



ACI UROLOGY NETWORK - NURSING

TRIAL OF VOID

HOSPITAL GUIDELINES

The following pages provide examples of clinical guidelines and patient information booklets to enable clinicians to develop their own resource material relevant to their hospital and Area Health Service. They have been compiled by clinicians for clinicians. If you wish to use this material please acknowledge those that have kindly provided their work to enable use by others. Revise all material with colleagues before using to ensure it is current and reflects best practice.

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With thanks to Jacqui Swindells and Lindy Lawler NSCCAHS and the ACI Urology/Continence Nursing Education Working Party Members for compiling this information December 2008.
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TRIAL OF VOID

GUIDELINES

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STATEMENT OF PRINCIPLE/OUTCOME

A trial of void assesses the ability of the bladder to empty.

STAFF

Registered nurse. Enrolled nurse or undergraduate student nurse under the supervision of a RN

ALERT

Patients with spinal cord injury at and above the level T6 should not have their catheter clamped because of the risk of autonomic dysreflexia which is a life threatening condition¹

HOSPITAL TRIAL OF VOID – URETHRAL CATHETER

EQUIPMENT

- Protective eyewear and apron
- Non sterile gloves
- 10ml syringe
- Bedpan / urinal
- Measuring jug
- Bladder scanner or in/out catheter set up

NURSING ACTION –URETHRAL CATHETER

1. Explain procedure to patient
2. Empty and record the amount of urine in the urine bag, or drained by the valve, on the fluid balance chart. Ensure the bladder is drained prior to removal of catheter.
3. Remove IDC (preferably 2400hr –see educational notes)
- 4 Advise the patient to maintain a fluid intake of 250 - /hour when awake (unless contraindicated) and record on the fluid balance chart.

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5. Advise the patient to void urethrally using a bed pan or urinal if they become uncomfortable or experience a desire to void.

If the patient is in discomfort they should be re-catheterised.

6. Measure and record each individual voided volume on the fluid balance chart.

7. If a patient has not voided for 6 - 8 hours and has no desire to void then rescan bladder/ reassess or recatheterise.

8. It is advisable to monitor the post void residual via a bladder scanner on at least 3 subsequent voids if possible.

9. For interpretation of outcome see educational notes.

10. Advise medical staff or experienced nursing staff of outcome (see educational notes)

HOSPITAL TRIAL OF VOID SUPRAPUBIC CATHETER

EQUIPMENT

- Protective eyewear and apron
- Non sterile gloves
- Catheter valve
- Bedpan / urinal
- Measuring jug

NURSING ACTION-SUPRA PUBLIC CATHETER

1. Staff need to be aware of the patient's usual urine production and voiding pattern (see education notes)
2. Explain the procedure to the patient
3. Remove the drainage bag and attach the SPC to a catheter valve.
4. Advise the patient to maintain a fluid intake of 250 mls/hour when awake (unless contraindicated) and record on the fluid balance chart.
5. Advise the patient to void urethrally using a bedpan or urinal when they have the desire to void.
6. Measure each individual voided volume and record on a fluid balance chart.
7. Following each void, drain any residual urine via the SPC into a measuring jug and record on the fluid balance chart as the post void residual

8. If the patient is unable to void urethrally (after 6 - 8 hours) **or they experience discomfort**, then release the valve and document the volume drained.
9. If the volume drained exceeds 300mls then the TOV is considered to have failed and free drainage or timed emptying via the valve should be resumed.
10. Advise medical staff or experienced nursing staff of outcome (see educational notes)
11. Document outcome in patient record.

EDUCATIONAL NOTES

- Bladder emptying occurs as a result of a complex interaction between the sympathetic and parasympathetic nervous systems and the physical structures of the bladder and urethra.
- Bladder dysfunction can result from a wide range of conditions. For example
 - bladder outlet obstruction
 - neurological dysfunction
 - following childbirth
 - following some surgical procedures
 - medications e.g. anticholinergics can contribute to urinary retention
- Chronic constipation, rectal examination may be required to assess for constipation.

Ensure that the patient is not constipated at the time of catheter removal as constipation can contribute to urinary retention and this may result in failed trial of void.

- Medical authorisation is required prior to TOV. Knowledge of the patients' medical history is crucial.
- Knowledge of the patients usual urine production is recommended to facilitate correct timing of the TOV e.g. some elderly patients will have low urine volume through the day and a large diuresis overnight.
- A maximum total bladder capacity should not exceed 600mls. (Voided volume + residual).
- The current recommendation is to remove the IDC at 2400hrs.ⁱⁱ ⁱⁱⁱ

INTERPRETATION OF OUTCOME OF TRIAL OF VOID

GUIDELINES

- The success of a TOV will also be determined by the patient's symptoms, such as frequency, nocturia and their functional bladder capacity.
- The significance of a post void residual is variable and requires individual patient assessment. As a guide a post void residual of one third to one half of the voided volume (up to approximately 300mls) can often be acceptable.
- If the patient fails the trial of void then the option of intermittent self catheterisation may be explored or the urethral catheter reinserted.

Successful trial of void:

- Complete bladder emptying with no or minimal post void residual over three consecutive voids (inpatient).

Unsuccessful trial of void:

- Patient unable to initiate any urethral void
- Small volume voids with high post void residuals.

Incomplete bladder emptying:

- The significance of a post void residual is variable and requires individual patient assessment. As a guide a post void residual of one third to one half of the voided volume (up to approximately 300mls) can often be acceptable.
- If the patient fails the trial of void then the option of intermittent self catheterisation may be explored

Guide only:

The residual bladder volume determines management

(courtesy of St George Hospital, Nursing Practice Manual section 9, page 22)

- 300 – 500mls residual = reinsert IDC & repeat TOV 48 hours. If TOV fails repeat in 2 weeks
- 600 – 800mls residual = reinsert IDC & repeat in 2 – 4 weeks
- >900mls residual = reinsert IDC or teach CISC & repeat in 4 weeks

ⁱ NSW state spinal cord injury service: health professional resources for the management of adults with spinal cord injury, version 2. April 2006

Urethral Catheter: Trial of Void [2010-11-20]

Rathnayake, Tharanga. Evidence Summaries - Joanna Briggs Institute. (Nov 20, 2010).

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