

Promoting Urinary Continence in Long- Term Care

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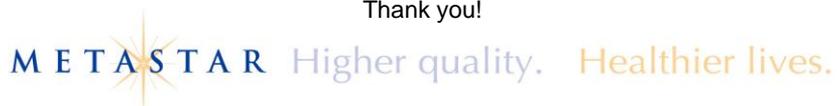
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Link to evaluation:

<https://www.surveygizmo.com/s3/2586292/February-24-2016-Promoting-Urinary-Continence>

Thank you!



Defining UI

- International Continence Society (2002) defines as “an involuntary loss of urine which is objectively demonstrable and a social or hygienic problem”
- Not a disease but rather a symptom that corresponds to various social and pathophysiological factors
- Contrary to popular belief, it is not an inevitable part of aging
- It is often curable and always manageable

- UI is high throughout the world and affects 17 million Americans
- Twice as common for women as men
- Prevalence is highest in the elderly with 50% of the homebound and institutionalized incontinent
- Increasing problem for adults over age 65
- UI and falls are the leading reasons for nursing home admission.

Prevalence in LTC and Community Dwelling Settings

- Watson and colleagues (2000) found in LTC:
 - 50% of residents are incontinent of urine
 - Non-random sample of nursing homes, only 15% of residents were assessed for UI and of these only 3% received treatment.
 - 99% of residents wore absorbent products. (Palmer and Newman, 2004)
- In community-dwelling settings:
 - it is estimated that 15-30% of these older adults have UI (Fantl, Newman, Colling, et al., 1996)

Impact on Health Status

- Significant UI related Co-Morbidities:
 - Depression, isolation and low self-esteem
 - Skin Breakdown
 - Urinary Tract Infections
 - Falls and fall related injuries

Economic Impact

- Expensive! \$16-26 billion spent annually on UI
 - Pads and laundry make up 55% of money spent
 - 1% spent on evaluation and management
 - 44% of expenses are incurred following adverse consequences of UI

- **Critical Question:** Why are expenses for evaluation and management so low?

Current Responses of Health Care Systems to UI

- Nurses – have always recognized UI as a health concern but have not always addressed
 - Traditionally seen continence as the role of a nurse specialist or urologist
 - Beginning to change practice to address
- Primary Care – providers are just now beginning to recognize their role in identifying UI.
 - PCPs in key positions to identify UI
 - Most common response of PCPs is to refer to Urology
- Medicare issued new CMS Surveyor Guidelines
 - The Long Term Care Survey
 - Quality Measures have been identified

Centers for Medicare & Medicaid Services (CMS) Response

- Revised CMS Surveyor Guidelines
 - “Surveyor Guidance for Incontinence and Catheter Use” (effective June 27, 2005)
 - Goal: To improve care and reduce costs
 - Focus:
 - Identification of UI in nursing home residents
 - Assessment and Evaluation
 - Development of Individualized Treatment Plans
 - Implementation of nursing interventions

Prevalence of Urinary Incontinence (UI)

- Over the past 2 decades many advances made in the treatment of incontinence
- *Problem:* More is known about the treatment of UI than is currently applied in practice

- Many reasons:
 - Care giver and clinician insufficient knowledge of UI
 - Reluctance of patients to discuss
 - Inadequately individualized care

Understanding Common Misperceptions of Bladder Problems in Frail Older Adults

- **Myth #1: UI is inevitable with age**

- **Fact:**

- While older adults are at an increased risk for UI to develop due to changes in kidney and bladder function with aging, UI is not an inevitable part of aging
- Many interventions can prevent, slow the progress or reverse UI

- **Myth #2: There is only one type of UI.**

- **Fact:**

- This false belief often leads to ineffective management and treatment of UI.
- There are many types of UI - transient, stress, urge, overflow, functional, mixed, reflux and total.
- Without an accurate diagnosis it is difficult to provide effective treatment.

Transient UI



- Appears suddenly and is present 6 months or less
- Usually treatable factors
- Can also be treatment induced (i.e. restricted mobility, changes in fluid intake, medications)
- Should be identified immediately and referred for evaluation - if UI persists >6 months it becomes established and prognosis is poorer
- One study of 53 nursing homes, investigators identified potentially reversible causes of UI in 81% of residents

Quick Assessment for Patients Experiencing a Sudden Change in Continence Status

- **D** delirium, diapers, dementia
- **R** restricted mobility, retention
- **I** infection, impaction, inflammation, dietary irritants
- **P** pharmaceuticals, polyuria

Overactive Bladder with or without Urge UI



- The most common type of UI in older adults
 - ▣ post-menopausal women
 - ▣ persons with neurologic conditions
- Involuntary urination that occurs soon after feeling an urgent need to void
- Loss of urine before getting to the toilet
- Inability to suppress the need to urinate

□ ICS definition:

- ▣ Urgency with or without urge UI, usually with frequency and nocturia
 - *Urgency* – sudden, compelling desire to pass urine which is difficult to deter
 - *Urge UI* – involuntary leakage of urine accompanied or immediately preceded by urgency
 - *Frequency* – complaint of voiding too often by day
 - *Nocturia* – waking up one or more times to void

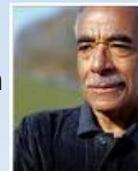
Stress UI

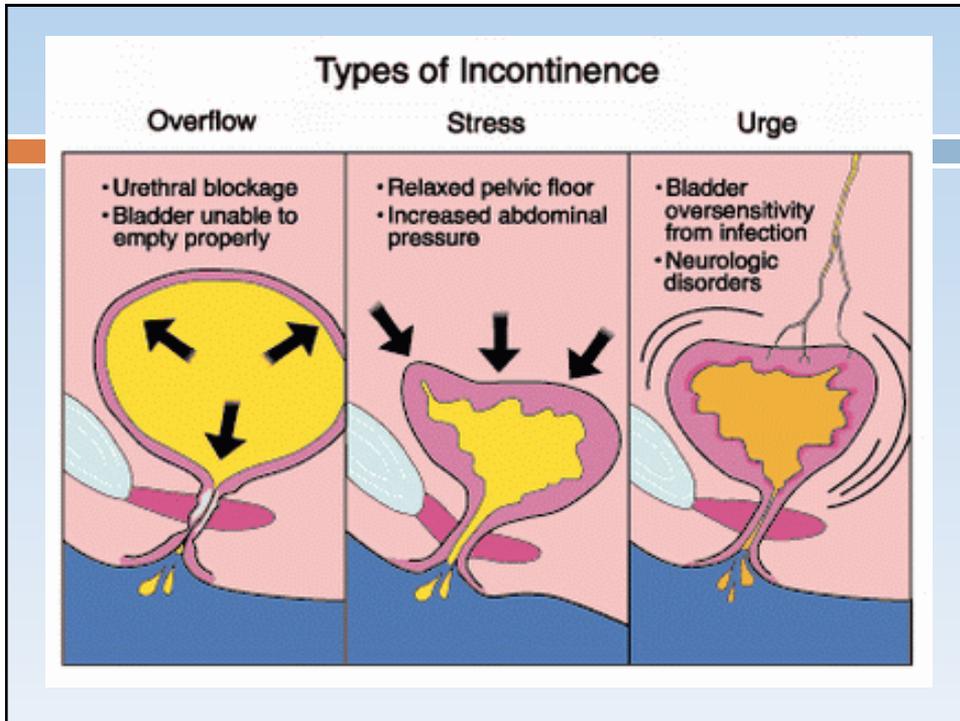
- Most common type of UI found in women prior to menopause (female athletes, post-partum women)
- Very likely to occur in men with prostatectomy and radiation (37-65% after prostate surgery)
- Urine loss with increased intrabdominal pressure
- Short urethra, poor pelvic floor muscle tone



Overflow UI (Urinary Retention)

- Involuntary loss of urine associated with over distention of the bladder
- Occurs when bladder becomes so distended that voiding attempts result in frequent release of small amounts of urine, often dribbling
- Possible causes:
 - obstruction of the urethra by fecal impaction
 - enlarged prostate
 - smooth muscle relaxants (relax the bladder and increase capacity)
 - impaired ability to contract due to peripheral neuropathy





Functional UI

- Inability to reach the toilet because of environmental barriers, physical limitations, loss of memory, disorientation
- Dependent on others and have no genitourinary problems other than UI
- Higher rates of functional incontinence are present in adults who are institutionalized



Mixed UI

- Urine loss has features of two or more types of UI
 - Most common with increasing age
 - Stress and Urge UI

Less Common

- Reflux Incontinence
 - the bladder empties autonomically but the person has no sensation of the need to void i.e. spinal cord injuries
- Total Incontinence
 - continuous and unpredictable loss of urine resulting from surgery, trauma or anatomical malformation

□ **Myth #3: There are no effective treatments for UI. It is unavoidable in nursing home residents.**

