STREAM

Empira

STREAM

Empowering people to live full, dignified, quality lives.

Program Manual

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Who is Empira?

Empira is a non-profit collaborative quality improvement organization with a vision of a future where aging is better tomorrow than it is today.

We inspire innovation programs and solutions to improve the aging experience with practical application of evidenced based research and collaboration and challenge the status quo with commitment to know and do better.

This program toolkit was created in collaboration with the STREAM CIS Nurses from our member organizations.

"I did then what I knew how to do. Now that I know better, I do better."
~Maya Angelou

STREAM Participating Facilities

Cassia:

- Lake Ridge, Buffalo
- Park View Care Center, Buffalo
- Harmony Gardens, Maplewood
- Elim Meadows, Milaca
- Elim Wellspring, Princeton
- Redeemer Residents, Minneapolis
- Lakeside Generations, Dassel

Volunteers of America:

- Homestead at Anoka
- Maplewood Care Center
- Rochester Rehab and Living
- Sleepy Eye Care Center

Presbyterian Homes and Services:

- PHS of Bloomington
- Boutwell's Landing, Stillwater
- Carondelet Village, St. Paul
- Flagstone, Eden Prairie
- GracePointe, Cambridge
- Harmony River, Hutchinson
- Johanna Shores, Arden Hills
- Lake Minnetonka Shores
- Maranatha, Brooklyn Center
- Waverly Gardens, North Oaks

Saint Therese

- Saint Therese of New Hope
- Saint Therese at Oxbow Lake
- Saint Therese of Woodbury

Our STREAM Collaborative Mission Statement: **Empowering people to live full, dignified, quality lives.**

How to Use this Toolkit

The information in this manual is designed to support communities with the implementation of this program through education, resources, tools, and best practices learned and created in this program to provide ongoing holistic care for incontinence.

The manual is organized by STREAM Cornerstone. Refer to the table of contents to locate the information you are looking for. The cornerstone tabs include: why this cornerstone is an important program element, what the best practices are, recommended strategies and interventions that were deployed by our STREAM communities, and supporting resources and staff education.

The introduction chapter of the manual provides communities with a reasonable and effective implementation guide walking through three phases- exploration, deployment, and diffusion. Beginning with exploration, your community will evaluate current care practices, culture, and resources available surrounding incontinence care. It will prepare the community to understand current state of the state and reveal areas of work. In deployment, the community will move to implementing the best practices, assessments, tools, and education. In diffusion, the community will ensure program elements have been embedded into all associated disciplines, evaluate retention of learnings, and establish sustainable processes to continue applying the STREAM approach.

Communities that strive to make an impact on quality data will also find information on the Minnesota Quality Indicators Scores in the incontinence domain, the current MDS section H, and RAI definitions of toileting programs and documentation requirements. If the community does not intend to pursue QI management, this information can be omitted from the implementation process.

If further assistance, support, or consulting is desired, please reach out to Empira at www.empira.org .

STREAM Program Introduction

From January 2020 to June 2023, Empira embarked on its fifth collaborative PIPP (Performance-based Incentive Payment Program) with 25 Minnesota care centers. The collaborative member facilities worked together to build this program from the ground up, with the support of subject matter experts, interdisciplinary teams at the facility level, and Empira providing project oversight and coordination. The acronym **STREAM** stands for Strategies Targeting Resident Elimination Assessment and Management.

Incontinence is widespread, affecting an average of 70% of residents in our collaborative. Although incontinence is common, it is not a normal part of aging. Incontinence presents a barrier to quality of life for residents, and is one of the top reasons for admission to long-term care. Toileting has a strong relationship and influence on several other common care plan areas including falls, sleep, nutrition, hydration, skin integrity and mobility.

STREAM challenges assessment practices that do not accurately reflect the resident condition and replaces it with objective-based assessments to improve accuracy and efficiency resulting in better quality of care. The assessment data along with resident empowerment, care team collaboration and increased knowledge paired together to emphasize accurate identification of individual root causes for common care problem areas leading to more effective individualized care plan strategies that align with resident care goals and capabilities. STREAM lead to:

- Reduction and elimination of unnecessary workflows for staff and unnecessary life interruptions for residents.
- Elimination of ineffective assessments that lead to predetermined care needs, and replaces them accurate and more effective assessments.
- Aligning care-planning strategies with causation and individualized life goals.
- Promoting healthy aging and dispel common myths on normal aging.

STREAM funding provided each community with a *Clinical Informatics Specialist* (Licensed Nurse or Occupational Therapist) who supported the Interdisciplinary team and process as the subject matter expert in bowel and bladder assessments. The *Clinical Informatics Specialist* jointly worked with the care team to prioritize technical assessments for residents to support admission, MDS, and significant change assessments. STREAM implemented new assessment technology to increase the effective use of resources. Technology included actigraphy, Tena identifi, and bladder scanners.

STREAM established program cornerstones; best practices, recommended tools and resources, and created education to sustain culture change within communities. This program successfully

challenged the status quo surrounding incontinence and elevated the comprehensive approach to best serve the residents in care communities.

STREAM PIPP Program Outcomes

The STREAM PIPP collaborative addressed three Minnesota Quality Indicator scores in the incontinence domain with a goal of average improvement of 15% over baseline:

- Incidence of worsening or serious bladder incontinence → Improved by 29.58%
- Prevalence of bladder incontinence without a toileting plan → Improved by 34.30%
- Prevalence of bowel incontinence without a toileting plan → Improved by 30.06%

By the end of the performance year, in comparison to the MN state rankings of all 335 nursing homes:

  - All 25 STREAM Facilities are in the top 25% of MN Nursing homes for Bladder Plans
  - All 25 STREAM Facilities are in the top 30% of MN Nursing homes for Bowel Plans

STREAM collaborative communities additionally saw improvements in the following areas:

- Improvement in staff workflow
- Improvement in culture and attitudes towards incontinence
- Improvement in resident participation of activities
- Improvement in quality of sleep for residents
- Reduction in falls
- Reduction in moisture associated skin dermatitis and urinary tract infection
- Reduction in product leaks and subsequent linen changes
- Cost savings on incontinent products
- Utilization of individualized interventions for incontinence vs. standard plans
- Improvement in documentation

The STREAM communities completed over 16,000 bowel and bladder assessments over the course of this project. The efforts of this project benefitted residents most importantly by streamlining comprehensive assessments, resident personal goals and preferences, and addressing the negative effects of incontinence for the individual. Families were appreciative of the advanced approach and providing person centered dignified care for incontinence for their loved ones.

Myths Surrounding Incontinence

There are many societal beliefs surrounding incontinence and the elderly. These beliefs, or "myths" about incontinence surfaced during the deployment of this program, and it is important to debunk the myths as they arise. This table highlights common myths- which are false, and the truth surrounding the myth that can change the culture of care.

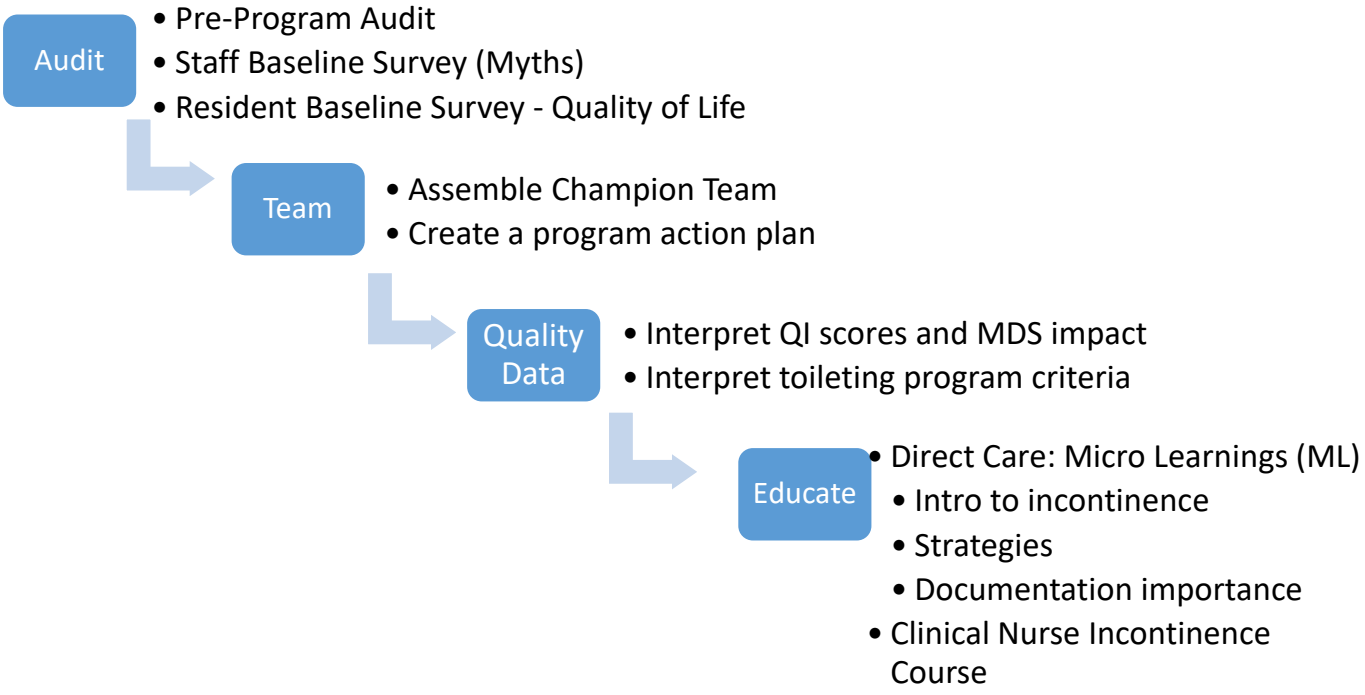
MYTH	DEBUNK THE MYTH: REALITY
Urinary incontinence is a normal part of aging.	**FALSE** **Incontinence is common but not normal.**
Nothing can be done to treat urinary incontinence in older adults.	**FALSE** **There are many strategies and interventions that improve incontinence even in the elderly.**
Strategies for managing incontinence in nursing homes are limited.	**FALSE** **There are numerous strategies for managing and improving incontinence proven to be successful.**
Drinking less fluid will improve urinary incontinence.	**FALSE** **Dehydration causes concentrated urine, which is irritating to the bladder lining and may make urgency/frequency worse.**
Older adults have accidents on purpose.	**FALSE** **Incontinence is defined as the lack of voluntary control of elimination. It is a dignity issue most people wish they could improve.**
Absorbent products are the only option to manage urinary incontinence.	**FALSE** **There are numerous strategies to managing urinary incontinence that can improve/lessen the episodes.**
Functional incontinence means the bladder is not functioning properly.	**FALSE** **The bladder in fact works fine - rather there is a physical, cognitive, or environmental barrier to continence.**
Residents who use a full mechanical lift are not appropriate for incontinence plans.	**FALSE** **Residents using full lifts can be continent if using bedpan, urinal.**

The best line of defense for constipation is PRN bowel medications.	**FALSE** **Rescue laxatives have harsh side effects and can cause incontinent episodes. Preventative lifestyle changes (dietary and hydration strategies, exercise, etc.) first.**
Standard toileting schedules of upon rising, before meals, HS and PRN are a best practice.	**FALSE** **Individualized plans that address the unique pattern and type of incontinence is best practice, including resident goal.**
Most residents get enough fiber at meal times.	**FALSE** **According to Passion for Dining and Nutrition, over 90% of adults do not meet the recommended amount of daily dietary fiber intake.**
If the hospital reports the new admit is incontinent, we should assume that is their normal status.	**FALSE** **The hospital rarely knows prior history of incontinence, and what happens in the hospital may be due to acute situations.**
Residents on hospice would not be appropriate for toileting programs.	**FALSE** **Incontinence is a barrier to quality of life, and approaches to improve it should be attempted alongside the resident's wishes for care.**
Residents with dementia would not be appropriate for toileting programs.	**FALSE** **Understanding how they communicate and using the right approach such as prompted or scheduled voiding, people with dementia can respond well.**
The larger the brief size, the better the protection.	**FALSE** **The brief must fit well and correctly or it will leak. Leaks often mean the brief is too large.**

Implementation Guide

In Phase One- Communities will gather baseline data to explore current practices, audit status quo, form a team to champion the project, begin to learn the intricacies of quality data in the incontinence domain, and introduce foundational education for direct care staff. Resources for implementation as outlined below are located throughout this manual, refer to index.

