Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

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NAME OF DOCUMENT	**Trial of VOID (TOV) - Management of a Patient Following Removal of a Urinary Catheter**
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FORMER REFERENCE(S)	Trial Of Void Bladder Scanning Regimen Suprapubic Catheter (SPC) Care and Clamp and Release Regime
EXECUTIVE SPONSOR	Nursing and Medical Clinical Co Director Women's Health and Gynaecology Services
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SUMMARY	This document outlines the appropriate care and management of a patient during trial of void following removal if indwelling catheter.
Key Words	Urinary Catheter, trial of void, urinary retention, urinary dysfunction

Contents

This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

A Trial of Void (TOV) is a common clinical procedure used to assess a patient's ability to urinate effectively. This assessment includes monitoring the volume of urine passed, patient's ability to fully empty bladder and any sign of discomfort or difficulty. The purpose of this document is to provide a clear guideline for healthcare providers to assess urinary function and intervene promptly if necessary. It ensures early detection and management of urinary retention and preventing potential complications associated with prolonged urinary dysfunction.

Table 1 – Definitions

Term	Definition
Trial of void (TOV)	A process to assess a patient's ability to empty their bladder by measuring the volume that was voided and assessing the residual via using bladder scanner or release of catheter valve. **Successful Trial of Void** - Complete bladder emptying with no or minimal post void residuals over two consecutive voids **Unsuccessful Trial of Void** - Patient unable to initiate any urethral void, voiding small volumes with high post void residuals requiring catheterisation.
Post void residuals (PVR)	The amount of urine left inside the bladder once the patient has voided- measure and record.
Urinary retention	The inability to empty all the urine from the bladder. It can occur in an acute or chronic setting.

2 RESPONSIBILITIES

2.1 2.1 Staff (medical, midwifery, Nursing, Allied health)

Role	Responsibilities
Medical Officers	• Document in eMR/ clinical notes when TOV commence. • Optimise patient's bowels to avoid constipation at the time of catheter removal. • Formulate a management plan when patient failed TOV
Registered Nurses/ Enrolled Nurses/ Registered midwifes.	• Ensure the five moments of hand hygiene are attended during the procedure. • Explained the TOV procedure to the patient. • Perform bladder scanner according to hospital guidelines • Escalating concerns or abnormal finding to seniors staff or treating team in a timely manner

3 PROCEDURE

3.1 Clinical Practice points (as previously called in LOPS)

Equipment

- PPE- Non-sterile gloves, eye protection
- 10ml Syringe or other size as indicated
- Disposable blue sheet
- Urine collector for toilet (witches hat)
- Catheter valve and leg bag if removing SPC

Procedure for TOV in patients with an IDC

- Check inpatients request on eMR (clinical/ progress notes) for trial of void to commence or assess patient clinical history and symptoms
- Ensure five moments of hand hygiene are adhered to throughout the procedure
- Check the balloon inflation port to determine the balloon size
- Deflate the balloon by attaching the appropriate sized syringe to the inflation port and allowing the entire contents of the balloon to passively deflate. Passive deflation reduces ridge formation which can cause pain and resistance on removal
- Gently withdraw the urinary catheter onto the blue sheet
- Document urine output from the catheter bag on fluid balance chart
- Discard waste in accordance with infection control policies and procedure
- Ensure the patient is adequately hydrated by recording all fluid intake

- Provide the patient with an appropriate receptacle for the collection of urine and advise them to use it when they have a desire to void
- Advise the patient on the importance of informing the nurses/midwives as soon as they have voided and perform a bladder scan within 10 minutes for accuracy.
- Measure and dispose of urine in toilet after each void and bladder scan residual.
- Document voids and residuals on patient's trial of void and fluid balance chart.
- If the patient has a history or urinary incontinence or incontinence is anticipated, provide appropriate continence aide and document the incident and amount appropriately.
- If the patient has not voided 4-6 hours post urinary catheter removal, a bladder scan must be performed and if clinical review or rapid response criteria is met (urine output less than 100ml in 4 hours), please action according to current hospital policy and guideline.
- To contact treating team for further management if trial of voids is unsuccessful.

Procedure for TOV in patients with an SPC

- Check patient's clinical notes on eMR of request for SPC clamp and release regime to be commenced.
- Explain procedure and rationale for SPC clamp and release regime to the patient and obtain verbal consent to proceed.
- Ensure five moments of hand hygiene are adhered to throughout the procedure
- Obtain required equipment .
- Open sterile dressing pack and don sterile gloves
- Disconnect SPC catheter from urinary drainage bag using dressing pack as sterile field.
- Clean end of SPC catheter with alcohol wipe.
- Insert 'flip flow' catheter valve and close (so that arrow points to bladder)
- Reapply new urinary drainage bag or leg bag.
- Dispose of waste and equipment whilst adhering to Royal Hospital for Women's infection control standards
- Don gloves and place urine collector in the patient's toilet.
- Inform patient to contact nurse when she feels the need to void
- Assist patient to toilet if required and instruct patient to void without straining into urine collector.
- Unclamp the SPC and allow to drain for 5 minutes into the urinary bag when patient has completed voiding
- Reclamp SPC after 5 minutes
- Measure and dispose of urine after each void and residual
- Document voids and residuals on patient's trial of void and fluid balance chart.

