Catheter care workbook
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Training and assessment information

Welcome
Welcome to your course and Premium Health. The aim of this resource is to provide the essential knowledge and skills you require to effectively care for residents with either a urethral or suprapubic catheter or external urinary drainage device.

Helping you to succeed in your course
We select our Premium Health trainers and assessors carefully. All are nurses or paramedics with appropriate qualifications, technical expertise and experience in both education and emergency first aid and in the disability or health care sector. This enables them to provide you with quality training which is grounded in experience and knowledge of the field.

Performance outcomes
On completion of this course, and as part of your assessment process, you will be able to:

- Identify different types of urinary catheters and external drainage devices
- Describe complications relating to the use of urinary catheters or urinary devices
- Identify that support workers are not authorised to insert or remove urinary catheters
- Define the correct infection control procedures for handling and cleaning urine drainage bags
- Demonstrate the changing of a urine drainage bag
- Demonstrate the emptying of a urine drainage bag
- Demonstrate the application of a condom drainage device

Statement of Participation
A Statement of Participation will be issued upon successful achievement of the assessment tasks in this non-accredited course.

Evaluation of the course
A student feedback form is provided at the back of the workbook. Your feedback is important to us as we use this as part of our continuous improvement cycle. Please complete the form at the end of your course.

Premium Health’s customer service
We offer you an on-going service in relation to course information and invite you to call our office on 1300 72 12 92 or email us on info@premiumhealth.com.au.

For more information about Premium Health specialised health and first aid courses, products, services and policies, access our website www.premiumhealth.com.au
Urinary catheter care

The urinary system

Urine is made in the kidneys and travels down two tubes called ureters into the bladder. It is collected and stored until the bladder is full enough to empty via the urethra. The average adult bladder usually can hold about 2 cups (400 - 600 mls) of urine for 2 to 5 hours. During the emptying process, this control moves from voluntary (under the person’s control) to involuntary control (under control of the brain). There are occasions when the bladder can empty involuntarily, e.g. following a fright.

The urinary bladder is a hollow, muscular sac that lies in the pelvis, just above and behind the pubic bone. The bladder’s main function is to store and release urine. The bladder is lined by layers of muscle tissue that stretch to accommodate urine. It swells into a round shape when it is full and gets smaller when empty. When empty, the bladder is about the size and shape of a pear. Urination (which occurs when the bladder is emptying or voiding) is usually infrequent and is usually under voluntary control.

As the bladder fills and reaches its limit, the sensation to urinate becomes stronger. At that point, nerves from the bladder send messages to the sacral spinal cord (the lowest part of the spinal cord) and then to the brain that the bladder is full. The urge to empty the bladder intensifies. The brain sends messages back to the bladder and the bladder muscles respond by contracting to start the emptying process. Two sphincters (valves) open to allow urine to flow out. Urine exits from the bladder into the urethra, which then carries urine out of the body.

Because the male urethra passes through the penis it is approximately 20cm long in contrast to the female urethra which is approximately 4cm long. The male urethra has a dual role. The vas deferens on each side joins the duct from the seminal vesicle to form the ejaculatory duct. This enters the urethra where it passes through the prostate gland. The next part known as the penile urethra is the channel for either urine or seminal fluid to exit. Reflex contraction of the muscular sphincter around the bladder opening prevents backflow into the bladder during ejaculation.

Bladder management

Some residents may require support with bladder management. Urinary catheterisation can be useful for people with bladder problems, such as urinary retention or bladder obstruction. It may be suggested for people who have long-term chronic problems that prevent them from emptying their bladder, for example, those with spinal cord injuries and pelvic nerve damage. Catheterisation can also be used on a temporary basis to help people retrain their bladders to empty, where there is the need for accurate monitoring of input and output such as after surgery, for comfort for the terminally ill and to manage intractable incontinence. It may also be needed after certain kinds of surgery such as trans-urethral resection.
Another common management tool is the use of continence aids such as pads and pull-up pants. A continence specialist, often a registered nurse employed by the supplying company, will advise on the most appropriate aids for a resident. External bladder control methods such as condom drainage or an external continence device (ECD) for males is another option. Also removing food and drinks from the diet that can worsen urinary frequency such as carbonated drinks, citrus fruit drinks, acidic juices and alcohol.

A bladder training program could be used to teach a resident how to postpone urge incontinence. Bladder training includes asking a person to hold on for a bit longer each time they get the urge to urinate. A continence specialist can teach deferment techniques which can be done sitting down or standing still.

