Urinary retention with bladder distention is a common complication following urogynecologic surgery. Prevention of bladder distention from post-operative urinary retention (POUR) can lead to safer patient care and improved surgical outcomes. Although POUR is recognized as a complication of urogynecologic surgery, published guidelines by professional organizations for the prevention and management of POUR were not found; however, recommendations for the development of clinical practice guidelines have been suggested (Ringdal, Borg, & Hellstrom, 2003; Rizvi, Khan, & Khan, 2005).

The need for standardized management of POUR for women undergoing urogynecologic surgery became apparent at the authors’ 572-bed Magnet-designated community teaching hospital following the growth of the gynecologic surgery patient population. Within the first four months of providing post-operative care to this new patient population, a few patients experienced bladder distention, necessitating catheterization with volumes greater than 1,000 ml; one patient required surgical site repair. Nurses questioned variation in physician practice of post-operative bladder management when conflicts arose regarding nurses’ recognition and clinical decision-making surrounding bladder distention. In addition, physician orders included the use of bladder ultrasound for bladder assessment. Nurses at the authors’ facility had limited experience with the use of the portable bladder ultrasound scanner. These concerns led these nurses and physicians to identify the need for evidence-based standardized management of early POUR to guide timely nurse decision-making at the bedside and ultimately support safe patient outcomes.

Lewthwaite and Girouard (2006) published an algorithm using catheterization to measure post-void residual (PVR) following continence surgery. Use of the algorithm resulted in fewer catheterizations and a shorter length of hospitalization. An algorithm is an effective method to standardize clinical decision-making. The use of algorithms has been identified as an effective method to impart knowledge and guide clinical decision-making (Rathbun & Ruth-Sahd, 2009).

A study to determine health care providers’ knowledge about bladder care reported unsatisfac-
Research Summary

Background
Urinary retention can be a significant post-operative problem for women undergoing urogynecologic surgery. Bladder distention can lead to impaired bladder function, urinary tract infections, and disruption of surgical repair with impaired surgical outcomes.

Purpose
The purpose was to determine whether an evidence-based algorithm to manage post-operative urinary retention in women who have undergone urogynecologic surgery would prevent urinary retention and improve voiding efficiency.

Methods
A pre- and post-intervention comparative design was used to evaluate patient outcomes before and after nurse education and training, and the implementation of an evidence-based algorithm.

Results
There was a statistically significant improvement in voiding efficiency and a reduction in urinary retention with the use of the algorithm.

Conclusions
A nurse-driven, evidence-based algorithm can improve the efficiency of voiding, reduce urinary retention, and decrease the incidence of bladder distention among this population.

Level of Evidence – VI
(Polit & Beck, 2012)

Research Question
Will the implementation of an evidence-based algorithm and comprehensive nurse education reduce the incidence of POUR in women undergoing urogynecologic surgery?

Conceptual Framework
The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model and guidelines were used to synthesize recommendations from the evidence (Dearholt & Dang, 2012). The JHNEBP model facilitates bedside nurses’ translation of evidence into nursing practice. During the translation phase of the JHNEBP model and guidelines, recommendations from the evidence are implemented as a pilot study. Preliminary outcomes are evaluated and reported to organizational decision-makers for support to disseminate successful interventions internally. Following the steps of the JHNEBP guidelines, a multi-disciplinary team determined it was feasible to implement recommendations from the evidence into practice. Buchko and Robinson (2012) described the development of an evidence-based algorithm to enhance clinical decision-making for prevention and management of POUR for women following urogynecologic surgery.

Problem Statement
Nurses and physicians identified that management of POUR following urogynecologic surgery was inconsistent. Several patients experienced adverse outcomes, which confirmed the need for a standardized evidence-based protocol. In addition, nurses within the authors’ organization had limited experience with the use of the bladder scanner. Physicians and nurses requested the implementation of a) a standard definition of urinary retention, b) a consistent protocol for voiding trials to minimize variation among practitioners, c) enhanced nursing knowledge and skill in use of the portable bladder ultrasound scanner, and d) consistent documentation of voiding trial results. A multidisciplinary team was formed to review the literature and develop an evidence-based algorithm to guide nurse decision-making (Buchko & Robinson, 2012).

Purpose of the Study
A pilot study was designed to determine whether comprehensive nurse education about POUR, use of bladder ultrasound, and implementation of an evidence-based algorithm could prevent POUR with bladder distention in women who have undergone urogynecologic surgery. The goals of standardizing practice were to decrease urinary retention and bladder distention, decrease the frequency of intermittent catheterizations, decrease the duration of continuous catheterization with an indwelling urethral catheter, decrease potential damage to surgical site, and use nursing time efficiently.
Methods

Research Design

A comparative descriptive design was used to evaluate patient outcomes before and after implementation of the algorithm and nurse education.

