Royal Cornwall Hospitals
NHS Trust

Bladder Care for the Obstetric Patient Clinical Guideline

V3.1

September 2024

1. Aim/Purpose of this Guideline

1.1 To provide guidance to Midwives and Obstetricians on the management of bladder care during labour and in the immediate post-partum period.

1.2 This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term woman or women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3 This version supersedes any previous versions of this document.

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

The Trust has a duty under the Data Protection Act 2018 and UK 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 UK 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 UK 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

2.1.1. Voiding dysfunction includes:

- Urinary retention (failure to pass urine spontaneously or within six hours of catheter removal).
- Multiple small void: may indicate overflow incontinence.
- Slow stream, dribble, incontinence.
- Incomplete emptying.
- Hesitancy.
- Frequency of micturition.

- Dysuria.
- Feeling of a full bladder.
- Absence of sensation.
- Straining to void.

2.1.2. Intrapartum bladder management is aimed at identifying risk factors for bladder dysfunction and adopting preventive measures to minimize the incidence and impact of post-partum voiding dysfunction (PPVD). A woman's bladder in the post-partum period tends to be under-active and in the immediate phase of post-partum diuresis, is vulnerable to retention. Bladder sensation may be affected following birth and women may not have the sensation of a full or over distended bladder.

2.1.3. Severe or prolonged bladder over distension can cause denervation, subsequent atonic bladder and long-term voiding difficulties. A single episode of bladder overdistension can lead to irreversible damage to the detrusor muscle and injury to parasympathetic nerve fibres. The incidence reported varies from 0.7% to 4% of deliveries.

2.2. Risk factors

Any woman can develop PPVD regardless of mode of delivery and analgesia used. However, the following women are at increased risk

- Epidural or Spinal anaesthesia.
- Primigravida.
- Prolonged labour.
- Assisted vaginal deliveries.
- Caesarean section.
- Significant perineal or periurethral trauma.
- Significant immobility.
- Past history of voiding problems.

2.3. Intrapartum and immediate post-partum bladder care

Adequate bladder care during labour and the immediate post-partum period can reduce the incidence of bladder over distension and enable prompt recognition of a woman with voiding dysfunction. A full bladder can delay descent of the presenting part and lead to avoidable intervention.

2.3.1. All women in labour should be encouraged to void every 2-3 hours. If they are unable to pass urine at 3-4 hours or at any time that a bladder is palpable, the bladder should be emptied with a catheter (New 2023). Bladder emptying including self-void should be documented as a volume throughout labour on the partogram and/or fluid balance chart.

2.3.2. Fluid balance is an essential part of care in both high and low risk women. It is important that this commences as soon as the woman is in established labour whether on delivery suite, in any of the birth centres or home (New 2023).

2.3.3. If the woman cannot self-void and an in-out catheter is required for a second time, an indwelling catheter should be recommended.

2.3.4. All women with an epidural should have an indwelling catheter that should be inserted once the epidural has been sited and within 3 hours of the previous void. The indwelling catheter should be left in for at least 6 hours after the last epidural top up or until the woman is mobile, whichever is the sooner. The time of removal of the catheter should be documented on the catheter care plan and the time and volume of the first void should be documented in the electronic patient record.

2.3.5. Any woman who has an indwelling catheter inserted during the first stage of labour should have the catheter removed completely before commencing active pushing. If required, reinsert a new catheter after the delivery (New 2024).

2.3.6. **Operative delivery/procedure under a normal epidural top up**

An indwelling catheter should be sited for at least 6-8 hours. If an additional stronger top up is administered, then this should be extended to at least 12 hours post-delivery. However, any extended period beyond this will increase the risk of UTIs and slow down recovery. The time of removal of the catheter should be documented on the catheter care plan or in the operative notes.

The time and volume of the first void with sensation should be documented in the electronic patient record.

2.3.6 **Operative delivery with a local anaesthetic** - The timing and volume of the first void with sensation should be documented in the electronic patient record. This should be no later than 6 hours post-delivery.

