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.

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

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

- **YES**
  - IDC is to remain in situ.
  - Reassess need for catheterisation within next 24 hours.

- **NO**
  - Q2. Has the clinical indication for catheterisation been resolved?
    - **NO**
      - Check for insertion difficulty, bowel movement in last 24 hours and medication history.
    - **YES**
      - Q3. Is the patient constipated or is taking medication that affects bladder contractility or tone?
        - **NO**
          - Q4. Did the patient void within 6hr of catheter removal?
            - **NO**
              - Leave catheter out
            - **YES**
              - Measure volume of void
                - Scan bladder to confirm residual volume (repeat as necessary to review trend)

Q5. Was voiding pain free?*

- **NO**
  - Monitor fluid balance.
    - Be mindful of clinical signs of urinary retention.
  - Leave catheter out

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

PATIENT VOIDED

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

**TRIAL OF VOID PROCEDURE (TOV)**


Encourage fluid intake. (Be mindful of any fluid restrictions)
Maintain fluid balance chart.

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

- **NO**
  - Q5. Was voiding pain free?*
    - **NO**
      - Monitor fluid balance.
        - Be mindful of clinical signs of urinary retention.
    - **YES**
      - Review fluid balance
        - Scan bladder
        - Prompt patient to void

PATIENT VOIDED

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*

- **A.** Recatheterise with IUC.
  - Restart catheter removal protocol as per MO/Specialist nurse’s documented instructions.

- **B.** Catheterise with Intermittent catheter

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

- **NO VOID**
  - Review fluid balance
    - Scan bladder
    - Prompt patient to void

No or small urine volume recorded on scan**

Moderate or large urine volume recorded on scan**

TEAM LEADER: MO: SPECIALIST NURSE TO FURTHER INVESTIGATE AND DOCUMENT PLAN

* 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 originally produced by HNE LHD and has been modified by the Clinical Excellence Commission.

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