BLADDER MANAGEMENT: DURING LABOUR AND THE POSTNATAL PERIOD

PURPOSE
To reduce the risk of postnatal voiding dysfunction.

While all women in the immediate postnatal period have the potential to experience urinary problems several factors increase the risk, i.e:
- Duration of labour prolonged first and second stages of labour\(^5,6\)
- Caesarean section for delay in the first stage of labour
- Duration of labour\(^1\)
- Assisted birth\(^1,2\)
- Episiotomy\(^1,2\)
- Epidural analgesia \(^1,2\) particularly with local anesthetic. (e.g. bupivacaine)
- Post Caesarean Epidural Morphine\(^1\)
- Perineal/vulval trauma
- Over distension of the bladder during/immediately following birth
- Larger infant than normal term baby
- Non English speaking mother
- Obesity(1)
- Nulliparity(1, 2)

PROCEDURE

In Labour

- Encourage the woman to void every 2 - 3 hours. If unable to void there should be a low threshold for catheterisation.
- Insert an Indwelling catheter (IDC) size 12fg for all women who have a palpable bladder, have a sensation of incomplete emptying or have an epidural / spinal for labour and birth.
- The catheter balloon should be deflated or removed prior to pushing to reduce the risk of urethral damage.
Immediate Postpartum:

- The IDC must be reinserted after delivery for women who have neuraxial analgesia. The IDC should remain in situ for at least 6 hours after the birth or until full sensation has returned. Once mobile, remove the catheter and monitor the first and second void.

- In women who have had spinal anaesthesia or epidural analgesia that has been topped up for a trial of instrument or CS the IDC should remain in situ for a minimum of 12 hours after birth.

Indwelling Catheter is also indicated for a minimum of 12 hours for

- PPH with syntocinon® infusion (for the duration of the infusion).
- 3rd or 4th degree tear

Consider an IDC to remain in situ for 24 hours if there is other significant genital trauma.

Postnatal Trial of Void (TOV): Spontaneous following birth or following initial removal of an IDC

- The timing and volume of the first two voids must be monitored.

- Screen all women within 2 hours of birth / removal of IDC for risk factors and symptoms of urinary retention.

- The woman must void within 4 hours of birth or removal of an IDC.

- If the woman is unable to void
  - Insert an indwelling catheter for 24 hours
  - Inform the Obstetric team
  - Remove catheter after 24 hours and encourage voiding within 4 hours. If the residual volume <150 mL for discharge with no follow up
  - If post void residual >150 mL the catheter is to stay in for 7 days. Follow up at the urology clinic.

- If the volumes voided are less than 150mL or greater than 600mL measure the residual volume by real time scan or intermittent catheterisation. The real time scanner is to be used only by midwives who have received appropriate training. The catheterisation must occur immediately after the void using an aseptic technique.

- Perform a urinalysis to exclude infection and send a MSU or CSU.
Residual Volumes Management
(For women whom have voided <150mL OR >600mL).

Insert in/out catheter and measure and document volume drained or measure residual volume with a real time scanner (RTS)

If < 500mL drained:
- Encourage voiding within next 2 hours, measure volume voided and post void residual with either an in out catheter or RTS
- If post void residual <150ml then no further management unless symptomatic

If >500mL drained:
- Insert indwelling catheter for 24 hours
- Inform Obstetric team
- Remove the catheter after 24 hours and encourage voiding within 4 hours. If residual volumes <150 mL for discharge with no follow up
- If post void residuals >150 mL catheter is to be reinserted and remain in for 7 days. Follow up at the urology clinic.

TOV Regime following removal of an IDC that has been inserted for an Unsuccessful Trial of Void

- Encourage voiding within 2 hours of IDC removal.
- Measure the volume voided and the post void residuals with RTS or intermittent catheterisation.
- If the post void residual volumes (x 2) are less than 150mL – no further action.
- If the post void residuals are >150mL reinsert the catheter. This should remain in situ for 7 days. Follow up at the urology clinic.

