



OFFICIAL

| OBSTETRICS AND GYNAECOLOGY CLINICAL PRACTICE GUIDELINE | |
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| Bladder Management | |
| Scope (Staff): | WNHS Obstetrics and Gynaecology Directorate staff |
| Scope (Area): | Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice) |
| This document should be read in conjunction with this Disclaimer | |

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Quick Reference 1: Labour, postpartum and gynaecology

Gynaecology

- 4 hours post operative[^]
- 4 hours post IDC removal

[^] Note: Check for varied post-operative instructions for specific medical orders

First stage of labour

- Encourage 2 hourly voids and document all voids
- If unable to void and bladder palpable (after max of 4 hours), insert IDC
- IDC with epidurals is recommended

Second stage of labour

- Encourage woman to void prior to commencing second stage
- In/out catheter prior to all assisted births
- In/out catheter if prolonged second stage (> 2 hrs)
- Remove IDC before active pushing (deflate balloon fully before removal)

Caesarean birth / post-operative

- IDC inserted

No urinary catheter – or – post IDC removal

- Encourage women to void within 2-3 hours (maximum 4 hours)
- Screen all women at 4 hours for risk factors and symptoms of urinary retention - see ***Abnormal void parameters**
- Encourage voiding by non-invasive measures (adequate analgesia, hydration, privacy)

Indications: Reinsert IDC immediately post-birth for ...

- Vaginal birth with epidural in labour - IDC remains in situ **at least 6 hours** after birth
- IDC in situ **at least 12 hours** after birth for:
 - Excessive perineal trauma
 - 3rd and 4th degree tears
 - Post partum haemorrhage
 - Epidural, spinal, pudendal block analgesia (top-up) for birth, with no sensation to void and Bromage score > 0

Normal void parameters

- 2 consecutive voids (150 mL to 600 mL)
- No symptoms (normal sensation and flow)
- Use *Abnormal void parameters as screening questions / mechanism to establish normal void

*Abnormal void parameters

- Unable, or straining / hesitancy, to void
- Altered sensation to void
- Dysuria (pain with voiding)
- Slow or stop/start flow
- Small (< 150 mL) or Large void (>600mL)
- Incomplete emptying
- Displaced uterine fundus

No further action unless symptoms of abnormal void function/parameters occur

Abnormal Void Management – see Quick Reference Guide 2

Morphine: if patients receive **epidural or spinal morphine**, the IDC is to remain in situ a **minimum of 12-hours after administration** (and overnight if the minimum in situ time occurs in the night).

Caesarean birth: IDC should remain in situ a **minimum of 12 hours**. Prior to removal, **check post-operative orders** for specific bladder management requirements (i.e. may specify longer IDC time).

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 to void every 2-3 hours

Note: For Enhanced Recovery After Surgery (ERAS) patients, refer to ERAS Pathway

Quick Reference 2: Abnormal void management

Abnormal void parameters* (see list)

- **or** - unable to void at 4 hours post-birth / removal of IDC / post-op

Note: Ensure patient has adequate analgesia, hydration, privacy, and actively manage constipation

*Abnormal void parameters

- Unable, or straining / hesitancy, to void
- Altered sensation to void
- Dysuria (pain with voiding)
- Slow or stop/start flow
- Small (< 150 mL) or Large void (>600mL)
- Incomplete emptying
- Displaced uterine fundus

Abnormal void parameters

- Encourage double void (if appropriate)
- Bladder scan to assess post void residual (PVR) volume, within 10 minutes of void
- Commence Bladder Diary (obstetrics), continue Fluid Balance Chart (gynae).
- Urinalysis: if positive nitrates send MSU for MC&S to exclude urinary tract infection
- Refer to Physiotherapy
- Encourage to void 2 – 3 hourly (to keep volumes between 150-600mL)
- On discharge, advise patient to contact Physiotherapy if normal sensation has not returned by 6 weeks postnatal.