2.3.7 **Spontaneous vaginal delivery**: Women should have the timing and volume of the first void with sensation documented in the electronic patient record. This should be no later than 6 hours post-delivery and prior to an early discharge home.

2.3.8 If a woman following a community birth has not successfully passed urine within 6 hours, they should call maternity triage and immediate arrangements need to be made to admit her to delivery suite.

2.3.9 On admission for suspected urinary retention, detailed questioning about bladder symptoms like frequency, difficult micturition, small voids, pain during micturition helps to identify retention. Questioning about bowel function may reveal constipation is the underlying cause and treatment improves bladder emptying. The amount of urine output must be documented using a fluid and balance chart at readmission. If the void is less than 150ml either an in-out catheter or bladder scan should be performed to check residuals. In the event of any pelvic mass 'in-out catheter' or bladder scan should be considered to rule out bladder distension.

2.3.10 **Women who have undergone repair of a third or fourth degree tear** under a spinal or epidural anaesthesia should have an indwelling catheter for at least 12 hours. If there is other significant genital trauma, consideration should be given to an indwelling catheter for 24 hours following delivery. The time of removal of the catheter should be documented on the catheter care plan and the time and volume of the first void with sensation should be documented in the postnatal section of the handheld notes.

2.3.11 If a procedure has been undertaken with prilocaine spinal, then a catheter may not be necessary. This can be confirmed with the anaesthetist and obstetrician.

2.3.12 If the woman has not voided prior to transferring to the postnatal ward or has a catheter in situ should be communicated to the postnatal ward staff.

2.3.13 **Caesarean section**

Removal of the urinary catheter should be carried out at 6-8hrs following Elective CS and 12 hours following an Emergency CS, unless instructed to leave in for a longer time by the surgeon. If the timing for removal of catheter falls after 00:00hrs, this can be delayed until 06:00hrs, to avoid disturbing the woman's sleep and retention occurring unnoticed overnight (New 2023). The time of removal of the catheter should be documented and the time of the first void with sensation should be documented on the catheter care plan.

2.4. Following the emptying of the bladder by catheterisation in the post-partum period:

- Check for vulval oedema and if present, maintain an indwelling catheter for 24hrs or until oedema has resolved.

- Ensure the woman is drinking at least 1500 ml of fluid in 24 hours.

2.5. Postpartum urinary incontinence

If continuous large volume urinary incontinence after first void, insert in-dwelling catheter for 7 days and follow TWOC pathway. If incontinence persists, rule out fistula (uretero-vaginal/vesico-vaginal) and refer to the physiotherapist.

2.6. Postpartum bladder care

2.6.1. First void with sensation following birth/catheter removal:

- Measure first void with sensation and document time and volume on electronic patient record

2.6.2. Void within six hours. If the woman has not successfully voided >150mls (in one void) or has not established sensation to pass urine within 6 hours of birth or catheter removal, residual volume should be checked either by in-out catheter or bladder scan.

2.6.3. Ensure active monitoring as every woman is at risk of urinary retention whatever the mode of delivery or type of analgesia. Signs and symptoms of difficulty voiding urine include frequency of passing urine, multiple small voids, passing small volumes, slow stream, dribble, dysuria, feeling full bladder or absence of sensation. If voiding dysfunction identified or suspected, perform bladder scan or in/out catheter to identify urinary retention.

