

# Your Catheter Journal

Information & advice for patients and care record for healthcare professionals

## Infection Prevention & Control Service

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**Patient Name** (affix patient sticker)

**Patient ID number** (NHS or Hospital no.)

### Information for patients and carers

#### How to use the catheter journal

The aim of this booklet is so you can keep a record of any care you receive for your catheter, even if you only have it for a short period of time.

We would like to encourage you to record any issues you have with your catheter, for example if it does not drain properly or your doctor has diagnosed a urine infection. You can find a section for your comments towards the back of this booklet (look for patient comments).

You should take this booklet with you to any appointments that you may have with a doctor or nurse. If you have any questions or would like further information, please speak to the doctor or nurse who is involved with your catheter care.



#### How to look after your catheter

- You should keep well hydrated and drink plenty of fluids.
- Ensure you empty your bowels regularly.
- You, your carers, or healthcare professional should always wash hands thoroughly before they touch any part of your catheter.
- Make sure your catheter is draining well and that you have no 'kinks' in the tubing.
- Ensure your drainage bag is below the level of your bladder.

- Your catheter should be secure as any pulling on the catheter or catheter tubing can cause irritation and increase your risk of getting a urine infection.
- Empty your bag into a clean jug, urinal or toilet.
- The tap on the bottom of the drainage bag should be cleaned with an antiseptic wipe before and after your catheter is emptied. Use soap and water when you are at home.
- Clean around your catheter daily with soap and water. Men should make sure that they wash underneath their foreskin.
- Ensure that you have always got adequate supplies of drainage bags, leg bags, over night bags and any other items you need for your catheter.
- Do not touch or disconnect your catheter unnecessarily.
- Do not use oil based creams or talcum powder around the catheter area.



## Symptoms to report

If you experience any of the following, please contact your GP, District Nurse, Practice Nurse or any other healthcare professional involved in the care of your catheter (this list is not exhaustive):

- Bleeding from your catheter or blood in your urine.
- If your urine stops draining from the catheter.
- If you are constipated.
- Your catheter falls out.
- If you develop a fever (high temperature) and/or rigors (shaking linked to a fever).
- New onset of pain in or around your groin or tummy.
- If you have any concerns about your catheter.

## Information for healthcare professional:

The catheter journal should be used to facilitate effective communication between the healthcare professionals within both Primary & Secondary care, who are involved in caring for the patient's urinary catheter.

The patient should be encouraged to take this document with them when they access any healthcare services.

Please complete the catheter journal each time you make a catheter intervention e.g. catheter change, if a Catheter Specimen of Urine (CSU) is taken including the CSU result and any action was required and note any problems with the catheter such as blocking or encrustation.

Please remember to review the patient before proceeding with the catheter change to establish if the catheter is still required and if a trial without catheter (TWOC) is indicated.

## **MRSA Screening**

Patients should have an MRSA screen taken within the last seven days prior to routine catheterisation. MRSA stands for Meticillin resistant *Staphylococcus aureus*. It is a type of *Staphylococcus aureus* bacteria (germ) that is resistant to certain antibiotics so MRSA infections can be quite difficult to treat. The screen should include a swab of the patient's nose and groin as well as a CSU taken from the catheter sampling port.

If the patient is found to be MRSA positive from any site then five days of topical MRSA treatment is advised. This will need to be prescribed by the patient's GP or Doctor caring for the patient. If the CSU is positive for MRSA then antibiotic treatment is only indicated if the patient is symptomatic of a Catheter Associated Urinary Tract Infection (CAUTI), this should be discussed with the patient's doctor and antibiotics should be given as indicated by the specimen's antibiotic sensitivities.

**CLINICAL INTERVENTION RECORD**

(tick appropriate box(s))

**FOR HEALTHCARE  
PROFESSIONALS USE ONLY****(A) Catheter Review Details**

- Please identify if the catheter is:  
☐ Long term ☐ Short term
- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
- Is there a continuing clinical need for the catheter:  
☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
| <input type="checkbox"/> Loss of motor senses/bladder control | <input type="checkbox"/> Monitoring urinary output      | <input type="checkbox"/> Failed TWOC<br>(Trial without catheter) |
| <input type="checkbox"/> Retention                            |   |  |
| <input type="checkbox"/> Other (provide details):             |   |  |

**(C) Patient specific catheter details**

- |                               |   |  |
|-------------------------------|---|--|
| Patients usual catheter size: | Preferred type of tap:<br><input type="checkbox"/> slide <input type="checkbox"/> lever | Leg bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
|                               | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> To initiate catheter care plan | <input type="checkbox"/> Administration of bladder maintenance solution | <input type="checkbox"/> Urgent catheter change   |
| <input type="checkbox"/> Patient education              | <input type="checkbox"/> Catheter Blockage                              | <input type="checkbox"/> MRSA screen              |
| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):

