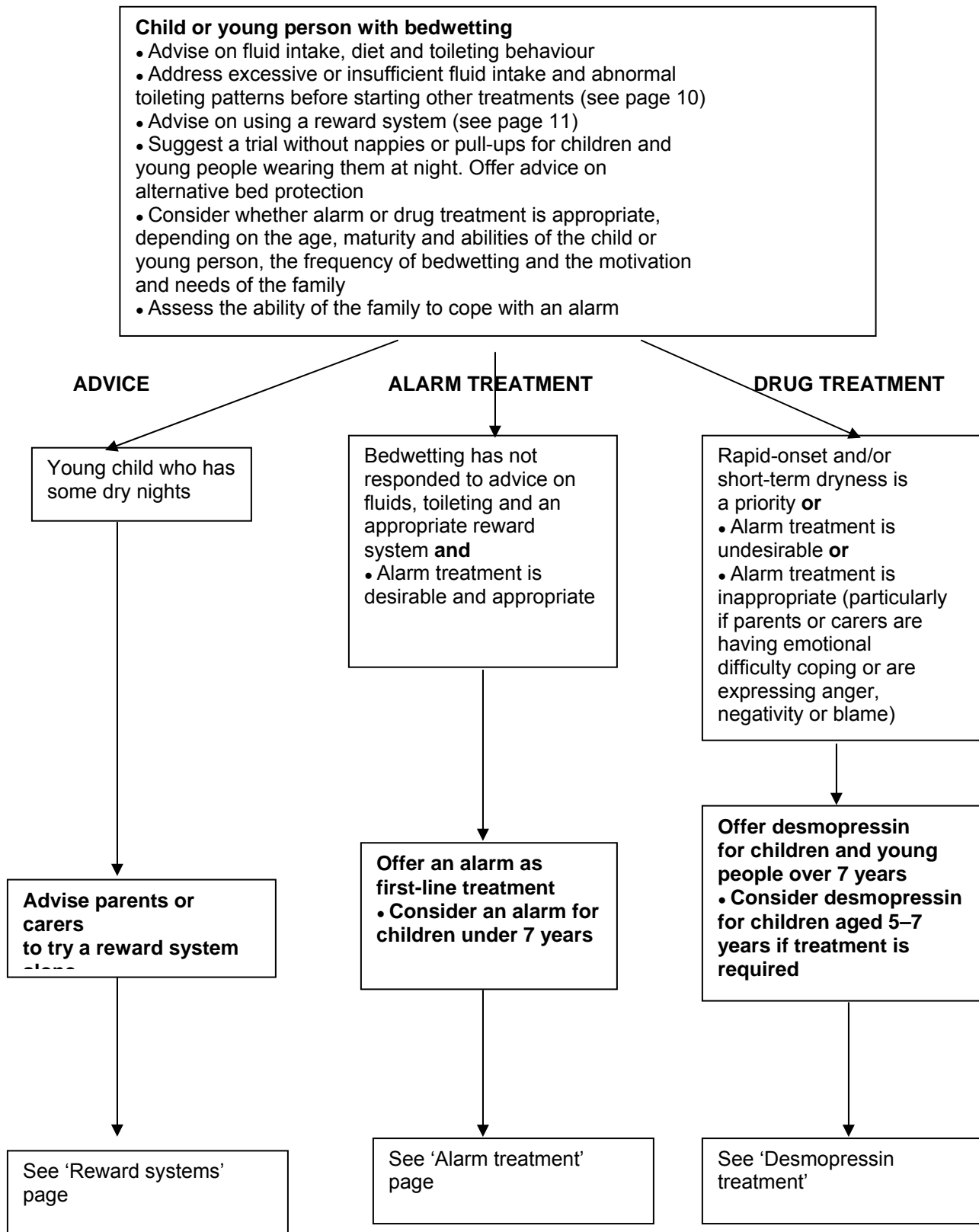
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UTI in Children. Urinary tract in children: diagnosis, treatment and long term management (2007) NICE clinical guidance 54