They include techniques such as:

- Pelvic floor muscle exercise program to strengthen pelvic muscle control. This might be 6 squeezes held for 6 seconds each, three times a day.
- Using mind distraction, like counting backwards from 100, or a task suited to the individual and their abilities

**Urinary incontinence or urinary retention**

Urinary incontinence or retention can impact on many aspects of a person’s life including their quality of life and relationships. It also may result in anxiety, embarrassment and concern about its impact on personal relationships.

**Urinary incontinence** is any involuntary leakage of urine and is a common and distressing problem. It is a symptom of the bladder’s inability to properly store or drain urine via normal voiding i.e. emptying of the bladder. Urinary incontinence almost always results from an underlying treatable medical condition.

There are several types of urinary incontinence. These include:

- **Stress incontinence** - due to insufficient strength of the pelvic floor muscles, commonly affecting women after vaginal births. It can occur after coughing, laughing, bending, squatting or during exercise
- **Urge incontinence** - involuntary passing of urine when the urge to pass urine is experienced
- **Overflow incontinence** - where the bladder constantly dribbles or continues to dribble for some time after urine has been passed. The bladder does not completely empty and therefore a moderate amount of urine is retained in the bladder. It is the extra urine produced in the bladder which constantly overflows – similar to a bowl of water will overflow when the tap is left running.
- **Functional incontinence** - occurs when a person knows they need to pass urine but cannot make it to the toilet in time. Causes include poor eyesight, poor mobility, poor dexterity, unwillingness to go to the toilet because of depression, anxiety or anger, drunkenness or being in a situation in which it is impossible to reach the toilet in time. There also may be problems such as confusion, dementia, or inability to communicate that prevents a person from reaching a toilet in time.
- **Bedwetting** - is episodic urinary incontinence while asleep and is normal in young children
- **Transient incontinence** - which is temporary incontinence: It can be triggered by medications, adrenal insufficiency, mental impairment, restricted mobility and faecal impaction (severe constipation), which can push against the urinary tract and obstruct outflow.
- **Structural incontinence** Structural problems or malformations in the urinary system can cause incontinence but is not common. These problems are usually diagnosed in childhood. Fistulas (openings from one area to another) caused by obstetric and gynaecological trauma or injury can also lead to incontinence
Urinary retention is a lack in the ability to urinate. It is a common complication in men with benign prostatic hyperplasia (BPH). It can also be caused by nerve dysfunction, infection or some medications.

The signs and symptoms of urinary retention are a poor urinary stream with intermittent flow, straining, a sense of incomplete voiding and hesitancy which is a delay between trying to urinate and the flow actually beginning. As the bladder doesn’t empty completely, this may lead to incontinence, nocturia (need to urinate at night) and an increased frequency in trying to pass urine.

Acute retention is a medical emergency, as the bladder may stretch and possibly tear. If the bladder distends enough it becomes painful. Diagnosis and/or treatment of urinary retention may require use of a urinary catheter.

Urinary catheters

A catheter is a conduit or method of draining urine from the bladder to an attached drainage bag or container for short-term, long-term or intermittent periods.

Urinary catheters can be kept permanently in place (an indwelling catheter inserted via the urethra or a Suprapubic catheter) or used on an in-and-out basis to drain the bladder on a needs basis by the method of intermittent catheterisation.

NOTE: Insertion of a urinary catheter is only done by trained health professionals

Uses for a short-term period, usually up to 1 week, include pre-operatively and immediate post operative periods to monitor urinary output and /or if medically indicated.

Catheterisation for the long-term is usually 6 weeks or more and uses include post-operative care after major surgery, urinary tract obstruction that is not correctable medically, palliative care, neurogenic bladder and retention. Long-term catheterisation can expose residents to an increased risk of infection. Therefore it is not recommended as a remedy for incontinence and should be considered as a last resort for these residents.

Intermittent catheterisation is also known as “in/out” catheters or intermittent self-catheterisation. These catheters are inserted and then removed immediately after emptying the bladder. They may be used for acute urinary retention, when a sterile specimen of urine is required or to check residual volume of urine left in the bladder. Other indications for use are for those who are unable to properly empty the bladder; bladder obstructions or with nervous system (neurological) disorders or women who have had certain gynaecological surgeries. Disabled residents with neurological disorders that cause paralysis or a loss of sensation in the perineal area may also use regular intermittent catheter insertion to empty their bladders.