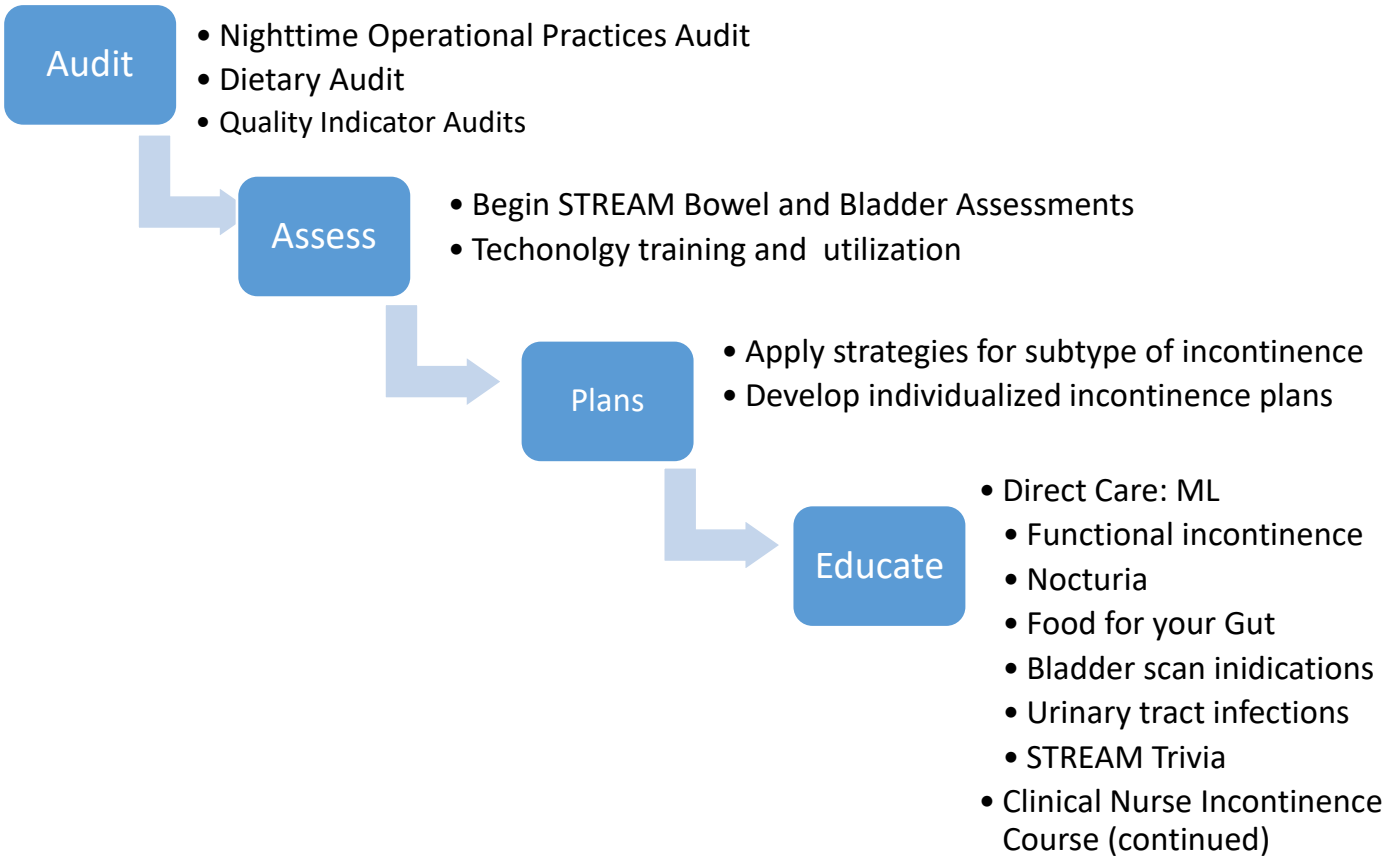
Phase One : Exploration



Implementation Guide

In Phase Two- Communities will begin to deploy program components, by doing in depth audits of care practices and MDS data, proceed with STREAM assessments using objective and subjective data, develop incontinence care plans to address unique needs based on root cause analysis, and provide new education to build knowledge of staff to incorporate a holistic approach to healthy elimination.

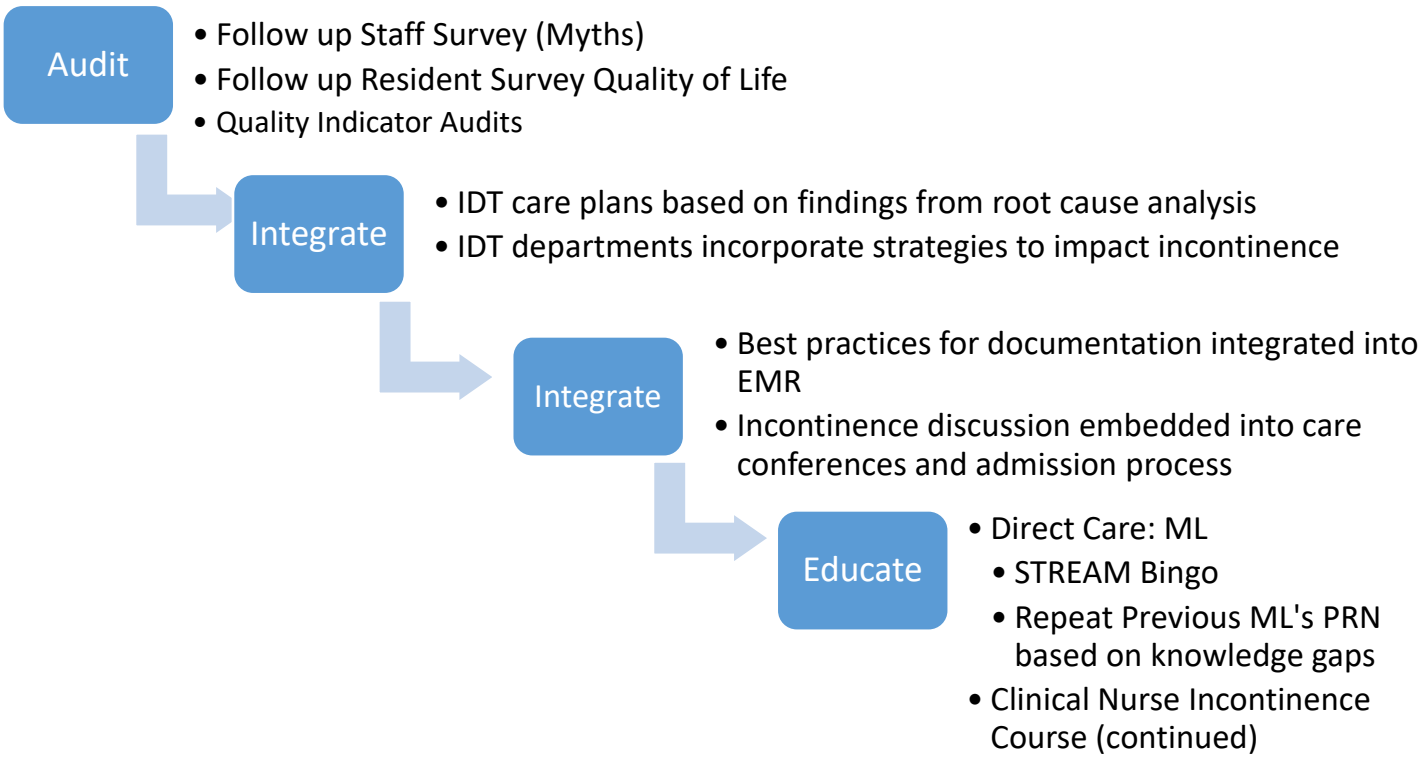
Phase Two : Deployment



Implementation Guide

In Phase Three- Communities will diffuse successful practices through operations, repeat baseline audits to evaluate positive change, integrate learnings into processes such as IDT case reviews, documentation, admission screening, and care conferences, will host education events to determine knowledge retention, and repeat prior education to ensure all staff are knowledgable of the program initiatives.

Phase Three : Diffusion



Sample: Project Action Plan

An action plan will assist with program implementation, ensuring action items are described and everyone knows their role, timeframe for completion, and progressing the work forward. Action plan managers can use colors to indicate progress, green = completed, yellow = continued work in progress/further action needed, red= past due or not started.

Project Action Plan				
Action Item	**Who's Responsible**	**Desired outcome**	**Timeline**	**Progress**

Pre-Program Operational Audit

Administration and Dept. leaders will complete this audit to gather baseline information about current community status, standards of care, and resources available. The intention of this audit is to reveal areas of needed operational changes. This toolkit will help you implement those changes. Some of the questions refer to a tab in this manual for more context if needed.

