CONSIDERATIONS:

1. A urostomy is formed when the urinary bladder is removed or when urine must be diverted from the bladder:
   a. All urostomies are "urinary diversions"
   b. Urostomies have many different names related to how they were surgically formed, but from a nursing/home care perspective there are two types:
      i. Incontinent urostomy (e.g., cutaneous ureterostomy, transureterostomy, ileal conduit, etc.)
      ii. Continent urostomy (e.g., Kock pouch, Indiana pouch continent diversion, etc.)
      iii. This procedure relates to continent urostomies
2. Continent urinary diversions surgically form a new "bladder" for the patient. This bladder can be formed in many different ways but basically:
   a. Approximately 8 inches of large intestine is removed from patient's intestines
   b. This piece of intestine is formed into a pouch with two valves, an intake valve and an output valve
   c. The ureters are attached above the intake valve
   d. The pouch becomes a reservoir for urine
   e. The output valve leads to the urostomy opening, through which a catheter can be inserted to drain the urine out of the reservoir
3. To drain the pouch, access it with a urinary catheter several times day:
   a. Cather is inserted into ostomy stoma and larger (distal) end of catheter is held over toilet. Urine in pouch empties by gravity
   b. Clean procedure is appropriate; sterile equipment is not needed
   c. Ultimately, pouch should be emptied at least 4 to 6 times a day, but initially catheterization must be done more often until pouch gradually grows larger
   d. Ultimately, pouch will be able to hold 500 to 1000 mLs
   e. Pouch should be emptied more often than usual if the patient drinks more than usual
   f. Pouch should be emptied whenever it feels full. Patient will feel a heaviness or pressure when it is becoming full
   g. Pouch should be emptied when it is 1/3 to 1/2 full
   h. Catheters can be used over and over again
4. Pouches are made from intestine, which produce mucous:
   a. Urine from the pouch will have strands of mucous in it, which is normal
   b. The mucous will collect at the bottom of the pouch and will need to be flushed out
   c. After draining the pouch, the patient will need to irrigate the catheter at least 1 to 2 times a day
5. Accessing & Irrigating the Pouch:
   a. The ostomy opening, formed from intestine, produces mucous; usually the catheter does not need lubrication
   b. If lubrication needed, only use water-soluble lubricant. Petroleum jelly will clog the tube
   c. When accessed, narrowing at the nipple valve can be felt by nurse, but catheter should move easily through valve. Never force the catheter, which will cause injury to valve, visible as bleeding
6. Home care clinicians may encounter patients with continent urostomies in the post-operative period (first 3 - 4 weeks post-surgery) or with well-established continent ostomy. The care will be different in the two periods. In the post-operative period:
   a. An indwelling catheter is placed to give the pouch a chance to heal without any distension
   b. Infection risk is high, due to accessing an area with unhealed wounds
   c. Irrigation needs to be frequent to prevent mucous/clots from sitting at bottom of pouch
   d. After a couple of weeks, the indwelling catheter will be removed and the patient will need to catheterize every 2 to 3 hours while awake and once at night, irrigating after each catheterization
   e. Gradually the time interval between catheterization will be increased until reaching 4 to 6 time's day and the irrigations will be decreased until reaching 1 or 2 per day
   f. Increase time by one hour the next week
7. Patient Teaching/Instructions:
   a. Empty pouch whenever you feel full. Pressure felt inside of abdomen or in the back is an indication that the pouch is full and needs to be emptied. If fluid intake has been higher, do not wait for the scheduled time to empty pouch
   b. Carry catheterization and irrigation supplies with you at all times
   c. If catheter cannot be washed immediately after use, place in a plastic container or bag and then wash when possible. Do not use the same bag that has the clean catheters
   d. Use clean technique and good hand hygiene with empty pouch to prevent infections. Use clean catheters, place on a clean paper towel while the patient is preparing for catheterizing or irrigating the pouch
   e. Wear medical-alert identification. Also carry a card giving instruction for inserting the catheter
   f. If the catheter will not go in, try the following:
      i. Relax, take deep breaths and try again

ii. Raise your head to expand abdominal muscles and consciously relax them
iii. Change positions: sit down, stand up or lie down
iv. Stop, and try again in a few minutes
v. If you feel full and cannot pass catheter, contact your physician or go to an emergency room

g. Urine leakage between emptying procedures especially at night need to be assessed and adjustment in patient routine are made. Assess the following:
   i. Assess fluid intake may need to empty sooner or decrease intake after later in evening
   ii. Set alarm clock to wake at night to empty pouch to prevent over distension
h. Stoma can be covered with gauze and tape, a small adhesive bandage or a stoma cover
i. Pouch will create mucous and needs to be irrigated daily and as needed

