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CLINICAL PROFESSIONAL RESOURCE

Acknowledgements

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Contents

Notes

It is recognised that care may be provided by registered nurses and midwives, health care support workers, assistant practitioners, nursing associates and student nurses and midwives, and trainee nursing associates. For ease of reading, the generic terms ‘nurse’, ‘nursing’ and ‘nurses’ are used throughout this document, unless specified.

The RCN recognises and embraces our gender diverse society and encourages this guideline to be used by and/or applied to people who identify as non-binary, transgender, or gender fluid.

The RCN also recognises that not all those born female, or male will identify with the same gender nouns, but for ease of reading use the term woman/man/men and where appropriate acknowledge nonbinary terms.

Introduction

Bladder and bowel care during childbirth is a critical part of maternity care, as the effective care and management can have short and long-term consequences for the woman and her family.

This guidance aims to provide information about bladder and bowel care throughout pregnancy, labour and into the postnatal period. The content should be considered alongside revisiting anatomy and physiology of the pelvic floor and related organs including the bladder, bowel and reproductive organs. It will also consider the possible complications and potential consequences of damage to these organs and promote good habits (such as pelvic floor muscle training and exercises), including reducing clinical risk. This is aimed at avoiding long-term problems which may have a negative impact on a woman's physical and mental wellbeing, as well as her partner and that of her wider family.

The guidance acknowledges and recognises current national guidance (such as Royal College of Obstetricians and Gynaecologists (RCOG), National Institute of Excellence in Health and Social Care (NICE) and Scottish Intercollegiate Guidelines Network (SIGN)) and can be used as a tool for midwives, nurses, nursing associates, health care support workers, maternity support workers, practice nurses, health visitors and other allied health care professionals, including physiotherapists involved in the care of women.

It is based on the general principles of excellent evidence-based care, including kindness, respect, dignity, informed consent and confidentially. All practitioners are encouraged to revisit their professional code of conduct and behaviour such as the NMC's Code (NMC, 2018).

Equally, health care professionals need to understand that the perceptions and experience of childbirth may differ in relation to disability, age, race, religion, sexual orientation and/or partnership status.

Other considerations that need to be taken account of include:

- every woman should be offered a chaperone to be present during an examination, procedure, treatment or any care, irrespective of organisational constraints or the