NOTE: Intermittent catheterisation is only done by trained health professionals or some independent residents who have been taught the procedure of intermittent catheterisation
Urinary catheterisation

A plastic tube known as a urinary catheter (such as a Foley catheter) is inserted into a resident’s bladder via their urethra or through a surgically made permanent opening above the pubic bone. A balloon located at the end of the catheter is usually inflated with sterile water to prevent the catheter from slipping out once it has reached the bladder.

Catheters come in a large variety of sizes, materials (latex, silicone, PVC or Teflon); and types (Foley catheter, straight catheter, whistle tip, tieman tip or coude tip catheter).

The smallest size is usually recommended, although a larger size is sometimes needed to control leakage of urine around the catheter. A large size can also become necessary when the urine is thick, bloody or contains large amounts of sediment. Larger internal catheters, however, are more likely to cause damage to the urethra.

Some people have developed allergies or sensitivities to latex after long-term latex catheter use. In such cases, Silicone or Teflon types should be used. Silver alloy coated urinary catheters may reduce infections.

The sterile procedure of catheterisation will be done by a nurse or doctor. If the correct technique is not used, trauma may be caused to the urethra or prostate (male). In addition, infection may be caused along the urinary tract, or the foreskin becomes trapped behind the glans penis (paraphimosis).

Gender differences

In males, the catheter tube is inserted into the urinary tract through the penis. In females, the catheter is inserted into the urethral opening. The male catheters are longer than female catheters due to the difference in the length of the urethra.
Suprapubic catheter

A suprapubic catheter is also an indwelling catheter however this catheter is placed directly into the bladder through the abdomen. The catheter is inserted above the pubic bone. The word supra means above and this gives rise to the name suprapubic. This catheter must be placed by an Urologist. The insertion in the abdomen and the tube must be cleansed at least twice daily with soap and water.

Indications for use a suprapubic catheter includes where a urethral catheter cannot be inserted into the bladder to relieve acute urinary obstruction and to relieve chronic retention of the neurogenic bladder. It is also indicated during and following pelvic or urological surgery and for those residents who require long-term catheterisation who are sexually active or have persistent problems with urethral catheters.

Advantages of Suprapubic catheters include:

- More hygienic as it is away from the genital area where infection has an easy passage to the bladder via an indwelling urethral catheter i.e. risk of contamination with microorganisms from the bowel and genital area
- Easier to change
- Pressure areas can occur with urethral indwelling catheters
- Less likely to get blocked
- They do not cause urethral damage
- More satisfactory for females and wheel chair residents
- Sexual activity less inhibited with absence of urethral catheter
- Resident independence – some residents may be able to change their own catheter

Complications for Suprapubic catheters include:

- Catheter must be replaced immediately if it falls out as the opening will close over if left too long
- Urine may still leak via the urethra especially if catheter is blocked or kinked
- Increased risk of bladder stones
- Skin break down around the stoma (opening) area
- Entry for infection

Contraindications include:

- Obesity or ascites (fluid in the abdominal cavity) which makes sitting or changing the catheter problematic
- An inability to fill the bladder to a minimum of 300mls
- A history of lower abdominal surgery
- Blood clotting disorders
Care of the suprapubic catheter

Although the principles of care and management of the suprapubic catheter are similar to those of a urethral catheter, there are differences. The suprapubic catheter emerges at right angles to the abdomen and needs to be supported in this position. Dressing and tapes should only be used initially until the stoma is formed and/or when absolutely necessary. If a dressing is required to secure the catheter it must be sterile.

Hygiene is important and once healed the suprapublic site should be washed with warm soapy water, preferably twice daily. Cleaning should be directed away from the insertion site.

**NOTE:** Talcum powder, creams and strongly perfumed soaps should be avoided. Residents should be made aware of the importance of hand washing both before and after handling the catheter drainage system, carers should follow standard infection control precautions for all procedures.

Catheter care

Some catheters, called silastic catheters, can remain in place for up to 12 weeks. These are usually changed in Out Patient Departments or by a District Nurse. The resident may have a small amount of blood in the urine because of the local irritation from the catheter, but this is not a urinary tract infection.

Catheter care should consist of good personal hygiene practices. The insertion site should be cleaned at least daily, usually during daily showering.

Sealed (e.g. taped, pre-sealed) drainage systems are better at preventing bacteria in the urine but this can be expensive.

