Ileal Conduit: Obtaining urine specimen for microbiology

Site Applicability

All VCH & PHC sites

Practice Level

NP, ET/WOCN: Basic Skill

RN: Basic Skill – Non-Catheter Method

Policy Statement

A consultation with a Physician is required.

Need to Know

- May be referred to as a urostomy, ileal conduit or ileal loop.
- A clean, uncontaminated specimen is necessary for accurate laboratory analysis.
- Bacteriuria is almost always found in patients with ileal conduits; asymptomatic bacteriuria in the presence of an ileal conduit should not be treated and prophylactic antibiotics are not recommended.
- Urinary samples should only be taken if patients are symptomatic (fever, chills, and/or flank pain).
- Never collect urine specimen for culture and sensitivity from the ostomy pouch or bedside drainage bag.
- Urinalysis is taken from a new pouch and urine is collected into a sterile collection container.
- Signs and symptoms of UTI: (May have one or more of these symptoms)
    - Fever (greater than 38°C)
    - Chills and/or diaphoresis
    - Cloudy urine
    - Strong smelling urine
    - Visible blood in the urine
    - Rigors
    - Flank pain
    - Nausea and/or vomiting
    - Increased mucus in urine
    - Malaise

  Even in the presence of S&S of infection clinical judgment is required to determine if a urine sample is required.
- Ensure patient is well hydrated

Indications: Uncontaminated urine specimen is required for microbiology.

Contraindications for taking a specimen using a catheter:

- Pain
- Inability to intubate stoma
- If force required catheterizing, stop and collect sample using non-catheter method.

Precautions: Use caution when inserting catheters into patients who have trauma, abnormality, stenosis, or strictures of the ileal conduit.

Equipment & Supplies

- Handwashing supplies
- Sterile catheter tray
- Sterile #14/16 French intermittent catheter
- Sterile specimen container with lid, label, and specimen bag
- Sterile and clean gloves
- Sterile normal saline
- Sterile water-soluble lubricant (for catheter method)
- Garbage bag
- Sterile 10 x 10 cm gauze
- Absorbent pad
- Urostomy pouching system
- Urine C&S specimen collection swab (e.g. Uriswab) – if applicable

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Procedure

Non-Catheter Method: RN skill without ET/WOCN training	
Procedure	**Rationale**
1. Encourage to drink water. 2. Gather necessary supplies and explain procedure to patient.	Inform patient of procedure to be performed. To ensure that urine is obtained.
3. Prepare/clean work surface.	
4. Position client. Place absorbent pad under patient to catch any urine.	The absorbent pad will prevents wetting of the bed or patient's clothes
5. Wash hands and put on personal protective equipment	Use universal precautions
6. Ensure client is sitting up ideally, raise the head of bed to 90 degrees	To enable the urine to flow with gravity
7. Don clean gloves	Use universal precautions
8. Remove entire ostomy appliance and dispose as per institutional policy.	Stoma must be exposed for assessment, cleansing and obtaining a sterile urine sample.
9. Cleanse stoma and peristomal skin using non-sterile gauze/wipes to remove all residue.	To prepare stomal and peristomal area.
10. Remove gloves, wash hands. Open sterile dressing tray and add sterile normal saline. Remove lid from the sterile specimen container keeping the lid sterile. Don sterile gloves.	Sterile technique for specimen collection is required to obtain accurate results; supplies must be kept sterile
11. Using aseptic technique; cleanse stoma with sterile normal saline and sterile 10 x 10 cm gauze using a circular motion from stoma opening outward.	Cleanse the stoma, removing and contaminants and aiding in obtaining a uncontaminated urine sample
12. Do not collect the first few drops of urine.	The initial few drops of urine may be contaminated
13. Hold the sterile specimen container under the stoma	To catch urine directly into the sterile container
14. Collect a minimum of 3 mL of fresh urine for sample	Minimum amount of urine must be collected to obtain accurate results. It may take a few minutes to obtain sufficient urine (5 to 10 min)
15. Replace lid and set aside specimen container	As not to contaminate the sample
16. Apply ostomy appliance See Ostomy Management: Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System	Apply the appliance to contain urinary output.
17. Send specimen and discard supplies according to the institutional policy.	Supplies are not to be reused

