

Gloucestershire Safety and Quality Improvement Academy 2026

Catheter Care summit – Training and Education Mandy Butler, Eve Spiers, Geraldine Matthews



Gloucestershire Hospitals NHS Foundation Trust

Background

Following an incident within the trust where a patient's safety was compromised due to the use and care given with the invasive devise of a urinary catheter.

A thematic review of Datix, PALS incident reporting was carried out to be able to understand the complete problem throughout the trust.

This showed many areas for improvement in the urinary catheter pathway.
A catheter care summit was set up, involving 80 multidisciplinary staff and stakeholders from across the healthcare system, and areas for improvement were discussed and identifying five key areas:

1. Staff training
2. Standardisation of care across the healthcare system including the discharge process
3. Documentation and communication across the healthcare system / and between pathways
4. Procurement and stock of equipment
5. Understanding the patient pathway across the healthcare system including escalation

What we did

To fully understand the scope of the problem, we conducted a survey across all staff groups involved in catheterisation and ongoing catheter care. The survey was distributed throughout community healthcare settings—including nursing homes, the acute trust, and community hospitals. Any staff member performing catheter-related procedures was invited to participate. A target of 100 completed questionnaires was set to provide a representative snapshot of current practice.

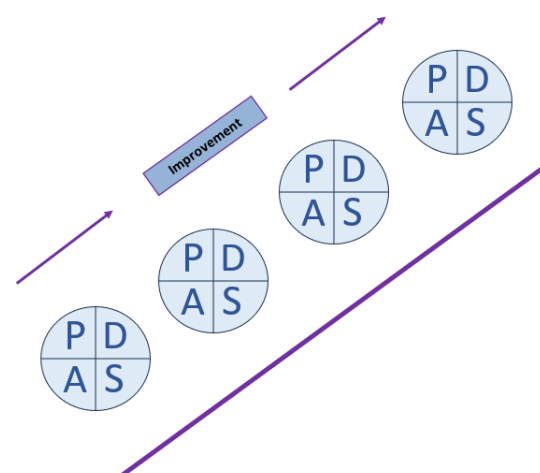
Urinary Catheterisation Audit Mar 2025			
100 qualified healthcare practitioners will be randomly selected from the Trust (L401) to participate in the audit			
Questionnaire:			
Name	Occupation	Register	Date
Healthcare professional (please tick appropriate box)	Registered Nurse	Registered Nurse	
	Registered Nurse Associate	Registered Nurse Associate	
	Student Nurse	Student Nurse	
	Support Worker	Support Worker	
Please tick all that apply			
1. Have you attended any urinary catheterisation training in the last 12 months?	Yes/No	Please state when	Yes/No
2. Do you have a competency for inserting a urinary catheter?	Yes/No	Female Catheterisation	Yes/No
3. When did you achieve your competency?	0-5 years 6-10 years 11-15 years 16-20 years More than 20 years	Male Catheterisation	Yes/No
4. Has your competency ever been discussed/reviewed yearly or your development/competence appraisal on knowledge & skills framework?	Yes/No	Other (please specify)	Yes/No
5. How frequently do you record on going care information of the catheter?	Less than 1 year 1-5 years 6-10 years More than 10 years	Other (please specify)	Yes/No
6. How was this delivered?	Face to face E-learning Virtual Other (please specify)	Other (please specify)	Yes/No
7. How do you document the insertion of a catheter to ensure the evidence of indication is correct and recorded after ongoing care of a urinary catheter?	Yes/No	Other (please specify)	Yes/No
8. How frequently do you record on going care information of the catheter?	Yes/No	Other (please specify)	Yes/No
9. What size catheters are routinely used on total catheterisation?	Yes/No	Other (please specify)	Yes/No
10. Do you know the difference between a long term and short-term catheter?	Yes/No	Other (please specify)	Yes/No
11. How long can a short-term catheter remain in place?	Yes/No	Other (please specify)	Yes/No
12. How long can a long-term catheter remain in place?	Yes/No	Other (please specify)	Yes/No
13. Where do you find the information that depicts what type of catheter is in use in being inserted?	Yes/No	Other (please specify)	Yes/No

The questionnaires were distributed across all ward areas, with encouragement for all disciplines to participate. Nursing staff engaged positively and contributed well to the process. However, participation from the medical staff was limited, which was disappointing given that they are the key prescribers / inserters of urinary catheters

Barriers and challenges

- Time for staff to complete the questionnaire
- Staff wanting to participate in the project
- Time to analyse the data
- Understanding the data

- Cycle 1A – Audit staff current practice staff knowledge/training
- Cycle 1B – EPR – increased staff availability to accurate record keeping
- Cycle 2A – Focussed EPR process in current catheter training
- Cycle 2B – Staff update/refresher training Webinar
- Cycle 3A – 3-year E-learning package (? Mandatory)