Figure 1.1 Key messages

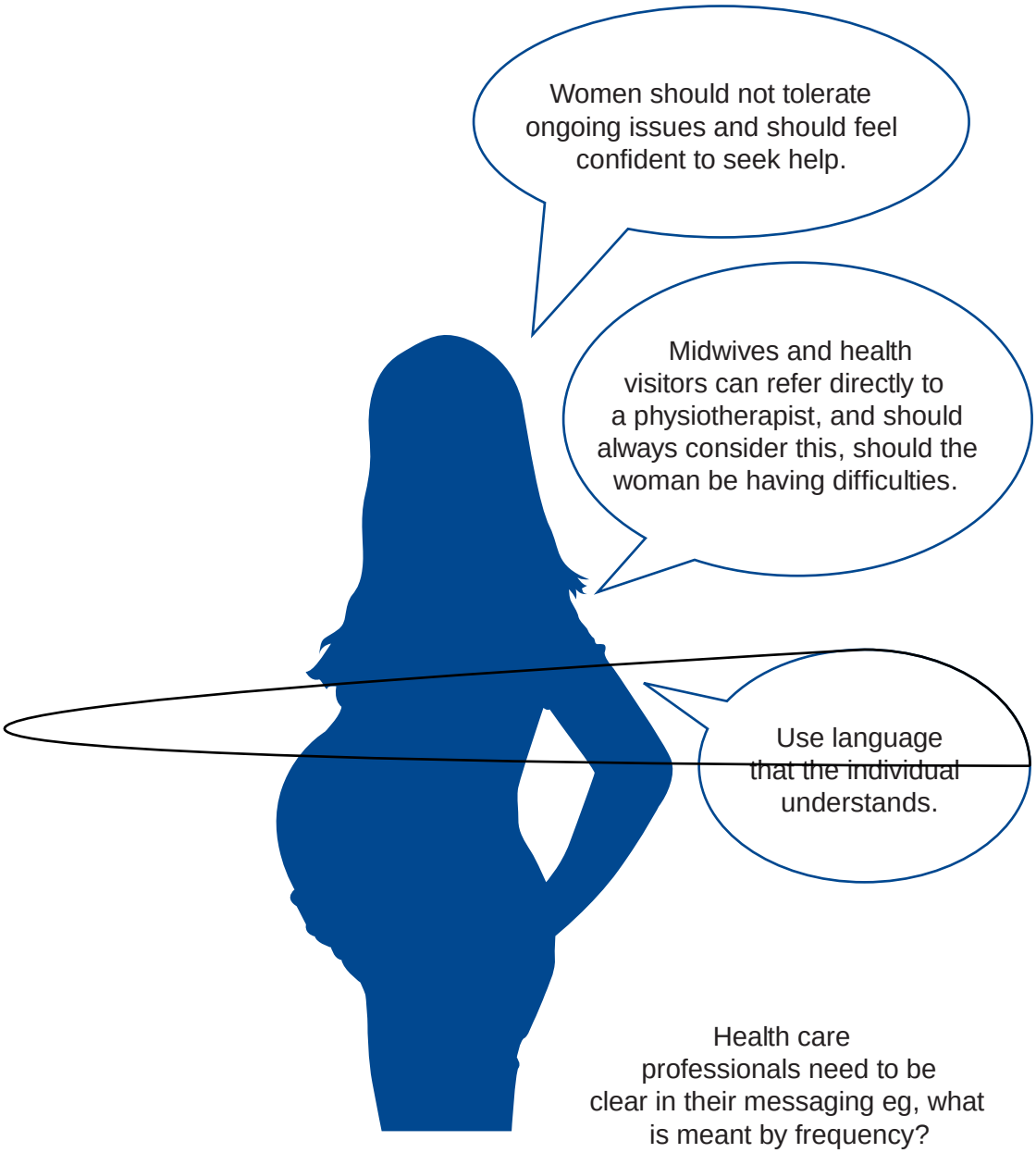


Figure 2.1 The Bristol Stool Chart

Reproduced with kind permission of Norgine.

Antenatal changes to bladder function

First trimester (first 3 months of pregnancy)

- An increase in progesterone levels results in the relaxation of smoot5.4 (f s)3.6 (5 (t)11.s)x5.2 (he r)9.9 (e)2

Intrapartum changes and care of bladder and bowels

Women should be encouraged to void regularly during pregnancy and during labour, the volume passed should be recorded on the partogram and fluid balance chart during labour (NICE, 2023). Incomplete bladder emptying can delay the descent of the baby, reduce the efficiency of the contractions and increase pain. The need for assessment of urinary symptoms and of bladder emptying and urinary residual throughout labour is critical to ensure accurate diagnosis and care. NICE (2023) recommends assessment at least every four hours. This should include:

- frequency of passing urine and bladder sensation
- fluid balance monitoring if sensation is abnormal or absent, if there is an inability to pass urine, or the woman is receiving intravenous fluids (including oxytocin)
- offering to insert a catheter if there are any ongoing concerns over the woman's ability to pass urine.

During labour there is an increased risk of bacteria entering the urinary tract. Urethral catheterisation, whether indwelling or in and out, also increases the risk of a UTI. The role of catheter fixation devices and good catheter care in preventing this, should be part of us(i)8.4 (s)3.6 (k o)15.4 (f a U)-9.3 (TI)-11.8 ((e)9 (a)6 (.4 (f25Tw0s)4.5 ((i)8.(g ur)16 (v) (t).6 (k o)15.4 (f a U

Some women may experience faecal urgency and/or incontinence, usually due to a weakened pelvic floor. Generally, this will improve after a few weeks, once the pelvic floor muscle strength improves. If it does not, then a referral to the pelvic floor specialist physiotherapists, bladder and bowel care service and/or the colorectal team should be considered.

