Intrapartum and Postpartum Bladder Care

Version: 1.0
Derived from: Intrapartum and Postpartum bladder care. V3 (FPH)
PN-08 Bladder Care-Intrapartum and Postpartum. Version 2, 12/12/2012 (WPH)

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Ratified by (Committee): Obstetrics and Gynaecology Clinical Governance Committee

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.
1. Introduction

Intrapartum bladder care and the management and prevention of postpartum urinary retention are of great clinical importance. 10-15% of women have voiding dysfunction to some extent. If voiding dysfunction is not recognised, over-distension of the bladder can lead to denervation and up to 5% may have permanent bladder damage.\(^1\,^2\) There is considerable variation in practice of bladder care in the UK.\(^3\)

There is a wide range of contributing factors and it is difficult to predict who will develop retention and all women should be regarded as at risk.

2. Women at highest risk:

- Primigravida women
- Prolonged labour, especially second stage of labour
- Epidural for labour/delivery, irrespective of mode of delivery
- Need to catheterise in labour
- Assisted vaginal delivery
- LSCS
- Perineal trauma: haematoma / bruising / clitoral / labial tear and episiotomy with inadequate analgesia.

Many women with voiding dysfunction during labour and postpartum may have no risk factors, so a high index of suspicion must be maintained.

3. Prevention of acute bladder distension in labour

- Obtain a urine sample and dipstick test at start of active labour. Record the volume and urinalysis in the notes.
- Encourage the woman to void every 2-3 hours. Record the time and volume passed on the partogram.
- Prolonged use of IV syntocinon is associated with fluid retention and reduced urinary output.
- If she is unable to pass urine after 3-4 hours, the threshold for catheterisation should be low especially if IV fluids are in progress – if the bladder is palpable and the woman cannot void, catheterise using an indwelling catheter with consent.
- All women having an epidural should have an indwelling catheter inserted when comfortable. This can be deferred to the next VE if that is within 1-2 hours.
- Instillagel should be used at each catheter insertion.
- Document the catheterisation, the reason, type, size and amount of water inserted into balloon.
- Record volumes of urine obtained and commence a fluid balance chart.
- The catheter balloon should be fully deflated at the onset of pushing to reduce the risk of urethral damage. The deflated catheter should be secured to the woman’s leg with tape to reduce the risk of it being pushed out. If the catheter does fall out, it is important to be aware of bladder filling during the second stage.
- If the catheter falls out in the second stage, a new catheter should then be inserted after birth and left in for the time period specified below.
4. Postnatal bladder care

- The timing and volume of the first void of urine should be monitored and documented for all women regardless of method of birth. This should be no longer than 6 hours post-delivery or removal of catheter. This void should be at least 150ml.
- Women with urinary incontinence should not be re-catheterised: referral to the Physio should be made prior to discharge. The woman can go home if she wishes and can be seen as an outpatient; ensure all women have the postnatal pelvic floor exercise leaflet.
- Follow the attached summary of bladder care flowchart for all women post birth or post removal of catheter.
- Women who have had an operative vaginal delivery should have their urinary output monitored using a fluid balance chart for at least 24 hours.
- Women who have had regional anaesthesia are at increased risk of urinary retention. An indwelling catheter should remain in situ for at least 6 hours following removal of a low dose epidural catheter and for at least 12 hours after an epidural top up or spinal anaesthetic.
- Women requesting early discharge should be assessed and advised on an individual basis. Under these circumstances, if the catheter is removed earlier than recommended the woman should be advised to be aware of the symptoms of urinary retention including frequent voiding and urinary incontinence and this should be documented in the notes.
- Women can be discharged home with the catheter in situ on free drainage. A leg bag can be used in the day but a 2 litre bag should be used overnight.
- Women should have an arranged time to return to the postnatal ward for trial without catheter (TWOC) as per the TWOC pathways (see pp 6-7, below).
- If the woman is still unable to pass urine or has residuals of >150mls, after the 3rd TWOC, the catheter should be removed and clean intermittent self-catheterisation (CISC) should be considered. The woman’s consultant must be informed if TWOC pathway (2) is unsuccessful.