Unable to void

- Bladder scan – Shows ≤ 600 mL
 - if ≤ 400 mL and unsuccessful double void, rescan in 1 hour
 - 401- 600 mL and unsuccessful double void, rescan in 30 mins
- Bladder scan – if > 600 mL, insert IDC on free drainage. Allow to drain and assess volume (after 10 min). If drains:
 - <600 mL, keep IDC in situ 24 hrs[#]
 - 600 – 1000 mL, keep IDC in situ 48 hrs[#]
 - 1001 – 1500 mL, keep IDC in situ for one week[#]
 - greater than 1500 mL, keep IDC in situ for two weeks[#]
- Inform medical team and Urogynaecology Nurse
- Send urine specimen for MC&S (refer to [Therapeutic guidelines for urinary tract infections](#))
- eReferral to Urogynaecology Nurse: [eReferral Login](#)

Note- As the bladder is a muscle, time frames may be variable and adjusted by the Urogynaecology team.

Second trial of void (after removal of IDC)

- Commence Bladder Diary (obs) or continue Fluid Balance Chart (gynae). Note- If altered sensation or large volumes- Refer to Physio. If large volumes, refer to Urogynaecology Nurse.
- Adequate fluid intake (i.e. 100 mL/hr)
- Encourage woman to void within 2-3 hours (to keep volumes between 150-600mL)
- Assess PVR with Bladder Scanner, ideally within 10 minutes of void
- Report PVR > 150 mL and bladder overdistention to Medical Officer and Urogynaecology Nurse

Return of normal void parameters

1. At least 2 consecutive voids, greater than 150 mL each, with PVRs (via bladder scan) less than 150 mL
2. No symptoms of abnormal void function/parameters

No further action unless symptoms of abnormal voiding function occur

High post-void residuals or unable to void

- Consider IDC - free drainage to leg bag

Refer ongoing management

- Review by Medical team and Urogynaecology Nurse

Bladder management: Maternity

Risk factors

In the immediate postnatal period, the potential to experience urinary problems is increased. Risk factors include:

- Duration of labour prolonged first and second stage of labour
- Assisted birth
- Caesarean section for delay in the first stage of labour
- Epidural analgesia particularly with local anaesthetic. (e.g. bupivacaine)
- Post Caesarean epidural morphine
- Episiotomy, perineal / vulval trauma
- Over distension of the bladder during / immediately following birth
- Previous history of an over distended bladder or urinary retention
- Larger than average term baby
- Obesity
- Non-English-speaking mother
- Nulliparity

Labour – first and second stage, and postnatal

- **Refer to Quick Reference Guide 1.**
- Encourage patient to void every 2 hours. If unable to void, there should be a low threshold for catheterisation.
- The indwelling catheter (IDC) balloon should be fully deflated and removed prior to pushing to reduce the risk of urethral damage.
- **The IDC balloon must never be partially deflated while in situ** - this practice is dangerous as it risks significant urethral trauma.
- **IDC minimum timeframes:**

Vaginal birth with epidural in labour

- Must be inserted during labour (remove IDC prior to active pushing)
- IDC must be **reinserted after birth.**
- Should remain in situ for a **minimum of 6 hours** after the birth or until full sensation has returned.
- Check dermatomes if the epidural contained local anaesthetic.

Epidural top up for birth – postpartum haemorrhage - 3rd or 4th degree tear

- Must be **reinserted after birth.**
 - Should remain in situ a **minimum of 12 hours** after the birth or until full sensation has returned.
- * If there is significant genital/perineal trauma, consideration should be given to an IDC for 24 hours following birth and until genital/perineal trauma has reduced.

Caesarean birth

- IDC to remain in situ for a **minimum of 12 hours** after birth.

Trial of void

Background guidance

- A trial of void (TOV) assesses sensation and the ability for the bladder to empty urine and resume normal function.
- **The aim of good bladder care and management is to monitor for urinary retention and avoid and prevent bladder overdistention / “bladder stretch”.**
- The intrapartum, postnatal and post-operative bladder is vulnerable to urinary retention, which is the inability to completely empty the bladder.

