Bladder Care - Early Labour and Postnatal – Full Clinical Guideline

Reference No.: OBS/12:23/B4

Contents

1. Introduction

During labour and after delivery there is a risk to the bladder of urinary retention. Overdistension of the bladder during this time can result in permanent bladder damage. If the bladder is stretched to 1000ml (or less in some women), there is a risk of causing hypotonic bladder and prolonged voiding dysfunction, which can have long term sequelae including recurrent urinary tract infections and incontinence. It can be very difficult to recognise the overdistended bladder and therefore prevention is the most appropriate clinical practice.

2. Purpose and Outcomes

Guidance to ensure a consistent approach to bladder care for all healthcare professionals involved in the care of women during labour and in the postnatal period.
Any woman giving birth can develop Post Partum Voiding Dysfunction (PPVD), but particular risk factors include:

- Epidural or spinal anaesthesia
- Prolonged labour
- Primiparity
- Perineal trauma
- Instrumental delivery
- Caesarean section
- Manual removal of placenta
- History of Female Genital Mutilation
- History of voiding disorders

- Large birthweight
- Constipation

Voiding alone is not an adequate indication of bladder function and needs to be combined with input/output charts and vigilance.

3. Abbreviations

EUA	-	Examination under Anaesthetic
FGM	-	Female Genital Mutilation
ISC	-	Intermittent Self Catheterisation
IV	-	Intravenous
MLC	-	Midwife Led Care
MROP	-	Manual Removal of Placenta
MSU	-	Mid Stream Urine
PPH	-	Post Partum Haemorrhage
PPVD	-	Post Partum Voiding Dysfunction
PU	-	Passed Urine
PVR	-	Post Void Residual
TWOC	-	Trial Without Catheter

4. Definition

Post partum voiding dysfunction is defined as failure to pass urine spontaneously within 6 hours of vaginal birth or catheter removal.

5. Documentation

Please ensure all assessments and individual plans of care are documented clearly in the appropriate records which may include some or all of those listed below:

- Electronic maternity records

6. Management in Labour (see Appendix A)

6.1 First Stage of Labour

- Encourage 4 hourly voiding, particularly if the patient has an epidural in situ. Increase surveillance and document if output is <150mls.
- Catheterise if the woman cannot pass urine at 4 hours if receiving IV fluids, there is a discrepancy between input/output or they have an obvious distended bladder (which is visible or palpable) and are unable to pass urine.
  This can be an in/out catheterisation initially. However, if 2 or more further catheterisations are likely to be required during labour, insert an indwelling catheter. This should be removed prior to the onset of pushing.

6.2 Second Stage of Labour

- Void before delivery - if the woman cannot void and you suspect a significant volume in the bladder, catheterise using an in-out catheter (especially women with an epidural in situ).
- Operative delivery - empty bladder prior to instrumental delivery.

6.3 Caesarean Section

- Indwelling Foley catheter should be inserted prior to starting the procedure.

6.4 Indwelling Catheter

Insertion of an indwelling catheter should be considered following:

- Following any post-delivery procedure under regional anaesthesia(e.g. MROP, repair of perineal trauma, EUA)
- Women who had Instrumental delivery under regional anaesthesia
- Mid cavity instrumental delivery
- Severe perineal or urethral trauma
- Prolonged labour

- Women who have received a spinal anaesthesia, including epidural to spinal top-up

A fluid balance chart should be kept for each woman with a catheter in situ.
Catheter should be removed following a minimum of 12 hours unless otherwise clinically indicated.

6.5 Inserting a Catheter

ANTT should be used for indwelling catheters. Stickers from the packaging should be used for indwelling catheters.

7. Postnatal Management (see Appendix B)

- All women SHOULD void within 6 hours of delivery and be encouraged to pass urine before leaving the labour ward.
- A verbal handover must include time of birth and whether the patient has passed urine or not.
- If unable to pass urine after 6 hours the woman requires catheterisation and if the bladder residual volume is >500ml, leave indwelling catheter in situ for 24 hours. If between 150 – 500mls, repeat in-out catheter in 4 hours and if >150mls insert indwelling catheter.
- Following the diagnosis of urinary retention obtain a sample for urinalysis and send an MSU for microscopy, culture and sensitivity.
- For women under midwife led care (including home births), the case will need to be discussed with the Consultant on call regarding referral/transfer to the maternity unit.
- The named Consultant obstetrician for women who have significant voiding difficulties postnatally should be informed, as they may require referral to the urogynaecology team.
- Ensure plan of care is documented

8. Removal of Catheter

- The fluid balance chart should be maintained for 24 hours after removal of the catheter, or in the case of enhanced recovery post elective caesarean section it should be maintained until discharge home if that is sooner than 24 hours after removal. When the catheter is removed do urinalysis. Send an MSU only if there is a strong suggestion of infection i.e. Nitrite positive or 3+ Leukocytes.
- The first Spontaneous void should occur within 6 hours, and should be measured and documented in the notes. The first void should be above 150ml.
- If less than 150ml - attempt conservative measures such as increased oral hydration, pain relief, walking; measure further void in 2 hours
- If no voiding within 6 hours, or the woman becomes uncomfortable before this, check residual volume by means of an in-out catheter. If the residual volume is greater than 150mls, insert an indwelling catheter, record the amount of residual urine and leave in situ for a further 24 hours.
- The named Consultant obstetrician for women who have significant voiding difficulties postnatally should be informed and a plan of care documented.
- If after a further 24hrs there is no spontaneous voiding 6 hours after removal of the catheter, check residual volume by means of an in-out catheter. If residual volume is greater than 150mls, insert indwelling catheter and leave in situ for a further 7 days.
- The woman should be brought back for a trial without catheter – please ensure the availability of the Urogynae specialist nurse for the appointment. If unavailable, then the gynae ward staff should be aware of the appointment but they should not be considered the first option.

