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Royal Cornwall Hospitals NHS Trust

Bladder Management Following Uncomplicated Gynaecological Surgery Clinical Guideline

V3.0

June 2023

1. Aim/ Purpose of this Guideline

1.1. All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of the bladder in the postoperative period following uncomplicated benign gynaecological surgery.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Background:

- There is little consensus in the literature of the best management of the bladder in the immediate postoperative period following uncomplicated gynaecological surgery.
- Women in the immediate postoperative period following gynaecological surgery have a high incidence of urinary retention.
- Urethral catheters are commonly used following gynaecological surgery.
- Indwelling catheters are associated with increased risks of urinary tract infection (UTI) and the longer they are in situ, the higher the risk of UTI.

2.2. Guideline for removal of catheter:

2.2.1. The planned date of removal of catheter should be clearly stated on the operation note / in the medical notes.

2.2.2. All urethral catheters are removed at 07.00 on the scheduled day of removal, unless otherwise stated in the medical notes.

2.2.3. Attached is the voiding protocol and post op bladder diary. The amounts voided and bladder scan residual volumes should be recorded on a bladder diary and dated and signed by the nurse

performing the check. This record should be at the patient's bedside at all times.

2.2.4. While awaiting woman to empty her bladder, she should be encouraged to drink normal amount of fluids and try to empty her bladder by going to the toilet / having a bath / shower etc.

2.2.4.1. Possible reasons for being unable to pass urine/ empty bladder completely:

- Bruising / swelling around bladder / urethra – especially following anterior vaginal wall repair – this will usually improve over 1-2 weeks.
- Overdistension of the bladder resulting in atonic bladder (acute / chronic).
- Poor urinary flow rates prior to surgery (may have been detected on urodynamics).
- Physical obstruction (e.g., sutures) – Suspect if unable to pass urine at all post op – speak to consultant in charge.
- Clot retention– suspect if a history of haemeturia.

NOTE for complex laparoscopic surgery for severe endometriosis:

Patients who fail their primary Trial Without Catheter (TWOC), need to be discharged with an indwelling catheter for one week and repeat TWOC on return. If they fail a second time it should be discussed with a member of the endometriosis team.

2.3. Guidelines for women sent home with an indwelling catheter

2.3.1. Ensure the patient is being discharged with a flip flo (instructed by nursing staff on ward) and a night bag. In some cases, where indicated by the operating surgeon, this can be a free drainage bag-leg bag. The patients are given a date at discharge and asked to return at 08:15 for catheter removal to TWOC / EGU (Emergency Gynaecology Unit) clinic.

2.3.2. Ensure has ward number on the discharge letter to call in an emergency.

2.3.3. Ensure has follow up appointment for TWOC usually in EGU.

2.3.4. There should be no need for prophylactic antibiotics unless patient symptomatic of a urinary tract infection.

2.4. Guidelines for women returning for Trial without catheter (TWOC)

2.4.1. Ward staff to discuss the option/process of catheter removal at home on the day of TWOC to save waiting time in the hospital after catheter removal which may be up to 4 hours.

2.4.2. Those patients who can remove catheters at home, get a bladder scan in EGU to measure residual volume in bladder following her void.

2.4.3. Patients who cannot remove catheters at home are seen early in the morning in EGU at 08:15 am (or Gynaecology ward if EGU closed).

2.4.4. The catheter is removed, and the patient sent away with instructions to drink as normal (or at least 1 litre of water over the next 3-4 hours). She may leave the hospital and indeed is encouraged to, in order to relieve any anxiety that may be present by being in hospital.

2.4.5. The patient is advised to attempt to void when she has the desire and to return to EGU at an allotted time (usually after 6 hours and by that time, most women would have voided twice) for a scan to measure post void bladder residual volume.

2.4.6. If she is unable to void at all / becomes anxious / distressed / is in pain, she should return to EGU earlier and follow the voiding protocol attached.

2.4.7. If patient is sent home with an indwelling catheter following an incontinence/prolapse operation, inform the surgeon who performed the operation (unless the plan was already made to discharge the patient with catheter in situ).

2.4.8. If patient voids >150ml and the post void residual is <150mls, reassure woman and discharge (complete discharge letter).

2.4.9. Patients with unsuccessful trial in EGU, who would be offered ISC, arrange a time / place to teach ISC and use the starter packs available in EGU / Gynaecology ward.

2.4.10. Before patient discharged home performing ISC, ensure has follow up arranged with the Bladder & Bowel Specialist Service by written referral and sending to via email to:

Enquiries.ContinencePromotion@Cornwall.NHS.UK

2.4.11. Bladder scan for post void residual check:

This may be done using a specific bladder scanner (located on Gynaecology ward) or using the USS machine in EGU (use the abdominal probe, select ‘menu’ and scroll down to ‘bladder volume’).

2.5. ISC Instruction

The aim is to train as many of the gynaecology nurses to be able to teach ISC

as possible. This is to be done in conjunction with community continence team - nurse continence consultant - using the same methods and same kit to ensure continuity.