Figure 2.2 – Correct toilet position

Pelvic floor function

The pelvic floor is complex, made up of the levator ani muscles, superficial perineal muscles, the urogenital diaphragm, the perineal membrane, endopelvic fascia and external anal sphincter (see Figure 2.3). The muscles are composed of type I (slow twitch, for endurance) and type II (fast twitch) muscle fibres. There is a greater proportion of slow twitch fibres (Marques et al., 2010). Pelvic floor functions include:

- support for the abdominal and pelvic organs against gravity and downward pressure
- strength to control bladder and bowel continence
- the ability to relax to allow appropriate bladder and bowel emptying
- sexual function
- assisting with the rotation of the baby's head during birth.

https://teachmeanatomy.info/pelvis/muscles/pelvic-floor

Figure 2.3 The pelvic floor

What happens during pregnancy?

Pregnancy and labour are significant factors in the develop?

Pelvic floor muscle training/exercises

Pelvic floor muscle training (also referred to as pelvic floor exercises) is known to be effective in treating symptoms of urinary incontinence (NICE, 2019c) and pelvic organ prolapse (Hagen et al., 2013). It is recommended for all women especially during antenatal care and following childbirth. Core stabilisation exercises are safe, beneficial and effective too for alleviating urinary symptoms and may be helpful for many women (Chin-Yin et al., 2023).

It is important to isolate a contraction of the pelvic floor muscles correctly. It has been found that many women do not have the correct technique (Bo, 2012), manifesting in a

Figure 2.4 How to complete pelvic floor exercises

Start as soon as possible antenatally and post-partum, increasing blood flow to the area can aid tissue healing.
Aim to undertake 3 times a day.
Start seated or lying and progress to upright and with activity.
Draw up both front and back passage. Start at back and draw up and forwards to front as if stopping passing both wind and water.
Long holds until fatigue (aim up to 10 secs max), repeat until fatigue.
Short holds until fatigue.
Relax muscles (let go) fully in between contractions.
Increase over time.
Avoid breath-holding and limit use of buttocks and abdominal muscles.

Further useful information regarding performing pelvic floor training/exercises can be found at: youtube.com/watch?v=v731EXFR2k4 (a video on pelvic floor exercises).

Figure 2.5 Key messages – reducing pelvic floor damage

Pelvic floor awareness and understanding by women.
Pelvic floor function knowledge and understanding by health care professionals.
Antenatal perineal massage.
Antenatal and postnatal pelvic floor exercise/training.

Pregnancy and childbirth are natural phenomenon; however, complications can arise which can have short and long-term effects. When it comes to bladder and bowel care, it is important to discuss the changes to physiology during pregnancy, labour and postnatally to ensure the woman understands what is normal, and when she needs to discuss any concerns she has with her midwife or health visitor. It is also important that all health care professionals caring for women reiterate that bladder problems may be common but that does not mean they are normal.

It is not uncommon for women to tolerate these complications because they assume bladder problems are the norm in the postnatal period (and as part of the ageing process), believing nothing can be done to help.

It should not be underestimated that any of these conditions may have a considerable impact on the woman, both her physical and mental wellbeing. Being unwell can affect the woman's mood and psychological state, and needs to be considered, even with conditions that may be considered common and short term. Developing a relationship with a new baby has its challenges and these can be exacerbated if the woman is

gastrocolic reflex and sit on the toilet after eating, even if they do not feel the need to go.

Laxatives can be considered if simple management strategies are not effective, such as Lactulose or Movicol. However, for most women dietary assessment and advice will be beneficial.

Perineal damage and repair

Damage to the pelvic floor, specifically the perineal body, which lies between the vagina

Postnatal urinary tract infections

Some women will experience UTIs postnatally which can be due to sensitivity and swelling of the vaginal and pelvic floor. Women should be encouraged to maintain effective postnatal hygiene and a good oral intake. In the case of a diagnosed UTI, antibiotics may be required.

Acute urinary retention

Acute urinary retention (AUR) is defined by the International Continence Society (ICS) as a 'painful, palpable or percussable bladder when the woman is unable to pass any urine' (ICS, 2018). This can happen following labour especially when the woman has any of the risk factors outlined in figure 3.1 .

Figure 3.1 Risk factors for going into urinary retention

Primigravida.
Instrumented delivery.
Perineal trauma – 2nd, 3rd, 4th degree tear, episiotomy.
Prolonged second stage.
Epidural – a side effect of this is decreased or absent bladder sensation
Caesarean section.
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.
Manual removal of placenta.