Always follow infection control principles for any method of bladder management support. This includes:

- Having the appropriate training in the relevant procedures prior to undertaking changing or emptying of catheter bags
- Always wear disposable gloves when cleaning catheters and/or changing or emptying catheter bags
- Dispose of continence aids as per organisational guidelines
- Dispose of faeces from continence aids and urine from drainage bags in the toilet
- Females should always be cleaned/wiped from front to back

Complication from catheters may include:

- Urinary tract or kidney infections
- Blood infections (sepsis)
- Structural damage such as urethral injury or skin breakdown, creating a false passage, urinary retention and discomfort
- Bladder stones
- Blood in the urine (haematuria)
- Catheter not draining
- Bleeding after catheter change
• Urine cloudy / debris present

**NOTE:** If the person appears to be in pain or discomfort associated with the catheter, contact the doctor as soon as possible

**Management of complications**

**Catheter not draining**
- Check for kinks in the tubing
- Check the catheter drainage bag is below the waist
- Adjust resident’s position to see if that helps the drainage
- Prepare to get the catheter changed by making arrangements for someone to visit i.e. Hospital in the Home (HiTH) or the district nurse

**Bleeding after catheter change**
- Ensure the catheter is still draining
- Increase resident’s oral fluid intake to dilute and flush out the blood
- If you suspect the catheter is not draining any urine seek medical attention immediately
- If the bleeding has not stopped within 24 hours or causes the catheter to block, seek medical attention immediately

**Urine cloudy or debris present**
- Could be a urinary tract infection – take a urine sample if problem with drainage occurs
- Have the catheter changed as soon as possible
- Taking cranberry juice or cranberry tablets can help reduce the amount of sediment urine
- Increase fluid intake to at least 3 litres per day if appropriate

**Bladder stones**
- Taking cranberry juice or tablets can help reduce the amount of sediment in the urine

**External bladder control methods**

**Condom drainage**
This is an external continence management method of draining urine from the bladder without use of a catheter. Condom drainage is more commonly known as condom or “Conveen” drainage but also can be referred to as a urisheath, uridome or urinary condom, penile sheath or external catheter.

It consists of a rubber sheath which fits on the outside of the penis (a strip of adhesive is on the inside of the sheath allowing it to stay in place). It allows the resident to empty their bladder without using a urinal, bedpan or toilet. The condom catheter is connected to a urinary catheter drainage bag. Urisheaths are available in different sizes and lengths. They should be selected and fitted by the appropriate health professional otherwise problems will be experienced. The resident must be assessed as to whether this method is suitable by a continence specialist. This includes checking that the uridome will fit well and that the skin tolerates the condom.

Additionally, medical or nursing staff must check that the incontinence is not being caused by a urinary tract infection or urinary retention. Treatment of these conditions may resolve the incontinence.

Silicone or latex uridomes are available in different sizes and lengths and come in one or two piece systems. Silicone uridomes are clear or transparent which makes it easier to monitor the health of the penile skin. Latex uridomes are not transparent; therefore the health of the skin cannot be monitored while it is in place. Latex sensitivity may cause allergies or skin reactions.
JBI CONNECT+ (The Joanna Briggs Institute, Faculty of Health Sciences, University of Adelaide) reports that in one study, men stated that they found uridomes to be comfortable and less painful than an indwelling catheter and that it restricted their activity less. Nurses reported that uridomes fell off more easily, leaked more often but were easier to apply. One piece uridomes were favoured over two piece sheaths as they were easier to apply and functioned better. Again silicone was preferred over latex as skin problems were easier to note due to the transparency of the silicone and allergic reactions were avoided.

Applying a urinary sheath or uridome
The uridome must be applied to dry skin. When applying the uridome, avoid constriction around the penis. Do not tape around the penis and do not allow the edge of the uridome to roll back and form a tight band. After the uridome has been applied, the penis must be inspected after 30 minutes and every four hours thereafter for 24 hours. Warming the unopened condom packed (by wrapping it in a warm face washer or carrying it in your pocket for 30min) will improve the adhesiveness.

Check for:
- Swelling or changes in colour to the penis which might indicate constriction
- Rubbing, chafing, skin irritation or redness
- Pulling or twisting which increases the risk of a urinary tract infection
- Kinking of the uridome which may cause urine to accumulate under the sheath
- Inability of the foreskin to retract

The uridome must be removed daily and the penis washed thoroughly. This can be done during showering.