Key actions

- Patient education
 - Fluid balance, charting fluid intake and output shall be accurately recorded on Fluid Balance Chart.
 - Encourage the patient to maintain or increase fluid intake (unless contraindicated) to approximately 2 L per day.
 - Educate the patient to try not to void too frequently i.e. aim for > 2-hour intervals.
- Patients who have urinary retention or a urinary catheter removed must be monitored to ensure the bladder is functioning and emptying efficiently.
- Ensure patient has adequate analgesia, privacy, and constipation treatment.
- Adequate fluid intake for hydration i.e. approximately 100 mL/hr.
- Aim to keep voids between greater than 150 mL and less than 600 mL, with a total bladder volume (voided volume plus residual) no greater than 600 mL. Voids <150mL or >600mL: If the exact volume is considered critical for management, then it should be weighed and patient rescanned.
 - **Normal void function:**
 - At least 2 consecutive voids, greater than 150 mL each, with residuals <150mL (via bladder scan).
 - No symptoms of abnormal void function/parameters (see abnormal void parameters in QRG 1)
 - Once passed TOV, if patient has any of these: feeling uncomfortable, void is slow, poor bladder sensation or voiding frequent small amounts, then suspect retention and/or UTI – do a bladder scan, urinalysis and MSU.
 - **Abnormal void function:**
 - **Refer to Quick Reference Guide 2 for plan of care.**
 - **Bladder stretch:** These patients are at increased risk of gradually declining detrusor contractility and bladder sensation in the future and need specialised patient education and management which is provided in collaboration with the Urogynaecology Nurse.
 - ‘Bladder stretch’ refers to a bladder that has expanded to accommodate more urine. A bladder stretch injury occurs when the

bladder is overstretched due to urinary retention, this can lead to muscle damage and a loss of bladder elasticity affecting its ability to contract and empty properly. This may take up to 3 months (or longer) to resolve.

- **Reduced or absent sensation** is a risk factor for bladder stretch, so refer to Physiotherapy.
- If voiding frequently (e.g. hourly), small voids of <150ml, and / or uncomfortable, despite bladder scan residuals being < 150mL, perform IMC for accurate measurement and continue TOV if volumes are low.
- If patients are discharged with an indwelling catheter (urethral or suprapubic), arrange for return TOV in outpatient setting:
 - OPH – Assessment Unit booking
 - KEMH – complete eReferral to Urogynaecology Nurse Clinic

Where patients are discharged “after hours” without inpatient review from the Urogynaecology Nurse, an eReferral must be made to the WNHS Urogynaecology Nurse.

eReferral to Urogynaecology Nurse: [eReferrals Login \(health.wa.gov.au\)](https://www.health.wa.gov.au/eReferrals/Login)

Additional key points - intrapartum and postnatal

- Refer to Quick Reference Guide 1 and 2
- The patients must try to void within 4 hours of birth or removal of an IDC.

Additional key points – gynaecology / non-obstetric

- Refer to Quick Reference Guide 2
- The patients must try to void within 4-hours:
 - post-operative (if no IDC) or
 - after removal of IDC
- Several trials may be required before achieving a positive outcome, particularly after urological surgery

Failed trial of void management

- Refer to Quick reference Guide 2
- For accuracy, voids are to be measured by weight if volume is less than 150mL or greater than 600mL.
- If the patient is voiding frequent or small amounts, and/or is uncomfortable, despite the bladder scan residuals being less than 150mL, perform an intermittent catheter, record drainage volume and inform the admitting team.
- Refer to ward physiotherapist if patient is experiencing altered sensation or flow.
- Factors associated with failure of a TOV include: past history of urinary retention; anaesthetic; constipation; medication (e.g. opioids, anticholinergics, antipsychotics) can also inhibit normal bladder function; mobility issues; postpartum diuresis. It is important that a full clinical assessment takes place prior to re-catheterisation.

Bladder scanning

Bladder scanners are a non-invasive and portable device that utilise ultrasound technology to digitally measure the bladder's urine volume, informing smart treatment decisions.

Key points

1. Bladder scanning is the first line of assessing bladder volume within the WNHS, as opposed to intermittent catheterisation.
2. All inpatient areas within the WNHS have access to a bladder scanner.
3. Clinicians should be competent in bladder scanning technique in order to obtain an accurate result during examination of urinary bladder. A demonstration on how to use the WNHS bladder scanner can be found at the link below:
 - [Caresono HD5 Bladder Scan Quick Guide](#) (External site - YouTube)
4. The bladder scanner should be cleaned with isopropyl wipes after each use and maintained according to the recommendations of the manufacturer. This includes periodic calibration and assessment on the consistency of the scanner measurement which should be similar to the amount of urine drained from the bladder on catheterisation.
5. The bladder scanner should only be used when clinically indicated, using the lowest exposure times. The use of the bladder scanner should not replace clinical judgement based on the clinical status of the patient.
6. Altered anatomy may interfere with the ultrasound waves.
7. Use with care in suprapubic / pelvic surgery patients, and those with scar tissue, surgical incisions, staples and sutures as ultrasound transmission and reflection may occur.
8. Do not use in the presence of open skin or wounds in the suprapubic region due to the risk of cross infection. Tegaderm can be applied over the wound
9. The patient should not have a catheter in their bladder as the balloon volume may affect the accuracy of the scan reading.

Procedure

1. Conduct a risk assessment.
2. Assess the patient's clinical history, symptoms and reason for the bladder scan.
3. Explain the procedure and obtain verbal consent prior to commencement.
4. Press the on / off button.
5. Press the 'scan' button.
6. Press the gender button. The screen will show a male or a female icon to indicate the gender that is selected. For patients who have undergone a hysterectomy use the female "H" option.
7. Apply a generous amount of water-soluble transmission gel to the patient's abdomen, 2cm above the symphysis pubis to facilitate contact between the skin and scanner.

8. Clean the rounded end of the scan head by gently wiping with a 70% isopropyl alcohol impregnated wipe.
9. Place the probe on the transmission gel.
10. Aim the scan head so the ultrasound is projected toward the expected location of the bladder. For most patients this means aiming the tip of the scan head towards the patient's coccyx, there is no need to apply extra pressure on the patient's abdomen.
11. Move the scan head over patients suprapubic area until the bladder is identified with a green border and green line through centre of image.
12. Hold the scan head steady throughout the scan. Depending on the bladder scanner available, either click the button on the scan head or once you hear a beep, the scan is complete, and the urine volume is displayed on the screen.
13. It is recommended to take several measurements to ensure maximum accuracy. Ensure that the bladder image is in all 4 quadrants.
14. Press 'done' for the scan results screen.
15. Clean the scan head using a 70% isopropyl alcohol impregnated wipe and remove any excess gel from the patient's abdomen.
16. The outcome of the scan must be recorded in the medical records. Document the result on the fluid balance chart. Inform the Medical Officer if there are any concerns about the result.
17. If unable to use bladder scanner due to wound dressing or if in doubt of accuracy, residual urine volume should be measured by drainage of the bladder using an intermittent catheter.

Indwelling catheter (IDC) management

Catheter Associated Urinary Tract Infections (CAUTI's) are one of the most common Healthcare Associated Infections (HAI's) causing increased length of stay and poorer outcomes for patients. Catheter use should therefore be rationalised, and ongoing requirement assessed daily to facilitate early and appropriate removal. See NMHS, SCGOPHCG Bladder Management and Urinary Catheterisation Nursing Practice Guideline, Reference NPG 44, December 2024.

WNHS endorses reference to the **SCGOPHCG [Bladder Management and Urinary Catheterisation](#)** Reference NPG 44, for evidence based best practice regarding:

Section 2.0 Urinary Catheterisation (Urethral):

- 2.1 Medical requirements
- 2.2 Safety requirements
- 2.3 Nursing management – including blocked catheters, bypassing catheters and urine specimen collection
- 2.4 Catheterisation requirements and procedure

Section 3.0 Removal of Indwelling catheter:

- 3.1 Medical requirements
- 3.2 Safety information
- 3.3 Nursing Management – includes procedure for removal.

Key points for WNHS patients

1. Catheters shall be secured to avoid trauma – see Figure 1 below:

Figure 1 – Catheter secured proximal to vulva to prevent inadvertent pulling



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.

Acknowledgement: The Royal Women's Hospital (Melbourne, Victoria, Australia), Bladder Management Guideline, March 2024. Located: www.thewomens.org.au

2. Urinary drainage bags positioned below the level of the bladder to facilitate drainage.
3. Educate the patient to clean the meatal area daily during routine daily showering
4. Assess and document the need for IDC daily and remove when not clinically indicated.
5. Patient transfer from ASCU to the ward **[CIMS recommendation June 2019]:**
 - Once the patient is cleared from ASCU by the team, the usual urine output and colour observations must continue until the woman leaves for the ward.
 - Once the patient arrives on the ward from ASCU, the urine output and colour need immediate documenting along with other observations or **check when last documented in ASCU fluid balance chart, DMR notes or ASCU observation chart and perform observations if nil recent.**
6. After all transfer situations (most commonly when patient requiring external CT or internal or external outpatient department (OPD) appointments): once the patient returns to the ward, the urine output and colour needs immediate documenting along with other observations.

Intermittent self-catheterisation (ISC)

Intermittent self-catheterisation (ISC) is when the patient passes a catheter into the bladder to drain urine and empty the bladder, at intervals throughout the day, with the catheter being immediately removed.

Patients who need to undertake ISC have voiding or bladder storage problems, resulting in retention of urine.

Patients will receive education, support and equipment from the Urogynaecology Nurse in order to learn and fully understand and manage their own bladder management plan of care.

eReferral to Urogynaecology Nurse: [eReferrals Login \(health.wa.gov.au\)](http://eReferrals.Login.health.wa.gov.au)

Suprapubic catheter (SPC)

A suprapubic catheter (SPC) is inserted directly into the bladder, just above the pubic bone. SPCs are inserted -

- to relieve acute urinary obstruction where a urethral catheter cannot be inserted into the bladder e.g. urethral stricture⁴
- to relieve chronic urinary retention⁴
- to relieve chronic retention of the neurogenic bladder
- for patients who require long-term catheterisation, who are sexually active, in a wheelchair or, have persistent problems with urethral catheters⁴
- during and following pelvic or urological surgery.⁴

WNHS endorses reference to **Section 4.0 Supra-pubic Catheterisation** of the SCGOPHCG [Bladder Management and Urinary Catheterisation](#) NPG 44, for evidence based best practice on Suprapubic catheter care, regarding -

4.1 Medical requirements

4.2 Safety information

4.3 Nursing Management – includes procedures for SPC change and removal.

Key points for WNHS patients

- SPC 1st changes are done with the Urogynaecology Nurses in the outpatient department, at 6 weeks.

Trial of void with SPC

Key points

See key actions and points within section “Trial of Void”.

Additional points:

1. If they are unable to void, document this, and immediately remove SPC spigot and allow straight drainage.²⁵ Record the residual²⁵ after 10 minutes of straight drainage (no longer) then report the residual amount to the medical team.
2. If the patient is voiding frequent or small amounts or is uncomfortable despite residuals of less than 150mL, flush the catheter and recheck the residual.
3. If unsure of what to do, open the SPC to straight drainage until the medical team has reviewed.

Equipment²⁵

- | | | |
|--------------------------------|-----------------------|-----------------------------|
| • Non-sterile gloves | • PPE | • Stitch cutter if required |
| • Bedpan / container in toilet | • Measuring jug | • Drainage bags |
| • Catheter spigot | • Fluid Balance Chart | (disposable) |

Procedure

1. Prepare: Check the medical order for commencing the TOV, explain the procedure to the patient.²⁵ Don relevant PPE and empty the drainage bag.
2. At 6am, disconnect the drainage bag and insert a catheter spigot to seal the catheter drainage temporarily, to allow the bladder to fill¹⁹.
3. Immediately after voiding, measure the void (per urethra). Remove catheter spigot and drain any residual urine remaining in the bladder, into a drainage bag, to determine the PVR volume.^{19, 25}
4. After 10 minutes, empty and record the volume in the drainage bag^{19, 25} (PVRV). Record both urethral void and SPC drainage on the fluid balance chart²⁵. Re-spigot the SPC.
5. Continue until there are two consecutive voids of >150mL, with residuals <150mL.
6. Once this has been achieved, leave the catheter spigot in situ until the next day.
 - For inpatients, measure all voids but do not measure residuals unless the patient is uncomfortable or has frequent small voids.
 - For outpatients, ensure the patient has clinic / Emergency Centre (EC) contact details.
7. Repeat the residual measurement with the next first morning void. If the void >150mL with a residual < 150mL, the catheter may be removed.
8. **Inpatients only:** If any residual > 150mL – put the catheter to straight drainage and inform the medical team.
9. A TOV has failed if there is a residual of >150mL. Leave the catheter on straight drainage for 24 hours if the residual is >150mL but < 600mL.
 - Commence a new TOV as recommended by the medical team.
 - Ensure the woman is not constipated as this can affect urinary retention and result in a failed TOV.²⁵
10. If the overall bladder volume is >600mL – leave the catheter on straight drainage for 48 hours. Inform the medical team.
11. Document the outcome in the patient's medical record.²⁵
12. If after initial success the patient starts to fail trial without catheter- check urinalysis and take an MSU / CSU and inform the medical team. If the urinalysis is positive for nitrites and or white cells inform the medical team.
13. If the patient fails the trial without catheter regime twice, the team Registrar or above shall review and discuss the situation with the team Consultant.
14. Consider review by Urology Nurse Practitioner or Urology Clinical Nurse Consultant

Female genital mutilation / cutting

Refer to WNHS [Female Genital Mutilation / Cutting \(FGM/C\)](#) guideline for additional bladder care considerations.

Bladder irrigation

1. A Medical Officer's order is required to initiate bladder irrigation.
2. Maintaining a sterile closed urinary drainage system minimises the risk of catheter associated infection.
3. Initial urethral catheterisation with a 3-way catheter shall be undertaken by a medical officer if there is a risk of rupturing a surgical anastomosis.
4. Hand hygiene shall be performed prior to and after contact with the patient and /or the equipment.
5. Use of PPE shall be in accordance with standard precautions.

WNHS endorses reference to the SCGOPHCG [Bladder Irrigation](#) Nursing Practice Guideline Reference NPG 45, **Section 1.0** for **continuous bladder irrigation management**, for evidence based best practice regarding -

- 1.1 Medical requirements
- 1.2 Safety information
- 1.3 Nursing management
- 1.4 Procedural information – includes equipment requirements, commencing the irrigation, and maintaining the regime.

Discharge planning and urinary catheter care at home

Discharging inpatients with an indwelling or suprapubic catheter requires patient education and referral to the Urogynaecology team in the Outpatient setting, via an eReferral:

eReferral to Urogynaecology Nurse: [eReferrals Login \(health.wa.gov.au\)](https://eReferrals.health.wa.gov.au)

Before leaving hospital, ensure patient is:

- Informed on general catheter care, securing to thigh/leg, ensure no kinks in tubing
- informed how to empty the leg bag or release catheter valve (aka spigot)
- informed how to change the leg bag
- informed how to attach and remove a night bag
- informed on wound care - dry dressing for insertion site if required (SPC only)
- informed on suture removal process 1 week after insertion (SPC only). Note: Check with Consultant first as this needs to be ordered.
- provide 1-2 leg bag and 1-2 night bags, and how to clean in-between use
- has a follow-up appointment or eReferral with Urogynaecology Nurse arranged
- handed patient information on IDC or SPC care, leg bags, overnight bags etc

References and resources

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Related WNHS policies, procedures and guidelines

Obstetrics and Gynaecology:

- Labour and Birth: Labour (First Stage); Labour (Second Stage)
- [Inpatient Postnatal Care](#)

Infection Prevention and Management Manual:

- [Aseptic Technique](#)
- [Hand Hygiene](#)
- [Standard and Transmission-Based Precautions](#)

Related NMHS, SCGOPHCH policies, procedures and guidelines

SCGOPHCH Nursing Practice Guidelines:

- [Bladder Management and Urinary Catheterisation \(Dec 2024\)](#)
- [Bladder Irrigation \(Jun 2023\)](#)









Useful resources

WA Health – patient information:

- [Bladder health](#)
- [Caring for your catheter](#)
- [General hygiene tips for your catheter](#)
- [Troubleshooting for your catheter](#)
- [Your indwelling urinary catheter](#)
- [Your lifestyle with a catheter](#)
- [Your suprapubic catheter](#)
- [Your self intermittent catheter](#)
- [What is a catheter?](#)

Forms:

- Fluid Balance Chart MR729 (KEMH) / MR144.1 (OPH)
- Bladder Diary MR043 (KEMH) / MR8.4 (OPH)

