Nursing Interventions for Continence Management in Long-Term Care

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WHAT IS URINARY INCONTINENCE (UI)?

A CONDITION WHERE INVOLUNTARY LOSS OF URINE OR STOOL IS A SOCIAL OR HYGIENIC PROBLEM (INTERNATIONAL CONTINENCE SOCIETY 2002)

• A SYMPTOM, NOT A DISEASE
• IT IS NOT AN INEVITABLE PART OF AGING
• IT IS OFTEN CURABLE AND MANAGEABLE
WHY IS THIS IMPORTANT TO US?

• UI IS PREVENTABLE AND TREATABLE
• UI IS NOT NORMAL….EVER
• COSTLY FOR FACILITIES
• LEADING CAUSE FOR ADMISSION TO LTC
• PREDISPOSES RESIDENTS TO SERIOUS AND COSTLY HEALTH COMPLICATIONS
  ➢ URINARY TRACT INFECTIONS
  ➢ PRESSURE ULCERS
  ➢ SKIN IRRITATION
  ➢ FALLS
FRAILTY

A MEDICAL SYNDROME WITH MULTIPLE CAUSES AND CONTRIBUTORS CHARACTERIZED BY DIMINISHED STRENGTH, ENDURANCE, AND REDUCED PHYSIOLOGIC FUNCTION THAT INCREASES AN INDIVIDUAL'S VULNERABILITY FOR DEVELOPING INCREASED DEPENDENCY AND/OR DEATH

• 75-85 YEARS OF AGE IS 17 TIMES GREATER THAN IN 1990
• 85 YEARS AND OLDER IS 50 TIMES GREATER
AGE RELATED BLADDER CHANGES

- Kidneys less able to concentrate urine during the day
- Decreased bladder capacity
- Delayed sensation
- Decreased bladder contractility
- Prostate enlargement
- Decreased estrogen
- Decreased pelvic floor muscle tone

Engberg & Li, 2017
CNS CHANGES

• COGNITION
• ABILITY TO FIND A TOILET
• COMMUNICATION
• THE FUNCTIONAL ABILITY
• VOLUNTARILY INITIATE VOIDING WHEN APPROPRIATE
THE PROBLEM

- INCONTINENCE IS A LEADING CAUSE FOR LONG TERM CARE PLACEMENT (FRIEDMAN ET AL., 2005)
- OVER 70% OF RESIDENTS IN LONG TERM CARE FACILITIES EXPERIENCE INCONTINENCE (GORINA ET AL, 2014)
- INCONTINENCE IS A MAJOR CONTRIBUTOR TO FALLS, RECURRENT URINARY TRACT INFECTIONS (UTIS), DEPRESSION, AND SKIN BREAK DOWN (KLAY & MARFYAK, 2005)
- INCONTINENCE EFFECTS QUALITY MEASURES (QM) INCLUDING SKIN BREAKDOWN, UTIS, FALLS AND RATES OF CATHETERIZATION (DHHS & CMS, 2006)
NANCY WATSON AND COLLEAGUES:

• 50% OF RESIDENTS WERE INCONTINENT ON ADMISSION
• ONLY 15% OF CASES HAD THEIR UI ASSESSED BY A CLINICIAN (DOCTOR OR NURSE)
• ONLY 1 CASE HAD COMPLETELY DOCUMENTED UI SYMPTOMS FOR THE PRESENCE OR ABSENCE OF STRESS, URGE OR OVERFLOW
• 81% HAD A REVERSIBLE CAUSE OF UI AT ONSET BUT ONLY 34% HAD THIS ADDRESSED
• 3% RECEIVED TREATMENT
COST

- $5.2\text{BILLION/YR OR }$17.27 \text{PER RESIDENT PER DAY ($6,281/YR)} \text{(FRENCHMAN, }2001)\text{)}
  - PADS/LAUNDARY = 55\%
  - EXPENSES INCURRED AFTER ADVERSE EVENT FROM UI = 44\%
  - EVALUATION/MANAGEMENT = 1\%
RESEARCH

KLAY AND MARFYAK (2005): NURSING INTERVENTIONS CAN IMPROVE PATIENT OUTCOMES IN A LONG TERM CARE FACILITY

- 93% REDUCTION IN UTIS
- >50% REDUCTION IN FALLS
- 50% REDUCTION IN PRESSURE SORES
TYPES OF UI

URGE INCONTINENCE  FUNCTIONAL INCONTINENCE

STRESS INCONTINENCE  OVERFLOW INCONTINENCE  MIXED INCONTINENCE
TRANSIENT UI

- SUDDEN ONSET USUALLY CAUSED BY A MEDICATION OR A TEMPORARY AND TREATABLE CONDITION (UTI'S, BLADDER IRRITANTS, CONSTIPATION, MOBILITY CHANGES)

- MAY ALSO BE TREATMENT INDUCED

- IDENTIFY IMMEDIATELY

- UI THAT PERSISTS >6MONTHS BECOMES ESTABLISHED AND PROGNOSIS IS POORER
TRANSIENT UI (CONT.)