Sampling Strategy

Data were extracted by retrospective chart review. The criteria for subject enrollment included a) women who had undergone urogynecologic surgery between August 2005 and December 2006, including suburethral sling, Marshall-Marchetti-Krantz or Burch procedure, vaginal hysterectomy, and anterior and posterior colporrhaphy; b) surgery performed by a gynecologist; and c) women cared for on the postpartum-gynecologic unit after transfer from the post-anesthesia-care unit. Women whose surgery was performed by surgeons other than gynecologists and who were cared for on a unit other than the postpartum-gynecologic unit were excluded from the study.

An a priori power analysis was calculated using G*Power 3.1.2 computer software for an independent \( t \)-test using parameters for a two-tailed test, anticipating a medium effect, with an alpha of 0.05 and power of 0.80. A minimum of 64 trials were needed for each group for an optimal total sample size of 128.

Procedure

The multidisciplinary team designed an evidence-based algorithm to prevent and manage POUR in women following urogynecologic surgery (Buchko & Robinson, 2012). The algorithm defined urinary retention, PVR, voiding efficiency, when and how to assess the patient using bladder ultrasound, when to catheterize (either intermittent or continuous), and success (see Figure 1). The BladderScan BVI 3000 (diagnostic ultrasound), a portable bladder ultrasound, was used by nurses to measure bladder volume.

Training for Nurses

Nurses caring for women following urogynecologic surgery engaged in a one-hour in-service about nurse-driven management of POUR. The educational information included how to use the algorithm as well as physiology of the urinary tract, normal voiding function, post-operative voiding complications, techniques to monitor and diagnose malfunction of voiding process, how to measure for PVR, the concept of voiding efficiency, and use of ultrasound technology for monitoring voiding function. Skilled nurse peers observed clinical nurses’ use of the portable bladder ultrasound scanner by return demonstration. Documentation of voiding trials was also empha-

Figure 1. Urinary Retention Algorithm

![Figure 1. Urinary Retention Algorithm](image)

catheterization, e) measurement of voiding efficiency, and f) urinary retention greater than 500 ml.

**General Analytic Strategies**

Chi-square test or Fisher’s exact test were used to test for significance for categorical variables. The pre- and post-intervention groups were unequal; therefore, the nonparametric alternative to the independent samples t-test, the Mann-Whitney U, was used to assess the difference between groups for continuous variables. Statistical significance is recognized as \( p < 0.05 \).

**Results**

A total of 56 women met inclusion criteria for the study. The average patient age was approximately 58 years. There were 15 women in the pre-implementation group representing 93 voiding trials and 41 women in the post-implementation group representing 219 voiding trials. Six women in the pre-implementation group (40%) and 6 women in the post-implementation group (14.6%; \( p < 0.092 \)) required reinsertion of an indwelling urethral catheter; these reinsertions were considered new voiding trials. Although all patients had urologic surgery, there were differences in the types of surgery between the groups. In the pre-implementation group, more patients had incontinence surgery (80%), whereas 66% of patients in the post-implementation group had incontinence surgery (5). Pelvic reconstructive surgery was more prevalent in the post-implementation group (61%) compared to the pre-implementation group (27%, \( p = 0.034 \)).

The average time to first void following removal of the indwelling urethral catheter increased with the new protocol; however, the time did not surpass the suggested goal of three to four hours following removal of the indwelling urethral catheter (see Table 1). Frequency of PVR urine measurement increased following implementation of the new protocol (\( p = 0.001 \)) (see Table 2). Bladder ultrasound assessments that measured greater than 300 ml of retained urine without intermittent catheterization decreased following implementation of the algorithm. There were fewer intermittent catheterizations performed post-implementation (13.2%) compared to the pre-implementation group (20.4%). Mann-Whitney \( U \) test identified that voiding efficiency was less in the pre-implementation group compared to the post-implementation group (median 0.27 vs. 0.58, respectively; \( p < 0.001 \)). There was more bladder distention in the pre-implementation group (10.8%) compared to the post-implementation group (2.7%, \( p < 0.05 \)). Fewer patients had reinsertion of an indwelling catheter (14.6%) following implementation of the algorithm compared to patients in the pre-implementation group (40%). In addition, there was no statistically significant difference in the length of time of continuous catheterization with an indwelling urethral catheter between the groups (see Table 2). The hospital length of stay increased significantly following implementation of the algorithm.

**Discussion**

The goal of standardizing practice to decrease urinary retention and bladder distention was realized in this pilot study. Use of the algorithm was demonstrated by increased frequency of bladder assessment, less use of intermittent catheterization, and significant improvement in the prevention of bladder overdistention (bladder volume over 500 ml). Lewthwaite and Girouard (2006) also documented a reduction in catheterization following implementation of a practice guideline for urinary drainage after surgery for urinary stress incontinence. Lewthwaite and Girouard (2006) did not use bladder ultrasound to determine bladder volume but relied on