- If the TWOC is unsuccessful the woman should be referred to Urogynaecology and offered intermittent self-catheterisation (ISC).
- All care and any actions taken should be clearly documented and the named consultant informed.

9. Information for women / Care of Catheter

Give the woman contact details if she has any concerns or problems with catheter:

RDH: Ward 314 – 01332 787314
QHB: Belvedere Center on Ext: 4136

Provide information leaflets: *Catheter Care at Home*

Ensure the woman is aware the catheter needs to be kept clean, simply by washing the catheter each day with warm, soapy water when taking a bath or shower and drying gently but thoroughly to prevent soreness. Advise the woman to wash the catheter **away from the urethra** to reduce the risk of infection.
Whilst the woman has a catheter in place, she will need to drink plenty of fluids to prevent urinary infection.

10. Monitoring Compliance and Effectiveness

As per agreed Audit forward programme

11. References

Glazener CMA, Abdalla M, Struod P et al. Postnatal maternal morbidity: extent, causes, prevention and treatment. Br J Obst Gynecol 1995, 102: 282-287.

Rohna Kearney; Alfred Cutner. Post Partum Voiding dysfunction. The Obstetrician and Gynaecologist 2011

Appendix A

Management in Labour

ENCOURAGE TO VOID 4 HOURLY

Commence fluid balance chart if catheterisation required

Unable to void at 4 hours – consider catheterisation especially in women that are receiving IV fluids; where there is a discrepancy between input-output or an obvious bladder and unable to PU

Catheterise prior to:
- Caesarean section
- Instrumental delivery
- MRoP
- 3rd/4th degree tear repair

Or after
- Spinal anaesthesia (catheterisation not required for those women with low dose spinals (max of 50mg bupivacaine)

Encourage to void/catheterise, at end of 2nd stage if problems with delivery of the placenta

Encourage to void within 6hrs of birth / removal of catheter

Catheter to remain in situ 12 hours
Or longer of clinically indicated by operation notes

Follow Appendix B

Ensure plan of care documented

Appendix B

Post Partum Management of Urinary Retention

NO VOID WITHIN 6 HOURS of birth or TWOC

If not voided within 6 hours:
insert catheter, measure and document volume drained

<150mls

150 - 500

>500mls

Conservative measures - oral hydration, pain relief, mobilisation
Measure next voided volume and PVR (either by bladder scan or in-out catheter)

<150mls

Repeat in 4hrs

>150mls

Insert indwelling catheter for 24 hours

Reassess if PVR >150ml, catheter to stay in situ for 1 week

If PVR <150mls no further management unless symptomatic

If unable to void or PVR >150mls

If TWOC fails, catheterise, teach ISC by appropriately trained personnel and refer for urogynaecology opinion

PVR = Post Void Residual Volume
ISC = Intermittent self catheterisation

Ensure plan of care documented

NB: All women requiring ISC to be reported on a Datix IR1 form

Documentation Control

Reference Number: CL:OBS/12:23/B4	**Version:** **UHDB Version 2.1**		**Status: FINAL**	
	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	1	July 2007	Midwife M Pickard, Cons Mr VN Chilaka / Mr M Cust / Miss RJ Hamilton Continence advisory team	
	2	Oct 2009	Mr V Chilaka - Consultant, Jayne Gregory - Lead Midwife J Chaplain - Nurse specialist. Continence advisory team, Maternity Development Committee	Updated in line with new evidence
	3	May 2011	Mr V Chilaka - Consultant Obstetrics & Gynaecology, G Maycock Midwife / J Chaplain - Urogynae Clinical Specialist Nurse	Review to reflect NICE guideline recommendations
	4	Dec 2014	Mr V Chilaka - Consultant Obstetrics & Gynaecology, J Chaplain- Urogynae Clinical Specialist Nurse	Review
	5	Nov 2017	Elizabeth Lancashire – Senior Midwife Gemma Maycock – Senior Clinical Midwife	Review, reflect ERAS
WC/OG/58	**Burton Trust prior to merged document:**			
Original 2009	6	April 2018	Cath Askey – Clinical Risk Midwife Sue Harrison – Senior Midwife	Review & Update
Version Control for UHDB merged document:				
	1	May 2020	Miss N Chikhes – Consultant Obstetrics & Gynaecology	Review & Merge
	2	Nov 2023	Miss N Chikhes – Consultant Obstetrics & Gynaecology Kristina Fairbrother - O&G Registrar	Review & Update - in line with national guidance
	2.1	June 2024	Lauren Wilkinson - Risk Support Midwife	To remove reference to MHHR due to the implementation of BadgerNet
Intended Recipients: All staff with responsibility for caring for women in labour and the early postnatal period				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors; Published on Intranet, Articles in Business unit newsletter; emailed via NHS.net				
To be read in conjunction with: Operative Vaginal Delivery (**I2**); Repair of Perineal Trauma (**P2**); Caesarean Section (**C7**); Royal Marsden Hospital Manual Clinical Procedures *(on FLO);* Indwelling Urethral Catheter – insertion & care (CG-T/2011/140).				
Consultation with:	O&G and Midwifery staff			
Business Unit sign off:	24/11/2023: Maternity Guidelines Group: Miss A Joshi – Chair 04/12/2023: Maternity Governance Group / CD - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 19/12/2023 V2.1: Ratified on the 14th June 2024 by exceptional ratification meeting for all levels of ratification				

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Key Contact:	Joanna Harrison-Engwell