Residential Hospice of Grey Bruce Inc. Nursing Manual	**DIVISION:** **CATEGORY:**	Nursing Hospice Residence	**POLICY NO:** 1-R-31
ISSUED BY: Executive Director	**SUBJECT:**	**Nephrostomy Tube Care**	**PAGE NO:** 1 of 3

POLICY:
Patients with a nephrostomy tube shall have the dressings changed by the RN using sterile technique. The nephrostomy tube shall be flushed according to specific physician orders.

PROCEDURE:
Dressing Change:

Supplies:
- 1 pair non sterile gloves
- 1 pair sterile gloves
- Sterile dressing tray
- 4 x 4 drain sponge – 2
- 4 x 4 gauze sponge – 2
- Paper tape
- Normal saline

1. Prepare sterile dressing tray, assemble all equipment and pour approximately 60cc of normal saline into sterile tray compartment containing cotton balls.
2. Don non sterile gloves and carefully remove the old dressing while holding the skin firmly so as not to pull on skin or dislodge tube. Note any redness, soreness, drainage or odour at the insertion site of the tube. This may indicate infection and will necessitate the dressing being changed more frequently as well as letting the physician know.
3. Remove non sterile gloves and don sterile gloves. Clean the skin around the exit site of the tube with normal saline soaked cotton balls in a circular motion, moving outward from the tube covering at least a 3 inch diameter. Allow to air dry.
4. Apply the drainage sponge around the tube and then cover with a 4 x 4 gauze sponge. Secure in place with paper tape. NB: An abdominal pad may also be required to cover the site for extra padding OR a transparent dressing (tegaderm) may be used in place of gauze.
5. Anchor the visible tubing with a catheter stabilization device to decrease amount of pull on it.
6. The dressing will be changed daily for the first 2 weeks following insertion. Thereafter it will be changed weekly unless there is drainage or it is wet.

Flushing the Nephrostomy Tube:

Supplies:
- Non sterile gloves

•10 cc syringe with a 22g needle
•10 cc sterile normal saline
•Alcohol wipes (2)

1. The RN will obtain specific orders for flushing the nephrostomy tube that include the type of solution, the amount of solution and the frequency of flushing.
NB: The renal pelvis can only hold 5 to 10 cc of fluid. Only this amount of normal saline and no more, should be used to flush the catheter to avoid distending and damaging the renal pelvis. If any resistance or pressure is felt as fluid is put in, stop the procedure.
2. Assemble the equipment and place on a clean table. Wash hands thoroughly and don non sterile gloves.
3. Fill 10 cc syringe with 5 – 10 cc sterile normal saline. Check that stopcock is in the "off" position.
4. Cleanse injection port with alcohol wipe. Remove cap from pre-drawn syringe of saline as well as from stopcock (if there is one) and remove needle from syringe.
5. Attach syringe to the open port of stopcock. Turn the stopcock control valve to the open position. Gently push on the syringe plunger to flush with 5 to 10 cc saline. DO NOT force the saline OR pull back on syringe. If the unable to flush, the RN will obtain orders from the physician to flush directly through the nephrostomy tube
6. Turn the stopcock off to the injection port allowing urine to flow into bag. Remove the syringe and replace cap on stopcock. Dispose of syringe in needle disposal unit.

Care of the Drainage Bag:

1. Keep the drainage bag below the level of the kidneys at all times to prevent a back flow of urine into the kidneys.
2. Keep the drainage bag closed to decrease the risk of infection.
3. Keep the nephrostomy catheter and drainage bag tubing free of twists, kinks or leaks

When to Notify the Physician:
•Sudden decrease in the amount of drainage with discomfort at the catheter site.
•Blood in or around the catheter.
•Fever greater than 38.5
•Persistent blood in the urine.
•Nausea and vomiting
•Chills
•Urine that is cloudy and has a strong odour.
•Back pain
•Catheter becomes dislodged or broken or begins to leak

DATE APPROVED: April 2004
DATE REVIEWED:
DATE REVISED: April 2013

APPROVED BY: