Guideline

Bladder Management - Intrapartum and Postpartum (including Trial of Void)

- Encourage the woman to void every 2 hours in labour and before beginning active second stage.
- Have a low tolerance for catheterisation if woman unable to void on 2 occasions.
- Catheterise immediately if the bladder is palpable and woman cannot void.
- Do not tape the catheter stretched to the thigh. This will decrease the mobility of the urethra, and decrease the mobility of the balloon in the bladder neck.
- During labour, use only 5-10mL of sterile water in the catheter balloon and ensure it is not the vagina.
- Problems with postpartum voiding are managed using the Trial of Void Pathways A and B.

1. Purpose

This clinical guideline outlines the requirement for prevention and treatment of peripartum bladder dysfunction at the Women's.

Some degree of voiding dysfunction affects 10-15% of postnatal women and can persist for some time following birth. Five per cent of women have significant and longer lasting dysfunction, which if not recognised in the early peripartum period (birth centre, postnatal ward) may lead to bladder over distension and overflow incontinence resulting in long-term, significant bladder damage and voiding dysfunction.

2. Definitions

Overt bladder retention

This is the inability to pass urine within six hours of birth thus requiring catheterisation, in which volumes greater than normal bladder capacity (normal 400-600mL in females) are drained from the bladder. The woman will often complain of pain and the desire to void, may have overflow incontinence mistaken as stress incontinence or may be asymptomatic particularly if an epidural was used during labour.

Covert bladder retention

The woman is able to void however fails to empty at least 50% of her normal bladder capacity, or a post void residual volume of greater than 150mL. These women will often have frequency and pass volumes of < 100mL.

3. Responsibilities

Staff responsible for intrapartum and postpartum bladder management of a woman should follow this guideline.

4. Guideline

4.1 Risk factors

Women at highest risk include:

- primigravida
- prolonged labour, especially prolonged stage 2
- epidural for labour/birth, irrespective of mode of delivery
- need for catheter in labour
- assisted vaginal birth
- caesarean birth
- perineal injury including haematoma, bruising or tear with inadequate analgesia.

Women without these risk factors may be susceptible to voiding dysfunction; a high index of suspicion must be maintained.

4.2 *Prevention*

Prevention of acute bladder distension

In labour

Encourage the woman to void every 2 hours. Measured volumes are preferred.

If the woman is unable to void on 2 occasions, the threshold for catheterisation is low.
If the bladder is palpable and the woman cannot void – catheterise immediately.

A soft catheter is preferable. Do not tape the catheter stretched to the thigh as this will decrease the mobility of the urethra and decrease the mobility of the balloon in the bladder neck.

Inflate the balloon with just 5-10mL of sterile water.

The balloon should be inflated with just 5-10mL of sterile water. If the woman does not have an epidural and catheterisation is merely for the purpose of emptying the bladder prior to a procedure, then an in-out catheter should be considered.

To prevent urethral injury, it is important that the balloon is in the bladder and not merely in the urethra. The taping in of the catheter is of equal importance and must be proximal to the woman's vulva to prevent inadvertent pulling and dislodgement. The Flexi-Trak anchoring device may be used (shown fig 1 below). If unavailable, micropore or similar tape can be used (shown fig 2 below).

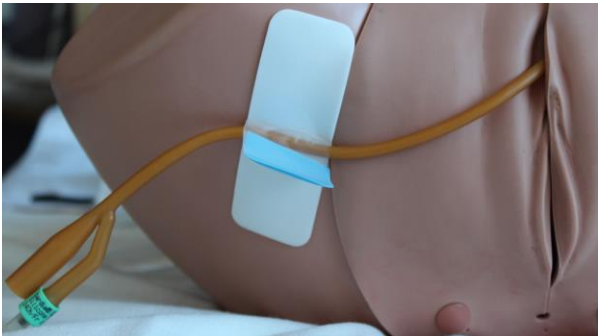

Fig 1: Taping using the Flexi-Trak. The blue wings can be trimmed for the woman's comfort - be careful not to trim too short.

