

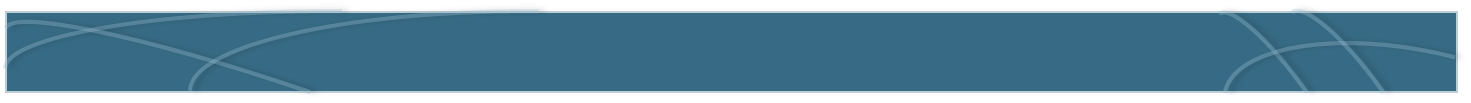
*In the absence of a written catheter removal order, use the flowchart below to identify whether a patient’s catheter can be removed and the appropriate removal procedure.*

*In settings where bladder scanners are not available, percussion of the bladder should be done*

*This is a generic protocol and* ***clinicians should assess each individual patient*** *to ensure that catheter removal is appropriate.*

CRITERIA INITIATED URINARY CATHETER REMOVAL PROTOCOL

FOR ADULT PATIENTS IN ACUTE CARE SETTINGS



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A clinical assessment of the patient should be undertaken before selecting a pathway marked with this arrow.

\* May not be appropriate for patients with spinal cord injury, stroke or delirium

\*\*Post void residual is variable and requires individual assessment. A post void residual volume of 1/3 of the voided volume may be acceptable.

\*\*\* Total bladder volume = volume voided + volume on scan

This tool was original produced by HNE LHD and has been modified by the

Clinical Excellence Commission.

**START HERE**

Patient has an **indwelling urinary catheter (IDC)** in place

**NO VOID**

Measure volume of void

Scan bladder to confirm residual volume

(repeat as necessary

to review trend)

**NO**

**YES**

Q5. Was voiding pain free\*?

Monitor fluid balance.

Be mindful of

clinical signs of

urinary retention.

**Leave catheter out**

Encourage fluid intake. (Be mindful of any fluid restrictions)

Maintain fluid balance chart.

**TRIAL OF VOID PROCEDURE (TOV)**

Remove catheter. Provide patient with receptacle to collect urine.

Educate patient on TOV procedure. Document removal in healthcare record.

**NO**

**PATIENT VOIDED**

* Review fluid balance
* Scan bladder
* Prompt patient to void

Team leader/MO/specialist nurse to determine and document clinical pathway (A, B, C) based on assessment of:

* Fluid balance
* Total bladder volume\*\*\*
* Clinical picture/history
* Pain or discomfort\*

Team leader/MO/ specialist nurse to further investigate and document plan

**IDC is to remain *in situ.***

Reassess need for catheterisation

within next 24 hours.

**YES**

Q1. Is there a documented medical order for the IDC to remain *in situ*?

Check for insertion difficulty, bowel movement in last 24 hours and medication history.

Q2. Has the clinical indication for catheterisation been resolved?

**NO**

Q3. Is the patient constipated or is taking medication that affects bladder contractility or tone?

**YES**

**NO**

No or small urine volume recorded on scan\*\*

Moderate or large urine volume recorded on scan\*\*

**C.** Wait for patient to void as per documented MO/specialist

nurse instructions.

**YES**

Q4. Did the patient void within 6hr of catheter removal?

**B**. Catheterise with

Intermittent catheter

**A.** Recatheterise with IUC.

Restart catheter removal protocol as per MO/Specialist nurse’s documented instructions.