

### PURPOSE

Urinary catheters may require irrigation to flush out blood clots or sediment that may be occluding the catheter. This practice support document outlines the steps for performing this procedure.

### POLICY STATEMENTS

Urinary catheter/bladder irrigation **requires a prescriber's order**. The order must include type and amount of irrigating solution and frequency of irrigation.

**Routine irrigation is to be avoided as it increases the risk of infection.**

The following assessment and troubleshooting steps should be taken prior to decision to irrigate catheter:

- No urine output x 1 hour
- Patient complaints of urinary retention (abdominal discomfort, urge to void)
- Palpate for distended bladder
- Site-to-source check (system intact, kinks, clamps, etc.)
- Reposition patient to optimize drainage
- Scan bladder
- Discuss assessment findings with team and obtain order

### SITE APPLICABILITY

All inpatient areas.

### PRACTICE LEVEL/COMPETENCIES

Catheter irrigation is a foundational nursing competency.

### EQUIPMENT

- sterile tray
- sterile 30 or 60 mL catheter tip syringe
- sterile irrigation solution prescribed (at room temperature), usually 0.9% sodium chloride is used
- sterile bowl for collection of drained irrigation fluid
- absorbent pad
- chlorhexidine gluconate/alcohol swabs
- sterile gloves
- new Urine Meter Drainage Bag

PROCEDURE	Rationale
1. <b>VERIFY</b> need for catheter/bladder irrigation and <b>CHECK</b> chart for prescriber's order to irrigate a urethral or suprapubic catheter.	<i>Ensures procedure is being applied correctly, to reduce unnecessary opening of the system and reduce risk of infection.</i>
2. <b>OBTAIN</b> help of colleague .	<i>To provide physical or emotional support.</i>
3. <b>IDENTIFY</b> patient, <b>EXPLAIN</b> procedure and <b>PROVIDE</b> privacy.	<i>Failure to correctly identify patients prior to procedures may result in errors.</i>  <i>Reduces child and family's anxiety. Evaluates and reinforces understanding of previously taught information and confirms consent for procedure.</i>
4. <b>ASSESS</b> for pain or bladder spasms and premedicate if needed.	<i>Medicating for pain before procedure can increase patient's comfort during and after procedure.</i>
5. <b>PERFORM</b> hand hygiene and <b>DON</b> gloves.	<i>Reduces transmission of micro organisms</i>

## CATHETER/BLADDER IRRIGATION – SYRINGE METHOD

6. <b>PLACE</b> patient in comfortable position – the dorsal recumbent is the most convenient if patient can tolerate it.	<i>The dorsal recumbent position facilitates flow of irrigation solution into the bladder.</i>
7. <b>PREPARE</b> supplies and arrange on sterile field.	<i>Maintains sterility of equipment.</i>
8. <b>PLACE</b> an absorbent pad under the connection of tubing and catheter.	<i>Absorbent pad protects linen and patient from urine and body fluids.</i>
9. <b>POUR</b> the irrigation solution into the sterile tray. <b>DON</b> sterile gloves and <b>DRAW</b> up prescribed amount of solution into syringe. Do not contaminate the syringe tip. Place on sterile field.	<i>Maintains sterility of irrigation solution and equipment.</i>
10. <b>PLACE</b> the sterile towel and bowl within easy reach of the site of the catheter and drainage tubing connection.	
11. <b>SCRUB</b> the connection site between the catheter and the drainage tube for 30 seconds using the CHG/alcohol swab and allow to dry. <b>CLEAN</b> up the catheter towards patient for 4-6 inches with second swab.	
12. <b>DISCONNECT</b> the catheter from the drainage tube, discard of drainage bag in bio hazard.	
13. <b>PLACE</b> the catheter over the edge of the sterile bowl.	
14. <b>CONNECT</b> syringe to catheter and gently instill ordered amount of solution and <b>MONITOR</b> patient for pain or discomfort. Stop procedure if patient complains and notify physician.	<i>Irrigates catheter.</i>
15. <b>REMOVE</b> syringe and observe returns for volume, colour and clarity and any solid material passed.	<i>Evaluates efficacy of treatment.</i>
16. <b>REPEAT</b> this procedure, if ordered, until the returns are clear or the desired amount of solution has been instilled.	<i>Passive drainage of urine decreases the likelihood of trauma to the bladder.</i>
<b>NOTE:</b> If unable to instill or aspirate fluid, the catheter is either not in the bladder, is sucking on the bladder wall, or blocked with clots/sediment. Notify physician, remove catheter, and prepare to insert new urinary catheter.	
17. catheter to new urine drainage bag. Check the tubing after reconnected to see if urine is flowing out of the catheter within 30-60 minutes. Assess if there is any urine in the bladder and if there is and there is still no urine flowing, the irrigation may have to be repeated.	<i>Evaluates efficacy of treatment and ensures system is intact and functioning.</i>
18. <b>REMOVE</b> equipment and dispose appropriately. <b>PERFORM</b> hand hygiene.	<i>Routine infection control practices; reduces transmission of microorganisms.</i>

### DOCUMENTATION

**DOCUMENT** on appropriate record:

- date and time
- assessment indicating need for irrigation (e.g. decreased urine output with indication of full bladder or increased sediment, clots, bladder spasms/pain).

- type and amount of irrigation solution used
- amount and quality of returns
- urine output, colour, clarity and any solids passed 30-60 minutes after procedure
- patient's response to procedure
- any other pertinent actions or observations

### REFERENCES

- Children's Hospitals and Clinics of Minnesota, Patient/Family Education – Urinary Catheter Irrigation. February 2010. Minneapolis, Minnesota.
- Cochran, S. (2007). Care of the Indwelling Urinary Catheter – Is it Evidence Based? *Journal of Wound, Ostomy and Continence Nursing*. 34(3):282-287.
- Porfyrus, S. (2008). Indwelling Urinary Catheter: Irrigation. In Trivits Verger, J. and Lebet, R.M., (Ed.), *AACN Procedure Manual for Pediatric Acute and Critical Care* (pp.822-825). St Louis, Missouri: Saunders Elsevier.
- Wilson, M, Wilde, M, Webb, ML, Thompson, D, Parker, D, Harwood, J, Callan, L and Gray, M. (2009). Nursing Interventions to Reduce the Risk of Catheter-Associated Urinary Tract Infection. *Journal of Wound Ostomy Continence Nursing*, 36(2):137-154.