□ **Fact:**

- There is much evidence showing that UI is treatable in community and long term care settings
- Nurses can support continence including:
 - Behavioral Interventions
 - Toileting regimes
 - Bladder urge inhibition/retraining
 - Fluid management
 - Bowel plan to address constipation

■ **Preservation of Mobility and Function**

- Walking/toileting/core strength
- Pelvic muscle exercises
- **Interventions to treat and manage contributing factors**
 - Environment/clothing
 - Assistive toileting devices
 - Appropriate absorbent product use
- **Consultation/Referral for:**
 - Vaginal Estrogen Replacement
 - Incontinence Devices i.e. pessaries
 - Pharmacologic Treatments for Urge UI and BPH

□ **Myth #4: UI falls under the purview of physicians: There's not much Nurses can do much to help.**

□ **Fact:**

- UI can be managed by non-pharmacologic treatments implemented by nursing staff.
- Thorough health histories, identification of risk factors and implementation of 3 day bladder diaries can provide the foundation for identifying the type of UI and implementing behavioral strategies.

□ **Myth #5: UI is unmanageable in people with dementia.**

□ **Fact:**

- Although UI is often concurrent with dementia, cognitive impairment alone has not been shown to cause UI
- While impaired cognition may affect a patient's ability to find a bathroom or to recognize the urge to void, it doesn't necessarily affect bladder function
- Prompted voiding has been demonstrated to be effective in improving dryness in cognitively impaired and dependent nursing home residents

□ **Myth #6: Complete continence is the only indication of successful treatment.**

□ **Fact:**

- Until recently, continence and incontinence were viewed at opposite ends of the spectrum with nothing in between
- Successful treatment may include:
 - dryness at night or during the day
 - fewer episodes of UI
 - a greater percentage of dry time
 - an increase in the number of times a person urinates in the toilet.
- Any improvement can be seen as a significant success and caregivers should acknowledge both their own efforts and that of the patient.

□ **Myth #7: Older adults don't mind being incontinent and wearing pads.**

□ **Fact:**

- Studies have found that UI represents a loss of control and made older adults feel angry
- They grieved the loss and were embarrassed, ashamed and depressed
- Many hid their UI fearing nursing home placement

- Incontinence pads are often referred to as “diapers” reinforcing the stereotype that a childlike loss of control and dignity accompanies aging
- Although, some adults wear pads to enhance a feeling of security, others do so because they haven’t been presented with other options
- Routine use of incontinence pads by *continent* residents in the nursing home communicates the expectation that the resident will become incontinent and is considered a breach of nursing ethics

- **Myth #8: Indwelling catheters are the best intervention for intractable UI**
- **Fact:**
 - In an effort to keep patients dry and to protect their skin, particularly in the face of understaffing, indwelling catheters are too frequently used.
 - Although the intentions may be good, these catheters are often used without consideration of the consequences.

- ❑ Continuous indwelling catheterization may be an appropriate management strategy for only a few patients and existing recommendations for care are based on short-term (less than 30 days) rather than long-term use.
- ❑ There are no recommendations for long-term indwelling catheters.

- ❑ **Myth #9: Prevention is impossible**

- ❑ **Fact:**

- ❑ Continence should be fostered as the norm in all health care settings.
- ❑ Maintenance of the person's functional abilities is the first step in maintaining continence.
- ❑ Combining wheelchair use with exercise twice daily, visible bathrooms, toileting at regular intervals or according to individual voiding patterns, easy to manage clothing, and CNA involvement in the care plan are key to promoting continence.

- ❑ The availability of necessary equipment such as standing lifts and full mechanical lifts with hygiene slings increase continence as does effective staffing.
- ❑ Education of the patient and their families regarding prevention and management strategies is also key.

Educating Residents and Families

- ❑ Age-Related Bladder Changes
 - ❑ Kidneys less able to concentrate urine during the day, bladder has less capacity resulting in frequency, urgency, nocturia
 - ❑ Delayed sensation resulting in urgency and less time to get to the toilet
 - ❑ Decreased muscle tone in the pelvic floor resulting in leaking or sudden loss of urine



Self-Care Strategies

- Important to educate residents and their families
 - Avoidance of bladder irritants - caffeine, alcohol, artificial sweeteners
 - Maintain adequate fluid intake - water!
 - Stop smoking - treat chronic cough
 - Avoid constipation
 - 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



What Nurses in LTC Can Do to Support Continence

Identify Residents at Risk for Developing UI and Put Prevention Strategies in Place