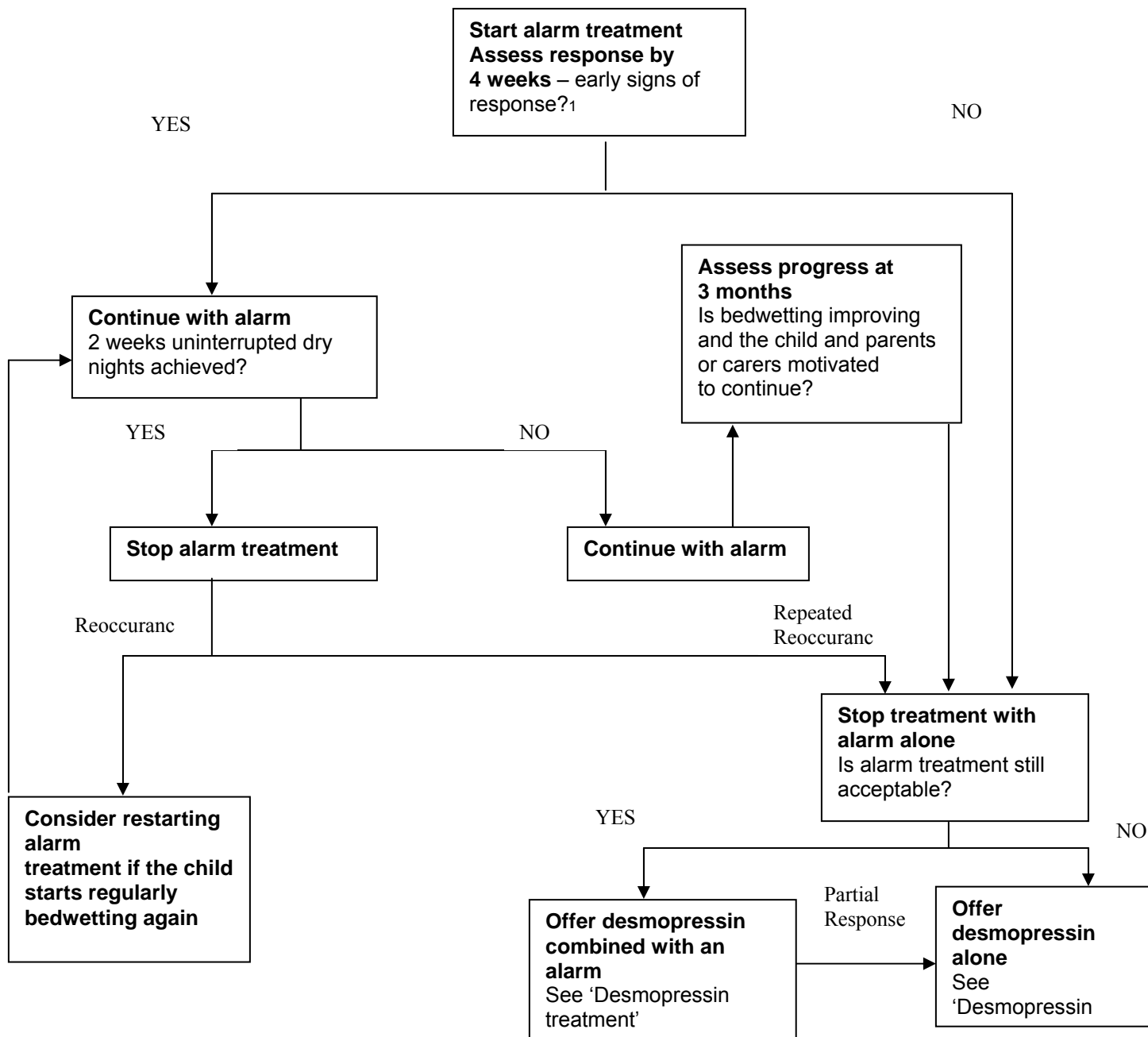
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Pediatric Assessment of toilet training readiness and issuing of products: an RCN care pathway (2006). Royal College of nursing