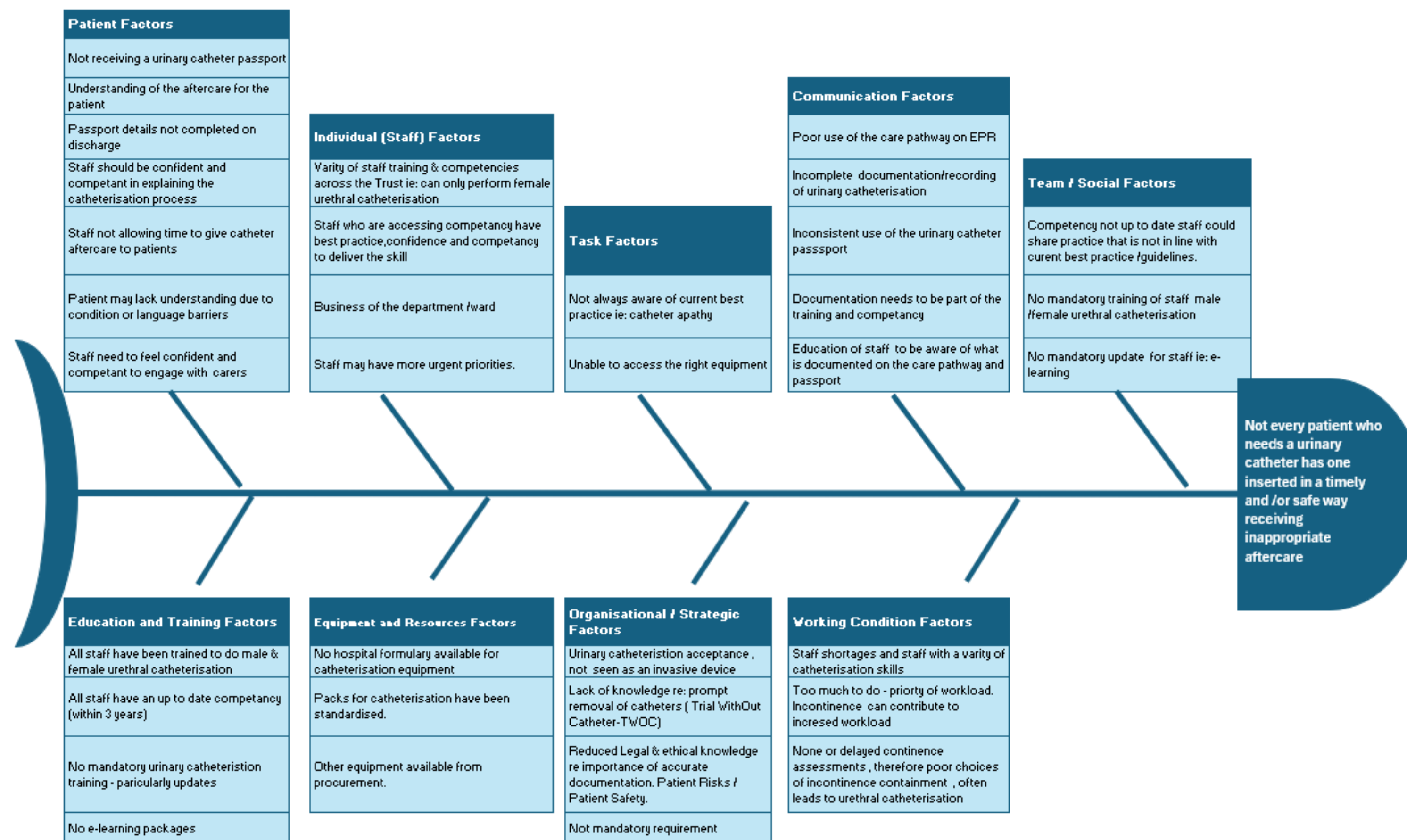
The Problem

Staff of all grades felt that training and levels of competencies for urinary catheterisation and ongoing catheter care could be improved.

Smart Aim

Increase the percentage of staff who already catheterise patients, as demonstrating a catheter care competency within the past three years from 29% to 60%

Fishbone diagram



Results

Total responses: 126. The sample is dominated by RGNs (95 / 126 = 75%), with smaller contributions from Support Workers (6), Nurse Associates (5), Student Nurses (2), Doctors (5) and Others/Not specified (9).

Training and Competency

- 75% of Nurses had an attendance in a training session.
- Doctors – small numbers and variation in their responses.