5. Auditable Standards

- The timing and volume of the first void is recorded for all women.
- The use of a fluid balance chart for all women having operative vaginal delivery.
- The consultant is informed of any woman who is unsuccessful at the TWOC pathway (2)

6. Monitoring compliance

- This guideline will be subject to three yearly audit. The audit midwife is responsible for coordinating the audit. Results presented to the department clinical audit meeting. Action plans will be monitored at the quarterly department clinical governance meeting.
7. **Communication**
If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

8. **Equality Impact Assessment**

This policy has been subject to an Equality Impact assessment.

9. **References**


5. NICE Guideline 132 Caesarian Section Nov 2011 guidance.nice.org/cg132
SUMMARY OF BLADDER CARE FLOWCHART

Unable to void within 6 hrs after delivery OR Unable to void within 6 hrs of catheter removal
OR 3 consecutive voids of less than 150mls OR Incontinence

Catheter inserted to assess residual
DO NOT USE BLADDER SCANNER

Residual less than 150 mls
Remove catheter
Continue to assess
2 more voids greater than 150mls
HOME

Inflate balloon leave as indwelling catheter
For 24 hrs if residual =150-800mls
For 48 hrs if residual = 800-1500mls
For 14 days if residual more than 1500mls
Home

Return to ward
Catheter removed
Follow Trial without Catheter Pathway (1)

If void greater than 150 mls on 2 occasions
AND residuals less than 150 mls
HOME no follow up

Unable to void OR
Voids less than 150 mls
With residual greater than 150 mls

Inflate balloon leave as indwelling catheter
For 7 days if residual less than 800 mls
For 2 weeks if residual is 800-1500mls
For 4 weeks if residual more than 1500mls
Home

Return to ward
Catheter removed
Follow Trial without Catheter Pathway (2)

If void greater than 150 mls on 2 occasions
AND residuals less than 150 mls
HOME no follow up

Unable to void OR
Voids less than 150 mls
With residual greater than 150 mls
Consider teaching Intermittent Self catheterisation.

Midwife to contact patient’s consultant if Pathway (2) is not successful
Trial without Catheter Pathway (1)

For women returning to the ward for the FIRST time with a catheter in situ due to a previous inability to void following birth or following removal of catheter after delivery

- Encourage NORMAL (i.e., 2litres in 24 hrs) NOT excessive fluid intake
- She should attempt to void every 3-4 hours.
- Document time and volume of all voids
- Immediately following void measure residual urine
- Less than 10 days postpartum use an in/out catheter to assess residual volumes
- Over 10 days bladder scanner may be used
- Consider CSU if symptomatic

Name ________________________________      Hosp No____________
DOB___________

Time of catheter removal_______ volume in bag______
Colour of urine ______________

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Able to Void within 4-6 hrs?

**NO**

Assess residual volume
Residuals more than 150ml
Leave as indwelling catheter
For 7 days if residual less than 800mls
For 2 weeks if residual 800-1500mls
For 4 weeks if residual 1500mls +
Home then return for TWOC

**YES**

1\text{st} Void greater than 150mls? AND residual less than 150 mls

**NO**

2\text{nd} Void greater than 150mls? AND residual less than 150 mls

**NO**

**YES**

Discharge Home
No follow up
Follow up TWOC on ward on following date______________
Trial without Catheter Pathway (2)

For women returning to the ward with a catheter in situ due to a previous inability to void and when an earlier Trial without Catheter has failed

- Encourage NORMAL (i.e., 2 litres in 24 hrs) NOT excessive fluid intake
- She should attempt to void every 3-4 hours.
- Document time and volume of all voids
- Immediately following void measure residual urine
- Less than 10 days postpartum use an in/out catheter to assess residual volumes
- Over 10 days bladder scanner may be used
- Consider CSU if symptomatic

Name ________________________________      Hosp No___________
DOB___________

Time of catheter removal_______ volume in bag_____
Colour of urine _____________

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Able to Void within 4-6 hrs?

NO          YES

Assess residual volumes
Residuals more than 150 mls
Or unable to void
Teach intermittent self-catheterisation

1st void greater than 150 mls
Residual less than 150 mls

2nd void greater than 150 mls
Residual less than 150 mls

Midwife to contact patient’s consultant if Pathway (2) is not successful.

Midwife’s Name _______________________ signature______________