Bladder Care Management during the Antenatal, Intrapartum and Postnatal Period Guideline

Guideline information

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Summary of document:
To maintain bladder function and to provide appropriate management to women during the intrapartum and postpartum period. To minimise the risk of prolonged voiding dysfunction in the puerperium and prevent its long term sequelae.

Scope:
This guideline applies to all health care professionals caring for women in pregnancy, during labour or post-partum.
The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

To be read in conjunction with:
NICE National Institute for Health and Care Excellence (NICE) Clinical guideline (CG) 190
NICE CG171 (2015) Urinary incontinence in women
Urinary incontinence in women: management | Guidance | NICE (opens in a new tab)
NICE QS77 (2015) Urinary incontinence in women
Overview | Urinary incontinence in women | Quality standards | NICE (opens in a new tab)
683 - Bladder Scanner Guideline (opens in a new tab)
396 - Urinary Catheterisation in Adults Policy and Procedure (opens in a new tab)
222 - Continence Care Policy (opens in a new tab)

Patient information:
Include links to Patient Information Library

Owning group:
Maternity Guideline, Audit and Research Group.
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Executive Director Job title:
Chief Operating Officer.

Reviews and updates:
Version 1 New guideline Approved 15/11/2021

Keywords: Bladder care, intrapartum, postpartum

Glossary of terms
PUR - Postpartum Urinary Retention
ISC - Intermittent self-catheterization
PVRV - post void residual volume

Contents

Scope
This guidance is to support clinicians when caring for women in the intrapartum and postpartum period

Aim
The aim of this guideline is to minimise the possibility of over-distension of the bladder which can cause a hypotonic bladder and prolonged voiding dysfunction with long term sequelae such as recurrent urinary tract infection, urinary incontinence and prolonged intermittent self-catheterization (ISC).

Objectives
- To maintain bladder function and to provide appropriate management to women during the intrapartum and postpartum period.
- To minimise the risk of prolonged voiding dysfunction in the puerperium and prevent its long term sequalae.

Introduction.
Bladder care during pregnancy, labour and postnatal is of paramount importance. Forgetting to ensure bladder emptying in labour or the sudden diuresis after with bladder volumes of 800ml or more can lead to permanent bladder damage.

Hormonal changes in pregnancy decrease the tone of the detrusor muscle to allow more storage of increased urine production. In the post-partum period, the tone remains reduced, increasing the risk of over distension and this is not helped by the physiological postpartum diuresis. Combined with trauma to the bladder, pelvic floor muscles and nerves during birth, the postpartum bladder can become underactive and is therefore vulnerable to the retention of urine.

Postpartum voiding dysfunction is defined as failure to pass urine spontaneously within 6 hours of vaginal birth or catheter removal following birth. It is described as a common problem in the first day or two after childbirth and occurs in 0.7 – 4% of all births. (RCOG)

Quick action to drain an over-distended bladder and a period of bladder rest (i.e. catheterisation with free drainage) is the best management to reduce the risk of long-term damage. However, vigilant bladder care during labour and in the post-partum period will reduce the risk of over distension and thus the need for catheterisation.

Whist urinary catheterisation can be essential for the safety and comfort of those women who have been identified as having bladder dysfunction it is also widely associated with urinary tract infections and sepsis. Whilst some women may need to be catheterised as part of treatment in the short term, it is important in most cases to undertake a TWOC before discharging home.

Types of Postpartum Urinary Retention (PUR).
Overt PUR: The inability to void spontaneously within 6 hours of a vaginal delivery, or after removal of a catheter after caesarean section

Covert PUR: post-void residual volume (PVRV) of greater than or equal to 150 mL after spontaneous micturition *without* symptoms of urinary retention and confirmed on bladder ultrasound scan or catheterisation

Symptoms and Signs to look out for.

Women who are symptomatic of voiding dysfunction such as:

- Slow urinary stream
- Unable to void.
- Reduced, or lack of, sensation to void.
- Difficulty in initiating a void.
- Passing small volumes 100mls or less.
- Frequent voids- every 30-60 minutes
- Urgency.
- Incomplete emptying and incontinence/ Post micturition dribble
- Slow or intermittent stream,
- Bladder pain or discomfort (this can be misdiagnosed as labour pain or wound pain after CB).
- Straining to void.
- Nocturia >2 times not related to baby feeding.

Symptoms can often be masked, and patients may appear asymptomatic, especially if they have had an epidural. In some cases, overflow incontinence due to over-distension displays as stress incontinence,

Verbal Questions

The following questions may help to identify those at risk of retention:

Think **VESSI**

- Did you pass a good **V**olume of urine?
- Did your bladder **E**mpty at the end?
- Do you have a **S**ensation that you want to pass urine?
- Was your **S**tream normal?
- Was there any **I**ncontinence?

Risk Factors associated with Bladder dysfunction

Antenatal Risk factors

- Retroverted Uterus
- Incarcerated uterus
- Fibroids
- Pre-existing voiding difficulties
- Congenital uterine anomalies
- Pelvic adhesions

Intrapartum and Post partum Risk factors

While some women develop postnatal dysfunction without identifiable risk factors, the following may increase the risk:

- Primigravida
- Prolonged labour (1st and 2nd stage)

- Epidural analgesia
- Instrumental birth
- Vulval & Perineal injury (Including bruising, haematoma, oedema, episiotomy and tears requiring suturing)
- Anal sphincter injury (3rd & 4th degree tears)
- Caesarean section
- Manual removal of placenta
- Natural postpartum diuresis – this plus an increased oral intake following labour may increase the risk of retention due to the volume of urine being produced, the perineal trauma and lack of sensation.
- Rapid diuresis following discontinuation of oxytocin.

Antenatal Bladder Care Management retention

Acute Antenatal retention is unusual and will usually resolve. The primary goal is to relieve the bladder

- An intermittent urinary catheter should be inserted after the patient has attempted to pass urine, the residual measured, and urine sent for culture.
- A clinical examination is required to determine and possibly address any underlying causes, such as retroverted uterus.
- If the residual is between 100 and 150ml but the woman voided 250ml or more, the catheter also does not need to stay in.
- If these parameters aren't met, consider use of CISC. If the woman is unable to manage CISC then re-catheterisation with indwelling catheter left on free drainage
    - If constipated, manage as appropriate
      Urogynaecology team input should be sought. An appropriate time interval for TWOC needs to be arranged.
    - If the woman attends and fails her TWOC, she will be taught to intermittently self-catheterise.

Intrapartum Bladder Care Management

Normal Labour without an epidural (including Midwifery Led Care)

1st Stage of Labour

- Ask to void every 4 HOURS and/or prior to a vaginal examination.
- If unable to void, use self- lubricated intermittent single use catheter to drain the
- Accurate fluid balance must be documented on Daily Fluid Intake/Output Chart
- If the use of an intermittent catheter is required **twice** in labour an Indwelling catheter should then be used.
- Remove indwelling catheter before active second stage is commenced
- NB For women on the ***All Wales Normal Labour Pathway*** bladder care remains paramount but it is not necessary to record urine output on a fluid balance chart unless there is concern. NICE (2023) recommend referral to obstetric-led care after six hours if a woman's bladder is palpable and she is unable to pass urine or, has required intermittent (in and out) catheter on two occasions .

2nd Stage of Labour

- Consider self- lubricated intermittent single use catheter if birth has not occurred within 4 HOURS after last void / drainage
- Accurate fluid balance must be documented

Home Birth

Following a homebirth, the woman should be instructed to make a note of the time of the first void and contact the community midwife if:

- This has not occurred within 6 hours or
- There are any symptoms of voiding dysfunction

The community midwife should then arrange referral to the Obstetric unit for management as described.

Labour with an epidural in situ.

- Requires intermittent urinary drainage (self-void or intermittent catheter) at least every 4 hours
- Combine with vaginal examination wherever possible
- Consider more frequent intermittent catheterisation if receiving intravenous fluids or palpable bladder
- Consider indwelling catheter **if**:
  - Two intermittent catheters within 8 – 12 hours.
  - If large volumes of intravenous fluids are clinically required and intermittent drainage required more frequently than 3 - 4 hourly.
  - Difficulty performing intermittent catheterisation / unable to self void.
  - If maternal medical history or current obstetric situation requires (e.g. Severe PET, magnesium sulphate i.e. fluid restricted)

- Remove indwelling catheter during active pushing.

Accurate fluid balance must be documented on Daily Intake/Output Chart

Assisted Birth

A woman undergoing an instrumental delivery should have her bladder emptied immediately prior to the procedure.

An in-out catheter can be used prior to delivery if they do not have an indwelling already.

Remove indwelling catheter prior to instrumental delivery, and then re catheterise post delivery.

Caesarean Birth

- An indwelling catheter should be inserted prior to start of procedure
- Catheter should be removed once the woman is mobile after procedure (approx. 6 hours) unless otherwise specified in operation notes

Bladder Trauma during surgery

Any Bladder Trauma during Surgery required IMMEDIATE Urology input and follow-up needs to arrange.

When to consider inserting an Indwelling Catheter.

Consider (re-)inserting an indwelling urinary catheter in women after:

- Regional anaesthesia and prolonged labour
- Mid-cavity instrumental birth
- Urethral trauma
- Severe perineal trauma (tears, episiotomy, grazes, oedema and bruising)
- Women receiving High Dependency Care
- All births and procedures in theatre, who have spinal anaesthesia (including combined spinal-epidural) or who have had epidural anaesthesia "topped up".

When to consider retaining Indwelling Catheter.

Consider if appropriate to leave an indwelling catheter in place for a longer period if:

- Significant perineal trauma/oedema
- Accurate measurement of the urine output is required
- Women receiving High Dependency Care

Regional anaesthesia can affect bladder sensation and therefore the indwelling catheter should be retain and not be removed until:

- The woman is mobile as a minimum and six to twelve hours after the last "TOP-UP" (unless specified otherwise in the operation notes).

Postnatal Bladder Care Management

It is important to recognise that acute retention can be painless in postpartum period especially following epidural analgesia.

Rantell et al (2019) state that there is no consensus for the routine assessment of postnatal post void residuals. Currently there are no standardised guidelines which detail how bladder function should be monitored. However, the following guidance will direct what action to take where there may be suspected problems or concerns

What is a "Normal Void"?

The first desire to urinate is usually when bladder holds 250mls and full bladder sensation is 400mls.

How much should women be advised to drink?

- The woman should be advised to drink to thirst i.e. approximately 100mls per hour, but ideally no more than 2 litres if breastfeeding, and 1.5 litres if not breastfeeding, over 24 hours.

- Excessive fluid will rapidly distend the postpartum atonic bladder and lead to difficulty voiding.

Voiding following birth or after indwelling catheter removal

There is a physiological diuresis after birth therefore most women will void a large volume within 4 hours of birth.

Midwives must monitor urine output within 4 and 6 hours of birth and also whether the woman felt it was at least a normal volume void for her.

Women need to void two x 250mls volumes of urine without difficulty before the midwife can document satisfaction that there are no voiding difficulties.

- Encouragement to pass urine **after 3- 4 hours** allows time for conservative measures to be tried (analgesia, mobilisation, bath or shower, privacy).

If a low volume void (i.e. <150mls) or no urine has been passed WITHIN 4 hours after birth, the midwife must

- Ensure the woman has adequate analgesia.
- Advise techniques to assist voiding:

  - taking a warm bath or a shower
  - splashing water on the perineum
  - running the taps

NOTE: If the woman is able to void initially in the bath or shower reassure her that following voids can then be measured

DO NOT ADVISE WOMEN TO INCREASE THEIR FLUID INTAKE EXCESSIVELY BUT TO MAINTAIN INTAKE BETWEEN 1.5 - 2L.

Post-Partum warning signs

- Inability to pass urine 6 hours following birth or catheter removal.
- Voided volume (if measured) of less than 250ml.
- Have signs of signs and symptoms of voiding dysfunction (see section 3)

Management of Retention and voiding dysfunction

All women should void within 6 hours of birth or indwelling catheter removal .No woman should be allowed to go longer than 6 hours without voiding or catheterisation postpartum (RCOG)

- If unable to void within 6 hours of birth or after removal of indwelling catheter (overt retention)

  OR

- Passing frequent small amounts of urine with the sensation of incomplete voiding (covert retention)

Management of care will depend upon the post void residual amounts.

Management of Women with overt or covert urinary retention

Access to monitoring equipment such as a bladder scanner is required when managing women with suspected or confirmed urinary retention, however, where bladder scanners are not available, an intermittent catheter with a receptacle attachment can be used just as accurately to measure residual urine.

A fluid balance chart must be commenced if there is suspicion of retention and accurately maintained from labour and not discontinued until passed urine successfully.

Overt urinary retention – i.e. unable to void.

When urine **has not** been passed 6 hours after the birth, despite measures to encourage voiding from 3-4 hours, assess the bladder volume by bladder scanner or urinary catheter.

Unable to Void		
Assessment findings		**Action**
If less than150mls of urine on scan/ emptied by catheter		Consider causes of decreased urine production such as hypovolaemia. If cause for decreased urine output is thought to be dehydration advise woman to drink between 1-1.5 litres over next 4 hours and reassess at 4 hours. Commence a strict fluid balance chart.
If bladder over 500mls on scan/emptied by catheter		A self-retaining catheter must be used to drain the bladder
	If between **500mls-999mls**	Leave catheter on free drainage for a minimum of **24 hours** followed by a TWOC
	If over **1000mls**	Leave catheter on free drainage for a minimum of **48 hours** followed by a TWOC

Covert urinary retention- i.e. passing frequent small amounts of urine with the sensation of incomplete voiding.

Management will be determined dependent upon the post void residual volume

Use a Bladder scan OR insert an automatic lubricated intermittent single use catheter, for post void residual volume (PVRV) in the following patients:

If Initial Post void residual (PVR) volume is less than 500mls		
Assessment findings		**Required Action**
1.If Post Void Residual Volume <500mls		Measure the next Void and then assess PVRV (using bladder scanner or Single use catheter)
2.If after next void	PVR is equal to or less than 150mls	•no further management needed in the *asymptomatic* patient.

	PVR is greater than 150mls and **symptomatic**	•Insert an indwelling catheter for **24 hours** followed by trial without catheter (TWOC)
	However, if asymptomatic but PVR are **increasing** on each following void	Insert an indwelling catheter for **24 hours** followed by trial without catheter (TWOC)
	If residuals are **not increasing** then continue to monitor for next 6 hours, and if no further increase allow home (give safe netting advice TCI etc.)	

3. If Initial PRV is equal to or greater than 500ml	
Assessment finding	**Required Action**
If PVRV is equal to or greater than 500mls	Insert indwelling catheter. Arrange for TWOC after 48 hours.

Further Management following initial diagnosis of urinary retention or voiding dysfunction

Identify any factors contributing to the delayed bladder emptying and to ensure adequate bladder drainage while waiting for normal function to return.

- Obtain MC&S/ CSU. Infection is an important contributory factor to prolonged voiding dysfunction.
- If a urinary tract infection is suspected, prompt antibiotic therapy following local guidelines and review with MC&S.
- Examine perineum. If swollen or painful, a catheter should be sited until the swelling and pain have settled.
- Ensure and provide adequate analgesia, as perineal pain is a significant factor in development of retention.
- Avoid and treat constipation if required.
- Document all actions and findings in the hospital notes.

Trial without Catheter (TWOC)

- All trial without catheters should be started as early in the day as possible, if done as an inpatient this can be done as early as 0600. Do not attempt a TWOC after 1700.
- The voided volumes and the PVRV must be recorded. Measurement of fluid balance must be documented on fluid balance chart. In women with an indwelling catheter time of removal of the catheter must be documented.
- Midwives must monitor urine output within 4 and 6 hours of removal of urinary catheter and also whether the woman felt it was at least a normal volume void for her. Encouragement to pass urine **after 3- 4 hours** allows time for conservative measures to be tried (analgesia, mobilisation, bath or shower, privacy).
- Clearly document using the Maternity Trail without Catheter (TWOK) Proforma.

First Trial without Catheter

The first TWOC appointments after 24 or 48 hours can be done as an outpatient within the maternity department on Day Assessment (GGH) or Gwenllian (BGH) (site dependent).

- See Appendix 2

First TWOC		
Assessment findings		**Required Actions**
If catheter is reinserted obtain and send CSU and send for C& S		
If unable to void at all within 6 hours, if bladder is not palpable and woman is comfortable.		Please perform bladder scan before in and out (intermittent) catheter If bladder is found to be empty, consider causes of decreased urine production such as hypovolaemia. If thought to be dehydrated advise woman to drink between 1-1.5 litres over next 4 hours and reassess at 4 hours. Commence a strict fluid balance chart
If unable to void at all within 6 hours or experiencing pain and has had adequate fluid intake		• Re-catheterise the woman for one week •Leave the catheter on free drainage for 48 hours then use flip flow valve with free drainage overnight. •Arrange second attempt at TWOC in one week This can be done as an outpatient within the maternity department In GGH will be reviewed on Day Assessment In BGH will be reviewed on Gwenllian
If able to void Measure void and assess PVR	If PVRV ≤150mls	No further action, discharge with safety netting advice
	If PVRV >150mls	Record further two voids. Advise double voiding i.e. try to pass urine 30 seconds after

		initially emptying bladder and try to pass urine again also encourage woman to press on bladder while passing urine.	
		if second PVR ≤150mls	No further action, discharge
		If second PVR is >150mls	Review by obstetric Review previous history If decision made to Re-catheterise the woman for **1 week**. •Leave the catheter on free drainage for 48 hours/ then flip flow /free drainage at night. •Arrange second attempt at TWOC in one week within the maternity department. Discuss with woman the possibility of CISC if second TWOC not successful

The obstetric team must be informed of first unsuccessful TWOC.

All women experiencing voiding dysfunction must have follow up after discussion with the responsible consultant or senior registrar after the first unsuccessful TWOC.

Second Trial without Catheter (TWOC)

The second TWOC appointment can be done as an outpatient within the maternity department on Day Assessment in GGH or Gwenllian (BGH) (site dependent).

Second TWOC		
Assessment		**Required Actions**
If able to void:	If second PVRV is <150mls	No further action, discharge

Record two voids	If second PVR is ≥200 mls	Advise double voiding i.e. emptying the bladder twice during one visit to toilet. Pass urine, sit and wait for 30-45 second and then try to pass urine again. Encourage patient to press on bladder while passing urine. Educate regarding CISC If the woman is unable to manage CISC then re-catheterisation is required. If re-catheterised fit flip flow for day use and keep catheter free drainage at night. Seek to urology urogynae for opinion for course of action

Second Unsuccessful TWOK

- When second TWOC is unsuccessful the woman must be reviewed by obstetric consultant or Registrar. Doctors to liaise with Urogynae / Urology department for opinion and decision of further course of action.
- Advise the woman to contact Triage for advice and support, until Urogynae or Urology Team have taken/ accepted referral and contacted the woman.
- Ensure woman has been referred to COBWEB (see appendix 2) for additional supplies

Clean Intermittent Bladder Catheterisation

For procedure when teaching Clean Intermittent Self Catheterisation see Appendix 4.

Discharge after unsuccessful TWOK

See Appendix 5.

- Ensure all women who leave hospital has a Catheter passport.
- Provide education in care and management of catheter/ flip-flow valve/ CISC.
- Give relevant patient information leaflets
- Provide 2 packs x 7 day Ugo Home Catheter Discharge Packs
- Supply additional x2 flip-flop valves.
- Complete the COBWEB referral form for further catheter appliances. These will be delivered to the woman's home (appendix 2).

- Date and time for any pending appointments
- TWO 7 day Discharge packs (equipment)
- Contact number for DAU/Triage/ Ward to contact if has any issues until next appointment.
- Patient information sheet for catheter care and Intermittent Self catheterisation

Women's Physiotherapy Department Referral

It is the responsibility of the midwife who discharges the woman from the postnatal ward to ensure that appropriate referral to the Physiotherapy department is completed. (See appendix 1)

Pelvic floor physiotherapy strengthens pelvic floor muscles and reduces bladder pressure. Coupled with minor lifestyle adjustments it can improve bladder tone and control.

Bladder scanner

Practitioners must recognise that on occasion a bladder scan may not give accurate readings in patients with a high BMI (>40) or with the presence of clots in the uterus. Antenatally inaccurate reading due to amniotic fluid is also a consideration.

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Appendix 1. Physiotherapy referral form

PHYSIOTHERAPY SERVICE
HYWEL DDA UNIVERSITY HEALTH BOARD
WOMEN'S HEALTH SERVICE MATERNITY REFERRAL

PATIENT DETAILS

NAME: ADDRESS POST CODE: DOB HOSPITAL NUMBER: TEL NO:	GP: SURGERY CONSULTANT:

PATIENT IS:

ANTENATAL: ☐ Gestation: POSTNATAL: ☐ Days:

TYPE OF DELIVERY:

DATE:

REASON FOR REFERRAL

PELVIC GIRDLE/BACK PAIN ☐

PELVIC FLOOR REHAB ☐

RISK SCORE (SEE OVERLEAF):

OTHER – Please specify:

.....

.....

RELEVANT INFORMATION

.....

.....

.....

.....

REFERRED BY:.....SIGNATURE:.....DATE:.....

