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TRUST CLINICAL GUIDELINE

Bladder Care in Labour & Postnatal Period

Overview

This guideline provides evidence-based guidance to staff regarding bladder care and management for women and birthing people in labour and postnatal period.

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Related protocols/procedures	SRH&WH: Care in labour, Caesarean Birth, Induction and Augmentation of Labour and Use of Oxytocin, Antepartum & Intrapartum Haemorrhage, Postpartum Haemorrhage, Postnatal Care. PRH&RSCH: Care in Labour, Caesarean Birth, Induction of labour, Obstetric Haemorrhage, Postnatal Schedule of Care. UHSx: Perineal Trauma, Hyponatraemia in labour
Standards	NICE (2024) NG192 Caesarean Birth NICE (2023) NG235 Intrapartum care NICE (2021) NG194 Postnatal Care
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	PRH&RSCH: MP040 Bladder Care
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Bladder Care in Labour and the Postnatal Period

1.0 Introduction

This guideline provides evidenced based practice on bladder care in labour and the postnatal period. It supports all maternity staff to identify those women and birthing people at risk of urinary retention and provides a clear management plan.

Intrapartum bladder care involves the identification of risk factors, prevention, detection, and early management of voiding dysfunction during labour and after birth.

10 – 15% of postnatal women and birthing people have a degree of voiding dysfunction for some time following childbirth and 5% have significant and longer lasting dysfunction (Bjork2003).

Postpartum urinary retention has a reported incidence of up to 14.1% after vaginal birth and 24.1% following caesarean birth and has several well-established risk factors (Bjork 2003).

Urinary retention is most likely to occur within the first 8 to 12 hours following birth because the onset may be slow and asymptomatic.

The bladder may take up to 8 hours to regain sensation following epidural anaesthesia and overdistension may occur during this time. If voiding dysfunction is not recognised, bladder overdistension can lead to further denervation with up to 5% suffering long term voiding dysfunction. It may also lead to recurrent urinary tract infections and/or urinary incontinence.

The normal capacity of the bladder is 300 to 600mls and overdistension of >1000 mL is a significant risk.

2.0 Scope

This guideline applies to the following:

- Midwives
- Obstetricians
- Maternity staff

3.0 Responsibilities

Midwives & obstetricians:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used within this guideline

CS Caesarean Birth	CSU Catheter Specimen Urine
FGM Female Genital Mutilation	IDC indwelling catheter
MSU Midstream Urine	OASI Obstetric Anal Sphincter Injury
SVD Spontaneous Vaginal Birth	TWOC Trial Without Catheter
UG Urogynaecology	UTI Urinary Tract Infection
U&Es Urea & Electrolytes	

5.0 Aim

- To optimise bladder health in labour and the postnatal period for all women and birthing people, whilst reducing the risk of infection and minimising damage to the bladder and urethra.
- To prevent both symptomatic and asymptomatic bladder overdistension.

6.0 Women and birthing people at high risk

All women and birthing people are at risk of voiding dysfunction during labour and after birth, though some are more at risk. Risk factors include:

- Primigravid
- Prolonged labour, especially second stage of labour
- Epidural/spinal anaesthesia for labour/birth, irrespective of mode of birth
- Need to catheterise in labour
- Assisted vaginal birth
- Caesarean birth
- Perineal injury: Haematoma/bruising/Obstetric Anal Sphincter Injury (OASI)
- Constipation
- Immobility
- Language barrier
- History of voiding problems

Please note that catheterisation might be more complicated in women and birthing people who have undergone reconstructive surgery of the genital tract including gender reassignment or female genital mutilation (FGM). Please make sensitive enquiries during pregnancy and if necessary, a consultant plan should be made in conjunction with the Urologist.

7.0 Diagnosis/presentation

Pregnant women and birthing people may not be aware of their bladder being full in labour, especially with an epidural, or following general, spinal or epidural anaesthesia in the postpartum period.