Initial treatments

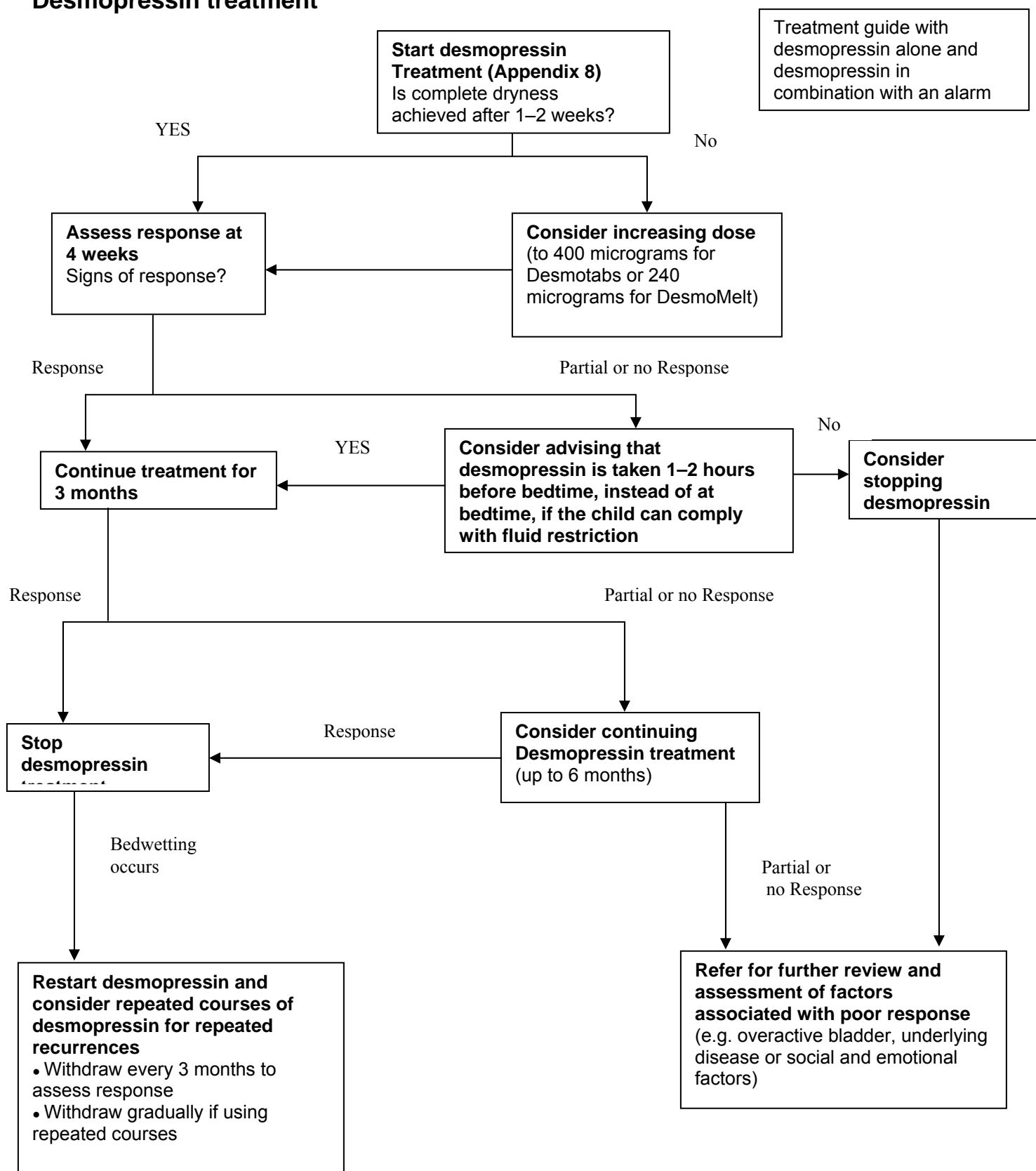


Alarm Treatment



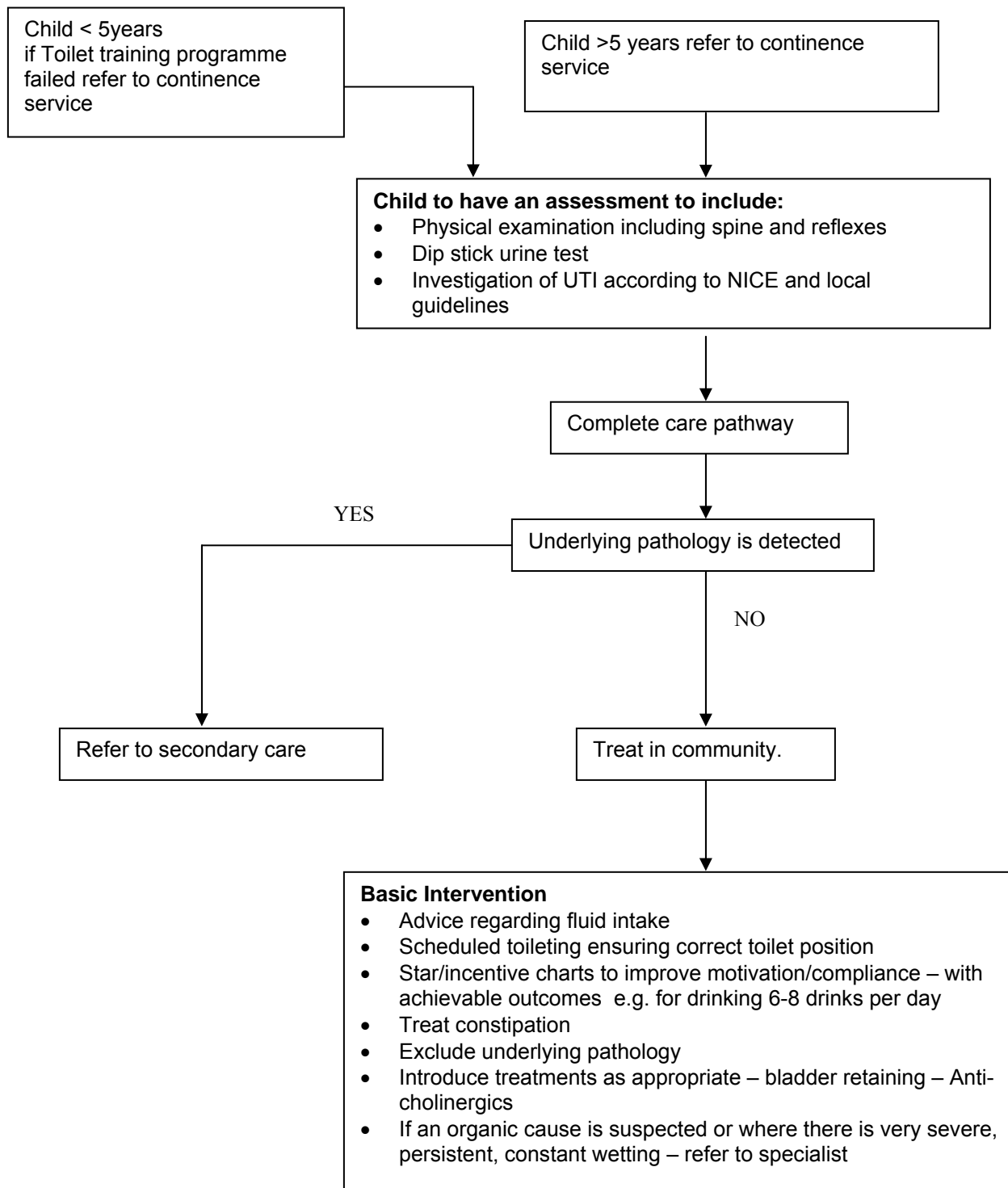
Early signs of a response to an alarm may include smaller wet patches, waking o the alarm, and the alarm going off later and fewer times per night, and fewer wet nights.

Desmopressin treatment



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

Daytime wetting



Desmopressin combined with an anticholinergic

Consider desmopressin combined with anti cholinergic 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.