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| Keywords: | mid-stream urine, MSU, urine sample, catheterisation, unable to void, Intermittent Catheter, postnatal bladder management, bladder management during labour, IDC, IDC insertion, Urinary tract infection, catheter associated infection, management of an IDC, indwelling catheter problems, IDC removal, TOV, trial of void, residual volume, post void residual, PVR, residual urine, bladder scanner, CSU, intermittent self-catheterisation, ISC, bladder, assessment, suprapubic catheter, non-real time bladder scanner, bladder scanner, bladder irrigation, bladder irrigation, catheter obstruction, bladder stretch, bladder diary | | |
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| Reviewed dates: | June 2019 (v2- CIMS recommendation); March 2020 (v3); Nov 2020 (v4); 3 March 2021 (v5); Feb 2022 (v6); Apr 2022 (v7); Apr 2023 (v8-amend); July 2025(v9) | Next review date: | Jul 2028 |
| Endorsed by: | Clinical governance Committee (CGC) | Date: | 23/07/2025 |
| NSQHS Standards (v2) applicable: | <div><input checked="" type="checkbox"/>  1: Clinical Governance</div> <div><input type="checkbox"/>  2: Partnering with Consumers</div> <div><input checked="" type="checkbox"/>  3: Preventing and Controlling Healthcare Associated Infection</div> <div><input type="checkbox"/>  4: Medication Safety</div> | <div><input type="checkbox"/>  5: Comprehensive Care</div> <div><input checked="" type="checkbox"/>  6: Communicating for Safety</div> <div><input type="checkbox"/>  7: Blood Management</div> <div><input type="checkbox"/>  8: Recognising and Responding to Acute Deterioration</div> | |
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Version history

| Number | Date | Summary |
|--------|----------|----------------|
| 1 | Oct 2017 | First version. |

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|---|----------|--|
| | | <p>History: Amalgamated 16 individual guidelines on bladder and urinary drainage dating from April 2002.</p> <p>Supersedes:</p> <ol style="list-style-type: none"> 1. (A6.1) Midstream Urine Specimen (dated June 2015) 2. (A6.2.1) Self Catheterisation (Intermittent) (dated June 2015) 3. (A6.2.2) Urinary Catheterisation: Intermittent (dated June 2015) (originally titled 'Use of an O'Neill Catheter') 4. (A6.3.1) Indwelling Catheter: Insertion (date amended April 2016) 5. (A6.3.2) Indwelling Catheter: Management (dated June 2015) 6. (A6.3.2.1) Indwelling Catheter: Emptying Drainage Bag (dated July 2015) 7. (A6.3.2.2) Indwelling Catheter: Blockage (dated July 2015) 8. (A6.3.3) Indwelling Catheter: Urine Specimen (dated June 2015) 9. (A6.3.4) Indwelling Catheter: Trial of Void (dated June 2015) 10. (A6.3.5) Indwelling Catheter: Removal (dated June 2015) 11. (A6.4) Suprapubic Catheter: Care of a (dated June 2015) 12. (A6.4.1) Suprapubic Catheter: Trial of Void (dated June 2015) 13. (A6.4.2) Suprapubic Catheter: Removal (dated May 2016) 14. (A6.5) Bladder Irrigation (dated Feb 2016) 15. (A6.7) Use of Non Real-Time Bladder Scanner (date amend Jan 2015) 16. Bladder Management: During Labour and the Postnatal Period (dated April 2015) <p>Rescinded: (A6.6) Urinary Incontinence Aids (dated June 2015)</p> |
| 2 | Jun 2019 | CIMS recommendation |
| 3 | Mar 2020 | Minor amendment- formatting, no content change |
| 4 | Nov 2020 | Intra/post - partum flowchart and table amended |
| 5 | Mar 2021 | Minor amendment- fixed hyperlink from contents page only |
| 6 | Feb 2022 | Minor amendment- OPH process added to postnatal flowchart on p22 |
| 7 | Apr 2022 | Amended postpartum table- IDC time frame changed to min. 12 hrs (+/- overnight) after spinal or epidural morphine. |
| 8 | Apr 2023 | Minor amendment- Added word 'morphine' to beginning of IDC alert box (to read clearer the box is for epidural with morphine or spinal with morphine) |
| 9 | Jul 2025 | <ul style="list-style-type: none"> • Major review, content condensed, streamlined and reformatted guideline. New quick reference flowcharts added. References updated • Flow chart volumes updated and changed throughout document to align to current WNHS urogynaecology practice • Table updated for intrapartum and postpartum voiding difficulties • Reduced or absent sensation is a risk factor for bladder stretch, so refer to Physiotherapy |

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