If there is no one on duty who is trained to teach ISC, then contact the Bladder & Bowel Specialist Service to ask for their help via 01726 873095 or generic email address:

bladderandbowelspecialistenquiries@nhs.net

(please note: the team are not able to teach ISC immediately).

See flow chart on next page:

Catheter removal time should be recorded on the fluid volume chart and on the bladder diary

- Encourage to drink normal amounts of mixed fluids.
- Women should be encouraged to try to void if haven't already at 4hours following catheter removal/after surgery.
- Measure the voided volume on **second void** and measure residual volume by bladder ultrasound scan soon after the void. (no later than 6hours from catheter removal/postop if coming out of theatre without catheter, with a normal fluid intake).
- Residual volume to be measured **immediately after the** patient passes urine per urethra (see note below about Endometriosis Patients).
- If uncomfortable & unable to pass urine before the 4 hrs interval, check residual by scan and follow protocol as below.

Void **more** than 150 mls with residual **less** than 150mls x once

On 2nd void, voided more than 150 ml with residual

Void **less** than 150 ml with residual more than 400 ml x 2nd void

Repeat void and residual check every 2 hours

Insert Foley catheter No 12 with Flip flo valve and leave in situ (and bag for the night)

No further checks needed, unless the woman feels she is unable to completely void subsequently.

At discharge:

- Foley's catheter in situ with flip flo valve for daytime and leg bag for night.
- Flip flo valve to be released every 4 hrs during day and leg bag on free drainage during night.
- Book trial without catheter in emergency gynaecology unit (EGU) in 5-7 days.
- Ward staff to discuss with the patient the option and process of catheter removal at home (if possible) on the day of TWOC prior to coming to EGU.
- If TWOC is unsuccessful again in EGU, arrangements to be made for the patient to learn intermittent self catheterisation (ISC).

NOTE for complex laparoscopic surgery for severe endometriosis: Patients who have more than 150mls in the bladder at their first TWOC, need to be discharged with an indwelling catheter for one week and repeat TWOC on return. Do Not follow the algorithm above for these patients. If they fail TWOC a week later (more than 150mls) it should be discussed with a member of the endometriosis team.

2.6. Postoperative Bladder Diary

CHA4447: Post Operative Bladder Diary (cornwall.nhs.uk)

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Audit the compliance to guideline and the voiding protocol.
Lead	Miss Farah Lone, Consultant Obstetrician and Gynaecologist
Tool	Ad hoc monitoring of guidance as part of routine audit activity on a WORD or Excel template.
Frequency	Biannual review presented at the Audit and Governance meeting.
Reporting arrangements	Audit and Governance meeting.
Acting on recommendations and Lead(s)	Audit and Governance meeting.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Bladder Management Following Uncomplicated Gynaecological Surgery Clinical Guideline V3.0
This document replaces (exact title of previous version):	Bladder Management Following Uncomplicated Gynaecological Surgery Clinical Guideline V2.1
Date Issued/Approved:	May 2023
Date Valid From:	June 2023
Date Valid To:	June 2026
Directorate / Department responsible (author/owner):	Miss Farah Lone; Consultant Obstetrician and Gynaecologist
Contact details:	01872 252685
Brief summary of contents:	All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of the bladder in the postoperative period following uncomplicated benign gynaecolgical surgery.
Suggested Keywords:	Post operative, voiding, gynaecology, bladder care
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Gynaecology Specialty Meeting
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	None required
Related Documents:	None required

Information Category	Detailed Information
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Gynaecology

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
13 Jun 14	V1.0	Initial Issue.	Lee Azancot; Data Administrator
11/04/2017	V1.1	Minor changes.	Farah Lone; Consultant
10/06/2020	V2.0	Full Update. Formatting updated and minor name change applied. Section 2.3.1. – wording changed. Section 2.4.3. – times changed. Section 2.4.7. – section updated to clarify operation and communication.	Miss Farah Lone; Consultant
11/08/2020	V2.1	Updated to new Trust format. Post-operative bladder diary updated at section 2.6 with CHA number.	Sarah Adamson; Care Group Secretary
April 2023	V3.0	Full update. Formatting updated. Section 2.4.1.1. wording amended. Section 2.3.1 wording amended. Section 2.4.4 timings amended. Voiding Protocol Following Benign Gynaecology Operation flowchart updated regarding overnight bagging. Link to bladder care diary added at section 2.6.	Miss Farah Lone; Consultant

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are

to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Bladder Management Following Uncomplicated Gynaecological Surgery Clinical Guideline V3.0
Directorate and service area:	Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Miss Farah Lone
Contact details:	01872 252685

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of the bladder in the postoperative period following uncomplicated gynaecological surgery.
2. Policy Objectives	As above.
3. Policy Intended Outcomes	As above.
4. How will you measure each outcome?	See section 3.
5. Who is intended to benefit from the policy?	All obstetrics and benign gynae patients.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology Specialty Meeting.
6c. What was the outcome of the consultation?	Approved- 16 May 2023
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the patient's needs – i.e., available in different languages if required/access to an interpreter if required

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on treatment.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Miss Farah Lone.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis