An Audit into the Documentation of Urethral Catheterisation

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Aims and Objectives of the Audit
- To ensure correct and accurate documentation of urethral catheterisation.
- To enhance the care of catheterised patients by:
  - Encouraging consideration of the indication and the appropriate infection control methods.

Why is Documentation Important?
- It provides a legal record and is fundamental in clinical care.
- Documentation of important information helps with diagnosis and management.
  - E.g. Urinary retention with residual of 500ml vs. 2000ml would imply different differential diagnoses.
- Enables effective planning for TWOC.
- Allows communication between healthcare professionals.

Current Guidelines
- Audit criteria based on approved guidance and recommendations from the Royal College of Nursing, NHS QI Improvement Scotland and the Department of Health.
- Recommendations were used to create specific items of necessary documentation.
- Our end aim was to achieve 90% of the criteria completed for each catheter.

Data Collection
- Data collected during January 2011.
- Collected from a range of wards across YDH.
- Catheters inserted in theatre were excluded (bias result as generally no documentation).
- Catheters inserted by auditors were excluded (bias as they knew required standards).
- A total data set of n=51 results were collected during the first cycle of the audit.
- The intervention below was implemented.
- A re-audit then took place to assess the impact of the intervention.

Proforma from Guidelines
15 specific items that included:
- Patient demographics.
- Indication for catheterisation and specifics about the process.
- Urine observations including residual.
- Type of catheter.

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Initial Audit Results:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Documented?</th>
<th>&gt;90% standard met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Yes 65%</td>
<td>No 35%</td>
</tr>
<tr>
<td>Time</td>
<td>Yes 63%</td>
<td>No 37%</td>
</tr>
<tr>
<td>Name</td>
<td>Yes 51%</td>
<td>No 49%</td>
</tr>
<tr>
<td>Role</td>
<td>Doctor 24%</td>
<td>Nurse 29%</td>
</tr>
<tr>
<td></td>
<td>Other 2%</td>
<td>Not Stated 45%</td>
</tr>
<tr>
<td></td>
<td>No document at all 29%</td>
<td></td>
</tr>
</tbody>
</table>

Results of Re-audit
- Successful implementation with excellent uptake.
- Positive feedback from the nursing and medical staff.
- Staff involved did not feel intervention was a burden or added to workload.
- Massive increase in compliance in all categories - High proportion 100% compliance.

Outcomes
- Successful initial integration into the surgical directorate.
- Subsequent Trust-wide implementation at York Teaching Hospital.
- Positive contribution to accuracy of documentation practice across the Trust.

References