PLEASE SEND COMPLETED FORM TO WOMEN'S HEALTH PHYSIOTHERAPY SERVICE
OUTPATIENT DEPARTMENT

PHYSIOTHERAPY SERVICE
HYWEL DDA UNIVERSITY HEALTH BOARD
WOMEN'S HEALTH SERVICE MATERNITY REFERRAL

PELVIC FLOOR RISK ASSESSMENT TOOL

RISK FACTORS	CIRCLE SCORE
LARGE BABY > 4kg (8LB)	2
MULTIPARITY	2
PROLONGED PUSHING >2 HRS	4
FORCEPS/VONTUSE	4
EPISIOTOMY	3
3RD/4TH DEGREE TEAR	6
EPIDURAL/SPINAL	2
MULTILPE PREGNANCY	1
CHRONIC CONSTIPATION	1
OBESITY	1
OLDER PRIMIPAREA (>35)	1
CONTINENCE PROBLEM	6
SYMPTOMS OF PROLAPSE	4
TOTAL SCORE (MAX 37)	

LOW/MEDIUM RISK (0-5) – LEAFLET

MEDIUM/HIGH RISK (6-14) – LEAFLET, ADVICE, CONSIDER PHYSIO REFERRAL

HIGH/VERY HIGH RISK (15+) – LEAFLET, ADVICE, PHYSIO REFERRAL

- **PATIENT WITH 3RD AND 4TH DEGREE TEARS, CONTINENCE SYMPTOMS OR PROLAPSE SHOULD BE REFERRED TO PHSIO OUTPATIENT SERVICE REGARDLESS OF TOTAL RISK SCORE**

ADDITIONAL PERINEAL WOUND BREAKDOWN RISKS

EXTENSIVE ODEMA ☐

BRUSING ☐

HAEMATOMA ☐

WOUND CONTAMINATION ☐

Appendix 2. COBWEB referral form for catheter appliances

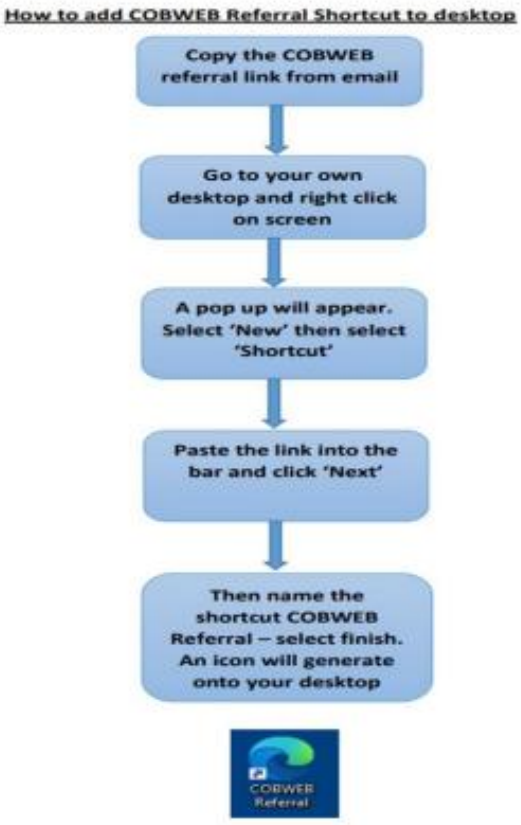
COBWEB referrals are completed via MS forms.

https://forms.office.com/e/5zA9iPLWPw -opens in new tab.

COBWEB referrals are completed via MS forms

https://forms.office.com/e/5zA9iPLWPw

See attached pathway, how to add COBWEB referral shortcut to desktop.



Appendix 3 Maternity Trial without Catheter (TWOK) Proforma

HDUHB 2025 Version 1.

Patient details

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Maternity Trial without catheter Proforma

Date		Time:	
History /Reason for initial catheterisation:	example: *Unable to void postnatally . PRV >320mls……*		
Obs / Medical History			
Other comments			
Allergies	Yes / No (circle)	If yes, state allergies:	
Reason for TWOC			
CSU /Dip Test (if symptomatic of UTI seek medical review)			
Time catheter removed:		Removed by:	
Void s:	(mls)	Post Void Residual (PVR)	(mls)
1st Void:		PVR:	
2nd Void:		PVR:	
3rd Void:		PVR:	
TWOC outcome : (circle) **Successful** / **Unsuccessful**			
Plan of Care:			
CISC : Yes / No (circle)			
CISC education by :			
Supplies: Single use catheters / bladder passport/ referred to COBWEB			
Appropriate Patient information Leaflets given :			
Discharged with Catheter	Yes/ No (Circle)	Supplies: (circle)	Leg Bag/Night bag/stand/passport referred to COBWEB
Discharge Signature And Date		Print Name:	

Appendix 4. Procedure for performing, and education of, clean intermittent self-catheterisation (ISC) in female patients.