Features of voiding dysfunction include:

- Inability to pass urine spontaneously or within 6 hours of catheter removal
- Frequent small voids
- Slow stream or dribbling
- Feeling of incomplete emptying
- Hesitancy
- Dysuria
- Frequency, urgency, lower abdominal pain
- Palpable bladder or deviated uterus
- Overflow incontinence

8.0 Bladder care and prevention of acute bladder distension

8.1 In labour

- Offer to test a urine sample with a dipstick test at the start of active labour (send MSU, if the dipstick is positive) and document the findings.
- Ensure adequate fluid intake – oral or intravenous. Do not overload. Record input and output on BadgerNet Maternity.
- Encourage the woman or birthing person to void every 3-4 hours and document on BadgerNet Maternity.
- Voided volume should be recorded if possible or if not practical an estimation of amount voided should be documented.
- If voided volume less than 100 mL review fluid intake and offer palpation of the bladder. If volume more than 500 mL, suggest the woman or birthing person empties bladder more frequently.

- If unable to pass urine after 3-4 hours, threshold for catheterisation should be low especially if the bladder is palpable and the woman or birthing person cannot void. Catheterise using an in/out catheter.
- If an in/out catheter is required a second time, then an indwelling catheter CH12 is recommended, unless birth is imminent.
- Note that intermittent catheterisation has a lower risk of urinary tract infections.
- Catheterisation should be done using aseptic technique and Instillagel® local anaesthetic gel should be used to lubricate and numb. Verbal informed consent should be documented.
- Document on BadgerNet Maternity:
 - Time and indication of catheterisation
 - Type and size of the catheter
 - Volume of urine obtained.
- If an indwelling catheter is inserted, the catheter tube should be secured to the thigh but be loose enough to allow the balloon to be above the presenting part as it descends below the bladder neck during the late first and second stages of labour.
- U&Es should be taken to assess for hyponatraemia if there has been low urine output (less than 100 mL in 4 hours) (see maternity guidance on fluid balance management).
- Encourage the woman or birthing person to empty bladder at the start of active second stage and prior to any operative birth.
- If there is a catheter in place, this must be removed prior to vaginal birth. Partial or total deflation of the balloon does not prevent damage to the urethra and/or bladder neck. A full bladder is associated with prolonged second stage and may prevent the uterus from adequately contracting in the third stage.
- If haematuria is seen, this should prompt further investigation. A vaginal examination should be performed to assess for signs of obstructed labour. On vaginal examination, the balloon of the catheter should be palpated, if possible, to ensure it is sitting in the bladder and is not trapped in front of the presenting part.

9.0 Bladder care following birth

9.1 Care of the postnatal woman or birthing person without a urinary catheter

RCOG recommends postnatal women and birthing people, should have voided within 4-6 hours of birth. Postnatal women and birthing people should be encouraged to void before leaving delivery suite/labour ward or Birth Centre and if this has not occurred, it needs to be clearly documented in the notes and verbally handed over to the postnatal ward staff, using the SBAR handover tool. NICE recommends that conservative measures should be taken to encourage postnatal women and birthing people who have been unable to void within 4-6 hours of birth.

Measures to aid voiding:

- Adequate analgesia
- Help to mobilise
- Privacy
- Warm bath or shower
- Running water

Postnatal women and birthing people should have the timing and volume of the first postnatal void documented in the postnatal records. The volume should be over 200 mL. If this has been measured as less than 200 mL the subsequent voids should also be measured, and a fluid balance chart should be continued until adequate volumes are achieved.

Passing urine alone is not an adequate assessment of bladder function as incomplete voiding leads to increasingly large residuals of urine in the bladder. This may also result in retention with overflow incontinence.

If there is evidence of urinary incontinence, consider the need for a bladder scan and physiotherapy referral.

Anyone unable to pass urine post-birth OR complains of pain OR passes frequent small amounts <200 mL please instigate management plan as [section 10.1 \(Appendix 1\)](#).

9.2 Care of the postnatal woman and person with a urinary catheter

If an indwelling catheter (IDC) has been required for postnatal period, then it should be removed when clinically indicated and the woman or birthing person is full mobile (for uncomplicated SVD - once mobile; caesarean birth - between 12-24 hrs and OASI - 24 hrs post-birth). Please note that IDC removal should be considered at 6 hrs post birth for those people on ERP post caesarean birth.

Please check operative birth notes on BadgerNet Maternity for individualised management plan.