Pre-Program Question	Review	Yes	No	Notes
Does the facility have resistance to challenge the status quo and affect change surrounding incontinence?	Staff feedback			
Does the facility receive negative grievances/feedback from residents or family about incontinence care?	Review grievances			
Does the facility have satisfactory quality indicator scores in the incontinence domain? (tab 8)	Review current QI data			
Does the facility have efficient staff workflow related to toileting residents?	Review workflow			
Does the facility rarely see residents falling related to toileting/elimination?	Review falls data			
Does the facility rarely have active incontinence-associated skin alterations?	Review wound documentation			
Does the facility rarely see incidence of urinary tract infections?	Review UTI data			
Does the facility offer a variety of incontinence products? (including overnight, underwear, liners, etc)	Review supplies			
Does the facility have an effective process for incontinent product sizing, fitting, and stocking?	Review procedure			
Does the facility find NAR charting paints an accurate picture of daily incontinence level and frequency?	Review ADL charting			
Does the facility consider incontinence as a root cause of other care concerns (behavior expressions, falls, skin, mood, etc.)? (tab 1)	Review IDT agendas			
Does the facility interview residents for meaningful individual goals when creating a toileting plan? (tab 2)	Review care plan			
Does the facility obtain prior history of incontinence beyond the hospital report upon admission? (tab 3)	Admission process			
Does the facility adopt a proactive approach to incontinence when noted upon admission? (tab 3)	Admission process			

Does the facility gather accurate 3 day urinary and 14 day bowel patterns? (volume, time of day, etc.) (tab3)	Review process			
Does the facility Therapy department evaluate and treat incontinence as a primary concern? (tab 4)	Review Therapy procedures			
Does the facility supply alternative toileting equipment (ex: bariatric bed pans, squatty potty, female urinal)? (tab 4)	Review supplies			
Does the facility incorporate activities that include core and pelvic floor strengthening, standing, etc. in routine offerings? (tab 4)	Review activity calendar			
Does the facility have accessible bathrooms with proper signage both in room and in the common areas (tab 4)	Review locations and signage			
Does the facility utilize functional maintenance programs? (tab 4)	Review FMPs			
Does the facility have effective communication to ensure progress is not lost during hand off of functional maintenance programs post-therapy? (tab 4)	Review FMPs			
Does the facility utilize food before medicine interventions for bowel management as part of the BM protocol? (tab 5)	Review bowel protocol			
Does the facility review and understand medications that affect bowel and bladder? (tab 5)	Review assessments			
Does the facility avoid routine rounding at night? (tab 5)	NOC work process			
Does the facility offer preventative nutritional or hydration measures to improve elimination? (tab 6)	Review dietary selections			
Does the facility provide thorough incontinence-specific education for staff upon hire or thereafter? (tab 7)	Orientation and education			

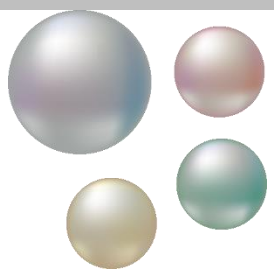
Congratulations on completing the first step in implementation of the STREAM program. Areas in this audit where your team indicated a **"No"** answer, identify the opportunities for improvement. For each of these areas there is a corresponding tab in the toolkit to guide you through quality improvement. Begin creating your action plan below. Follow the implementation guide to lead you through the process.

Operational action items				
Action Item	Who's Responsible	Desired outcome	Timeline	Progress

Top 10 Clinical Pearls - STREAM

What is a clinical pearl?

- Insider knowledge, words of wisdom
- Continence "street smarts"
- Advice on practice and patient care



STREAM Top 10 Pearls

1. **Debunk the MYTH**
    a. Incontinence is <u>not</u> a normal part of aging
2. **Root Cause Analysis**
    a. Causation and type of incontinence
    b. Individualize program based on cause/type
    c. Behavioral modifications improve Incontinence
3. **Align Operational Practices**
    a. Start on admission- the sooner the better
    b. Mobility, functional maintenance
    c. Correct product use
4. **Technology**
    a. Use new technology for objective data
    b. Identify unique voiding patterns
5. **Resident Driven**
    a. 'Know the Resident' is applied
    b. Resident driven goals and preferences
    c. What matters most to the resident is honored

6. **Medications**
    a. Meds are not the only solution- food before medicine
    b. Medication alignment- correct and appropriate meds
7. **Relationships are important**
    a. Resident and family involved in care planning
    b. IDT, MDS, clinical, medical provider engagement
8. **Holistic Care Planning**
    a. Cultural sensitivity
    b. Increase quality of life
    c. Consider non-pharmacological interventions
9. **Nursing Assistants are Key**
    a. NAR's have a primary role in outcomes
    b. Consistency of care
    c. Consult with NAR's/Caregivers for care planning
10. **All Staff Engagement**
    a. Share findings and communicate success
    b. Development and deployment of education
    c. Accurate Documentation

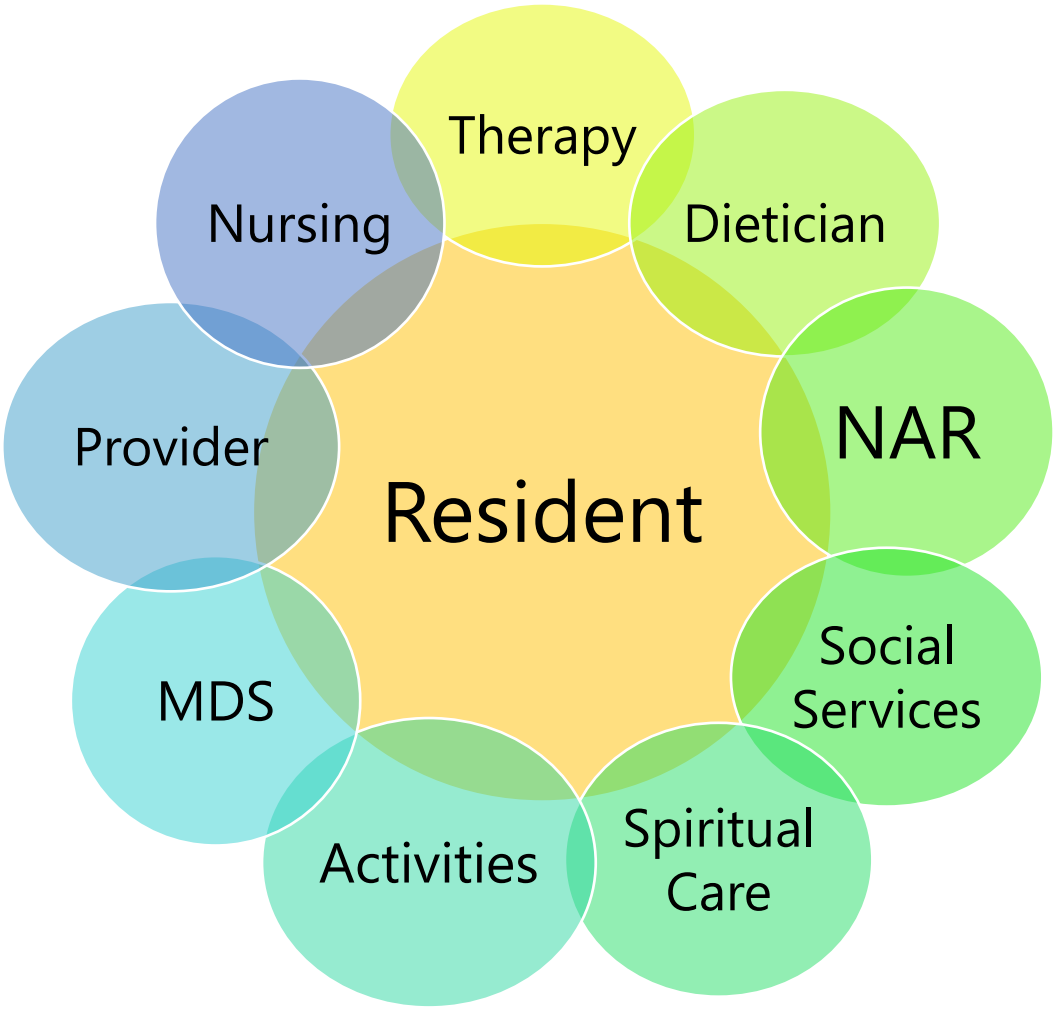
Cornerstone

Team-Based Approach

The resident is the center of the team.