Procedure:
1. Place an absorbent pad or bath towel under the resident
2. Wash the penis using soap and water. Rinse and dry the penis carefully.
3. You may want to clip the hair or even shave the area near the base of the penis. Removing hair from this area will keep it from being caught in the condom or the attachment.
4. Inspect the penis to make sure it does not have any broken or reddened skin
5. Wash, rinse, and dry your hands
6. Hold the penis at a 90 degree angle from the body. Gently roll the condom over the penis. Leave 3-5cm or 1 to 2 inches of the condom catheter at the end of the penis.
7. Wrap the sheath holder around the condom at the base of the penis. Do not wrap the sheath holder too tightly because this may stop blood from going to the penis.
8. For condom catheters with internal adhesive, gently grasps the penis and compresses so that the entire shaft comes in contact with the condom
9. For condom catheters with external adhesives strips, wraps the strip around the outside of the condom in a spiral direction, taking care not to overlap the ends
10. Connect the condom catheter to the tube of the urine bag
11. Make sure the condom is not twisted where it attaches to the catheter
Joanna Briggs Institute summarises best practice as routinely monitoring the uridine and penis for the following:

- Checking for skin damage caused by allergic reaction
- Checking for poor hygiene
- Checking for swelling of the penis 30 minutes after application
- Rechecking the penis and drainage bag every 4 hours thereafter
- Replacing the sheath every 24 hours

**Urine drainage bags**

Any catheter or external urinary device that is left in place for a period of time is attached to a drainage bag to collect the urine. There are a few different types of drainage bags such as leg bags or overnight bags.

Urine drainage bags are connected to the outlets of the catheter or condom drainage. Infection control procedures must be followed in the connection, disconnection and emptying of drainage bags. Drainage bags can be either a leg bag worn during the day or an overnight bag which is usually hung on a holder attached to the side of the bed.

**Leg bag**

A smaller drainage device that attaches by elastic bands to the leg. A leg bag is usually worn during the day, as it fits discreetly under pants or skirts, and is easily emptied into a toilet. There is a special urine bag for wheelchair bound people. This is attached to the thigh and empties from the top of the bag. It also has a special outlet tap for those residents with limited dexterity.

**Bedside overnight bag hanger**

Larger bags are used overnight and for those who have larger volumes of urine such as patients post-surgery. This device is hung on the side of the patient's bed on a urinary catheter holder and positioned below the level of the resident’s bladder to aid in efficient drainage.

**Support systems for drainage bags**

Leg bags require support to allow the person to move around freely. There are a number of systems varying from stretchable fabric or elastic or Velcro straps.
Different types of outlet taps

Draining the leg bag
A leg bag is a urine collection bag that is strapped to the leg. It is smaller than the bag used at night. This smaller bag allows easier movement. However, the leg bag must be emptied every 3 to 4 hours.

To drain the bag, follow these steps:
- Wash and dry your hands with soap and water
- Unfasten the lower leg strap
- Remove the cap and open the clamp. Do not touch the drain port outlet or allow it to touch the urine measuring container or toilet seat
- If the urine is to be measured, drain it into a container that is being used only for this purpose. Measure the amount of urine, record it, and then empty the urine into the toilet. If the urine does not need to be measured, drain the urine into the toilet
- After the urine has drained completely, wipe the drain port and the cap with a cotton ball or gauze soaked with povidone-iodine (such as Betadine) or alcohol swab. Close the clamp and fasten the lower leg strap
- Wash and dry hands with soap and water.

Care of a urine catheter bag
If the resident is using a leg bag during the day, the drainage bag should be cleaned in the morning when changing to the leg bag. The leg bag should be cleaned at night when changing back to the drainage bag. The drainage bag should be replaced at least monthly, or more frequently if there is clouding, odour or discoloration of the bag.

Cleaning the catheter bag
1. Wash hand with soapy water and dry before and after cleaning the bag
2. Close outlet tap on leg bag and tighten straps, making sure the catheter is well secured and not pulling
3. Disconnect night bag and empty urine into toilet or a container
4. Rinse overnight bag with warm soapy water, a few drops of dishwashing liquid is recommended
5. Hold the bag connecter under the tap to run the water through the bag and tubing, rinse again with running water to clear the soap from the bag
6. With tap open, hang bag to drain in a clean place e.g. over a towel or shower rain
7. Replace bag if it is damaged or leaking

Always follow Manufacturer’s recommendations on how long a urine collection bag should be used

