PURPOSE:
To remove contents of the internal reservoir at regular intervals via catheter.

CONSIDERATIONS:
1. Never force the catheter as you can traumatize mucosa and cause bleeding.
2. The nipple valve opening will not be located in the same place on all patients.
3. There is a narrowing at the nipple valve felt by the nurse as a different sensation as the catheter proceeds through the valve.
4. Due to the mucosal lining of a stoma, most patients do not need a lubricating jelly. If lubrication is needed, use only water-soluble types. Never use petroleum jelly.
5. The catheterization schedule is as follows:
   a. Every 2 to 3 hours for one week.
   b. Increase time by one hour the next week. Continue with this method until the patient is able to regulate own schedule.
6. Patient instructions include the following:
   a. Pressure felt inside of abdomen or in the back is an indication that the pouch is full and needs to be emptied.
   b. Clean catheters are never placed with soiled catheters.
   c. Clean catheters are always placed on a clean paper towel while the patient is preparing for catheterizing the stoma.
   d. Keep catheter with you at all times.
   e. Occasional flecks of blood in urine are normal.
   f. If leakage from stoma at night, decrease fluid intake after 7-8 p.m.
   g. Stoma can be covered with small adhesive bandage - this is usually sufficient.
7. Pouch will create mucous and needs to be irrigated daily.

EQUIPMENT:
Catheter – i.e., 24 Robinson straight, 20-22 French Coude’ Tip Red Robinson
Appropriate receptacle for urine collection
2 resealable plastic bag
Antimicrobial solution
Cotton sponges
Clean paper towels
60 mL syringe, catheter tip (extra syringe optional)
Stoma coverings, i.e., Telfa coverings cut to appropriate size, manufactured stoma cover, large self-adhesive bandage
Water-soluble lubricant (optional)
Squeeze bottle (optional)
Personal protective equipment
Impervious trash bag

Normal saline
Piston syringe

PROCEDURE:
1. Adhere to Standard Precautions.
2. Explain procedure to patient.
3. Remove clean catheter from resealable plastic bag and place on clean paper towel.
4. Empty external collection devise, if being used.
5. Moisten cotton sponge with antimicrobial solution and swab stoma from inside out.
6. Lubricate tip of catheter with water-soluble lubricant if desired.
7. To locate nipple valve:
   a. Insert catheter gently, turning catheter tip in all directions.
   b. Change patient’s position (lying, sitting, and standing).
8. After inserting catheter into pouch, empty pouch by gravity drainage.
9. Drain pouch completely. If catheter drains slowly, remove catheter and check if openings are plugged with mucus. To remove mucus:
   a. Rinse catheter with hot water.
   b. Run antimicrobial solution through center of catheter using tip of a squeeze bottle or extra syringe.
   c. Insert into stoma to drain urine from pouch.
10. Place soiled catheter into empty resealable plastic bag until it can be cleaned.
11. Remove antimicrobial solution from stoma and skin with warm water and cotton sponges.
12. Place covering over stoma.
13. Discard soiled supplies in appropriate containers.
14. One time per day, after draining pouch completely, irrigate with 30-40 mL normal saline and drain. Repeat if necessary to clear pouch of mucous.

AFTER CARE:
1. Soak used catheters in hot, soapy water. Use syringe to run water through catheter. Use same method to rinse with clear, hot water, making sure all soapy residue has been removed.
2. Dry outside of catheter with paper towel.
3. Using a squeeze bottle or an extra syringe, run antimicrobial solution through the center of the catheter.
4. Catheter can then be placed on a clean paper towel to air dry.
5. Document in patient's record:
   a. The amount, color, and odor of urine.
   b. Patient’s response to procedure.
   c. Instruction given to patient/caregiver.
   d. Communication with physician when necessary.