- STREAM Best Practice: Use an interdisciplinary team approach
- STREAM Best Practice: Resident is the focus and the main driver
- STREAM Best Practice: Engage front line staff in planning

It takes a team to know the resident.



A cornerstone of the STREAM program is to use a team-based approach to know the whole person, and inform incontinence management. Disciplines perform specific assessments and gain valuable knowledge about the resident from their perspective. Bring all departments together to share what they know will create a well-rounded picture of who the resident is and how to best meet their needs.

The Interdisciplinary team reviews, interprets, and care plans based on findings from technology, other data collection, and interviews of resident, family, and staff. A holistic approach to care will address the unique biological and psychosocial needs of older adults. The resident is part of the team and the driver of decisions.

Interdisciplinary Team Integration

The practices from this program are far-reaching and can be embedded into aspects of service and surveillance guided by leadership or quality service teams.

The Interdisciplinary Team can integrate learnings from this program into committees, meetings, and communication such as:

- Care Conferences
- Admission processes
- Stand Up or other daily communication reports
- QAPI Committee (Quality Assurance Performance Improvement)
- QIIP Projects (Quality Improvement Incentive Payment)
- Falls Committee
- Resident Council
- Family Council
- New Employee Orientation
- Staff Development
- IDT daily meeting agenda

Engage front line staff

The front line/direct care staff have the most frequent, personal, and consistent interaction with the residents day in and day out. They hold an invaluable amount of knowledge of the residents' preferences, routines, and needs. Many staff have a typical routine for resident cares, and have insider knowledge of what could be done to make care more efficient for the resident.

Interdisciplinary teams must prioritize obtaining feedback from direct care staff and involve them in care planning. Part of the STREAM bowel and bladder assessment is to interview direct care staff. You will find this interview in the Know the Person tab of this manual.

Provide staff with results of the resident's bowel and bladder assessment, as this will raise awareness of the specific interventions and why those are indicated. When staff understand the "why" they are more likely to accept and implement change.

IDT Case Review

While conducting root cause analysis for a resident's condition or concerns, it may be helpful to present the situation in a case study format for IDT to further explore. It is an effective method to organize and understand the situation, background, assessment, and recommendations. This is an example of a case study template shared by our STREAM consultant Dr. Rosemary Laird.

STREAM Case Study Format

Dr. Laird: The Approach to a Case Study

Who?	- Age - Gender - Other relevant factors - Chronic illness/conditions - Functional Status - Medications
What?	- Current condition/Symptoms of concern - Past Evaluations/Treatments
Why?	- What's the working diagnosis - Do we know why it's happening (RCA)
How can we help?	- How can we fix this - What can technology tell us - Interventions - Non-Pharmacologic
Did we help?	- Evaluate interventions - Current status

Example Care Planning Table

When determining what interventions to apply to a resident for incontinence management, it may be useful to use a tool - like this care plan table - to plot your methods, assign duties, procure equipment, and have a plan to evaluate the intervention. This is an example of a care plan table shared by our consultant Dr. Rosemary Laird.

Dr. Laird: Blank Care Plan for Interventions/Strategies
**F= Functional * S=Stress * U=Urge and Over-active *O= Overflow*

UI *	Strategy	Responsible Team members	DME/ UI Product selection	Benefit Check Due

STREAM

Cornerstone

Know the Person

Empower residents and promote quality of life.

- STREAM Best Practice: Identify resident's goals and preferences
- STREAM Best Practice: Use specific measurable goals
- STREAM Best Practice: Utilize the right appropriate product
- STREAM Best Practice: Observe the resident as part of the assessment

Know the Person

A STREAM best practice is to obtain the resident's goals and preferences for incontinence/toileting. This section includes the STREAM Resident Interview to be conducted within the bowel and bladder assessment. It gathers their perception of their symptoms, conditions, history, barriers, and goals for care. If creating a care plan goal and intervention without the resident's input and assent, the plan may not be effective. The resident's voice drives the plan.

Further, learn how the resident communicates, their preferences for assistance, and the best way to approach them for ADLs. They may have comfort preferences in using the bathroom (ex: privacy, length of time to sit, positioning, etc.) for staff to honor to ensure dignity and comfort.

Observation of the resident is part of the STREAM bowel and bladder assessment. Observe their transfer status, level of ADL assistance, ability to perform self-cares, manage clothing and products, and the quality of the urine stream.

Residents with cognitive deficits or dementia may have difficulty communicating their bowel and bladder needs. Behavioral expressions are communication of an unmet need. Using root cause analysis, discern if incontinence/toileting needs are contributing to behavioral expressions (wandering, calling out, removing clothing, etc.). Anxiety and fear may be the root cause of incontinence (ex: fear of falling, fear staff will not come).

To know more about the person, interview the staff who consistently care for them. This section includes a staff interview to be conducted within the bowel and bladder assessment. Staff have valuable feedback and insight into what type of strategies would suit the resident. They have more information to share verbally than could be found in ADL documentation alone. Streamlining the subjective data from interviews with objective assessment data, a meaningful plan can be created.

The negative consequences of incontinence can have a profound impact on a person's quality of life, but affects each person differently. A Resident Quality of Life Audit is included in this section, which serves a dual purpose: 1) baseline community audit for QOL impact, 2) individual resident interview to note personal perception of incontinence impact on QOL.

Remember, it takes a team to know the resident.

STREAM Resident Interview

1) How many times do you urinate in a 24- hour period?
2) On average, what is the amount and type of fluid you take in?
3) Are there any environmental factors that create problems with using the bathroom (ex: poor lighting, no grab bars, toilet seat too high or low, clothing restriction, etc.)?
4) Are you experiencing any major stressors? What are these stressors? Are these stressors new?
5) Do you have illnesses that affect your urinary function? (ex: kidney disease, diabetes, high blood pressure, heart disease, neurological disorders, etc.)?
6) How often do you get out of bed at night to urinate? Is this new?
7) Do you have trouble getting to the bathroom in time?
8) Do you experience urine leaks with any of the following:
    a. Sneezing or coughing
    b. laughing
    c. Lifting heavy objects
    d. Bending over
    e. Exercising
9) Do you get a strong urgent feeling to use the bathroom?
10) Do you experience any of the following:
    a. Difficulty starting a urine stream
    b. Feeling of bladder fullness after urinating
    c. Frequent or constant dribbling urine
11) Are you experiencing pain or burning with urination?
12) In the last year, have you had a urinary tract infection? How many?
13) In the last year, have you had kidney stones? If so, how many times?
14) Identify Toileting Goals: What are your goals :

15) Other pertinent information:

STREAM Staff Interview

1) How does the resident transfer to the toilet?
2) Are there any environmental factors that create problems with using the bathroom (ex: poor lighting, no grab bars, toilet seat too high or low, clothing restriction, etc.)?
3) How often does the resident get out of bed at night to urinate (use the toilet bedpan urinal or commode)? Do they need assistance?
4) What is the resident's current routine for toileting now?
5) Is the resident continent or incontinent? Please explain.
6) Does the resident ask/use the call light to use the bathroom, or do you prompt or take them?
7) What time does the resident get up in the morning, and go to bed at night?
8) What incontinence product do they wear (day and night)? Is their current product fitting well/working well?
9) How many briefs does the resident wear/change on your shift?
10) What could we do differently for this resident, for their bathroom needs?
11) How could we improve their care plan?