D- DELIRIUM, DEPRESSION

I- INFECTION

A- ATROPHIC VAGINITIS

P- PHARMACEUTICALS (SPECIFICALLY HYPNOTIC AND SEDATIVE AGENTS (DULL THE SENSES AND SLOW RESPONSE TO THE URGE TO URINATE))

P- PSYCHOLOGICAL, PAIN, POLYURIA

E- EXCESS FLUIDS, ENVIRONMENTAL BARRIERS (AFTER RECEIVING DIURETIC MEDICATION)

R- RESTRICTED MOBILITY (BED REST, PHYSICAL RESTRAINTS)

S- STOOL IMPACTION/CONSTIPATION
WHY A LACK OF TREATMENT FOR UI?

- MORE THAN 50% OF NURSING HOME RESIDENTS HAVE UNTREATED UI
  (WATSON ET AL, 2004)
- LACK OF HEALTH CARE PROVIDER KNOWLEDGE ABOUT UI
- MYTHS ABOUT INCONTINENCE IN OLDER ADULTS
- RELUCTANCE OF OLDER ADULTS TO REPORT THEIR PROBLEMS WITH INCONTINENCE
- LACK OF INDIVIDUALIZED CARE

SPECHT, 2005
UI IS MANAGEABLE

- EVIDENCE PROVES UI IS TREATABLE
- WITHIN THE SCOPE OF PRACTICE FOR RNS’ AND ADVANCED PRACTICE NURSES
- NON-PHARMACOLOGICAL TREATMENTS:
  - TOILETING
  - PROMPTED VOIDING
  - BLADDER TRAINING
  - PELVIC EXERCISES
  - INTERMITTENT CATHETERIZATION

(MASS ET AL 2008)
IDENTIFY RISK FACTORS

• ASSESSMENT STARTS ON ADMISSION

▶ ENVIRONMENTAL ASSESSMENT

▶ LIFESTYLE

▶ MEDICATIONS

▶ COGNITIVELY IMPAIRED

▶ NEUROLOGICAL DISEASE

▶ OTHER CO-MORBIDITIES
INITIAL INTERVENTIONS

1. RESIDENT AND FAMILY INTERVIEW (THIS BEGINS ON ADMISSION)
   ➢ ASK EVIDENCED BASED QUESTIONS UPON ADMISSION

2. INITIATE 3 DAY BLADDER DIARY
   ➢ GATHER DATA, LOOK FOR PATTERNS, ASSESS FREQUENCY AND VOLUME OF VOIDS

3. USE OF A BLADDER SCAN
   ➢ PORTABLE US USED TO SCAN THE BLADDER FOR VOLUME AND/OR POST VOID RESIDUAL
   ➢ HELPFUL TO RECOGNIZE RESIDENTS WITH INCOMPLETE BLADDER EMPTYING OR URINARY RETENTION
BEHAVIORAL TREATMENT

- AVOIDANCE OF BLADDER IRRITANTS - CAFFEINE, CARBONATION, ALCOHOL, ARTIFICIAL SWEETENERS
- MAINTAIN ADEQUATE FLUID INTAKE - WATER!
- STOP SMOKING - TREAT CHRONIC COUGH
- AVOID CONSTIPATION (REGULARITY RECIPE)
- PAY ATTENTION TO WEIGHT
- DRESS COMFORTABLY - AVOID RESTRICTIVE CLOTHING
- CONSIDER ABILITY TO ACCESS THE TOILET - ASSISTIVE DEVICES, NEGOTIATING A PROACTIVE PLAN WITH CAREGIVERS
- MANAGE CHRONIC HEALTH PROBLEMS I.E. DIABETES, COPD
- MAINTAIN GOOD GENITAL HYGIENE - KEEP CLEAN, WIPE FROM FRONT TO BACK
SCHEDULED (TIMED) TOILETING

- Has been shown that many individuals with incontinence, including those with dementia, can be maintained continent if they are regularly assisted with toileting (Specht & Maas, 2004)
- Sets a schedule for urinating determined by personal habits
- Usually every 2 hours while awake
- Be mindful and tailor according to the residents activities for a more individualized approach

Appropriate resident: cannot self toilet
### SCHEDULED TOILETING

<table>
<thead>
<tr>
<th>DAY</th>
<th>EVENING</th>
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<tbody>
<tr>
<td>1. upon awakening</td>
<td>6. before dinner</td>
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<tr>
<td>2. after breakfast</td>
<td>7. after evening activities</td>
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<tr>
<td>3. mid-morning</td>
<td>8. at bedtime</td>
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<td>4. before lunch</td>
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<td>5. after afternoon nap</td>
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### NIGHT