Constipation

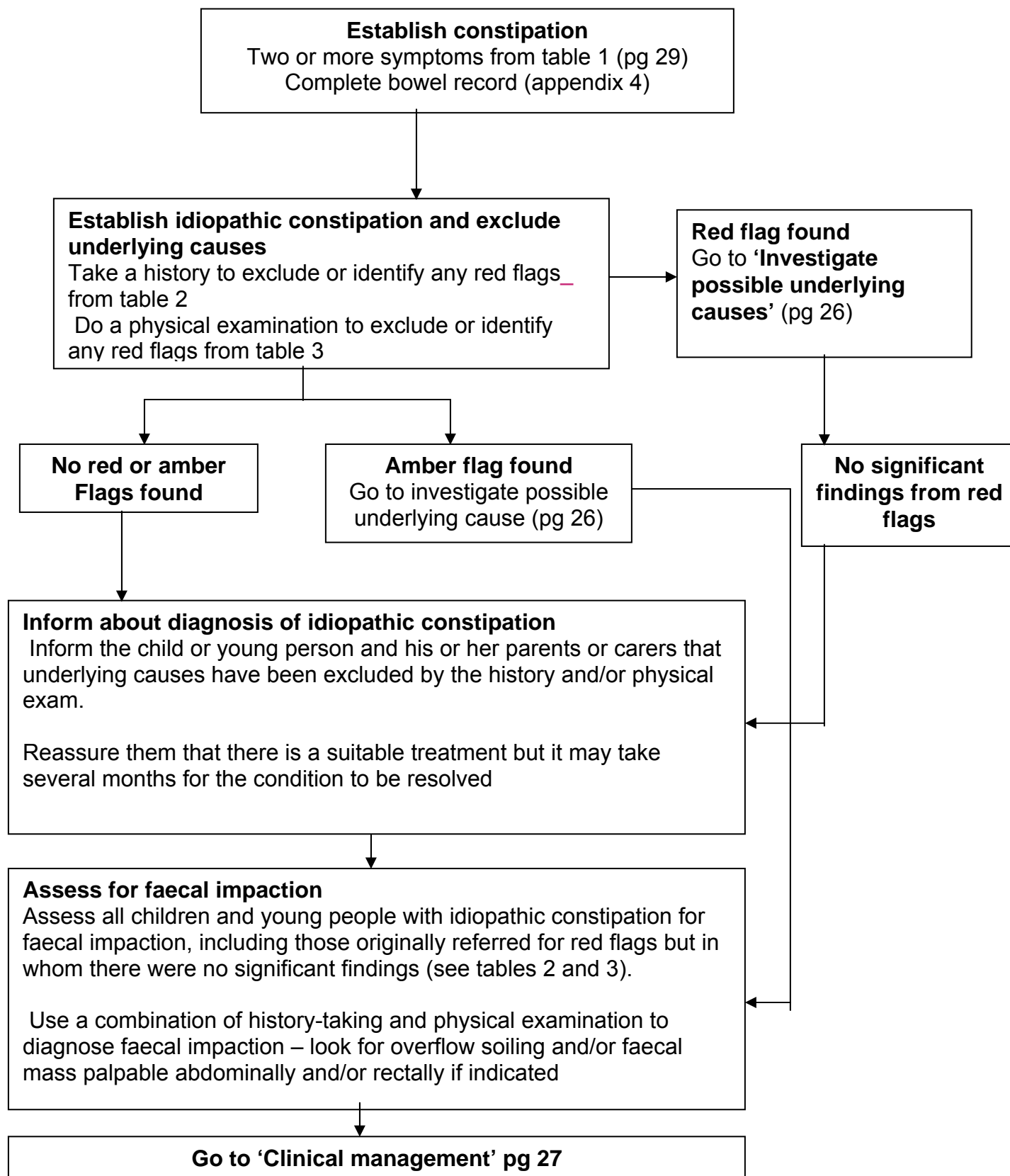
Introduction

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.

Patient-centered care

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 carers 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.