12) Other pertinent information:

STREAM Audit- Resident Quality of Life Impact

Resident Quality of Life Impact Audit

Community: _____ Date Completed: _____

1. Interview 10 residents and ask them how toileting needs effect areas of their daily life.

Resident	Gender	Age	Incontinence (Bladder, Bowel, or Both)	Responses	How does toileting (bathroom) needs affect your daily life in the following areas?								
					time spent on BR needs	Doing things you enjoy	Going on outings	Relationships	Dignity	Privacy	Eating and drinking	Sleep	Other comments
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													

2. After completing the resident surveys please take a moment and record your thoughts and take-aways from resident responses.
   - What patterns or trends did you notice with the resident responses?
   - What surprised you the most about their answers?
   - If you had a magic wand, what would you change about the current status quo after listening to residents' responses?

Goal setting

***obtain the resident's personal goal for incontinence**

As teams determine goals for incontinence care based on assessments and alongside the resident, it is important to set meaningful and obtainable goals with a foreseeable outcome. For the STREAM program, teams utilized the SMART goal method to ensure goals were specific to the resident and their type of incontinence, could be measured and evaluated, were attainable with appropriate strategies, realistic considering the resident's conditions and priorities, and had a time frame to review success.

Image derived from https://www.hydratemarketing.com/blog/the-importance-of-setting-smart-goal

Cornerstone

Root Cause Analysis

- STREAM Best Practice: Understand Incontinence before creating a Plan
- STREAM Best Practice: Utilize technology to determine cause and create a plan
- STREAM Best Practice: Interventions match cause and unique voiding pattern
- STREAM Best Practice: Incontinence is not a normal part of aging

Understanding Incontinence

Albert Einstein said, *"If I had an hour to solve a problem and my life depended on it, I'd spend 55 minutes thinking about the problem, and 5 minutes thinking about the solutions."*

What he means is, you have to truly understand the problem before you can jump to creating a plan to fix it. Interventions would be weak and ineffective if chosen without knowing the cause(s) of the problem. The interventions have to match the cause.

The STREAM program set out to creating meaningful plans to directly target the type and causes of incontinence. To do this, STREAM approached incontinence assessments and management by applying Root Cause Analysis (RCA). Root cause analysis helps identify what, how and why something happened to prevent reoccurrence of negative outcomes (ex: incontinence).

STREAM teams also included incontinence as part of discussions for root cause analysis of other care concerns such as wound rounds, falls, infections, behavioral expressions, etc. Teams learned to see how incontinence was connected in the bigger picture. Teams who use this RCA approach to solve problems are more likely to achieve their desired outcomes, because they know what it is they are aiming to fix.

In this section, the steps of root cause analysis are described. The types of incontinence are defined, followed by strategies to consider for management. Then, the components of the STREAM bowel and bladder assessment (RN) will be shared. Finally, several tools created and used in this program that the clinical informatics found helpful for note taking/data gathering of their assessments.

"Incontinence is not a diagnosis, but rather a Symptom of an underlying problem."
-Dr. Rosemary Laird

4 Steps of Root Cause Analysis

Step 1 Investigate

- Don't work on the interventions or solutions until you've determined the causes of incontinence. What is the real problem we're trying to solve? **Gather Clues, Evidence, Data.**

Step 2 Identfy the Cause(s)

- Identify the Cause(s).What type of incontinence is this? What are contributing factors? **What is the root cause(s) of the incontinence?** This is a symptom of what underlying issues?

Step 3 Align Intervention(s)

- Reflect the resident's goals. Standard intervention lists can exacerbate the problem! **Match causation and intervention.** Choose interventions to directly target the causes of incontinence. Individualize the plan.

Step 4 Evaluate

- Monitor on a routine basis, the interventions and expected outcomes. To identify if the problem is worse, continues, or improves. **Measure what you expect to improve**.

Urinary Incontinence

Incontinence Definition: The lack of voluntary control over bladder or bowel elimination.

Interventions for all Types of Urinary Incontinence

For all types and causes of urinary incontinence, the following interventions and strategies should be reviewed during assessment and observation:

- **Diet** → Avoid bladder irritants such as sugar, reduce amount of caffeine and/or carbonated drinks, avoid foods high in acid, spicy foods, and alcoholic beverages.
- **Fluids**→ Consume 1.5-2 L of fluid unless contraindicated (preferably water) to maintain hydration. Limit fluids near bedtime. Limit caffeine intake.
- **Skin**→ Ensure perineal cares are completed, which helps decrease skin breakdown, irritation, fungal infections, and UTIs.
- **Medication alignment**→ Help eliminate unnecessary medications that may increase incontinence symptoms.
- **Reduce stress**→ High levels of stress increase cortisol which decreases the antidiuretic hormone (ADH) and causes increased urination
- **Equipment** → ensure supplies and equipment are provided as indicated to aide elimination (such as urinal, commode, bedpan)
- **Sleep**→ Decrease episodes of fragmented sleep, which impairs the body's ability to produce and release antidiuretic hormone.

Subtypes of Urinary Incontinence

Incontinence is an umbrella term. There are in fact several different types of incontinence with unique symptoms and management strategies. Assessments should determine the suspected type of incontinence before proceeding to planning.

Stress Incontinence

Symptoms: Urine leaks with pressure on the pelvic floor, ex: during sneezing, coughing, laughing, lifting, exercising, bending over

Risk Factors:

- Pelvic floor weakness
- Hysterectomy
- Pelvic Prolapse
- Prostate enlargement or cancer
- Obesity
- Post menopause

Interventions may include:

- Pelvic floor exercise (ex: Kegels)
- Other exercise/activity to engage the pelvic floor and core
- Functional restoration

Urge Incontinence (overactive bladder)

Symptoms:

- Sudden strong urgency to void
- Leaking/dribbling urine with urgency (*urge incontinence)
- Increased frequency of voiding
- Voiding small amounts of urine
- Waking up at night, usually several times, with the urge to void

Interventions may include:

- Bladder Training
  - Goal is to increase the amount of time between emptying the bladder and the amount of fluids the bladder can hold
- Functional restoration
  - Kegel exercises to improve pelvic floor strength
- Post-tibial neuromodulation (PTNM)
- Medication alignment re: overactive bladder symptoms

Overflow Incontinence

Symptoms:

- Unable to fully empty bladder (retention)
- Feeling of a full bladder even after voiding
- Frequent or constant dribbling
- Bladder distention, decreased sensation
- Weak urine stream, weak bladder contractions

Risk Factors:

- Weakened bladder muscles
- Blockage within the urinary tract
- Neurological disorders
- Spinal cord injury

Interventions may include:

- Double void to empty bladder/residual urine
- Catheterization
- Toileting schedule
- Bladder scanner assessment for volume/voiding needs

Functional Incontinence

Definition: A physical, cognitive , or environmental barrier to continence. Also known as disability-associated incontinence.