Determine if resident wants to be awakened to void and identify at what time.
PROMPTED VOIDING (PV)

- CAREGIVER PROMPTS VOIDING
- STEPS:
  1. REMIND ON A SCHEDULE
  2. ASSIST AS NEEDED TO TOILET
  3. POSITIVE REINFORCEMENT FOR SUCCESS
  4. REMIND WHEN YOU WILL BE BACK
- A STUDY EXAMINING THE EFFECTIVENESS OF PV IN MANAGING UI AMONG RESIDENTS DEMONSTRATED PROMPTED VOIDING TO DECREASE THE RATE OF INCONTINENCE BY 9.1% (LAI, C. & WAN, X., 2017)

APPROPRIATE RESIDENT: DEPENDENT OR MORE COGNITIVELY IMPAIRED RESIDENTS WHO HAVE URGE OR MIXED INCONTINENCE
BLADDER TRAINING

• USEFUL TO CONTROL URGENCY AND FREQUENCY AS WELL AS INCREASE BLADDER CAPACITY

• STEPS

1. STOP...DO NOT MOVE
2. SQUEEZE PELVIC FLOOR MUSCLES QUICKLY (QUICK FLICKS) 5 TIMES
3. BREATHE, EXHALE SLOWLY
4. RELAX AND DISTRACT YOURSELF
5. PROCEED TO THE BATHROOM ONCE THE URGE SUBSIDES

APPROPRIATE RESIDENT: FAIRLY INDEPENDENT WITH ADLS – OCCASIONAL INCONTINENCE – AWARE OF NEED TO VOID – HAS GOAL TO MAINTAIN HIS OR HER HIGHEST LEVEL OF CONTINENCE
URGE PEAKS

Stand still
Urge starts

Squeeze
Sit and lean or stand up on toes

Distract yourself

Walk calmly to toilet if still needed
Urge subsides

Urge curve

Action
PELVIC FLOOR EXERCISES

• STRENGTHENS VOLUNTARY PERI-URETHRAL AND PER-VAGINAL MUSCLES THAT CONTRIBUTE TO CLOSING FORCE OF URETHRA AND SUPPORT OF PELVIC ORGANS

• CAN BE USED TO SUPPRESS URGE

• 8 SETS OF SQUEEZE 3 SECONDS/RELAX 3 SECONDS 4X/DAY

• IMPORTANT TO TEACH THE CORRECT TECHNIQUE

• CONSISTENCY AND ISOLATING CORRECT MUSCLE IS THE KEY

APPROPRIATE RESIDENT: COGNITIVELY INTACT – ABLE AND WILLING TO PARTICIPATE – HAS URGE AND/OR STRESS INCONTINENCE
CONTAINMENT

• DO NOT USE FOR CONTINENT RESIDENTS
• 99% OF RESIDENTS ARE USING ABSORBENT PRODUCTS?!
• UTILIZE THE APPROPRIATE SIZE ABSORBENT PRODUCT ACCORDING TO THE RESIDENTS NEEDS
• DO NOT USE FEMININE HYGIENE PRODUCTS, THEY ARE NOT MADE FOR URINE
• CHANGE PRODUCTS AS SOON AS THEY ARE WET
• MAINTAIN GOOD GENITAL HYGIENE BY PROVIDING REGULAR PERI CARE AFTER WET EPISODES
REVIEW OF NURSING INTERVENTIONS

• INITIAL INTERVENTIONS
• BEHAVIORAL TREATMENTS
• SCHEDULED TOILETING
• PROMPTED VOIDING
• BLADDER RETRAINING
• PELVIC FLOOR EXERCISES
• CONTAINMENT
OUTCOMES

COMPLETE CONTINENCE IS NOT REALISTIC

1. Independent continence
2. Dependent Continence
3. Contained continence

(THE FRAIL ELDERLY COMMITTEE OF THE 3RD INTERNATIONAL CONSULTATION ON INCONTINENCE)
TAKE HOME POINTS

1. NURSING STAFF PLAY A KEY ROLE IN SUPPORTING CONTINENCE IN LTC

2. IMPLEMENTING CONSERVATIVE INTERVENTIONS TO PROMOTE CONTINENCE IS WITHIN THE NURSES’ SCOPE OF PRACTICE

3. SMALL CHANGES MAKE BIG IMPACTS ON THE RESIDENTS QUALITY OF LIFE AND REDUCE THE RISK FOR RELATED SEVERE HEALTH PROBLEMS

4. CONTINENCE IS NOT ALL OR NOTHING
Thank you for attending!

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