Royal Hospital For Children
South Glasgow Hospitals
Standard Operating Procedure
Best Practise Guidelines for caring for patients with Peritoneal Catheters
Contents

This Standard Operating Procedure has been devised to assist any nursing/medical staff dealing with patients with above.
Care of Peritoneal Catheters should be based on a basic understanding of tissue repair and factors affecting the healing process.
The named nurse is personally accountable for his/her practise.
The named nurse should recognise when he/she does not have the knowledge or experience to deal with a Peritoneal Catheter site and seek advice from senior nursing staff or Tissue Viability specialist nurse.
Peritoneal site assessment will be carried out prior to application of any wound management products.
Wound management products used will be appropriate for stage of healing.
Accurate documentation will be undertaken at each dressing change.
The nurse will work in partnership with medical staff, seeking advice when necessary to ensure that patients needs are met in a safe and effective manner.

1.0 Nursing requirements

1.1 Nursing staff caring for patients with Peritoneal Catheters should have a basic understanding of wound healing.
1.2 Nursing staff caring for patients with Peritoneal Catheters should be aware of factors affecting healing.
1.3 Wound assessment should take place prior to application of any wound management product.
1.4 Progress will be documented on wound assessment chart at each dressing change if necessary.

2.0 Standard Care

2.1 Do not clean or disturb exit site of newly inserted Peritoneal Catheter for 7 to 10 days unless dressing has become dislodged or wet.

3.0 Dressing requirements

3.1 Administer adequate analgesia prior to dressing change if required.
3.2 Explain procedure to patient and carer.

3.3 Assemble all equipment required prior to procedure to ensure wound exposure time kept to a minimum.
3.4 Carry out dressing procedure in cubical or treatment room when possible.
3.5 Apply principles of aseptic technique to reduce risk of infection.
3.6 Clean wound only if necessary using Prontosan liquid - ensure that liquid is at room temperature and not cold.
3.7 Do not use cotton wool to clean and ideally irrigate with Prontosan liquid.
3.8 If showering in hospital, run water for 5 minutes prior to showering.
3.9 Gently pat dry the wound and surrounding skin.
3.10 Apply Premierpore or appropriate sterile dry dressing.
3.11 Document assessment and treatment on Wound Assessment Chart and Care Plan.
3.12 Plan and document wound review date.

4.0 Follow up

4.1 If wound complex or slow to heal contact Tissue Viability Nurse specialist.
4.2 Contact and inform multidisciplinary team if required.
4.3 Provide parents/carers/patients with dressing supplies if required for dressing changes at home for 7 days.
4.4 Inform Renal Liaison Nurse Specialist of any supply requirements.

5.0 Specific Care

5.1 If Peritoneal exit site is inflamed, painful or malodorous, clean using Prontosan liquid, swab site and send for Microbiology culture. Send swab to Virology if requested by medical staff.
5.2 Discuss initial treatment with medical staff and access swab result in 48 hours.
5.3 Inform Renal Liaison Nurse, and arrange for dressing changes and review.
5.4 Advise parents to contact ward or Renal Liaison Nurse with any concerns immediately.