Guideline No: 21 Bladder Care

VERSION 6

AMENDMENTS MADE: Removal of recording the volume of first void.

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NAME AND DESIGNATION OF GUIDELINE AUTHOR(S): Mark Doyle, Consultant, O&G

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MONITORING COMPLIANCE WITH THE GUIDELINE

| Minimum requirement to be monitored | Auditable Standards – See below |
| Process for monitoring              | Audit of Guideline              |
| Responsible individual/group/committee | Risk Management Department     |
| Frequency of monitoring             | 3 yearly                       |
| Responsible individual/group/committee for review of results | Obstetric & Gynaecology Audit Meeting |
| Responsible individual/group/committee for development of action plan | Audit Lead |
| Responsible individual/group/committee for monitoring of action plan | Divisional Clinical Governance Steering Group |

COMPLIANT WITH:

1. NHSLA Maternity Standard 5, Criterion 7

AUDITABLE STANDARDS

1. All health care records have a documented time of first postnatal void
2. All indwelling catheters are removed within six hours of delivery unless there are specific instruction for this to remain insitu
3. All women who have not voided within 6 hours of delivery or following removal of a catheter and with a residual urine volume of > 400 ml are referred for consultant review
4. All women who continue to have voiding problems after 12 hours have a documented management plan in the health care records
5. All women who continue to have voiding problems should be referred to the Urogynaecology Team
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1.0 INTRODUCTION
An empty bladder is essential in reducing discomfort, preventing bladder distension and aiding normal progress of labour. A full bladder can hinder descent of the fetal head and reduce efficiency of uterine contractions. The pressure of the fetal head on the bladder may lead to oedema, bruising, postnatal retention and long term urinary dysfunction. In addition, epidural anaesthesia has been linked to postnatal urinary retention and voiding difficulty.

A number of physiological and psychological factors may contribute to an inability to pass urine in labour. In some cases, the only way to empty the bladder is by catheterisation. Urinary infection is the most commonly acquired hospital infection and about 80% of these are associated with urinary catheters. The first step to avoiding catheter associated urinary infection is to avoid unnecessary catheterisation.

Postpartum urinary retention is considered to be a common complication; however the amount of reported incidences varies from 1.7% to 17.9%. The initial postpartum void should take place within six hours of delivery or within six hours of catheter removal. The incidence of urinary retention is greatly increased with primigravidae, epidural anaesthesia, instrumental deliveries and extensive perineal and vaginal trauma.

2.0 GUIDELINE REGIME

2.1 Intrapartum Bladder Care
For guidance on intrapartum bladder care WITH or WITHOUT an Epidural (See Appendices 1 & 2).

2.2 Postpartum bladder Care
The time of the first void of urine post delivery will be recorded in the notes by the midwife caring for the woman. If a woman has not passed urine within 4 hours of delivery then medical review will be sought.

2.3 Patients with Indwelling Catheters
These will be removed between 6 -12 hours following delivery unless a different instruction is written in the case notes.
After removal of the catheter a record of the time of the first spontaneous void of urine will be made in the notes by the midwife caring for the woman. If a woman has not passed urine within 4 hours of delivery then medical review will be sought.

2.4 Routine postpartum care
All women will be asked daily if they are having any problems passing urine by the midwife caring for her. If there are problems or the midwife has clinical suspicion of a problem she will seek medical review.
3.0 Documentation
During labour, oral intake and urinary output should be recorded within the intrapartum care record. It is the responsibility of the midwife to record within the health care record the time of the first void postpartum.

4.0 Patients Referred for medical advice
This will be seen within 2 hours by a doctor who will review and exam the patient and document a plan of care in the case notes.

5.0 REFERENCES


6.0 RELATED DOCUMENTS
Indwelling Catheter Pathway
Appendix 1

Bladder Care in Normal Labour
WITHOUT EPIDURAL

- **NO VOID FOR 4 HOURS**
  - Walk to toilet or offer bedpan
    - Spontaneous void
      - Continue to monitor intake and output
    - No spontaneous void
      - Check for palpable bladder
        - No palpable bladder
          - In and out catheter measure and test
        - Bladder palpable

- **NO VOID FOR 8 HOURS**
Appendix 2

Bladder Care in Normal Labour
WITH EPIDURAL

NO VOID FOR 4 HOURS

Spontaneous void, measure and test

Offer bedpan

No spontaneous void

More than 150 mls

Less than 150 mls

Check for palpable bladder

Continue to monitor intake and output

Bladder not palpable

Bladder palpable

In and out catheter or Foley's catheter based on clinical judgement, Measure and test
Appendix 3

Managing post partum voiding problems

The aims are:
- To encourage a normal filling emptying cycle
- To prevent over distension of the urinary bladder where voiding is a problem for the patient.
- To empower the women to manage her problem

Immediate action
- Decide is there retention of urine or an under production of urine?
- Assess the post micturition volume of urine in bladder by either a bladder scanner estimation or an in/out catheter estimation if a bladder scan is unavailable.
- If there is inadequate production of urine decide why and treat the cause.
- If there is an inability to void adequately either total or partial (residual volume >150mls) then:
  - Empty bladder - Ask patient to void again if she is able to, if not empty using an in out catheter (if not already performed).

Instigate
- A regular post micturition residual volume assessment by the midwifery staff caring for the patient, any residual volume > 149 mls needs treating.
- The midwife to ask patient to void again (double void) if the patient is able to, if not teach the patient clean intermittent self catheterisation and use this to empty residual urine on each occasion.

Encourage
The patient to learn how to empty her bladder independently with CISC if needed.

Discontinue
This management when 2 voids are > 150 mls and 2 residual estimations are < 150 mls.

Arrange
Review by urogynaecology team if the problem does not resolve in 48 hours.