<p><b>(G) Is the patient known or suspected to have a CAUTI:</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was antibiotic therapy indicated:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of antibiotic (if applicable):</p> <p>Causative organism if known e.g. Ecoli:</p>	<p><b>(I) Care setting where intervention given</b> (provide details):</p> <p><input type="checkbox"/> Hospital .....</p> <p><input type="checkbox"/> Intermediate care .....</p> <p><input type="checkbox"/> Nursing or residential home .....</p> <p><input type="checkbox"/> Patients own home .....</p> <p><input type="checkbox"/> Other .....</p>								
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DATE		TIME							

**CLINICAL INTERVENTION RECORD**

(tick appropriate box(s))

**FOR HEALTHCARE  
PROFESSIONALS USE ONLY****(A) Catheter Review Details**

- Please identify if the catheter is:  
☐ Long term ☐ Short term
- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
- Is there a continuing clinical need for the catheter:  
☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
| <input type="checkbox"/> Loss of motor senses/bladder control | <input type="checkbox"/> Monitoring urinary output      | <input type="checkbox"/> Failed TWOC<br>(Trial without catheter) |
| <input type="checkbox"/> Retention                            |   |  |
| <input type="checkbox"/> Other (provide details):             |   |  |

**(C) Patient specific catheter details**

- |                                |   |  |
|--------------------------------|---|--|
| Patient's usual catheter size: | Preferred type of tap:<br><input type="checkbox"/> slide <input type="checkbox"/> lever | Leg bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
|                                | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> To initiate catheter care plan | <input type="checkbox"/> Administration of bladder maintenance solution | <input type="checkbox"/> Urgent catheter change   |
| <input type="checkbox"/> Patient education              | <input type="checkbox"/> Catheter Blockage                              | <input type="checkbox"/> MRSA screen              |
| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):

<p><b>(G) Is the patient known or suspected to have a CAUTI:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was antibiotic therapy indicated:  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of antibiotic (if applicable):  Causative organism if known e.g. Ecoli:</p>	<p><b>(I) Care setting where intervention given</b>  (provide details):</p> <p><input type="checkbox"/> Hospital .....</p> <p><input type="checkbox"/> Intermediate care  .....</p> <p><input type="checkbox"/> Nursing or residential home  .....</p> <p><input type="checkbox"/> Patients own home  .....</p> <p><input type="checkbox"/> Other  .....</p>								
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**CLINICAL INTERVENTION RECORD**

(tick appropriate box(s))

**FOR HEALTHCARE  
PROFESSIONALS USE ONLY****(A) Catheter Review Details**

- Please identify if the catheter is:  
☐ Long term ☐ Short term
- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
- Is there a continuing clinical need for the catheter:  
☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
| <input type="checkbox"/> Loss of motor senses/bladder control | <input type="checkbox"/> Monitoring urinary output      | <input type="checkbox"/> Failed TWOC<br>(Trial without catheter) |
| <input type="checkbox"/> Retention                            |   |  |
| <input type="checkbox"/> Other (provide details):             |   |  |

**(C) Patient specific catheter details**

- |                               |   |  |
|-------------------------------|---|--|
| Patients usual catheter size: | Preferred type of tap:<br><input type="checkbox"/> slide <input type="checkbox"/> lever | Leg bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
|                               | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> To initiate catheter care plan | <input type="checkbox"/> Administration of bladder maintenance solution | <input type="checkbox"/> Urgent catheter change   |
| <input type="checkbox"/> Patient education              | <input type="checkbox"/> Catheter Blockage                              | <input type="checkbox"/> MRSA screen              |
| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):



<p><b>(G) Is the patient known or suspected to have a CAUTI:</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was antibiotic therapy indicated:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of antibiotic (if applicable):</p> <p>Causative organism if known e.g. Ecoli:</p>	<p><b>(I) Care setting where intervention given</b> (provide details):</p> <p><input type="checkbox"/> Hospital .....</p> <p><input type="checkbox"/> Intermediate care .....</p> <p><input type="checkbox"/> Nursing or residential home .....</p> <p><input type="checkbox"/> Patients own home .....</p> <p><input type="checkbox"/> Other .....</p>								
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- Please identify if the catheter is:  
☐ Long term ☐ Short term
- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
- Is there a continuing clinical need for the catheter:  
☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
| <input type="checkbox"/> Loss of motor senses/bladder control | <input type="checkbox"/> Monitoring urinary output      | <input type="checkbox"/> Failed TWOC<br>(Trial without catheter) |
| <input type="checkbox"/> Retention                            |   |  |
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**(C) Patient specific catheter details**

- |                               |   |  |
|-------------------------------|---|--|
| Patients usual catheter size: | Preferred type of tap:<br><input type="checkbox"/> slide <input type="checkbox"/> lever | Leg bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
|                               | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> To initiate catheter care plan | <input type="checkbox"/> Administration of bladder maintenance solution | <input type="checkbox"/> Urgent catheter change   |
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| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):

