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Contact	Stephanie Spain: Trauma Prgm Mgr Adult
Area	Trauma Surgical Critical Care
Applicability	Erlanger Health - Baroness

Neurogenic Bladder Practice Management Guideline (for Paraplegia & Quadriplegia)

1. Process/Procedure Description

Develop a regimented and consistent approach to bladder management in Quadriplegic or Paraplegic patients with alteration of normal bladder function (Neurogenic Bladder Dysfunction) and to facilitate consistent nursing interventions.
Scope: All Trauma/Surgical Critical Care Staff/Nursing along with all Erlanger

2. Who Should Read This Process/Procedure?

3. Definitions

Neurogenic bladder dysfunction can be a result of diseases and/or injuries of the brain or spinal cord. These include but are not limited to congenital malformation, spinal cord injury or lesion, tumor or neoplasm of brain or spine, degenerative disease, vascular occlusion or hemorrhage, and traumatic/ anoxic brain injuries.

4. Process/Procedure

Step:	Process Instructions/Description:
1.	Bladder program may be initiated when the patient is, a. Alert enough to cooperate. AND b. Functionally able to participate and/or has family available and willing for training. AND

	c. Catheter-free. A Physician should assess and order the removal of the catheter and initiation of the bladder program. AND d. Medically appropriate per a trauma physician(MD order necessary for obtunded patients).
2.	Nursing and the physician should perform a comprehensive genitourinary assessment including urinary output and any signs or symptoms of complications or infections.
3.	Intermittent catheterization (IC) programs should be scheduled according to urine outputs. IC procedure performed utilizing sterile technique.
	a. IC every 4 hours if urine volume exceeds 500 ml. per catheterization for 48 hours.
	b. IC every 6 hours if urine volume is less than 500 ml. per catheterization for 48 hours.
	c. Goal is to maintain bladder volumes less than 500 ml. with each catheterization. d. Urinary output should be < 3000 ml. per day when intermittent catheterization is used. e. Encourage 6-8 glasses of caffeine free fluids throughout the day. Best practice is to limit po fluids in the P.M. f. If patient has reflex voiding, condom caths may be used for males and Ditropan may be used for females. g. If patients are sensitive to catheterization, may use 2% xylocaine jelly with lubrication and apply to the tip of the catheter. a. Following use, wash the xylocaine jelly tip with soap and water and dry and store with topical medications. b. A physician's order should be obtained prior to using xylocaine jelly.
4.	The patient should be protected from nosocomial infection. a. Staff members should perform catheterizations using sterile technique. b. The nurse should inform the patient that sterile technique is only practical during hospitalization and should educate and instruct the patient and caregiver on how to perform clean IC and how to clean and store IC equipment for home use. 1. Each catheter reusable at home for 1 week. 2. The catheters should be washed using a bleach solution. Collecting devices should be washed with antimicrobial soap and water after each use. Catheters and collecting devices should be dried, and stored in a clean dry place. If traveling and needing to take supplies with the patient, they should be stored in a paper bag (not plastic). 3. The patient and caregiver should be educated on proper hand washing technique to be utilized prior to each catheterization.
5.	The nurse should assess the patient for potential complications related to the bladder program. a. The patient should have an ongoing assessment and evaluation for signs and/ or symptoms of a urinary tract infection (cloudy foul smelling urine, hematuria, elevated temperature, c/o dysuria, burning or pain) or any other problems related to bladder function. The physician should be notified of any abnormal findings. They should also

	be instructed on when to seek medical attention for a potential urinary tract infection. b. Every patient being monitored on the bladder management program should have a graphic record initiated upon start of the program documenting each intermittent catheterization procedure, urine volume color, turbidity, sediment and calculi with patient's response to the procedure. c. The patient and caregiver should be educated regarding the importance of keeping a record and should receive instruction on how to maintain when performing self-catheterizations.
6.	The patient should be monitored for signs and symptoms of autonomic dysreflexia. An over-distended bladder may stimulate this condition. Signs and symptoms include Goose bumps, sweating, or red blotches above the level of injury, hypertension (increase of 30-40mmhg systolic), stuffy nose, severe/pounding headache, and bradycardia. Any of these symptoms could be present, but not necessarily all of these symptoms. If noted and patient has a foley catheter, foley should be checked for kinks. When noted, raise the head of the bed, perform intermittent catheterization (if patient doesn't have foley present), and notify the physician.

References:

Approval Signatures

Step Description	Approver	Date
COO	Robert Maloney: Executive VP & Chief Operating Officer	06/2023
Trauma Services Committee Approval	Stephanie Spain: Trauma Program Manager	06/2023
	Stephanie Spain: Trauma Program Manager	06/2023

Applicability

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