APPENDIX 1

TRIAL WITHOUT CATHETER (TWOC) - PROCEDURE AND GUIDANCE

INTRODUCTION

Infection prevention and control and continence guidelines specify that **newly inserted urinary catheters should be removed, where appropriate, within 48 hours** to reduce the risk of urinary sepsis and promote return to normal bladder function. The majority of catheters can be removed promptly. **Reasons for further assessment before removing a catheter at 48 hours:**

- Obstructive uropathy.
- Lower urinary tract obstruction with acute kidney injury.
- Malignant feeling prostate associated with retention.
- High residual volume – (more than 1000mls, more likely to fail TWOC).
- Grade 3 and above sacral pressure sore.
- End of life care where movement causes pain and distress.
- Acutely ill patient requiring specific fluid management.
- Unresolved constipation.

BEFORE DOING A TWOC (refer to specialty specific section on following pages to note exception prior to commencement of TWOC)

- Supply a TWOC information handout (BAUS leaflet).
- Review medication that may cause retention (e.g. anti-cholinergics, opiates).
- Check for constipation.
- In men consider giving an uro-selective alpha blocker 24-48 hours prior to TWOC
  a. Patient has symptoms of benign prostatic enlargement (lower urinary tract symptoms - LUTS).
  b. Residual greater than 1000mls.
  c. Patient will tolerate postural hypotension (avoid if there is a history of falls).
- Antibiotic prophylaxis is **NOT** indicated, unless it is traumatic or there is a history of urosepsis. (See trust antibiotic prophylaxis policy).
- DO NOT give prophylaxis if the patient has:
  a. Allergies.
  b. Receiving current antibiotic therapy.
  c. Or has a resistant organism to preferred prophylaxis (discuss with microbiology).
  d. Have renal failure (discuss with pharmacy).
- A bladder scanner should be available – this can be performed by staff who have been shown and deemed competent by experienced staff.
- Perform TWOC without delay.
- Keep a record of fluid balance and post void residuals.

If the patient has specific urological or gynaecological reason for retention, refer to SPECIALITY SPECIFIC INFORMATION

TWOC PROCEDURE FOR PATIENT WITH NO REASON TO FAIL

Patient with:

- **Urethral catheter for less than 72 hours.**
- **Catheter post-surgery (no pre-existing LUTS or episodes or retention).**
- **No significant co-morbidities (e.g. poor mobility, chronic conditions).**

1. Explain the TWOC procedure to the patient.
2. Obtain and document verbal consent to remove the catheter.
3. Ensure the patient is aware of the signs of urinary retention.
   a. Increase frequency.
   b. Passing small volumes of urine.
   c. Lower abdominal pain.
   d. Hesitancy to void.
   e. Feeling of incomplete bladder emptying.
4. Remove the urinary catheter in accordance with the Trust catheter policy.
5. Encourage the patient to drink 200mls of fluids every hour.
6. Once the patient has passed 2 volumes of 200mls or more without retention symptoms, scan their bladder.
7. If the residual is less than 100mls – the TWOC has been successful.
8. Document the outcome and any additional follow-up.
9. Advise patient of risk of future episodes of urinary retention and who they should report to in this instance.

TWOC PROCEDURE FOR PATIENTS WITH A REASON TO FAIL

Patients with:

- **Pre-existing bladder or bowel problems.**
- **Co-morbidities.**
- **Long standing catheters.**
- **Previously failed TWOCS.**
- **Supra-pubic catheters.**
- **Check if possible previous documented post void residuals.**

Follow the procedure above, also follow post void scanning and manage residuals as below.