Healthcare professionals caring for postnatal women and birthing people who have had a caesarean birth (CS) and who have urinary symptoms should consider the possible diagnosis of:

- Urinary tract infection
- Stress incontinence (occurs in about 4% of postnatal women and people after CS)
- Bladder injury - follow individualised care plan (occurs in about 1 per 1000 after CS).

Postnatal women and birthing people with an indwelling catheter should be advised on catheter care to minimize the risk of infection. This includes washing the catheter their own catheter lead, once mobile, at least twice each day using downward strokes away from the body and washing the area where the catheter enters the body with water only. Bathing or showering daily is recommended.

Ideally the catheter should be removed in the morning to give the whole day for assessment of voiding. Ideally the urinary catheter should not be removed between 22.00 and 06.00. However, depending on workload and individual request, this can be reviewed on an individual basis.

Leg bags can be offered so that women and birthing people can be more independent with mobilising around the bed space and caring for their newborn.

If an IDC is not draining urine despite adequate hydration. Points to consider:

- Is the catheter lead kinked or blocked? Visual check, reposition patient, flush catheter.
- Is the catheter sited correctly? Consider re-siting catheter if concerns.
- Check baseline U&E's and fluid balance and consider if repeat is indicated.

10.0 Trial without catheter (TWOC)

- When catheter has been removed, the woman or birthing person should be signposted to the Bladder Care information leaflet ([Catheter Care - Sussex LMNS](#)) on BadgerNotes which provides details on post catheter bladder care.
- Document on BadgerNet Maternity the volume, time, and date of TWOC, as well as further management plan.
- Advise the postnatal woman or birthing person to attempt to pass urine within 4 hours after the removal of a urinary catheter (See [Appendix 1](#)).
- A second void should be measured and passed within 4 hours of the first void.
- Confirm that the postnatal woman or birthing person is not constipated, advise on fluid intake recommending that they drink to thirst, mindful of diet, and consider laxatives if required.
- Perform a bladder scan immediately if:
 - The woman or birthing person has not passed urine within 4 hours (or sooner if uncomfortable)
 - They have passed less than 200 mL
 - Complaining of difficulty of passing urine (follow flow chart in [Appendix 1](#)).
 - Symptoms of complete urinary incontinence.

10.1 Management post scanning the bladder

If <200 mL in bladder:

- Advise hydration and follow TWOC process. Review fluid balance and refer to maternity fluid balance guidance if necessary.

If 200-500 mL in bladder:

- In-out catheter and re-start TWOC process

If 500-1000 mL in bladder:

- Indwelling catheter (IDC) for 24 hours, urine dip/send CSU, after which repeat TWOC process.
- If second TWOC unsuccessful - see section below.
- Note: If >1000 mL ml see below.
- **RSCH/PRH:** Postnatal woman or birthing person returns to ward for TWOC.
- **WH/SRH:** refer via BadgerNet Maternity to on-going community support and TWOC at home or return to ward depending on suitability.

* The default for everyone going home with an IDC should be a free drainage bag, however, the option of a flip-flow vs free drainage catheter could be considered in selected cases following discussion with the on-call consultant.

* Anyone going home with an IDC should be explained basic catheter care/hygiene and be taught how to empty their bag. Refer women and birthing people to the Catheter Care leaflet ([Catheter Care - Sussex LMNS](#)) and ensure they have grab-bag of supplies.

If volume >1000 mL/second failed TWOC:

- Dip urine and send CSU
- Datix
- Obstetrician review and plan documented on BadgerNet Maternity.
- IDC for 7 days to rest the bladder and allow bladder muscle tone to recover.
- Refer via BadgerNet Maternity to Community Continence Nurse Referral for on-going community support and TWOC at home (in case this cannot be covered, the woman or birthing person is asked to return to the postnatal ward).

10.2 Second unsuccessful ‘trial without catheter’ (TWOC) management

- After removal of indwelling catheter, check and document the subsequent 2 voided volumes.
- Post void residuals should be checked within 30 minutes after person has voided with a bladder scan.
- If voided volume is above 200 mL and post-void residuals are <150 mL, then the woman or birthing person can be reassured and discharged, with no further investigations required.
- However, if bladder dysfunction persists, offer another indwelling catheter to be inserted for 7 days. This should be a free-drainage bag.