Risk Factors/Causes:

- Impaired mobility. *Ex: Unsteady gait, bradykinesia, impaired balance*
- Cognitive impairment. *Ex: Inability to locate a bathroom*
- Communication barrier. *Ex: Unable to make needs known*
- Motor and sensory impairment. *Ex: False depth reception*
- Psychological impairment. *Ex: Fear of falling*
- Difficulty removing clothing in time *ex: arthritis of hands*

Interventions may include:

- Safe Environment
    - Proper footwear
    - Proper transfer and ambulating equipment
    - Proper lighting

- Environmental Cueing
    - Contrast of color comparing toilet seat and flooring
    - Proper bathroom signs
- *Individualized* Toilet Schedule
- Ensure individual wears clothing that is easy to take off when feeling the urge to void
- Ensure call-light is within reach
- Functional restoration
    - PT/OT, endurance/strength, exercise, ambulation programs
- Repetitive use of the same bathroom helps instill muscle memory

Mixed Incontinence:

Definition: Individual experiences more than one type of incontinence. Causes are multifactorial. *Ex: Stress and Functional. Urge and Stress.*

Interventions may include:

- Interventions will match/address the types of incontinence involved

Bladder Toileting Program Strategies (MDS)

Individualized Toileting Schedule

- A specific and unique toileting schedule used fo to help promote bowel and bladder continence. Toileting is planned around unique voiding patterns and resident's preference for routine and activities
- Helpful for functional, overactive, urge incontinence
- The goal is to toilet proactively to avoid incontinent episodes

Timed Voiding

- Follow a daily bathroom schedule going at set times during the day. A person may plan to urinate every 2, 3, or 4 hours.
- Helpful for Urge incontinence/OAB, functional incontinence
- The goal is to prevent that urgent feeling and gain control.

Double Voiding

- Emptying your bladder twice. Void normally, pause 20-30 seconds, then lean forward (or stand up and sit back down) and void a second time.
- This may be helpful for people who have trouble completely emptying their bladders, ex: overflow incontinence, nocturia
- Added Benefits: complete bladder emptying, better sleep, fewer UTIs, fewer trips to the bathroom

Prompted Voiding

- Approach: Verbal Prompts, Regular reminding, Regular schedule, Offer assistance, Praise/ Positive Reinforcement
- The goal is to increase self-initiated voiding and decrease incontinent episodes.
- Helpful for residents with cognitive impairment, functional incontinence

Bowel Incontinence

Bowel Incontinence is an umbrella term for the inability to control the passing of feces, flatus, and/or mucus.

Causes: muscle or nerve problems, constipation, diarrhea, hemorrhoids, surgeries, rectal prolapse, rectocele

Risk factors: age, gender (female), nerve damage, dementia, decreased mobility

Pattern: To understand the resident's bowel status and unique toileting pattern/routine, review 14 days of bowel movement documentation. Additionally, more information can be obtained from:

- Resident interview
- Staff interview
- Bowel Diary
- Bristol stool chart

Identifying the Type of Bowel Incontinence

There are 3 types of bowel incontinence: Passive, Urge and Functional:

Symptoms	Symptoms	Symptoms
No sensation or awareness of it happening	A sudden urgent feeling of needing to pass stool, and the person cannot hold it in time	Cognitive, Physical, or psychosocial limitations that impair the ability to reach a bathroom
⬇	⬇	⬇
Passive Incontinence	Urge Incontinence	Functional Incontinence

Interventions for all Types of Bowel Incontinence

For all types and causes of bowel incontinence, the following interventions and strategies should be addressed/considered during assessment and observation:

- **Diet** → Consume recommended dietary intake of daily. Avoid foods that may trigger loose stool.
- **Fluids** → Consume 1.5-2 L of fluid unless contraindicated (preferably water) to maintain hydration and prevent constipation
- **Bowel Medication**→ Anti-diarrheal drugs or bulk laxatives
- **Medication alignment**→ help eliminate unnecessary medications that may increase incontinence symptoms
- **Exercise**→ Pelvic floor strengthening to strengthen sphincter control, and ambulation to stimulate a bowel movement
- **Bowel Training** → Specific/preferred time of the day helps gain control. Allow enough time to sit for bowel movement.
- **Avoiding constipation**→ This is an important measure, especially for those with bowel incontinence of loose stools (side effect of laxatives).

Bowel Toileting Program Strategies (MDS)

Best Time

- Review bowel pattern history/documentation, and interview resident and staff. Determine ideal time of day for resident to sit for a bowel movement based on typical pattern and resident preference. Add this individualized plan to the resident's care plan

STREAM Assessment Process

Who Should I Assess?

Examples of residents who make ideal candidates for STREAM:

1. Residents within their ARD/MDS window
2. New admission to long term care (LTC)
3. LTC Resident (prioritize)
4. Resident with sudden or recent condition changes
5. Resident in the transitional care unit with potential to move in to LTC
6. Residents needing root cause analysis of a problem, ex:
    a. new or worsening incontinence
    b. falls related to toileting
    c. incontinence related skin damage
    d. woken at night for elimination needs

STREAM Assessment: Data Gathering

Objective Data

- **Physical Observation/Assessment**
- **Utilize Technology**
- **Voiding patterns, Trends**
- **Chart Review**
    - Diagnosis
    - Medications
    - Hospital H&P
    - Hospital Discharge Summary
    - Clinical Assessments
    - Progress Notes
    - MDS

Subjective data

- **Resident interview**
- **Family interview**
- **Staff interview**
- **IDT case review**
- **Pre admission screen**

STREAM: Bowel and Bladder Assessment

1. **Obtain MDS schedule** to identify resident and ensure resident is within ARD/MDS window.
2. **Complete bowel and bladder assessment (using subjective and objective data):**

A STREAM Assessment may include the following elements:	
☐ Review resident's chart ▪ Latest Bowel and Bladder and Braden assessment ▪ Toileting History ▪ Current Care Plan ☐ Review NAR documentation ☐ Observe NAR care sheet ☐ Interview NAR staff ☐ Complete "STREAM Resident Interview" ▪ Noting impact on daily life ▪ Obtain resident's perspective of their toileting history ▪ Identify resident's personal goals ☐ Observe resident toileting ☐ Observe unique voiding/BM pattern ☐ Determine if technology will be implemented If yes, ⇨	☐ Bladder Scanner as indicated ☐ TENA Identifi 3-day assessment ☐ Actigraphy ○ Receive permission from resident/responsible party to proceed with technology ○ Establish proper notification and documentation with care team for technology **Actigraphy and Identifi ideally should be used simultaneously

3. **Analyze findings and Recommend management strategies**
4. **Complete bowel and bladder assessment documentation in EMR**
5. **Update care plan**
    a. Educate team and resident on interventions and changes to the care plan
    b. Update care guide/team sheet for staff
    c. Support implementation of care plan changes with staff and resident
    d. Add NAR documentation task as needed to capture the plan and episodes of continence
6. **Evaluate effectiveness of plan** minimally quarterly, and with next MDS assessment window
7. **Attend Care Conference as appropriate**