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Catheter Method: ET/WOCN/NP	
Procedure	**Rationale**
1. Gather necessary supplies and explain procedure to patient.	Inform patient of procedure to be performed.
2. Prepare/clean work surface.	
3. Position client. Position absorbent pad under patient to catch any urine.	The absorbent pad prevents wetting of the bed or patient's clothes
4. Wash hands and put on personal protective equipment.	Use universal precautions
5. Set up catheter tray and supplies using sterile technique	Sterile technique for specimen collection is required to obtain accurate results; supplies must be kept sterile
6. Don clean gloves	Clean technique required, use universal precautions
7. Remove entire ostomy appliance and dispose as per institutional policy.	Stoma must be exposed for assessment, cleansing and intubation to obtain a sterile urine sample.
8. Cleanse stoma and peristomal skin using non sterile gauze or wipes to remove all residue	To prepare stomal and peristomal area
9. Remove gloves, wash hands. Open sterile dressing tray and add sterile normal saline. Remove lid from the sterile specimen container keeping the lid sterile. Open water soluble lubricant may be required. Don sterile gloves.	Sterile technique for specimen collection is required to obtain accurate results; supplies must be kept sterile
10. Use sterile technique; cleanse stoma with sterile normal saline and sterile 10 x 10 cm gauze, using a circular motion from stoma opening outward.	Cleaning the stoma removes contaminants and aids in obtaining an uncontaminated urine sample
11. Do not collect the first few drops of urine.	This will help to remove any cleansing agent
12. Lubricate the intermittent catheter with water soluble lubricant	Aid in the ease of insertion of catheter into the Ileal conduit
13. Place the distal end of the catheter into the specimen container.	To collect the urine specimen
14. Gently insert the catheter tip into the stoma, until urine flows or no more than 7.5 cm. Never force the catheter, if resistance is met pull back and reinsert, or rotate the catheter until it continues to slide in with ease.	Depending on the abdominal contours, the catheter may need to be advanced to maximum 7.5 cm to allow urine to flow freely Do not force catheter if resistance is met, this could lead to the perforation of the conduit.
15. Hold the catheter in position until urine begins to flow. If no urine returns, reposition the patient and/or ask them to cough.	Urine returns indicates the correct location. Lack of returns may indicate the catheter in an incorrect position. Reposition the catheter. If no returns, reposition the patient. Slight shifts may aid in urine returns. It may take a few minutes to obtain sufficient urine (5 to 10 min), If insufficient returns consider patient may be dehydrated.
16. Collect a minimum of 3 mL of fresh urine for sample.	Minimum amount of urine must be collected to obtain accurate results
17. Replace lid and set aside specimen container	As not to contaminate the sample

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18. Remove the catheter; clean the stoma and peristomal skin and pat dry.	Clean dry skin aids in appliance adhesion
19. Apply stomal appliance. See Ostomy Management: Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System	Apply the appliance to contain urinary output.
20. Send specimen and discard supplies according to the institutional policy.	Supplies are not to be reused

Expected Patient/Client/Resident Outcomes

Urine sample is obtained from ileal conduit without contamination of the specimen and without trauma to the ileal conduit.

Unexpected Patient/Client/Resident Outcomes

Trauma, bleeding, pain, contact Most Responsible Person (MRP) if required.

Documentation

Document in accordance with VCH/PHC documentation standards.

Include:

- the time,
- the appearance of the stoma,
- the procedure performed,
- the catheter type and size used,
- the appearance and amount of urine collected,
- the patient response

Related Documents

- BD-00-12-40049: Ostomy Management: Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System

References

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Sarasota Memorial Hospital. (2009). Nursing procedure: Obtaining urine specimen from ileal conduit/urostomy (Culture and sensitivity)

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Date of Approval/Review/Revision

Approved: November 19, 2015

Posted: November 20, 2015

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