- Lifestyle Factors
 - diet/bladder irritants
 - smoking, weight
 - functional changes/mobility
- Constipation
- Female
 - Childbirth
 - Hypoestrogen State i.e. Menopause
 - Pelvic surgery
- Prostate hypertrophy and/or surgery

- Medications
- Cognitive Impairment
 - Dementias
 - Delirium
- Neurologic Disease
 - CVA
 - Parkinson's Disease
 - MS
- Other co-morbidities
 - Diabetes
 - Heart Failure
 - Arthritis
 - Depression/anxiety

Assess Continence Status

- Nursing Assessment on Admission
 - Resident and family interview
 - Adding evidence based questions to nursing assessment upon admission can encourage patients to report UI
 - Are you having any problems with your bladder?
 - Do you ever lose urine when you don't want to?
 - Do you ever leak urine when you cough, laugh, sneeze or exercise?
 - Do you wear pads to protect your clothes from urine leakage?
 - Do you ever leak urine on your way to the bathroom?
 - Hand off from setting from which they are being admitted
 - Review of medical records

- Weekly Nursing Summary
 - Continence status documented in chart by the primary nurse
 - Includes toileting plan
 - Includes change of condition
- MDS Quarterly Review
 - Section H on the MDS Assessment Tool

Gather Objective Data

- Bladder Diaries
 - Used to determine voiding patterns and frequency, # of incontinent episodes
 - Complete in a timely and accurate way
 - Wide variety of tools exist
 - Implement for 3 days

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble. The "sample" line shows you how to use the diary.

Your name: _____
Date: _____

Time	Drinks	Signs to the Bathroom		Accidental Leaks		Did you feel a strong urge to go?	What were you doing at the time? (Walking, exercising, driving, etc.)
		How many times?	How much urine?	How much urine?	How much urine?		
Sample	Coffee 2 cups	✓	✓	✓	✓	Yes	Running
6:00 a.m.						Yes/No	
7:00 a.m.						Yes/No	
8:00 a.m.						Yes/No	
9:00 a.m.						Yes/No	
10:00 a.m.						Yes/No	
11:00 a.m.						Yes/No	
12:00 p.m.						Yes/No	
1:00 p.m.						Yes/No	
2:00 p.m.						Yes/No	
3:00 p.m.						Yes/No	
4:00 p.m.						Yes/No	
5:00 p.m.						Yes/No	
6:00 p.m.						Yes/No	

The blue check in a circle is a marker for making copies that you can use as a bladder diary for as many days as you need.

Determine Bladder Emptying

- Bladder Scan - portable ultrasound that scans the bladder for void residual
- Straight cath
- Monitor for signs and symptoms of incomplete bladder emptying



- Physical Exam

- In addition to cognition, mobility and function also

- Abdominal exam

- Uro-Genital Exam

- Skin changes consistent with Incontinence Associate Dermatitis

- In women inspect for:

- Signs of hypoestrogenemia (i.e. pale, thin, fragile tissues)

- Structural changes (i.e. pelvic organ prolapse, urethral caruncle)

- Loss of Pelvic floor tone (i.e. observable urine loss with position change or coughing)

- Rectal exam

- Bulbocavernous Reflex

- Presence of Stool

- Rectal Tone

- Neuro Exam

- Lower extremity reflexes

- Sensation

Assessment: Determining Type of UI

- Predicated on:
 - Subjective (History):
 - Bladder symptoms (Stress, Urge, Mixed, Functional, Overflow)
 - Chronic Illnesses/Risk factors
 - Social and cognitive status
 - Medication review
 - Objective (PE):
 - Collected data
 - Bladder Diary
 - Bladder emptying
 - Focused physical exam
 - Mobility & Function
 - Abdominal
 - Urogenital
 - Rectal

Putting an Individualized Continence Plan of Care in Place

- Includes Continence Goals:
 - Maintaining dignity and quality of life
 - Individualizing continence plan of care
 - Reducing the risk of UTIs
 - Reducing the risk of falls
 - Maintaining skin integrity

Nursing “Toolbox” for Continence Management

- Partnering with resident (and family) to put plan in place
 - Interventions to treat and manage contributing factors that put continence at risk
 - Fluid management
 - Bowel plan to address constipation
 - Environment/clothing
 - Assistive toileting devices
 - Appropriate absorbent product use
- Behavioral Interventions
 - Toileting regimes
 - Bladder urge inhibition/retraining