For SPC site care

- Explain procedure and rationale to patient.
- Obtain equipment required (dressing pack, 0.9% normal saline irrigation solution, appropriate dressing)
- Screen patient for privacy and use.
- Ensure five moments of hand hygiene are adhered to throughout the procedure.
- Remove old dressing if present without non-sterile gloves
- Inspect SPC site for discharge or signs of infection
- Using sterile gauze moistened with normal saline clean around the SPC site in a circular motion inwards to outwards
- Dry the site with gauze using the same circular motion
- Apply appropriate dressing if indicated, otherwise leave site exposed
- Ensure the SPC is securely anchored to the patient's leg with catheter fixative
- Dispose of rubbish in accordance with infection control policies
- Document procedure in clinical/progress notes on eMR
- Once the patient is mobile, independent and showering, the SPC site can be cleaned in the shower daily. The area is then towel dried carefully on completion. It is not recommended to redress the SPC site after 7 days due to infection risk and colonisation.

3.2 Documentation

- Clinical notes/Progress note on eMR
- Trial of void chart
- Fluids balance chart (record oral fluids intake and urine output)
- Clinical care pathway if applicable

3.3 Education Notes

TOV with IDC

- Patients should be encouraged to maintain an average oral intake of between 1500 to 2000mls per day, unless otherwise indicated by patient's medical history or medical officer.
- If void is over 200mls and bladder scan residual is below 100mls on two consecutive occasions, then bladder scans can be ceased.
- If residual is more than 150mls and less than 400ml, please ask patient to double void (void and measure, walk ten minutes, re-void and measure and then do bladder scan) and aim for residuals to be less than previous scan and please reassess in 2-4 hours.
- If residual is over 400-600mls, perform in/out catheterisation and continue trial of voids until pass or as per medical team's instruction.

- If residual is over 600ml, please insert IDC and notify treating team. Patient might be discharged home with catheter for 1-2 weeks at treating consultant's discretion.
- If residuals continue to be high in the evening, please consult treating team to consider inserting IDC for overnight and recommence TOV next morning.
- If patient is discharged home with indwelling catheter, please provide education on how to care for a catheter at home and provide a copy of patient home catheter management booklets for reference.
- To notify bladder CNC with patients' details for ongoing follow up and for team RMO to arrange day admission on ward for TOV prior discharge.

TOV with SPC

- Patients should be encouraged to maintain an average oral intake of between 1500 to 2000mls per day, unless otherwise indicated by patient's medical history or medical officer.
- Encourage voiding after 4 hours of clamping and aim to keep total void and residual volume under 600ml.
- Urinary catheter bags only require changing when: the system is broken (bag falls off or is removed) if sediment or discolouration is noted within the bag.
- Evidence does not support frequent changing of catheter bags as a preventative for urinary tract infection.
- Patients should always have their catheter attached to a urinary drainage bag or leg bag as maintaining a closed system reduces the risk of UTI. Urinary drainage bags should be on a free-standing catheter stand so that the patient can mobilize freely.
- If the patient experiences any discomfort and cannot pass urine urethrally or has no sensation to void after 4-6 hours, then unclamp the catheter and drain for 5 minutes, then reclamp. If the discomfort continues, if haematuria is present or if residual is 600ml or more, place the SPC on free drainage and notify the patient's Medical Officer. If pain subsides or was never present, re-clamp the SPC and begin clamp and release regime again. Residual urine should then be documented on fluid balance chart or trial of void chart.
- If patient is having ongoing high residuals, please notify team for further management plan. To commence home education regarding on how to clamp and release SPC as soon as possible.
- Provide patient home catheter management booklets if patient is going home with a catheter.
- To notify bladder CNC with patients' details for ongoing follow up and for team RMO to arrange day admission on ward for TOV prior discharge.

3.4 Implementation, communication and education plan:

The revised CBR will be distributed to all medical, nursing and midwifery staff via @health email. The CBR will be discussed at ward meetings, education and patient quality and safety meetings. Education will occur through in-services, open forum and local ward implementation strategies to address changes to practice. The staff are asked to respond to an email or sign an audit sheet in their clinical area to acknowledge they have read and understood the revised CBR. The CBR will be uploaded to the CBR tab on the intranet and staff are informed how to access

3.5 Related Policies/procedures

- Infection prevention and control in healthcare settings policy https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2023_025.pdf
- Infection Control: Cleaning (Shared) Patient Care Equipment Guideline https://www.seslhd.health.nsw.gov.au/node/9141
- Recognition and management of patients who are deteriorating https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_018.pdf
- Bladder care during labour and the postpartum period https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/bladdercarelabourpostpartum2020.pdf
- Insertion and management of urethral catheters for adult patients https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_015

3.6 References

- ACI Urology Network- Nursing. Supra pubic catheter (SPC) -Adult Clinical Guideline, Competencies & Patient Information Leaflet. OCT 2014 https://aci.health.nsw.gov.au/__data/assets/pdf_file/0018/256131/ACI-Suprapubic-catheter-adult-clinical-guideline-competences-patient-information.pdf
- Multi-disciplinary development and implementation of a trial of void algorithm to standardize and reduce indwelling urethral catheter use. Trial of void algorithm https://pubmed.ncbi.nlm.nih.gov/38913619/
- Clinical Excellence Commission. Catheter associated urinary tract infections (CAUTI) prevention. May 2016 https://www.cec.health.nsw.gov.au/keep-patients-safe/infection-prevention-and-control/healthcare-associated-infections/cauti-prevention
- Clinical Excellence Commission. Criteria-initiated urinary catheter removal. 2016 https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/296076/Criteria-Initiated-Urinary-Catheter-Removal-Protocol.pdf

4 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services

5 CULTURAL SUPPORT

For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

6 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
July 2024	1	CNC Benign Gynaecology
15.8.24	1	RHW BRGC