EQUIPMENT:

Gloves
Impervious trash bag
Urinary Catheter 16 °F or 18 °F or coude tipped catheter
Appropriate receptacle for urine collection
2 resealable plastic bag/containers
Cotton sponges, washcloth or towette
Clean paper towels
Stoma coverings, i.e., gauze and tape or an adhesive bandage manufactured stoma cover
Water-soluble lubricant (optional)
Equipment for irrigation:
60 mL syringe Bulb or piston-type
Water or normal saline
Container for holding water or saline
Equipment for draining
Impervious trash bag

PROCEDURE:

1. Catheterization:
   a. Adhere to Standard Precautions and explain procedure to patient
   b. Place clean catheter on clean paper towel
   c. Remove the dressing/stoma cover
   d. Wipe away any mucous that has accumulated with the washcloth or towelette
   e. Moisten catheter tip with water or with water-soluble lubricant
   f. Place large end of catheter in drainage container or position over the toilet
   g. Place tip of catheter gently through the stoma until urine is flowing easily
   h. If resistance is met, pause and then continue with gentle pressure until it passes into pouch:
      i. Insert catheter gently, turning catheter tip in all directions
      ii. Change patient's position (lying, sitting, and standing)
   i. Hold the catheter in place until urine stops flowing. Take a few deep breaths and move catheter around the pouch to be sure it is empty
   j. If catheter drains slowly, remove catheter and check if openings are plugged with mucus. To remove mucus:
      i. Rinse catheter with warm water, cleaning away mucous, and reinsert
      ii. If it still won't drain, irrigate the catheter as per the irrigation procedure
   k. Withdraw the catheter slowly, allowing extra urine to drain if present
   l. Pinch catheter before removing it from stoma to prevent drips of urine getting on clothing
   m. Clean the catheter if at home
   n. If not convenient to clean catheter, place soiled catheter into empty resealable plastic bag/container until it can be cleaned
   o. Place covering over stoma
   p. Discard soiled supplies in appropriate containers
2. Irrigation:
   a. When irrigation is due, plan ahead before performing catheterization
   b. Fill 60 mL syringe with about 50 mL water or saline, as ordered)
   c. Insert syringe with water or saline into distal end of catheter
   d. Gently push water or saline into pouch
   e. Withdraw fluid gently with syringe, or remove syringe from catheter and allow fluid and mucous to drain
      [**Note**: Use only enough pressure when instilling or withdrawing fluid to break up mucous; using excessive force may cause injury]
   f. Repeat until fluid returns clear (no more mucous)
      [**Note** Do not instill more fluid if fluid instilled does not return]
3. Cleaning Catheters:
   a. Wash used catheters in warm soapy water
   b. Flush the inside of the catheter with warm soapy water several times using a catheter-tipped syringe or turkey baster
   c. Swish catheters so soapy water runs through inside of catheter
   d. Rinse catheter well inside and out with clean water making sure all soapy residue has been removed
   e. Dry outside of catheter with paper towel

f. Hang over clean surface or place catheter on a clean paper towel to air dry
g. When catheters are dry, place into a clean plastic bag/container to store
h. Catheters can be used for many months. Discard and obtain a new catheter if it becomes:
    i. Can no longer be completely cleaned
    ii. Becomes too soft
    iii. Becomes cracked
    iv. Becomes stiff

AFTER CARE:

1. Document in patient's record:
    a. Type and size of catheter used
    b. Amount, color, and odor of urine
    c. Type and amount of irrigation fluid and number of times irrigated
    d. Patient's response to procedure
    e. Instruction given to patient/caregiver
    f. Communication with physician when necessary
2. Teach patient/caregiver as per “Patient Education/Instructions.”
3. Communicate with physician immediately if unable to access pouch. Alert physician to adverse changes in urine or stoma.

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