Procedure for changing a urine catheter bag
1. Explain the procedure and obtain verbal consent
2. Identify and collect equipment
3. Wash your hands and put on disposable gloves
4. Place paper towel or incontinent sheet under catheter outlet port
5. Clamp catheter by kinking with fingers or clamp (if supplied)
6. Wipe connection of catheter and bag with alcohol
7. Allow to dry for 20 seconds
8. If rubbing alcohol is used, pour onto a gauze pad or cotton ball
9. If the replacement bag is not a new sterile one, clean the tubing end of the replacement bag
10. Disconnect the catheter from the drainage bag/leg bag tubing, being careful not to tug on the catheter end
11. Avoid touching the tube or catheter ends as you disconnect them
12. Connect the new/replacement bag tubing to the catheter snugly to prevent leaking using a non-touch technique
13. Clean the connection site again with alcohol
14. Close new collection bag port and unclamp catheter
15. Position draining/collection bag on straps/ hook below resident’s bladder
16. Ensure there are no kinks in the tubing
17. Empty and record urine as per care plan

Procedure for emptying a urine catheter bag

1. Explain the procedure to resident
2. Collect all necessary equipment
3. Wash and dry your hands before and after emptying the bag
4. Wear disposable gloves
5. Use a clean jug large enough to avoid spillage e.g. 2-3 Litres
6. Clean the catheter outlet with an alcohol wipe
7. Empty the catheter by opening the outlet at the bottom of the catheter bag
8. Do not allow the outlet to touch the floor
9. After emptying the bag, wipe the end of the catheter outlet with an alcohol swab
10. Close the outlet on the bag
11. Note the amount and colour of drainage – record if necessary
12. Empty jug carefully into the toilet
13. Clean the jug as per procedure

**IMPORTANT:** Under no circumstances should carers insert or remove catheters.
When to call a doctor
You should contact the doctor or continence nurse if any of the following occur:
- Unexplained fever, shivering, chills or changes in behaviour
- Pain in the bladder or the back
- Urine is cloudy or has an offensive odour or blood is seen
- Catheter falls out
- Urine stops flowing for several hours or there is abdominal discomfort
- Urine keeps leaking around the catheter

Cranberry juice and urinary system health
If a resident has a catheter or undertakes intermittent self-catheterisation, there is a greater risk of developing a urinary infection. The conclusion of a study published in the *British Medical Journal* (June 29, 2001) is that cranberry juice has a beneficial effect on the health of the urinary system. It appears to reduce the likelihood of urinary tract infections, cystitis or mucus in the urine.

Cranberry juice or capsules seem to:
- Help to make the urine more clear
- Help to prevent urinary infections developing
- Help to prevent attacks of cystitis
- Help to reduce bladder pain
- Help to prevent the formation of bladder or kidney stones
- Prevent catheters from blocking as often by reducing the frequency of urinary infections
- Reduce the mucus in some people’s urine following certain types of operations
- Enhance the effect of some antibiotics being used to treat urinary infections.

Drinking about 200mls of cranberry juice twice a day i.e. a total daily intake of 400mls, at breakfast and dinner, is recommended.

Contraindications for cranberry juice or capsules:
- Cranberry juice should not be taken by diabetics as it contains sugar.
- Cranberry juice is an acidic irritation to the stomach in those people who have ulcers or are prone to heartburn.
- If a person is on Warfarin or any other anti-coagulant medication, cranberry juice or cranberry capsules should not be taken as it can interact with the medication. If more information is needed, discuss this with the doctor, nurse or pharmacist.

Summary
In managing urinary catheters and external urinary drainage devices, support staff must ensure that guidelines and care plan strategies are strictly followed to ensure best care of residents.

This includes:
- Following all organisational policy and procedures or Practice Manual guidelines
- Following strict infection control and hygiene guidelines
- Following up to date care plan instructions and procedures
- Ensuring all continence equipment or devices are well maintained and in good repair
- Ensuring all continence equipment or devices are stored correctly
- Referring any concerns immediately to a Supervisor
- Ensuring adequate hydration to maintain urinary system health
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http://www.joannabriggs.edu.au/
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Better practice procedures on male and supra-pubic catheterisation

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Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010)

Cranberry Juice:


Department of Health and Ageing
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National Bowel Cancer Screening Program

Convatec
Links: For health professionals; for carers; Living life to the fullest; peristomal skin care; products etc.

Royal Children’s Hospital, Melbourne
http://www.rch.org.au

Links to: Victorian Children’s Stoma Association
Stomal Therapy Unit, Royal Children’s Hospital 03 9345 5338
Young Ostomates United Inc.
P.O. Box 1433 MDC
Narre Warren VIC 3805
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