<p><b>(G) Is the patient known or suspected to have a CAUTI:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was antibiotic therapy indicated:  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of antibiotic (if applicable):  Causative organism if known e.g. Ecoli:</p>	<p><b>(I) Care setting where intervention given</b>  (provide details):</p> <p><input type="checkbox"/> Hospital .....</p> <p><input type="checkbox"/> Intermediate care  .....</p> <p><input type="checkbox"/> Nursing or residential home  .....</p> <p><input type="checkbox"/> Patients own home  .....</p> <p><input type="checkbox"/> Other  .....</p>		
<p><b>Comments:</b></p>			
CARE PERFORMED BY		DESIGNATION	
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**FOR HEALTHCARE  
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- Please identify if the catheter is:  
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- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
- Is there a continuing clinical need for the catheter:  
☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
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| <input type="checkbox"/> Retention                            |   |  |
| <input type="checkbox"/> Other (provide details):             |   |  |

**(C) Patient specific catheter details**

- |                               |   |  |
|-------------------------------|---|--|
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|                               | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
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| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):

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- How long has the patient required a catheter:  
☐ Days ☐ Weeks ☐ Months
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☐ Yes ☐ No (initiate TWOC)

**(B) Reason for catheter** (please tick)

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|---|---|--|
| <input type="checkbox"/> Enlarged prostate                    | <input type="checkbox"/> Preservation of skin integrity | <input type="checkbox"/> Post-surgery                            |
| <input type="checkbox"/> Loss of motor senses/bladder control | <input type="checkbox"/> Monitoring urinary output      | <input type="checkbox"/> Failed TWOC<br>(Trial without catheter) |
| <input type="checkbox"/> Retention                            |   |  |
| <input type="checkbox"/> Other (provide details):             |   |  |

**(C) Patient specific catheter details**

- |                               |   |  |
|-------------------------------|---|--|
| Patients usual catheter size: | Preferred type of tap:<br><input type="checkbox"/> slide <input type="checkbox"/> lever | Leg bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No       |
|                               | Catheter valve:<br><input type="checkbox"/> Yes <input type="checkbox"/> No             | Overnight bag:<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

**(D) Please identify catheter related action taken on this contact**

(there may be more than action)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> To initiate catheter care plan | <input type="checkbox"/> Administration of bladder maintenance solution | <input type="checkbox"/> Urgent catheter change   |
| <input type="checkbox"/> Patient education              | <input type="checkbox"/> Catheter Blockage                              | <input type="checkbox"/> MRSA screen              |
| <input type="checkbox"/> Routine catheter change        | <input type="checkbox"/> Catheter bypassing                             | <input type="checkbox"/> CSU                      |
| <input type="checkbox"/> TWOC                           |   | <input type="checkbox"/> Other (provide details): |

**(E) Catheter details (size, material, batch number).****Affix catheter sticker below**

Date: ..... /..... /..... Time: ..... : .....

Date for next catheter change:

..... /..... /.....

**(F) Is the patient known to be MRSA positive:**☐ Yes ☐ No

If YES and the patient was positive for MRSA colonisation, was decolonisation prescribed (provide details):

<p><b>(G) Is the patient known or suspected to have a CAUTI:</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was antibiotic therapy indicated:  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of antibiotic (if applicable):  Causative organism if known e.g. Ecoli:</p>	<p><b>(I) Care setting where intervention given</b>  (provide details):</p> <p><input type="checkbox"/> Hospital .....</p> <p><input type="checkbox"/> Intermediate care  .....</p> <p><input type="checkbox"/> Nursing or residential home  .....</p> <p><input type="checkbox"/> Patients own home  .....</p> <p><input type="checkbox"/> Other  .....</p>								
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CARE PERFORMED BY		DESIGNATION							
DATE		TIME							

**Patient Comments**

Please add any comments about your catheter that you feel are important to you and the team involved in caring for your catheter. For example “my catheter seems to be leaking urine” or “the colour of my urine looks darker today”. \*Remember to contact the doctor or nurse involved in your catheter care if you are worried about your catheter in any way\*.

Date & time	Your comments



## Further Information:

### National Health Service

Urinary catheter

<https://www.nhs.uk/conditions/urinary-catheters/>

### National Health Service

MRSA

<https://www.nhs.uk/conditions/mrsa/>

### Bladder & Bowel UK

Supporting people with bladder and bowel problems

Tel: 0161 214 4591

<https://www.bbuk.org.uk/>

### Healthtalk

Living with a urinary catheter

<https://healthtalk.org/introduction/living-urinary-catheter/>

(All websites accessed 04 February 2025).

## Sources used for the information in this leaflet:

National Institute for Health and Care Excellence (2014) *Infection prevention and control quality statement 4: urinary catheters*. [QS61]. Available at: <https://www.nice.org.uk/guidance/qs61/chapter/quality-statement-4-urinary-catheters> (Accessed 04 February 2025).

Loveday, H. P., Wilson, J. A., Pratt, R. J., et al. (2014). epic3: national evidence-based guidelines for preventing healthcare-associated infections in NHS hospitals in England. *Journal of Hospital Infection*, 86, S1-S70.

If you would like to suggest any amendments or improvements to this leaflet please contact SWB Library Services on ext 3587 or email [swbh.library@nhs.net](mailto:swbh.library@nhs.net).



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ML5562

Issue Date: January 2025

Review Date: January 2028