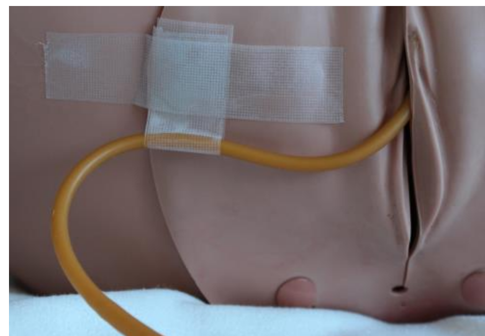

Fig 2: Any kind of tape can be used. Anchoring as shown reduces the risk of inadvertent dislodgement. Ensure that drainage is not compromised.

Postpartum

Urine volumes should be representative of patient oral input, keeping in mind normal diuresis in the postpartum woman.

If postpartum urinary retention is suspected or the woman is unable to void, threshold for catheterisation should be low.

Use the Trial of Void sticker (see right) for all postpartum women and manage her voiding ability as advised.

This yellow-bordered sticker is to be placed in the progress notes of all postpartum women and completed by midwives looking after them to clearly document this.

(AFFIX PATIENT LABEL)

Notes | Sign, Print name Designation

Delivery date: / / @ Mode: NVB Vac Forceps CS Weight:
Perineal Trauma: N/A 1 2 3A 3B 3C 4 Epis Swelling

Post-partum void: / / @
Voided within 6/24 post-delivery? Yes No
Normal urge to void? Yes No
Normal commencement/flow? Yes No
Bladder feels empty post void? Yes No
Voided volume 150mL-700mL Yes No
Signature:______ Name:______

IDC removal: / / @
TOV 1: / / Time: ______ ______mL
Normal urge to void? Yes No
Normal commencement/flow? Yes No
Bladder feels empty post void? Yes No
Voided volume 150mL-700mL Yes No
Signature:______ Name:______
TOV 2: / / Time: ______ ______mL
Normal urge to void? Yes No
Normal commencement/flow? Yes No
Bladder feels empty post void? Yes No
Voided volume 150mL-700mL Yes No
Signature:______ Name:______

If 'No' to any criteria:
☐ Commence FBC (input & output)
AND
☐ Refer to Physiotherapy (on-call via switchboard weekends/ public holidays)

Signature: ______
Name:______
Date:______

4.3 Diagnosis

A common error is failure to diagnose the bladder distension and incomplete bladder emptying.

Symptoms of voiding dysfunction/retention

Symptoms of voiding dysfunction may include:

- no urge to void
- inability to void within 6 hours of birth or within 6 hours of catheter removal urinary frequency, urgency
- lower abdominal pain
- palpable bladder
- overflow incontinence
- voided volumes of <100mL.
- poor commencement /flow of urine
- sense of incomplete bladder emptying

If a woman experiences the above symptoms, commence a Fluid Balance Assessment Chart (MR2054) and refer to physiotherapy using Internal Referral (OP20), notify the physiotherapist (ext 3160), via pager 53167 or using the on call service available via switchboard (on weekends and public holidays).

In order to assess bladder function, the first postpartum void must be recorded, and the woman asked about urge, flow and feeling of complete emptying.

If an IDC has been inserted, document the planned removal time and ensure that 2 formal trial of voids are completed.

If trial of void criteria are not met, commence a Fluid Balance Assessment Chart (MR2054) and a referral to physiotherapy actioned.

Further management is guided by the Trial of Void pathways A and B.

4.4 Treatment

Refer to Trial of Void pathways A and B.

Physiotherapist Continence nurse advisor (urogynaecology outpatient clinic)	Phone: (03) 8345 3160 Phone: (03) 8345 3144

5. Evaluation, monitoring and reporting of compliance to this guideline

Compliance to this guideline or procedure will be monitored, evaluated and reported through clinical incidents reported through VHIMS.