- Postnatal women and birthing people at this point should have a full review by the obstetric team and further management plan made.
- Follow up must be arranged for all postnatal women and birthing people being discharged with a catheter in-situ.
- Refer via BadgerNet Maternity Community Continence Nurse Referral on-going community support and TWOC at home +/- CISC.

10.3 If urinary incontinence is suspected following TWOC

- This may occur due to retention (overflow incontinence) or due to a temporary effect of delivery on the pelvic floor muscles and nerves. Once retention has been excluded by bladder scan, the postnatal woman or birthing person should be reassured that the incontinence will improve over time.
- Postnatal women and birthing people should not be catheterised in this circumstance as this will increase the risk of UTI's and will not improve bladder function and may delay recovery. They should be offered pads to contain any leakage.
- Encourage to perform pelvic floor exercises -signposting to the LMNS website - [Sussex LMNS | Local Maternity & Neonatal System](#)
- Encourage regular voiding every 2-3hrs even with lack of sensation to void.
- Skin care can be discussed, and women and birthing people be advised to use emollient preparation for washing to help prevent skin irritation.
- Refer to physiotherapy via BadgerNet Maternity.

11.0 When to use an indwelling catheter CH12

- Postnatal women and birthing people post LSCS or operative birth and anyone having spinal/epidural analgesia.
- Postnatal women and birthing people with distended bladder in labour.
- If there are persistent issues with retention or voiding dysfunction.
- Retained placenta.
- PPH (postpartum haemorrhage).
- 3rd/4th degree tear.
- Extensive perineal trauma including periurethral tear or extensive labia/perineal swelling that is likely to impede voiding such as haematoma.

Use of an indwelling catheter should be documented on BadgerNet Maternity (including date and time of insertion).

