CRITERIA INITIATED URINARY CATHETER REMOVAL PROTOCOL
FOR ADULT PATIENTS IN ACUTE CARE SETTINGS

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.

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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?

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

NO

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

YES

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

PATIENT VOIDED

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

NO

Q5. Was voiding pain free*?

YES


NO

Leave catheter out

Measure volume of void
Scan bladder to confirm residual volume (repeat as necessary to review trend)

NO

PATIENT VOIDED

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

NO

No or small urine volume recorded on scan**

Leave catheter out

Moderate or large urine volume recorded on scan**

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.

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*

* 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.

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

This tool was original produced by HNE LHD and has been modified by the Clinical Excellence Commission.