If the patient is not able to void after the initial 4 hours insert an IDC

- If drainage is more than **500mL in one hour**, leave catheter insitu for **24 hours**. Repeat the Trial of Void as outlined above.
- If drainage is more than **1000mL in one hour** leave catheter in situ for **48 hours** on free drainage, liaise with the urology nurse practitioner, urology registrar or a member of the Urogynaecology team.
- If no intrapartum antibiotics prophylaxis has been given commence prophylactic antibiotics after 6 hours and discontinue when the catheter is removed.
Prevention and Management of Postpartum Urinary Retention

Voiding difficulty, unable to void or no sensation of bladder filling within 4 hours of birth OR removal of IDC

Encourage to void within 30 minutes
Instigate non-invasive measures: analgesia, privacy, Ural, void in shower, relaxed void, mobilise

If voids < 150ml or >600 ml

Perform a post void bladder residual EITHER by RTS OR intermittent catheterisation (in/out).

Residual Volume <500ml
Encourage patient to void within next 2 hours
Measure volume voided and perform a post void residual (by either RTS OR intermittent catheter)

If post void residual <150ml then no further management unless symptomatic.

If unable to void or post void residual >150ml

Residual Volume >500ml

Insert an IDC for 24 hours
Inform the obstetric team
Remove the catheter after 24 hours and encourage voiding within 4 hours.

Remove catheter after 24 hours and encourage voiding within 4 hours.

Post void residual <150mls.

Cleared for discharge without any follow up.
Provide patient with physio contact number if has any urinary symptoms post discharge

Post void residual >150mls

Re-insert IDC
IDC to stay in for 7 days
Follow up with Urology Nurse Practitioner for TOV as an out patient.

Unable to void
Insert IDC

If drainage:
• >500ml in one hour, leave IDC in situ for 24 hours.
• >1000ml in one hour, leave IDC insitu for 48 hours.

Ref to Urology Nurse

• If no intrapartum antibiotics prophylaxis has been given commence prophylactic antibiotics after 6 hours and discontinue when the catheter is removed.

Ref: KEMH Clinical Guidelines – Bladder Management during Labour and the Postnatal Period
| Following Vaginal Birth with Epidural/ CSE in labour | Following:  
- Instrumental/ Vacuum Birth  
- PPH  
- 3rd or 4th Degree Tear with epidural/ CSE | Following Caesarean Birth | Following Epidural MORPHINE Top Up |
|--------------------------------------------------|-------------------------------------------------|-----------------------------|----------------------------------|
| • An IDC must be inserted during labour.  
• An IDC must be reinserted after delivery.  
• It should remain in situ for at least 6 hours after the birth or until full sensation has returned  
• Assess motor function to ensure sensation has returned to normal.  
• Check dermatomes if the epidural contained local anaesthetic | • **IDC must be reinserted after delivery.**  
• It should remain in situ for at least 12 hours after the birth or until full sensation has returned.  
• If there is other significant genital trauma, consideration should be given to an indwelling catheter for 24 hours following birth | • IDC should remain in situ for a minimum of 12 hours after birth. | • IDC to remain insitu for a minimum of 24 hours post Morphine administration |

**BLADDER MANAGEMENT: INTRAPARTUM AND POSTPARTUM**

**Note:**
- Always check Bromage score prior to removal of IDC  
- Remove IDC or ambulate only if Bromage Score ≤ 2  
- The first void should always be within 4 hours of IDC removal.  
- Encourage the woman to void every 2-3 hours
**REFERENCES (STANDARDS)**


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| National Standards – 1 Clinical Care is Guided by Current Best Practice |  
| Legislation - Nil |  
| Related Guidelines / Policies – |  
| Management of the Bladder and Urinary Drainage Apparatus |  
| Labour (First Stage): care of the Woman |  
| Labour (Second Stage): Management |  
| Postnatal: Subsequent Care |  
| Other related documents – Nil |  

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| RESPONSIBILITY |  
| Policy Sponsor | HoD Urogynaecology |  
| Initial Endorsement | April 2015 |  
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| Last Amended |  
| Review Date | April 2018 |  

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Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.