- **If post void residuals on bladder scanning (PVRs) are below 100mls:** it can be considered that the patient has passed their TWOC and discharge as above with follow-up.
- **If PVRs are 100-300mls:**
  - Advise double voiding.
  - Do not reinsert the catheter, unless the patient demonstrates the signs of retention (patient could a small capacity bladder).
  - Reinforce signs of urinary retention.
  - Perform a further scan after further voiding.
  - If these scans are consistent, discharge the patient with follow-up and reinforce the signs of urinary retention and where to obtain help should it occur.
  - Document the outcome of the TWOC.
- **If PVRs are 300-500mls and patient is able to void:**

- Discuss with the patient the risks/merits of clean intermittent self catheterisation (CISC) if they are consistently high.
- If unable to perform CISC, discuss re-catheterisation if the patient is demonstrating signs of urinary retention.
- If patient declines advise about further episodes of urinary retention and where to obtain help.
- Document the outcome of the TWOC and arrange follow-up.
- Refer to community continence team/neighbourhood teams (if patient housebound), if performing CISC or has indwelling catheter. **Ensure that all patients with an indwelling catheter are given a catheter passport on discharge home.**

- **If PVRs are 300-500mls and the patient is unable to void or has signs of urinary retention reinsert a long term catheter:**
  - Obtain consent to re-catheterise, as per Trust catheter policy.
  - Secure catheter with a stabilising device (e.g. G strap, Stat-lock, clinifix) to reduce shunting and traction on the catheter.
  - Discuss use of catheter valve as an alternative (NOT FOR PATIENTS WITH RECENTLY RECONSTRUCTED BLADDER NECK OR RISK OF BLADDER PERFORATION).
  - **Complete a catheter passport.**
  - Refer to community teams, explain outcome of TWOC.
  - Arrange outpatient TWOC:
    a. Alex – UIC, Claire Franks – via email.
    b. WRH – Helen Worth / Sam White – via email.
    c. KTC – Penny Templey /Jayne Cox – via email.
  - For patients being discharged with a catheter provide a home from hospital pack, and if required a spare valve. Refer to relevant community team.

SPECIALITY – SPECIFIC INFORMATION

UROLOGY

- Inpatient TWOC – any issues contact on call team.

Outpatient

- Request TWOC as above.

Acute Urinary Retention

- Men should be assessed for TURP or alternative lower urinary tract surgery. To be discussed with medical team.

Post Radical Prostatectomy/Radical Cysto-Prostatectomy/Patients with known bladder perforation.

TWOC only to be done by urology team. **DO NOT RECATHETERISE – refer back to urology. NO CATHETER VALVES TO BE USED IN THESE PATIENTS.**

- Catheters must remain on free drainage.
- Nurse performing TWOC must ensure that a cystogram is not required.
- Consultants may request antibiotic cover for some patients.

- On discharge give discharge pack with continence products.
- Re-inforce pelvis floor exercises (PFE's).

Other Urology TWOC Patients

- Teach Pelvic Floor Exercises (PFE's)/bladder re-training.
- Teaching of CISC to be considered before indwelling catheter.
- FOR ADVICE CONTACT UROLOGY CNS's via switchboard or email.

GYNAECOLOGY

Inpatient TWOC

- If a patient fails her TWOC re-catheterise and refer to the uro-gynaecology CNS team.
- Women with acute urinary retention should be assessed by the uro-gynaecology team.
- Patient can be taught CISC if able, as an option if unsuccessful TWOC.
- Refer to community team for further support.

ELDERLY CARE/MEDICINE/OTHER SURGERY

- Patients can be referred as above if they have an unsuccessful inpatient TWOC.

COMMUNITY TWOC

- For patients living in Worcestershire who are not under any speciality service, refer to the Neighbourhood Teams for assessment and possible TWOC.
- If the patient is out of area and requires community follow-up contact the GP or Community Team.

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Please attach patient sticker her or record

Name:

NHS No:

Hosp No:

D.O.B: D D M M Y Y Male Female

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Trial Without Catheter (TWOC)Chart

DATE_____ TIME	FLUID INTAKE (mls)	URINE PASSED (mls)	CONTINENT (YES/NO)	POST VOID RESIDUAL (bladder scan)	SIGNED
Time of TWOC 24 hr HH:MM _____					
Time post TWOC + 1 hour _____					
+ 2 hours _____					
+ 3 hours _____					
+4 hours _____					
+5 hours _____					
+6 hours _____					
+ 7 hours _____					
+ 8 hours _____					
+ 9 hours _____					
+ 10 hours _____					
Total					