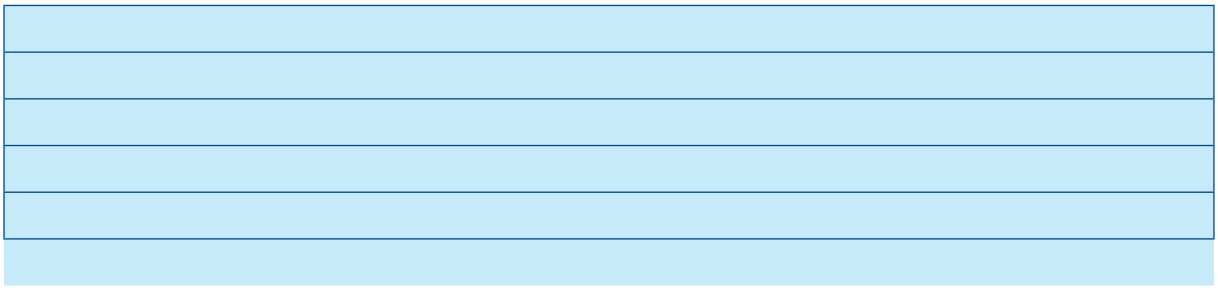
Signs and symptoms of acute urinary retention (AUR)

It is vital that a woman's bladder function is monitored closely following labour to ensure there are no issues preventing her from passing urine, with a risk of developing urinary retention. If a woman has not passed urine within four hours, investigations should be carried out to determine whether this is acute retention of urine, with referral to obstetric-led care if it continues past six hours (NICE, 2023). The signs and symptoms of AUR are outlined in figure 3.2 .

Intermittent self-catheterisation can be considered if, following a trial without catheter (TWOC), the bladder continues to not empty fully or be unable to empty at all. A referral to the urology or urogynaecology team would be advised at this point for further investigation. Figure 3.3 outlines the complications a woman may face as a result of postnatal urinary retention.

Women who have just had a baby or who have just had their catheter removed or TWOC should be advised to drink to thirst not to "to drink as much as they can". Often women drink excessively after their catheter has been removed because if they delivered in a maternity unit, they know once they have passed urine, they can be discharged home.

Figure 3.3 Potential complications from urinary retention



Instrumental births

Instrumental births may cause issues with bladder function. Women who have had an instrumental method of birthing may experience:

- lack of sensation to go to the toilet
- significant urinary incontinence.

If a catheter has been inserted during labour it should remain in situ for a minimum of 12 hours following an instrumental birth, manual removal of placenta or repair of 3rd or 4th degree tears.

If there is no sensation to void

Advise three-four hourly trips to the toilet, even if no sensation. This will prevent the bladder over distending. Encourage double voiding (sitting on the toilet, emptying the bladder and then trying to empty again to ensure the bladder is as empty as it can be). Pelvic floor exercises/training should also be carried out two-three times a day.

Women often notice that the sensation to void returns as any perineal swelling goes down post-labour, although they should be advised that this is not always the case. The sensation can often take weeks, if not months, to return to normal.

Significant urinary incontinence

Some women are not able to control their bladder and suffer with significant urinary incontinence following an instrumental delivery. These women should not be catheterised as this will increase the risk of UTIs and will not improve bladder function. Alternatively, they should be advised to wear pads to contain the leakage and to continue with pelvic floor exercises two-three times daily. Sensitivity about the challenges of this choice of managing incontinence should be explored when talking to women.

They should be reviewed by a pelvic floor specialist physiotherapist around six weeks to check their progress. Often symptoms significantly improve as swelling reduces and the pelvic floor strengthens again.

Prevention

Use of warm compresses during the second stage of labour is associated with

Postnatal care

After sustaining an OASI, women are usually discharged home with a course of antibiotics and stool softeners. It is recommended that women with OASI have contact with a health care professional 24-48 hours after hospital discharge to ensure bowel evacuation has taken place. Faecal impaction can lead to disruption of sutures and referral to hospital may be needed for manual evacuation.