2.6.4. Action to be taken if altered voiding function:

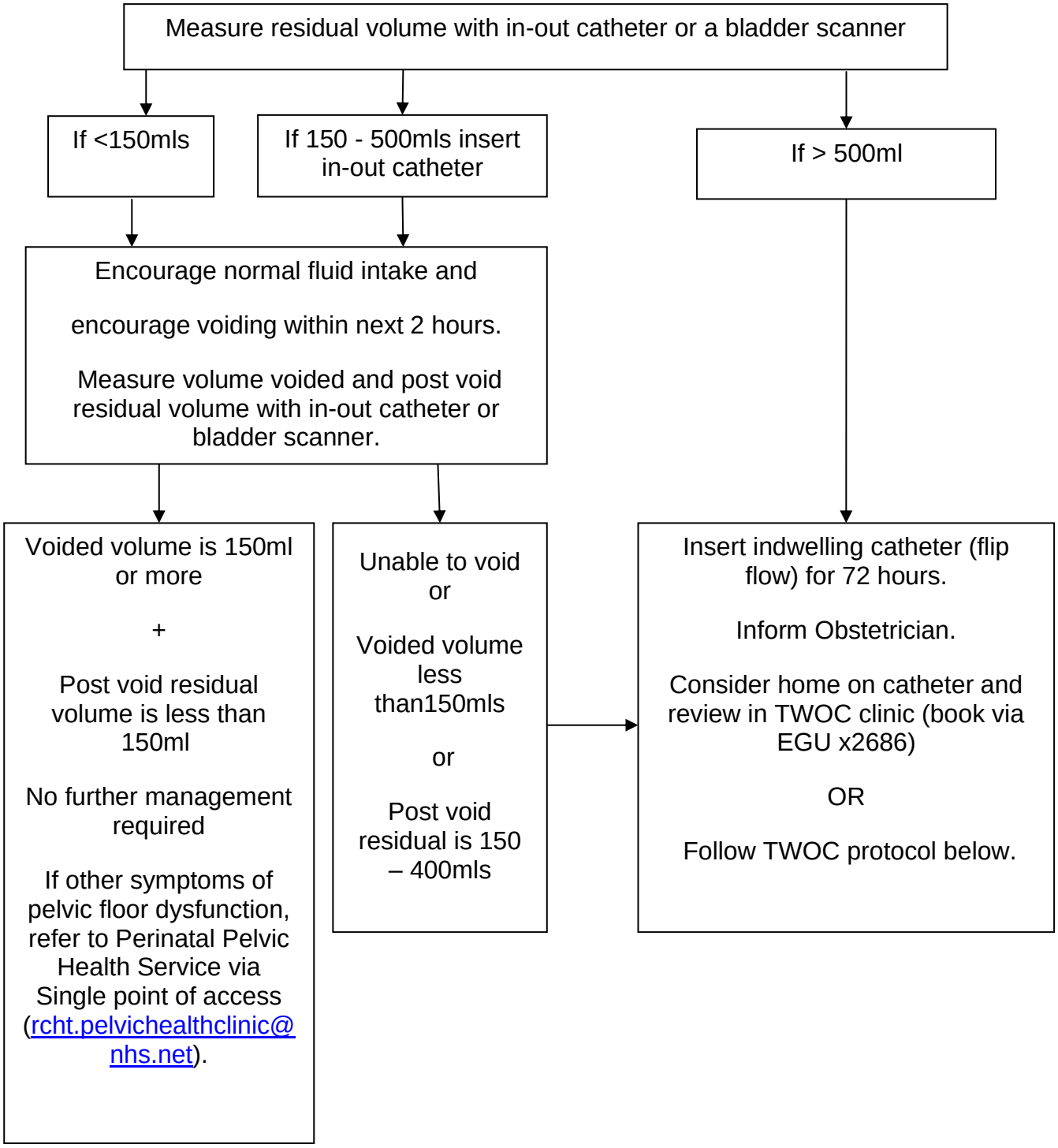
- Ensure patient is not constipated and that bowels have been opened after delivery.
- If severe vulval oedema, insert an indwelling catheter until oedema has resolved.
- Dipstick urine specimen to exclude infection. Send MSU or CSU as indicated.
- Start fluid chart and record fluid intake and output.
- Ensure the woman is drinking at least 1500ml of fluid in 24 hours. This may need to be increased if the woman is breast-feeding or the environment is very hot.

