MSSIC Guideline for Policy Re: Pre-op PVR Screening

Example: H.F. West Bloomfield Pre-op PVR Screening Initiative

Developed an initiative to capture previously undetected, pre-existing UR through pre-op PVR bladder scanning. This was only a piece of their QI Initiative to reduce UR.

They built a pre-op order into standard order sets for all spine surgery patients. Wording in the order: Please have patient void preoperatively and obtain a bladder scan within 30 minutes of void. Document amount voided as well as post void residual volume.

They then designated where documentation would occur and what it must contain in order to meet the initiative requirements. Documentation procedure: The pre-op nursing staff documents the PVR bladder scan volume on the I/O flowsheet in Epic and documents a nursing note stating that the PVR scan was done within 30 minutes of the patient voiding.

Finally, the team drafted a support document that ties this together establishing that the spine surgeons support a finding of a pre-op, PVR bladder scan of 150cc or greater as pre-existing UR for the MSSIC abstractors. Wording: "Any patients with a pre-operative, post void residual bladder scan of 150cc or greater will be considered to have baseline, pre-existing urinary retention at Henry Ford West Bloomfield." This is signed by the surgeons and kept as a support document for audit purposes.

This serves as a formal plan/protocol with the spine surgeons and MSSIC.

Important: This intervention was only a piece of the successful QI Initiative to reduce UR at HFWB. Pre-op PVR bladder scanning has only accounted for about an 8% reduction. Their overall reduction was 77%. The other components of early ambulation, reduction of intra-op catheter use, and revision of their post-op bladder protocol accounts for the majority of the UR reduction. Their revised bladder protocol is in the MSSIC UR Prevention Practices/Guidelines document.

That is what HFWB did and what they cleared with us for QI and audit purposes. This is also being implemented at other sites. It helps some, and does raise awareness for patients that had previously gone undetected. However, the other interventions are the ones that appear to make the most difference in rates.

Requirements:

These are the vital pieces needed for MSSIC in order to correlate pre-op, PVR bladder scan volume results and pre-existing UR. The site's protocol must outline:

- Date of implementation
- Specifically outline procedure to be implemented and where it will this take place? (i.e.: In pre-op, after patient changes into surgical gown, have patient void and obtain a bladder scan within 30 minutes of void. Document amount voided as well as post void residual volume...)

    - It must be post void and within a designated period of time of the patient voiding (i.e. 30 min.)
- Define the threshold. HFWB, and two other sites, were comfortable with 150cc or greater. This is not dictated by MSSIC. We would expect that surgeons would work with their Urology colleagues to determine a threshold that they are comfortable with as physicians.
- Documentation: Must be a specific place in the EMR and clear that it was post void and within the defined time frame of the void
- Support document, signed by surgeons, that ties this together establishing that the spine surgeons support a finding of a pre-op, PVR bladder scan of ____cc or greater as pre-existing UR for the MSSIC abstractors.