History-taking and physical examination



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

Clinical management

NO

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

Diet and lifestyle

Do not use dietary interventions alone as first line treatment

Treat constipation with laxatives and a combination of:

Negotiated and non-punitive behavioral 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 a 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.

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 Paediatric Continence Advisor.

Table 1 Key components of history taking to diagnose constipation

Key components	Potential findings in a child younger than 1 year	Potential findings in a child/young person older than 1 year
Stool patterns	<p>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).</p> <p>Hard large Stool</p> <p>Bristol stool type 1</p>	<p>Fewer than three complete stools per week (Bristol Stool type 3 or 4,</p> <p>Overflow soiling (commonly very loose [no form], very smelly [smells more unpleasant than normal stools],</p> <p>Stool passed without sensation.</p> <p>Bristol Stool Form 1</p> <p>Large, infrequent stools that can block the toilet</p>
Symptoms associated with defecation	<p>Distressed on stooling</p> <p>Bleeding associated with hard stool</p> <p>Straining</p>	<p>Poor appetite that improves with passage of large stool</p> <p>Waxing and waning of abdominal pain with passage of stool</p> <p>Evidence of retentive posturing: typical straight legged, tiptoed, back arching posture</p> <p>Straining</p> <p>Anal pain</p>
History	<p>Previous episode of constipation</p> <p>Previous or current anal fissure</p>	<p>Previous episode(s) of constipation</p> <p>Previous or current anal fissure</p> <p>Painful bowel movements and bleeding associated with hard stools</p>

Table 2 Key components of history taking to diagnose idiopathic constipation

Key components	Findings and diagnostic clues that indicate idiopathic constipation	'Red flag' findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation
Timing of onset of constipation and potential precipitating factors	<p>In a child younger than 1 year: Starts after a few weeks of life Obvious precipitating factors coinciding with the start of symptoms: fissure, change of diet, infections</p> <p>In a child/young person older than 1 year: 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</p>	Reported from birth or first few weeks of life
Passage of meconium	Normal (within 48 hours after birth, in term baby)	Failure to pass meconium/delay (more than 48 hours after birth, in term baby)
Stool patterns		'Ribbon stools' (more likely in a child younger than 1 year)
Growth and general wellbeing	<p>In a child younger than 1 year: Generally well, weight and height within normal limits</p> <p>In a child/young person older than 1 year: Generally well, weight and height within normal limits, fit and active</p>	No 'red flag', but see 'amber flag'. Go to Investigate possible underlying causes
Symptoms in legs/locomotor development	No neurological problems in legs (such as falling over in a child/young person older than 1 year), normal locomotor development	Previously unknown or undiagnosed weakness in legs, locomotor delay
Abdomen		Abdominal distension with vomiting
Diet and fluid intake	<p>In a child younger than 1 year: Changes in infant formula, weaning, insufficient fluid intake</p> <p>In a child/young person older than 1 year: History of poor diet and/or insufficient fluid intake</p>	

Table 3 Key components of physical examination to diagnose idiopathic constipation

Key components	Findings and diagnostic clues that indicate idiopathic constipation	‘Red flag’ findings and diagnostic clues that indicate an underlying disorder or condition: not idiopathic constipation
Inspection of perianal area: appearance, position, patency, etc	Normal appearance of anus and surrounding area	Abnormal appearance/position/patency of anus: fistulae, bruising, multiple fissures, tight or patulous anus, anteriorly placed anus, absent anal wink
Abdominal examination	Soft abdomen. Flat or distension that can be explained because of age or excess weight	Gross abdominal distension
Spine/lumbosacral region/gluteal examination	Normal appearance of the skin and anatomical structures of lumbosacral/gluteal regions	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
Lower limb neuromuscular examination including tone and strength	Normal gait. Normal tone and strength in lower limbs	Deformity in lower limbs such as talipes Abnormal neuromuscular signs unexplained by any existing condition, such as cerebral palsy
Lower limb neuromuscular examination: reflexes (perform only if ‘red flags’ in history or physical examination suggest new onset neurological impairment)	Reflexes present and of normal amplitude	Abnormal reflexes