6. References

1. Andolf E. Iosif CS. Jorgensen C. Rydhstrom H. Insidious urinary retention after vaginal delivery: prevalence and symptoms at follow-up in a population-based study. Gynecologic & Obstetric Investigation. 38(1):51-3, 1994.
2. Ramsay IN. Torbet TE. Incidence of abnormal voiding parameters in the immediate postpartum period. Neurourology & Urodynamics. 12(2):179-83, 1993.
3. Malinowski J. Bladder assessment in the postpartum patient. JOGN Nursing. 7(4):14-6, 1978.
4. Groutz A. Gordon D. Wolman I. Jaffa A. Kupferminc MJ. Lessing JB. Persistent postpartum urinary retention in contemporary obstetric practice. Definition, prevalence and clinical implications. Journal of Reproductive Medicine. 46(1):44-8, 2001.
5. Lee SN. Lee CP. Tang OS. Wong WM. Postpartum urinary retention. International Journal of Gynaecology & Obstetrics. 66(3):287-8, 1999.
6. Yip SK. Hin LY. Chung TK. Effect of the duration of labor on postpartum postvoid residual bladder volume. Gynecologic & Obstetric Investigation. 45(3):177-80, 1998.
7. Jeffery TJ. Thyer B. Tsokos N. Taylor JD. Chronic urinary retention postpartum. Australian & New Zealand Journal of Obstetrics & Gynaecology. 30(4):364-6, 1990.

7. Legislation/Regulations related to this guideline

Not applicable.

8. Appendices

Appendix 1: Maternity Trial of Void- Pathway A (initial management)

Appendix 2: Maternity Trial of Void-Pathway B (subsequent management)

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Appendix 1

Maternity Trial of Void: Pathway A

Maternity: Trial of Void- Pathway A

Woman voids within 6 hours of birth
OR
within 6 hours of IDC removal

YES →

Woman voids within 6 hours after birth/post IDC removal with:
- Normal urge to void
- Normal commencement/ flow
- Bladder feels empty post-void
- Voided volume 150-700 mls
- Needs 2 consecutive voids measured if post-IDC that meet the above criteria

YES → **Passed TOV**

NO → Commence FBC and refer to Physiotherapy

(on-call weekends and public holidays)

→ Midwife closely monitors FBC until seen by physio

→ If FBC shows:
- Output greater than input
- Void volumes 150-700mL

→ Continue FBC and await Physiotherapy input

→ If FBC shows:
- Output less than input
- Void volumes less than 150mL
- Void volumes more than 700mL

→ Midwife to ask woman to void and within 15 mins, perform in/out catheter to assess PVRV

→ PVRV less than 150mL → Continue FBC

Await Physiotherapy review

→ PVRV more than 150mL → **Failed TOV**

NO → Woman unable to void within first 6 hours despite attempting to do so. → **Failed TOV**

Failed TOV → Insert IDC for 24-48 hours and document volume drained on IDC reinsertion → Follow TOV Pathway B

Maternity Trial of Void – Pathway B

Maternity: Trial of Void- Pathway B

IDC has been reinserted for 24-48 hours

↓

Remove IDC and insert new yellow TOV sticker

↓

Measure first 2 voids and post-void residual volumes (PVRV) with in/out catheter

Pass= voids more than 150mls and PVRV less than 150mls.
Fail= PVRV more than 150mls

- **Pass x 2** → **Pass TOV**
- **Pass x 1 Fail x1** → Further void and PVRV → **PASS** → **Pass TOV**; **FAIL** → **Failed TOV**
- **Fail x 2** → **Failed TOV**

Pass TOV

Refer to physiotherapy if:

- *decreased urge to void*
- *voided volumes greater than 700mL*
- *urinary incontinence.*

Failed TOV

- Leave IDC in situ
- Home with IDC 5-7 days
- Contact In-Charge on 5 South to arrange readmit for TOV
- Discharge home with leg bag *(ensure education has been provided before discharge).*