- Preservation of Mobility and Function
 - Walking/toileting/core strength
 - Pelvic muscle exercises
- Consultation/Referral for:
 - Vaginal Estrogen Replacement
 - Incontinence Devices i.e. pessaries
 - Pharmacologic Treatments for Urge UI and BPH

□ **Partnering with Residents to Achieve Continence**

- Talk with cognitively able residents to find out what would be helpful to them in staying dry
- Reassure them that you will do what you can to help them stay dry
- Follow through
- Involved CNAs
- Communication shift to shift

□ **Identify and address lifestyle factors/health habits that put continence at risk:**

- Fluid management
- Reduce Bladder irritants (caffeine, alcohol, NutraSweet)
- Smoking cessation/chronic cough management
- Weight loss/management
- Support function and mobility

□ Toileting

- Understand the different approaches that can be used
- In addition to ambulating to the bathroom and sitting on the toilet, toileting regimes can also be used with bedside commodes and bedpans
- Recognize that daytime and night time toileting plans may not be the same
- Help residents choose clothing that will be easy to manage when toileting (i.e. avoiding zippers, buttons, etc.).

□ Based on Bladder Diaries Determine a Toileting Regime

- Independent
- Scheduled
- Prompted
- Social Contenance



Independent

- Able to toilet themselves
- Manage clothing
- Confident in social situations

Scheduled Toileting (Habit)

- Goal: To find a schedule that works for dryness
- Keep a record, go by the clock
- Every 2-3 hours is usual
- Should reflect the resident's routine and activities rather than the NH
 - i.e. upon rising, after meals, after rest, before bed

Prompted Voiding

- Supports voiding habits + positive reinforcement for continence behavior
- Effective in mild dementia/cognitive impairment
- Relationship of the caregiver to the patient very important
- Steps:
 - 1. Remind on a schedule
 - 2. Assist as needed to the toilet
 - 3. Positive reinforcement (praise) for success
 - 4. Remind when you will be back

Bladder Retraining

- Helpful in controlling urgency and frequency
- Key to urge control is to not respond by rushing to the bathroom
- Involves techniques for postponing urge to void
 - Slow, deep breaths
 - Distraction
 - Self-statements "I can wait" or "It's not time yet"
 - Quick Flicks
- Improvement is gradual but will occur

- Social Continence

- Appropriate for those with intractable UI
- More than “check and change” – *avoid this language!*
- Move thinking to focus on dignity “social continence”
- Utilizes an absorbent product
- Goals:
 - Keep dry
 - Odor free
 - Skin in good condition

- About Absorbent Products

- Avoid using absorbent products with patients who are *continent*
- In those patients that need a product, match the right size and type of absorbent product with the amount of urine typically lost
- Maintain good genital hygiene by providing regular peri-care after wet episodes
- Change as soon as they are wet
- Consider other collection devices

□ **Support Function and Mobility**

- Assist residents in ways that support their function and mobility
- Work with patients to maintain core strength through daily ambulation and getting up and down from a chair
- In Residents who are cognitively able and personally motivated offer pelvic muscle exercises

□ **Pelvic Muscle Exercises**

- A series of 10 squeeze/relax repetitions using the pelvic floor muscles
 - Can be taught and reinforced by the nurse
 - Can be incorporated into Restorative Nursing Activities
- Focus is on:
 - Isolation of correct muscles
 - Strengthening of muscles
- Goal is to:
 - Prevent UI
 - Improve bladder symptoms/continence

- **Provide ongoing nursing assessment to identify changes in:**

- continence status
- bowel function
- cognitive function
- mobility
- skin integrity
- MDS Quarterly Review
 - Repeat bladder diary
 - Adjust care plan
- Resident/CNA Report
 - Repeat bladder diary
 - Adjust care plan

In Summary

- Nurses Have a Key Role in Supporting Continence in LTC that includes:
 - Acknowledging the impact of UI on *quality of life*
 - Identifying residents at risk for developing UI and put prevention strategies in place
 - Identifying residents with changes in bladder function/continence status and providing nursing assessment to determine contributing factors/type of UI
 - Implementing individualized plans of care to preserve and restore continence/bladder status
 - Engaging residents and families in education and health behavior change strategies to support continence
 - Providing information about further evaluation and treatment options. Making referrals as needed

Benefits of Continence Care



- Respects resident dignity and quality of life
- Addresses issues related to quality, safety and cost of care
- Family feels supported and confident in your care
- Reduces CNA workload and improves job satisfaction

Thank You for all you do!

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