**Table 1. Descriptive Statistics for Outcomes**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Intervention (n = 15) M</th>
<th>Pre-Intervention (n = 15) SD</th>
<th>Post-Intervention (n = 41) M</th>
<th>Post-Intervention (n = 41) SD</th>
<th>t-Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to first void (minutes)</td>
<td>168.53</td>
<td>81.53</td>
<td>225.68</td>
<td>187.79</td>
<td>0.261</td>
</tr>
<tr>
<td>Length of time for indwelling urethral catheter (hours)</td>
<td>10.90</td>
<td>5.54</td>
<td>12.53</td>
<td>3.89</td>
<td>0.169</td>
</tr>
<tr>
<td>Length of stay (days)</td>
<td>0.87</td>
<td>0.52</td>
<td>1.48</td>
<td>0.68</td>
<td>0.003</td>
</tr>
</tbody>
</table>

**Table 2. Clinical Outcome Frequency**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Implementation n = 93 Trials</th>
<th>Post-Implementation n = 219 Trials</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>PVR measured</td>
<td>47 (50.5)</td>
<td>155 (70.9)</td>
<td>0.001</td>
</tr>
<tr>
<td>Intermittent catheterization</td>
<td>19 (20.4)</td>
<td>29 (13.2)</td>
<td>0.107</td>
</tr>
<tr>
<td>Urinary retention greater than 300 ml</td>
<td>17 (18.3)</td>
<td>27 (12.3)</td>
<td>0.167</td>
</tr>
<tr>
<td>Urinary retention greater than 500 ml</td>
<td>10 (10.8)</td>
<td>6 (2.7)</td>
<td>0.008*</td>
</tr>
</tbody>
</table>

*Fisher’s exact test.
voided measurement and patient report of bladder sensation.

Although Fedorkow et al. (2005) found PVR results were not accurate with the bladder ultrasound, clinical experts from the authors’ organization believed use of the portable bladder ultrasound would provide sufficient accuracy for early detection of urinary retention to prevent damaging bladder distention. Fedorkow et al. (2005) documented patient reports of higher pain levels with the use of bladder ultrasound compared to catheterization. Anecdotally, nurses from the authors’ organization reported that patients requested the use of the bladder ultrasound over catheterization. Measurements for cost and nursing time were not collected; however, with fewer catheterizations, improvement in efficiency of nursing time can be anticipated (Teng, Huang, Kuo, & Bih, 2005) and also decrease cost as suggested by Frederickson et al. (2000).

The length of hospitalization increased in this study, whereas the study by Lewthwaite and Girouard (2006) demonstrated a shortened length of stay. The patient populations in the two groups of this study differed, with the post-implementation group having more complex surgery. The length of hospitalization is often shorter following incontinence surgery than for patients having pelvic reconstructive surgery. An increase in the length of stay in the post-implementation group is likely related to more women having pelvic reconstructive surgery.

Limitations

Although the results of the study demonstrated significant improvement in the prevention of bladder over distention, there were limitations of this study. Because this was a pilot study, there were insufficient numbers to demonstrate statistical significance for every outcome. In addition, a larger comparison group would give more meaning to the results. Ongoing analysis of the algorithm is recommended to determine sustainable change in practice and outcomes.

Only 56% of nurses attended the educational program, which was offered at eight different times during the day and evening shifts over two months. For implementation to be successful, every nurse must understand and use the voiding trial algorithm. Since attendance of the educational program was limited, a computer-based training was designed, and completion became mandatory. This education evaluated nurses’ knowledge of POUR through case studies that focused on the use of the algorithm in decision-making. In addition, a standardized physician order set was developed to formalize use of the algorithm for all patients having urogynecologic surgery.

Implications for Practice

Translating evidence-based guidelines for nurses to prevent and manage urinary retention and bladder distention for patients undergoing urogynecologic surgery was challenging. Stakeholder involvement was critical to the development and implementation of the algorithm. Nurse participation in education about the algorithm and clinical knowledge of POUR was fundamental to create a change in nursing practice and patient outcomes. Identifying barriers to implementation and sustainability of an evidence-based practice change should be part of the implementation plan. Sustainability of the practice change is anticipated with completion of mandatory computer-based training and leadership support.

Another barrier was the inconsistent documentation of both PVR and bladder assessment. Nurses reported that results were not recorded because the portable bladder ultrasound was not available when needed. Following identification of the problem, the nurse manager purchased a second bladder scanner.

Based on the JHNEBP model and guidelines, when outcomes of an evidence-based pilot study are favorable, the next step is to implement the recommendations more broadly, if appropriate (Dearholt & Dang, 2012). In the authors’ hospital setting, the urogynecologic patient may be cared for on a general surgical unit; therefore, the hospital-wide Nursing Practice Council (shared decision-making structure) was approached to accept the voiding trial algorithm for use throughout the hospital. The request was met with approval and encouragement because the practice recommendation was based in evidence. In addition, because a majority of the findings from the literature were based on the general surgery population, the Nursing Practice Council also requested a change in nursing practice for all post-operative patients to prevent and manage POUR. One focused evidence-based practice project improved outcomes for women undergoing urogynecologic surgery and led to changes in care for all surgical patients within the authors’ institution.

References