Table 4 Laxatives: recommended doses

Laxatives	Recommended doses
<p>Macrogols Polyethylene glycol 3350 + electrolytes</p>	<p>Paediatric formula: Oral powder: macrogol 3350 (polyethylene glycol 3350)b 6.563 g; sodium bicarbonate 89.3 mg; sodium chloride 175.4 mg; potassium chloride 25.1 mg/sachet (unflavoured). 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)</p> <p>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</p>
<p>Osmotic laxatives Lactulose</p>	<p>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)</p>

Table 4 Laxatives continued

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

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) 2009. 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 (May 2010) 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.

c 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.

Intermittent catheterisation (ISC)

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 medical professionals must always be a sterile procedure.

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
- 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

How often does the patient need to catheterise?

The frequency of ISC is very individual and is dependent upon individual needs.

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 therapy.

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.

Size Adult 12 Ch – 14 Ch.

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

Length Standard (Male) 43cm – used for males or for females who prefer a longer length or in female patients where 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. (Refer to appendix 2)

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 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.

EQUIPMENT REQUIRED FOR 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)

Alcohol based hand wash solution if no hand washing facility available

Soap, water and towel if genitalia area is soiled

Patient's notes to record procedure and catheter details

Utilise clinical Intermittent clinical care plan (appendix 10)

PROCEDURE FOR INTERMITTENT URETHRAL CATHETERISATION: Male Patients

Method	Rationale
1. Explain the procedure to the patient	Obtain the patient's consent and co-operation.
2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)	Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour
3. Document consent has been given	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)
4. Place protective sheeting below the patient's buttocks.	To maintain patient comfort and protect work area Reduce risk of cross infection
5. Wash and dry hands, put on apron and open the pack to receive sterile equipment	Reduce risk of cross infection.
6. Put on sterile gloves and arrange sterile field.	Reduce risk of cross infection.
7. Retract the foreskin (if present). Thoroughly cleanse shaft, glans and urethral meatus. Swab away from the urethral orifice. Dry thoroughly.	Reduce infection.
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.	Create sterile field and help prevent contamination
9. Lubricate intermittent catheter according to manufacturer's instructions.	Prevent urethral trauma, minimize discomfort and reduce the introduction of infection.
10. Discard gloves and put on another pair of sterile gloves.	Maintain sterility.
11. Position the sterile receiver to catch urine. Open the inner cover of the catheter.	
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.	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.
13. Remove the catheter slowly.	Maximise bladder drainage, minimise trauma.
14. 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.
15. Measure and chart urinary output if	To obtain baseline information

necessary.	
16. Clear away equipment and dispose of clinical waste.	To reduce risk of cross infection
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.

PROCEDURE FOR INTERMITTENT URETHRAL CATHETERISATION: Female Patients

Method	Rationale
1. Explain the procedure to the patient	Obtain the patient's consent and co-operation.
2. Offer Chaperone and document name of chaperone if present. As RCN (2004) NMC (2008)	Reduce patient anxiety maintain dignity of patient. To protect both staff and patient from improper behaviour
3. Document consent has been given	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)
4 . Place protective sheeting below the patient's buttocks.	To maintain patient comfort and protect work area reduce risk of cross infection
5. Wash and dry hands, put on apron and open the pack to receive sterile equipment	Reduce risk of cross infection.
6. Put on sterile gloves and arrange sterile field.	Reduce risk of cross infection.
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.	Reduce infection.
8. Arrange the sterile drapes.	Create sterile field and help prevent contamination
9. Lubricate intermittent catheter according to manufacturer's instructions.	Prevent urethral trauma, minimize discomfort and reduce the introduction of infection.
10. Discard gloves and put on another pair of sterile gloves.	Maintain sterility
11. Position the sterile receiver to catch urine. Open the inner cover of the catheter.	
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).	
13. Remove the catheter slowly.	Maximise bladder drainage, minimise trauma.
14. 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.
15. Measure and chart urinary output if necessary.	To obtain baseline information
16. Clear away equipment and dispose of clinical waste.	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.