Women who sustain obstetric anal sphincter injuries are at high risk of developing wound complications in the early post-partum period, warranting immediate and consistent follow-up (Lewicky-Gaupp et al., 2015).

Midwives and all health care professionals who have contact with women postnatally, should be aware of the local protocols and that women who have undergone OASI repair should be reviewed 6-12 weeks post-partum. This should include detailed referral/ transition of care to the health visitor and specialist physiotherapist. Where possible, review should be by health care professionals with a special knowledge of OASIs (RCOG, 2015). All women who undergo OASI repair should be provided with clear instructions of the expected care pathway for the duration of care required.

The psychological impact of pelvic floor dysfunction

The psychological impact of any form of pelvic floor dysfunction can be as great as the physical symptoms experienced. Suffering with new onset incontinence, having an episiotomy or laceration to the perineal body and/or experiencing urinary retention will inevitably have an impact on body image, relationships, a woman's sex life and general mental wellbeing. If the birth experience was particularly traumatic then women may suffer with PTSD. It is essential that any health care professional asks the woman how she is feeling at every opportunity and knows where to refer her for psychological support, counselling and/or assessment of new onset symptoms if necessary.

Physiotherapists, midwives, health visitors, practice nurses and nurse specialists are all likely to see postnatal women and have the opportunity to identify any concerning or continuing issues. They should all be aware of what is provided locally to enable referral for further support as required. Some hospitals have access to debriefing sessions and counsellors to help women cope with the psychological impact of events following birth.

recognise that some aspects of care may not have been as women would have expected. This needs to be recognised, acknowledged and managed positively.

All organisations that provide health care should have a risk management process to report concerns when there may be an issue with the care provided. This includes bladder and bowel trauma and injury, which can then enable a local investigation to be undertaken to see if there is any learning to enhance future practice. All health care professionals should be familiar with their local risk management process and how to action any concerns they have.

The IMMDS report (2020) First Do No Harm was clear in its messaging about the importance of a duty of candour, providing clear information to women during care, ensuring they understand how to raise concerns and provide assurance that any concerns will be carefully considered and responded to.

During antenatal care

Women should be supported and always be reassured that complaints will be dealt with efficiently and investigated fully.

New initiative to support improvement in perinatal pelvic health 2021

Since 2021 there has been an initative by NHSE called the Perinatal Pelvic Health Services (PPHS). The ambition of this intiative, as part of the NHSE Long-Term Plan, is to engage local service provision to improve the prevention, identification and treatment of 'mild to moderate' pelvic floor dysfunction following birth and reduce the number of women living with pelvic floor dysfunction postnatally and in later life. The intention is that local models will respond to a set of service principles that can be adapted to suit local working practice. Please see this guide for implementation for service providers: england.nhs.uk/long-read/implementation-guidance-perinatal-pelvic-health-services

It is recognised there are differences in how women are able to access services that are available to them around the UK. The above initiative has identified that women who answer yes to any of the four questions below will benefit from specialist advice and support with pelvic floor exercises. These questions can be integrated into everyday care for those who are involved in supporting women up to one year postpartum.

1. Do you have any bladder or bowel problems?

2. Do you have any lower back, groin, hip or butto (i)9.1 (, h)7.5vadnen-G/MCID 1059 >0<</Lang (en-G36 (

5. Conclusion

Care of the bladder and bowel are implicit parts of care in pregnancy, labour and postnatally and the need to understand why this is important cannot be overstated. The consequences of complications can have an impact on a woman's life for a long time afterwards. Such potentially life-changing complications may also affect her relationship with her partner and wider family, as well as her ability to look after her child/children.

Women are often fearful, embarrassed or have limited knowledge of normal physiology and therefore rely on health care professionals to ensure they understand what is normal and to report anything that feels unusual or abnormal to them.

Current national guidelines from NICE/SIGN, the NMC and the OASI care bundle support best practice and include the need to communicate effectively, recognise symptoms and act accordingly. This is also an area of emerging evidence, where practices are sometimes based on experience and local learning in practice, rather than research and evidence. This creates opportunities for health care professionals to engage in enhancing care through research as well as through listening to and supporting women.

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