MANAGEMENT OF THE BLADDER
AND URINARY DRAINAGE APPARATUS

BLADDER IRRIGATION

Keywords: Bladder, irrigation, washout, catheter, bladder irrigation chart, catheter obstruction

PURPOSE

To reflect the best available evidence in the management of the woman requiring bladder irrigation.

KEY POINTS

1. A Medical Officer’s order is required to initiate bladder irrigation.
2. Maintaining a sterile closed urinary drainage system minimises the risk of catheter associated infection.
3. Initial urethral catheterisation with a 3 way catheter shall be undertaken by a medical officer if there is a risk of rupturing the surgical anastomosis.
4. Hand hygiene shall be performed prior to and after contact with the woman and/or the equipment.
5. Use of PPE shall be in accordance with standard precautions.

EQUIPMENT

- Y type irrigation set
- 2 x 2000mL “Uromatic” sodium chloride 0.9% solution for irrigation – room temperature.
- Non sterile gloves
- 2L urinary drainage bag
- IV pole
- Bladder washout chart

PROCEDURE

1. If a 3 way indwelling catheter is not already insitu, insert the appropriate sized 3 way Foley catheter. Size 22f catheters are recommended for bladder washouts.
2. Perform hand hygiene.
3. Prepare irrigation line
   I. Remove protective covering from irrigation set.
   II. Ensure the clamps in line are closed.
   III. Insert the spike into the insertion port of the irrigation solution container using a non touch technique. Repeat with the second bag.
   IV. Place both bags of irrigation solution on the IV pole at the end of the bed.
   V. Open one clamp and prime the tubing, then re clamp.
   VI. Repeat the priming with the second bag.
4. Assess the woman’s knowledge and provide education as required.
5. Position the woman supine on the bed with the catheter exposed.

6. Hang both bags above the level of the woman’s head for gravitational flow, with one bag higher than the other (Use a J hook).

7. Label the bags with consecutive numbers for monitoring the amount of fluid irrigated into the bladder.

8. Perform hygiene.

9. Put on non sterile gloves.

10. Swab the irrigation lumen of the catheter with an alcohol swab and allow to air dry.

11. Prime the line.

12. Connect the irrigation tubing to the irrigation lumen of the catheter using a non touch technique.

13. Ensure the catheter is secured to the woman’s leg with adhesive tape.

14. The irrigation / drainage tubing shall be positioned over the anterior aspect of the woman’s leg.

15. Connect the 4 litre catheter bag to the outlet lumen using a non touch technique.

16. Open both clamps and run both bags simultaneously. Only change the top bag.

17. Observe the washout a minimum of every 15 minutes to ensure the irrigation solution bag is not empty and the catheter is not occluded.

18. Titrate the flow of the irrigation fluid according to the colour of the output, presence of clots or as per medical officer’s instructions.

19. Empty the 4L catheter bag into a measuring jug.

20. Replace the empty bag of irrigation fluid with a new bag ensuring it is labelled with the next consecutive number.

21. Record on the bladder irrigation chart
   I. Date
   II. Time
   III. Bag number, amount irrigated in
   IV. Amount drained out
   V. Balance
   VI. Colour

22. Enter the urine output onto the fluid balance chart.

**MANAGEMENT OF CATHETER OBSTRUCTION**

1. Clamp irrigation bags and turn off the roller clamp.

2. Check the fluid balance / bladder irrigation charts for signs of urine / irrigation retention.

3. Assess the catheter and tubing for patency, kinking, traction and leakage – correct as required.

4. Ensure the catheter tubing is adequately secured.

5. Check the irrigation solution for:
   - Remaining volume
• Height of the stand
• Level of the fluid in the drip chamber

6. Check the drainage bag for:
• Amount
• Colour
• Consistency
• Position – reposition if required.

7. Attempt using the “ball pump” on the drainage bag:
• Inform the woman of the potential discomfort.

• Close the distal clamp
• Ensure the proximal clamp remains open and squeeze the “pump ball” in an attempt to expel any clots on the end of the catheter
• Once the “pump ball” has been squeezed twice, release the distal slide clamp and assess if there is any flow of urine
• If urine drains, assess the colour and volume.
• Recomence bladder irrigation.
• Inform the medical officer and shift coordinator
• Document in the progress notes, the colour of the output and the woman’s tolerance of the washout.
• If there is nil drainage – inform the Medical Officer immediately.

REFERENCES / STANDARD
National Standards – 1- Care provided by the clinical workforce is guided by current best practice
Legislation -
Related Policies -
Other related documents – KEMH Clinical Guideline, Section:
• Obstetrics & Midwifery: Antenatal Care: Minor Symptoms / Disorders of Pregnancy: Management of Constipation in Pregnancy
• Pharmacy: Antimicrobial Stewardship: 3.4 Antibiotic Treatment for Vaginal Infections

RESPONSIBILITY
Policy Sponsor | Nursing & Midwifery Director OGCCU
Initial Endorsement | April 2002
Last Reviewed | February 2016
Last Amended | 
Review date | February 2019