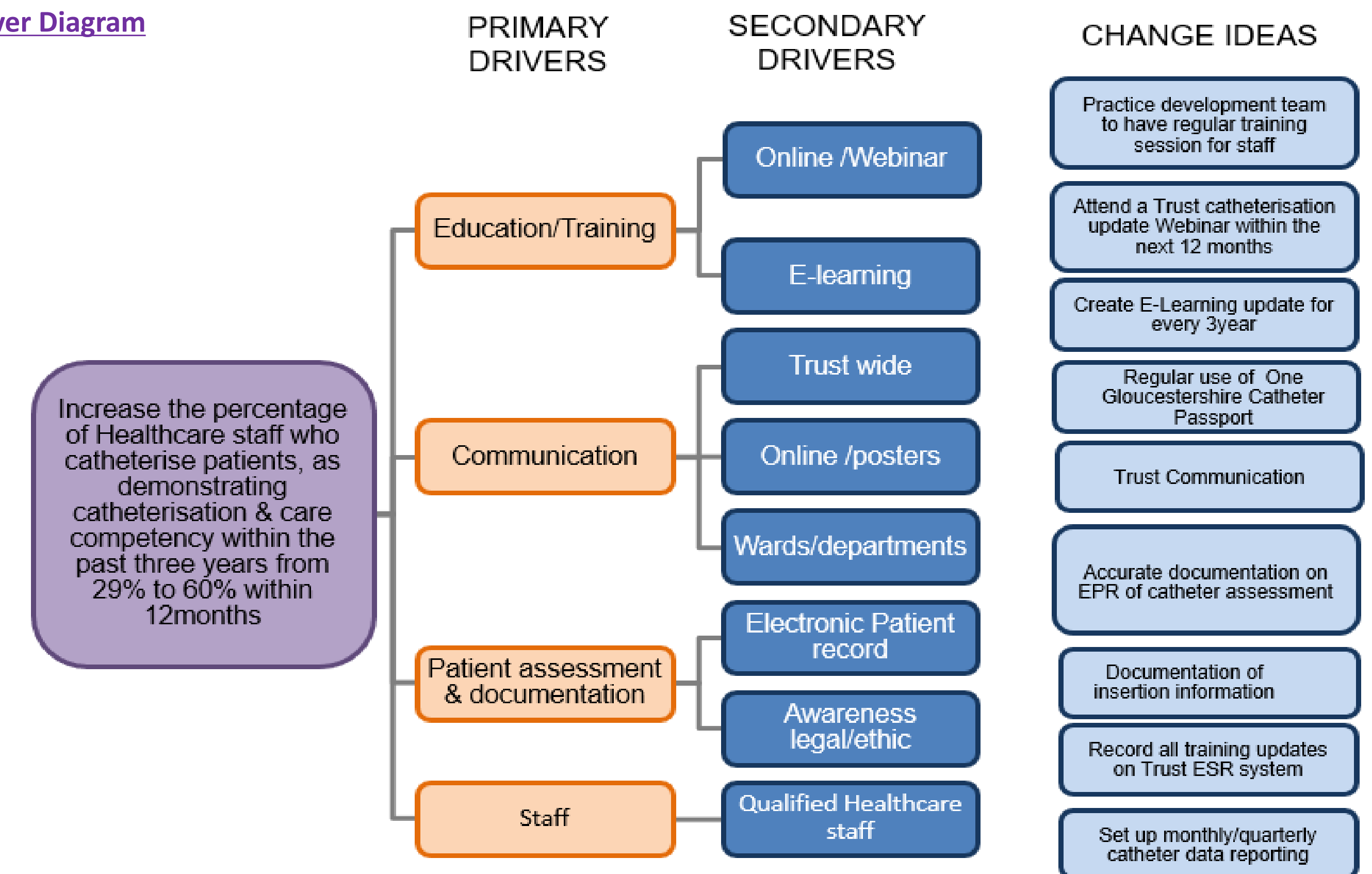
Competencies

- 69% of nurses had a current competency
- Attained:
- 0-5 years = 44%
- 5-10 years = 30%
- 10-15 years = 12%
- 15-20 years = 18%
- Over 20 years = 18%

Documentation

- There were differences in the documentation – staff were not always aware of the correct procedures to follow and where to document. Prio to the survey the care pathway for Catheter insertion and ongoing care was introduced – although at the time of the survey not all staff had been trained in its usage, potentially contributing to variation in practice

Driver Diagram



Results

Catheter passports

- Staff were aware of catheter passports, but there was uncertainty around ownership and responsibility, and passports were not consistently used across the wider healthcare community.

Escalation of problems

- There were inconsistencies in who staff should escalate catheter-related concerns to, leading to delays and variation in practice.
- Unclear escalation routes can result in delayed interventions and potential patient safety risks.
- Standardising escalation pathways will help ensure timely decision-making and support staff confidence.
- Clear guidance and communication across teams are essential to maintain consistent, safe catheter care.

Conclusion

Not all staff have received formal training or achieved competency in catheterisation, increasing the risk of inconsistent practice and the development of unsafe habits. Regular updates are essential to ensure changes in procedure are communicated effectively, but current attendance levels mean key updates may not be reaching all staff.

Implications for Practice

- There is a risk of variation and unsafe practice without consistent, competency-based training.
- Improved access to regular updates is necessary to ensure procedural changes are reliably disseminated.
- Strengthening training pathways will help ensure safe, standardised catheter care across services.