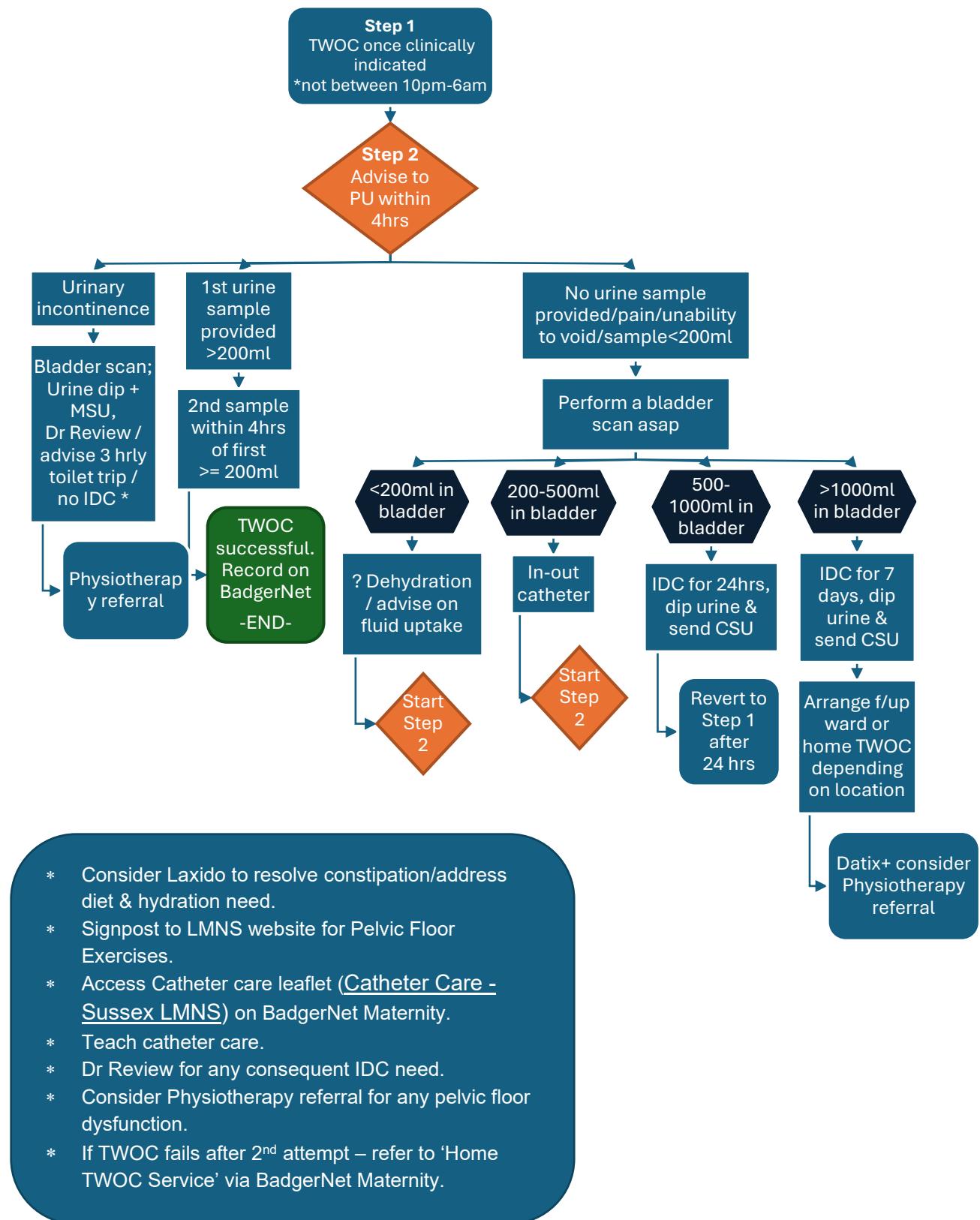
12.0 Documentation

Accurate documentation is essential. All staff involved should provide written documentation of actions undertaken on BadgerNet Maternity.

It is important to record:

- The time of the first void intrapartum and postpartum
- The volume of the first void intrapartum and postpartum
- Referral to the Obstetric team as appropriate
- Plan of management
- Indwelling catheter inserted.

Appendix 1: TWOC flowchart



Appendix 2: Monitoring

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Urine retention >1000mls	Datix & case review	Patient Safety Midwives	On-going	Maternity Safety & Quality Meeting

Appendix 3: Guideline Version Control Log

Version	Date	Author	Comment
1.0	November 2024	Franciska Ambrus & Lorna Gisborne Pelvic Health Specialist Midwives	New Trust wide maternity guideline replacing: <ul style="list-style-type: none">• MP040 Bladder Care (RSCH&PRH)• CG1137 Bladder Care (SRH&WH)

Appendix 4: Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	Age	No	
	· Disability	No	
	· Gender (Sex)	No	
	· Gender Identity	No	
	· Marriage and civil partnership	No	
	· Pregnancy and maternity	No	
	· Race (ethnicity, nationality, colour)	No	
	· Religion or Belief	No	
	· Sexual orientation, including lesbian, gay and bisexual people	No	
2.	Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?	No	
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	NA	
4.	Is the impact of the document likely to be negative?	No	
5.	If so, can the impact be avoided?	NA	
6.	What alternative is there to achieving the intent of the document without the impact?	NA	
7.	Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?	NA	
8.	Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?	Yes	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net (01273 664685).

Appendix 5: Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	Comments
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development, and clinical supervision as appropriate?	All new members of staff are shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint.

		Yes/No	Comments
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Previous versions will be archived as part of the uploading onto sharepoint process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, departmental noticeboards, and safety huddles.

Appendix 6: Additional guidance and information

Glavind K, Bjork J. (2003) Incidence and treatment of urinary retention postpartum. International Urogynaecology Journal. 14(2):119-2, 2003 Jan

F.Karim G. Araklitis 2022 The management of Urogynaecological problems in pregnancy and the postpartum, 2022; 24: 167-75 <https://obgyn.onlinelibrary.wiley.com/doi/10.1111/tog.12816>

Lim JL. Post-partum voiding dysfunction and urinary retention. Aust N Z J Obstet Gynaecol. 2010 Dec;50(6):502-5. doi: 10.1111/j.1479-828X.2010.01237.x. Epub 2010 Nov 2. PMID: 21133858.

NICE (2024) [NG192 Caesarean Birth](#)

NICE (2023) [NG235 Intrapartum care](#)

NICE (2021) [NG194 Postnatal Care](#)

Portsmouth Hospitals University (Aug 2021) Bladder Care Guideline

Sam P, Nassereddin A, LaGrange CA. Anatomy, Abdomen and Pelvis: Bladder Detrusor Muscle. [Updated 2023 Aug 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK482181/>