Institution:

Validity period:

CLINICAL situation OR TARGET POPULATION

Person 18 years of age or older with functional autonomy decline possibly due to a major neurocognitive disorder

**AND**

who presents with the following symptoms:

* The inability to empty their bladder

**AND**

* A sensation of bladder fullness **OR** abdominal discomfort

HEALTH PROFESSIONALS OR OTHER PERSONS WHO CAN EXECUTE THE PRESCRIPTION[[1]](#footnote-1)

* *Health-care facilities that wish to write a collective prescription using this template* ***must specify in this section the health professional(s) or group(s) of health professionals*** *who can execute this prescription. The instruction in italics (!) must then be deleted from the version that will be made available.*

contrAindications TO USING THIS PRESCRIPTION

* The same contraindications as those listed for the application of Québec national medical protocol No. 888023, namely:
  + - * Recent (< 3 months) prostate or bladder neck surgery
      * Recent (< 3 months) urethral or prostate trauma
      * Pelvic trauma with bleeding from the urinary meatus following a serious accident
      * Known or presumed acute prostatitis
      * The presence of a penile prosthesis
      * The presence of an artificial urinary sphincter
      * A history of urethral stenosis

Québec’S national medical pROTOCOL

Refer to current Québec’s national medical protocol No. **888023**, drafted by the *Institut national d’excellence en santé et en services sociaux* and published on its website, when executing this prescription.

LIMITS OR situations where a consultation with an authorized prescriber is mandatory

* Failed catheterization (e.g., technical difficulties or a lack of cooperation from the patient) (Refer to physician or specialized nurse practitioner within 24 hours).
* Symptoms suggestive of acute urinary retention despite a bladder volume of 300 ml or less as measured with a portable bladder scanner (Refer to physician within 24 hours).
* A catheterization-related complication (suspected trauma or hematuria possibly caused by malpositioning of the catheter) (Refer to physician within 24 hours).
* When more than 1.5 L of urine is drained within 30 minutes after catheterization, followed by hourly diuresis of more than 200 ml ⁄ hr for 4 hours (Refer to physician or specialized nurse practitioner within 24 hours).
* An allergic reaction (Refer to physician or specialized nurse practitioner within 24 hours).
* Suspected acute prostatitis: fever (or chills) and perineal pain (Refer to physician or specialized nurse practitioner within 24 hours).
* A suspected urinary tract infection (Refer to physician or specialized nurse practitioner within 24 hours).
* Suspected epididymitis: progressive testicular pain, usually unilateral, and scrotal erythema or edema on the affected side, with or without fever (Refer to physician or specialized nurse practitioner within 24 hours).
* Suspected renal impairment: low diuresis (less than 30 ml ⁄ hr for 4 or more hours) (Refer to physician or specialized nurse practitioner within 24 hours).
* If weaning off the catheter is being considered (Refer to physician within 7 to 10 days after urinary catheter was installed).

documentation

Complete the community pharmacist liaison form, if need be. Refer to the template available in the section entitled “[Protocoles médicaux nationaux et ordonnances associées](https://www.inesss.qc.ca/thematiques/medicaments/protocoles-medicaux-nationaux-et-ordonnances-associees.html)” on INESSS’s website.

identification of responding prescriber

* *Health-care facilities that wish to write a collective prescription using this template* ***must specify in this section the mechanism of identification of the responding prescriber*,** *whose name must be entered on the liaison form upon individualization of this collective prescription. The instruction in italics (!) must then be deleted from the version that will be made available.*

implementation process

1. **development OF current version (identification of the authorized prescriber or prescribers concerned and of the persons responsible, if applicable)**
2. **VALIDATION OF CURRENT VERSION (identification of the authorized prescriber or prescribers concerned and of the persons responsible, if applicable)**
3. **APPROVAL OF CURRENT VERSION BY THE REPRESENTATIVE OF THE INSTITUTION’S CPDP**

Last name: First name:

Signature: Date:

1. **APPROVAL OF CURRENT VERSION BY THE SIGNING AUTHORIZED PRESCRIBERS (NON-INSTITUTIONAL)**

| Last and first name | License number | Signature | Telephone | Fax |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **REVIEW**

Effective date:

Date of last review (if applicable):

Scheduled date of next review:

Signature of responding authorized prescriber (if applicable):

Signature: Date:

1. The authorized health professional or other authorized person must be sure to have the necessary qualifications to execute this prescription (e.g., training) [↑](#footnote-ref-1)