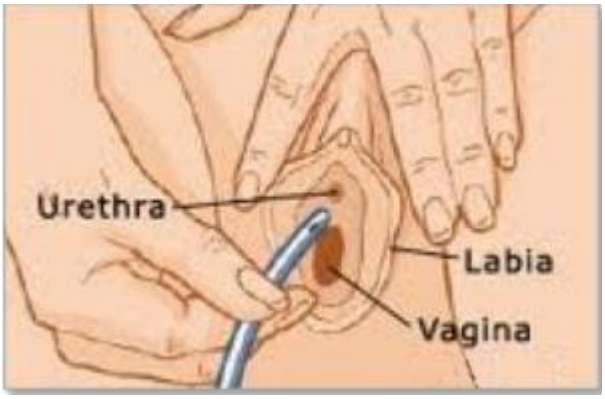
Equipment Required: Mirror (for female patients when teaching self-catheterisation) appropriately sized single use pre lubricated catheters for a female patient &suitable container for collecting urine if required

- Wash hands using liquid soap and running water or alcohol gel. Healthcare professionals must wear gloves. Patients performing the procedure do not need to wear gloves when self-catheterising, however good hand hygiene is essential.

- Advise woman to take up a comfortable position, depending on mobility (e.g. sitting on toilet, standing with one foot placed on toilet seat)

- Spread the labia and wash genitalia from front to back with soap and water, and then dry. Advise the woman that if she is performing the procedure where this is not possible, e.g. public toilet the use of disposable wet wipes is recommended.

- Open the catheter packaging or container. Follow manufacturers' instructions to activate lubricated coating (N.B. some catheters require activating with water or gel, others are ready to use).



- Find the urethral opening above the vagina. A light and mirror can be used to help to teach the patient to identify the urethral opening. Explain that the opening of the urethra in front of the vagina and behind the clitoris (pictured)

- Explain that if it is difficult to see the urethra, gently draw the labia forwards & upwards with their fingers; it may be possible to feel the urethral opening like a small pit on a sensitive mound;

- Gently insert the catheter into the urethra approximately 5cm or until urine drains, taking care not to touch the part of the catheter entering the body.

- Drain the urine into the toilet or suitable container. When the urine stops flowing slowly remove the catheter, pausing if more urine starts to flow.