2.6.5. If a patient has loss of bladder sensation (with or without urinary leakage) and no residual urine volume has been identified via bladder scanner or in-out catheter:

- Encourage normal fluid input throughout day
- Encourage timed voids to be made every 2-3 hours depending on fluid consumption and environment.
- Ensure referral to the Perinatal Pelvic Health Service via the single point of access email (rcht.pelvichealthclinic@nhs.net) is completed for review of symptoms.

2.7. Suspected Urinary retention protocol

N.B. Always measure voided volume. Test residual volume within 20 minutes. In-out catheter is considered most accurate method of measuring volumes.



3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Auditing Tool.
Lead	Audit midwives.
Tool	Was more than one in/out catheter used? Was a Foleys catheter inserted if unable to PU a second time and delivery not imminent? **No indwelling catheter:** Was the first void documented in notes and on the electronic record? Was the first void within 6 hours of delivery? If not voided within 6 hours of delivery was the flow chart followed? **Indwelling Foleys catheter in situ:** Was catheter left in situ for 6 hours post-delivery? Was catheter removed at 6-8 hours post instrumental delivery? Was catheter removed 6-8 hours post ELCS? Was catheter removed 12 hours post EMCS or 3rd/4th degree tear? Was the timing of the first void documented on the catheter chart? Was the first void within 6 hours of catheter removal?
Frequency	1% or 10 sets whichever is the greater, of all health records of women who have delivered will be audited over a 12-month period.
Reporting arrangements	A formal report of the results will be received annually at the maternity risk management and clinical audit forum, as per the audit plan. During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed.
Acting on recommendations and Lead(s)	Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed. Action leads will be identified and a time frame for the action to be completed. The action plan will be monitored by the maternity risk management and clinical audit forum until all actions completed.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within a time frame agreed on the action plan. A lead member of the forum will be identified to take each change forward where appropriate. The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan.

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 Care for the Obstetric Patient Clinical Guideline V3.1
This document replaces (exact title of previous version):	Bladder Care for the Obstetric Patient Clinical Guideline V3.0
Date Issued/Approved:	September 2024
Date Valid From:	September 2024
Date Valid To:	May 2026
Directorate/Department responsible (author/owner):	Kirsty Sturgeon, Specialist Pelvic Floor Dysfunction Physiotherapist. Rachel Mullins, Pelvic Health Midwife.
Contact details:	01872 258492
Brief summary of contents:	To provide guidance to midwives and obstetricians on the management of bladder care during labour and in the immediate postpartum period. To give guidance for the correct documentation of bladder care.
Suggested Keywords:	Bladder, care, labour, post, delivery, urine, incontinence, retention.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** Yes
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guideline Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thrilby
Links to key external standards:	CNST 5.7

Information Category	Detailed Information
Related Documents:	• **Rohna Kearney, Alfred Cutner; Postpartum voiding dysfunction**; The Obstetrician and Gynaecologist, 2008; 10:2:71-74. • Ching-Chung L. Shuenn-Dhy C. Ling-Hong T. Ching-Chang H. Chao-Lun C. Po-Jen C. **Postpartum urinary retention: assessment of contributing factors and long-term clinical impact;** Australian and New Zealand Journal of Obstetrics and Gynaecology. 2002; 42(**4**):365-8, • Dorflinger A, Monga A.**Voiding dysfunction**.Curr Opin Obstet Gyneco 2001; 13:507-12. • Jeffery TJ. Thyer B. Tsokos N. Taylor JD. (1990) **chronic urinary retention postpartum.** Australian and New Zealand Journal of Obstetrics and Gynaecology; 1990 Nov. 30(**4**):364-6. • Watson WJ. (1991) **Prolonged postpartum urinary retention**. Military Medicine; 1991. 156(**9**):502-3. • Carley ME. Carley JM. Vasdev G. Lesnick TG. Webb MJ. Ramin KD. Lee RA. **Factors that are associated with clinically overt postpartum urinary retention after vaginal delivery**. American Journal of Obstetrics and Gynecology; 2002; Aug 187(**2**):430-3. • Glavind K. Bjork J. (2003) **Incidence and treatment of urinary retention postpartum**. International Urogynecology Journal; 2003; Jun 14(**2**):119-21. • Zaki MM, et al. National survey for intrapartum and postpartum bladder care: assessing the need for guidelines. BJOG; 2004. • Monitoring compliance and effectivenessNational Institute for Health and Care Excellence (2019) Caesarean section cg132, London: NICE. Available at: www.nice.org.uk/guidance/cg132/resources/ caesareansection -pdf-35109507009733 (accessed 4 February 2021). • National Institute for Health and Care Excellence (2017) Intrapartum care for women and babies CG190, London: NICE. Available at:

Information Category	Detailed Information
	www.nice.org.uk/guidance/cg190/chapter/Recommendations#second-stage-of-labour (accessed 4 February 2021). RCN Bladder and Bowel care In Childbirth (2021).
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2011	V1.0	Initial version	Changes to compliance monitoring only
September 2012	V1.1	Changes to compliance monitoring only	Jan Clarkson Maternity Risk Manager
November 2015	V1.2		Rex Sote, Obs and Gynae Direcorate
July 2016	V1.3	Timing of removal of catheter post LSCS changed. Postpartum bladder care changed in line with Trust gynae bladder care CG.	Miss Aylur Rajasri consultant obstetrician and Dr Rex Sote
September 2019	V2.0	Reviewed, no changes noted	Seren Crowder, Delivery Suite coordinator
March 2023	V3.0	Reviewed. Added frequency of bladder care in labour, fluid balance in all settings, indwelling catheters with all epidurals.	Joanne Crocker, Delivery Suite Ward Manager

Date	Version Number	Summary of Changes	Changes Made by
September 2024	V3.1	Reviewed. Updated guidance around bladder care, urinary retention and trial without catheter. Referral pathways updated to reflect changes to CIOS Perinatal Pelvic Health Service provision	Kirsty Sturgeon, Specialist Pelvic Floor Dysfunction Physiotherapist and Rachel Mullins, Perineal/PPHS Midwife

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 Care for the Obstetric Patient Clinical Guideline V3.1
Directorate and service area:	Obstetrics and 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):	Kirsty Sturgeon, Pelvic Floor Dysfunction Physiotherapist.
Contact details:	01872 25 2361

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)	To provide guidance to midwives and obstetricians on the management of bladder care during labour and in the immediate post-partum period. To give guidance for the correct documentation of bladder care
2. Policy Objectives	To ensure safe management of the bladder through labour and immediate post-partum period.
3. Policy Intended Outcomes	To ensure safe management of the bladder through labour and immediate post-partum period.
4. How will you measure each outcome?	Compliance monitoring tool
5. Who is intended to benefit from the policy?	Pregnant and newly delivered women

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: Yes • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Maternity Guidelines Group Cornwall & Isles of Scilly Perinatal Pelvic Health Service
6c. What was the outcome of the consultation?	Guideline Agreed
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	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
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: Kirsty Sturgeon, Pelvic Health Physiotherapist.

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

Appendix 3. Pelvic Health Referrals

Cornwall and Isles of Scilly Perinatal Pelvic Health Service (PPHS)

Antenatal or postnatal:

Asks for additional pelvic floor muscle exercise support/advice

Anismus

Chronic constipation

Dyspareunia (painful sex)

Faecal urgency

Incontinence:

- Faecal
- Flatus
- Urinary

Prolapse

Loss of bladder sensation with incontinence

Loss of bladder sensation (sudden onset)

Obstructed defaecation/incomplete rectal emptying

Pelvic organ prolapse

Rectal prolapse

Vaginismus

Perineal wound dehiscence or wound concerns

Refer to Cornwall and Isles of Scilly Perinatal Pelvic Health Service via single point of access email:

rcht.pelvichealthclinic@nhs.net

Musculoskeletal (MSK) Physiotherapy:

Antenatal or postnatal:

Abdominal diastasis

Pelvic girdle pain

Thoracic pain

Lumbar spine pain

Sacro-iliac joint pain

Carpal tunnel syndrome

Refer via Maxims

How to make a Maxims referral for MSK Physiotherapy Service

1. Log in to **Maxims**
2. Type in patient **CR number**
3. Access correct **patient record**
4. On the Demographics blue bar at the top right of the screen- click on '**More'**
5. Click on **Patient Internal Referral/Add to WL**
6. **Type PHY into the Service box and a list of options will appear**
7. Select **Physiotherapy MSK Outpatient Service**
8. Select urgency: **Urgent - Yes**
9. Select whether **referral is for a new condition: Yes or No** (n.b. referrals will be rejected if the urgency and referral for new condition options are not completed)
10. Complete the **Service Specific Questions**
11. Complete the **Clinical Details**
12. **Press Save to submit referral**

Appendix 5. Adult Bladder and Bowel Specialist service referral form

The service expects that any red flag bladder or bowel symptoms will have been escalated to the relevant team prior to making this referral. We do not accept referrals for product orders or fitting.

Please include a patient summary with this referral and ensure patient consent has been given for this referral.

Patient details

Information required	Response
Patient name	
Date of birth	
NHS number	
Address	
Postcode	
Telephone number	
Email	
Ethnicity	

Names of carer, family member or friend (if applicable):

Click or tap here to enter names of carer, family member or friends.

Clinician details

Information required	Response
Name of referring clinician	
Designation	
Address	
Telephone number	
Email	
Date of referral	
Name of GP	
Address of GP	

Location of patient at time of referral:

Other professionals involved in care:

Patient needs

Does your patient have needs that you feel might be able to be accommodated with reasonable adjustments to normal outpatient clinic arrangements, such as downstairs, wide door access, no lifts?

☐ Yes ☐ No

Does your patient have a cognitive impairment, such as a learning disability or dementia?

☐ Yes ☐ No

Does your patient have a sensory impairment?

☐ Yes ☐ No

Does your patient have a physical impairment?

☐ Yes ☐ No

Is an interpreter required?

☐ Yes ☐ No

If yes, which language?

Referral details

Primary reason for referral:

Treatment and management already undertaken:

Referral information

If you have an enquiry about indwelling urinary catheterisation, contact the team by email at the address below or call 01726 873 095.

Please arrange a pre or post void scan if the following symptoms present:

- hesitancy to void.
- intermittent or weak flow.
- straining to void.
- feeling of incomplete emptying.
- recurrent urinary tract infection.

Please also consider a referral for an ultrasound of the kidneys, ureter, and bladder.

Return your completed referral form by email to bladderandbowelspecialistenquiries@nhs.net.

Appendix 6. Summary of user instructions for BARD SCAN IIs Real Time Ultrasound Bladder Scanner

For more detailed instructions please follow the instructions on the lid of the scanner.

1. Switch on: - use the rear Power button to switch on the unit. If the battery is flat, please plug into the mains adaptor.
2. Placing Probe: - Use ultrasound gel for good contact. Position the probe two fingers width above the pubic symphysis.
3. **Start with Tranverse Scan**: - Place probe with the black dot to patient's right and blue button to patient's head. Press scan or blue probe button.
4. **Identify the bladder**: look for dark oval/circle.
5. Press freeze or blue probe button: - This is your interim or quick scan reading.
6. **Sagittal Scan**: - Place probe with the black dot to patient's head and blue button to patients left. Press sagittal scan on screen.
7. **Identify the bladder**: look for dark oval/circle.
8. **Press freeze or blue probe button to freeze. This is your final combined reading.**
9. **Press red button on screen to finish. Print result and file in patient notes.**

Appendix 7. Trial without catheter (TWOC)