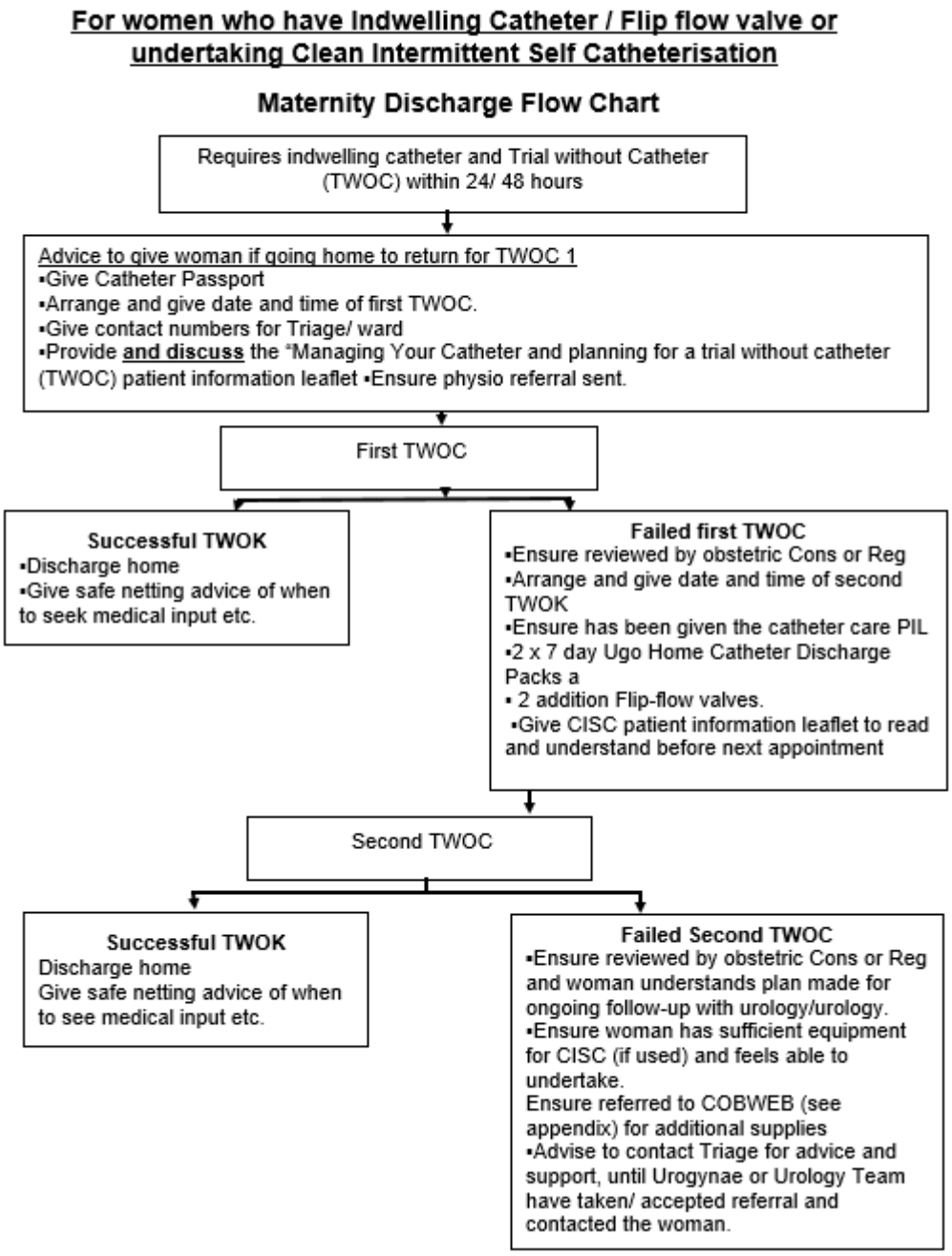
- Dispose of the catheter and any equipment used according to HDUHB policy.

General advice to give to woman

- Don’t flush catheters down the toilet.
- If finds any difficulty using the catheter - take some time to relax before trying again
- If inability to self-catheterise - contact the catheter nurse or midwife as they may need a temporary indwelling catheter
- If unable to remove the catheter - relax and wait a few moments before trying again; coughing whilst you draw back the catheter can help
- symptoms of a urine infection – if has pain in lower abdomen (tummy), you feel unwell, or are having hot and cold spells, advise should contact your GP.

Ensure all woman is given the Hywel Dda Maternity patient information leaflet, Intermittent Self Catheterisation (CISC) in Women

Appendix 5.


For women who have Indwelling Catheter / Flip flow valve or undertaking Clean Intermittent Self Catheterisation
Maternity Discharge Flow Chart
Requires indwelling catheter and Trial without Catheter (TWOC) within 24/ 48 hours
Advice to give woman if going home to return for TWOC 1
•Give Catheter Passport
•Arrange and give date and time of first TWOC.
•Give contact numbers for Triage/ ward
•Provide and discuss the "Managing Your Catheter and planning for a trial without catheter (TWOC) patient information leaflet •Ensure physio referral sent.
First TWOC
Successful TWOK
•Discharge home
•Give safe netting advice of when to seek medical input etc.
Failed first TWOC
•Ensure reviewed by obstetric Cons or Reg
•Arrange and give date and time of second TWOK
•Ensure has been given the catheter care PIL
•2 x 7 day Ugo Home Catheter Discharge Packs a
• 2 addition Flip-flow valves.
•Give CISC patient information leaflet to read and understand before next appointment
Second TWOC
Successful TWOK
Discharge home
Give safe netting advice of when to see medical input etc.
Failed Second TWOC
•Ensure reviewed by obstetric Cons or Reg and woman understands plan made for ongoing follow-up with urology/urology.
•Ensure woman has sufficient equipment for CISC (if used) and feels able to undertake.
Ensure referred to COBWEB (see appendix) for additional supplies
•Advise to contact Triage for advice and support, until Urogynae or Urology Team have taken/ accepted referral and contacted the woman.