STREAM: Physical Assessment/Observation

A thorough bowel and bladder assessment includes physical observation of the resident. The nurse will go to the resident's room to actively observe and participate in the toileting ADL. In completing a head to toe exam and receiving first hand perspective of care requirements, here are some things to assess:

Oral Cavity & Swallowing	Complications with swallowing may lead to dehydration which plays are role in urinary output as well as constipation/ increasing waste in the body.
Neurological	Assess orientation and alertness. If aphasia or dysphasia is present, learn how the individuals communicate in their own way. Increased risk for retention (be observant for UTIs)
Abdominal	Properly locate and palpate the bladder → observe distention or spasticity, pain/tenderness, and note if the bladder is firm or soft. Assess Bowel sounds
Perineal Skin	Observe area for rash, skin breakdown, fungal growth, dryness, uterine/vaginal/rectal prolapse. Ability to assist with personal cares. Assess MASD (see next page)
Urethral Meatus	Observe for bruising, blockage, or issues caused by current or previous use of an indwelling catheter such as tissue erosion
Characteristics	Note character of urine stream- dribbling, hesitancy, stop and go, forceful, etc. and/or bowel movement (Bristol Stool Chart). Note positioning and time needed
Mobility	Assess gait, distance to bathroom, balance, assistive devices in use, transfer, clothing management, and fall risk.
Lower extremities	Assess for edema, neuropathy, pain

STREAM and Skin

***The following are highlights from the Tena CEU course for Moisture Associated Skin Dermatitis.

What is MASD? Inflammation or skin erosion of the epidermis caused by prolonged exposure to a source of moisture ex: urine, stool, sweat, wound drainage, saliva, mucus.

- MASD Is as prevalent as 41% in LTC.
- Subtype: IAD- incontinence associated dermatitis.
- Use a consistent term to describe MASD.
    - GLOBIAD categorization tool is recommended
- Top layer of skin + urine = pH changes to alkaline.
- Bacteria grows in alkaline environment, and skin is more prone to damage
- Prone to secondary infections (Fungal)
- MASD: Likely at risk for pressure injury too.
- MASD: often misclassified as pressure stage 1/2. MASD is never full-thickness, and normally found in skin folds.
- MASD Skin Care Best Practice: Soap and water can be drying. Wiping the skin repeatedly with a washcloth can be more irritating/damaging. **A no-rinse cleanser with pH balance is ideal.**

Assessment Tools- Technology

Utilizing technology, objective data can be obtained and can reveal unique voiding patterns, routines, habits, trends, etc. Technology can assist with identifying the root causes of incontinence and creating an effective plan. The table below shows the 4 pieces of technology used by the Empira collaborative for STREAM:

TENA Identifi		Identifi tracks when an individual voids and generates a report with patterns and volumes. The sensor-wear briefs are worn for a 72-hour period. Tenaidentifi.essity.com
Bladder Scanner		Provides information on bladder capacity and function.
Actigraphy		Actigraphy is a watch worn on the wrist to assess sleep, wake, and activity patterns. Also provides information on light exposure, bed mobility and nighttime disruptions.
NURO System (PTNM)		Percutaneous Tibial Neuromodulation (PTNM), provided by NURO system, sends electrical impulses through the tibial nerve to help normalize transmission pathways from the central nervous system to the bladder. It can be effective in the treatment of overactive bladder, with symptoms of urinary urgency, frequency, and urge incontinence.

Resident Data Collection Worksheet

***This SBAR document is an optional tool for the assessor's own note taking*

Is this resident incontinent? Bladder Bowel Both How long has resident been incontinent? _____

What type(s) of incontinence? _____

Complete **SBAR** Table

Situation	
Background Include resident's age, gender, current toileting plan, toileting products use, mobility, and nutrition	
Assessment Include data from basic and advanced assessments, pertinent information from resident interview, and other observations, what type of incontinence	
Recommendation Include solutions to match cause for type of incontinence	

STREAM Resident Data Collection Worksheet

***This optional worksheet is for the assessor to collect notes during*

STREAM RESIDENT WORKSHEET

Resident _____ DOB_____ MRN _____ MD _____Today's Date_____

Code Status _____ ARD _____ PT --- OT --- ST --- Nursing Rehab Program _____

Diagnoses:	**Urine Status:** incontinent continent	**Pain**
	SubType of Incont.:	Scheduled pain meds:
	Date Incont. Started:	
	Frequency of Incont:	PRN pain Meds:
	Incontinence Product(s):	
Meds:		Acute/ Chronic:
	Meds Impacting UI:	Location:
	Catheter?	**Falls**
	Hx UTI? Date:	# of falls:
	Quality of Urine Stream: dribbling, stop/go, consistent, forceful	Hx of Falls:
	Observed Toileting:	Related to toileting?
	Current Toileting Plan:	
		Cognition/Mood
	Bowel Status : incontinent continent	Cognition- Impaired Intact
	SubType of Incont:	Ability to use Call Light:
Vision: Impaired Intact	# BM in past 7 days:	Mood:
Review ADLs: identify toileting barriers	Stool: (Bristol chart)	Behavioral Exp:
Sling Size		
Transfers	Date Inc. Started:	**Skin/ Body**
Bed Mobility	Meds Impacting BM:	Hx Pressure ulcers or MASD?
Walk in room	Pattern:	Braden Score:
Walk in corridor	Current Toileting Plan:	Body audit:
Loc on Unit	*(other)*	Peri-area:
Loc Off Unit	**Technology**	Physical Assessment:
Toileting - transfer to/from toilet -clothing mgmt -peri care/ hygiene	**Tena Identifi:** consent __	S/Sx PVD: No pedal pulses -- cold extremity – thin shiny taught skin LE - c/o pain LE w/ exercise – c/o LE pain lying in bed S/Sx Venous stasis- LE Edema – brown discoloration LE - hx cellulitis S/Sx Neuropathy: loss of sensation – foot deformities- tingling LE
Nutrition & hydration		**Devices**
Dental: dentures partial natural teeth		grab bars – hi/low bed - body pillow - wander guard- perimeter mattress– floor mat -- electric w/c – Electric chair - anti lock brakes - elevated toilet seat commode over toilet Urinal Bedpan
Chewing/Swallowing Issues:		
Meals, % Eaten:	**Sleep: Actigraphy**: assent __	**Labs**
Fluid : Intake @ Meals Between Meals Type of fluids Total daily fluid amt	Rise _____ HS_____ Nap _____ Sleep preference/ sleep meds/ aids:	
Supplements:	x/NOC to toilet/change:	
Current Weight/Trends:	Bladder scanner/ PVR:	

Cornerstone

Active Engagement

Recognize that functional incontinence is the #1 type in LTC

- STREAM Best Practice: Involve Therapy PT/OT to improve incontinence
- STREAM Best Practice: Identify incontinence barriers to active engagement
- STREAM Best Practice: Access to bathrooms and adaptive equipment
- STREAM Best Practice: TR offers opportunities to move the body

Active Engagement During the Day

Incontinence can be a barrier to active engagement during the day. Incontinence can effect socialization, motivation, dignity and mood. Residents may avoid certain activities, gatherings, or outings for fear of incontinence. Activities staff and direct care staff should observe when incontinence is getting in the way of resident's participation and ability to enjoy the event and report those to IDT for solutions.

Interdisciplinary teams should interview the resident to learn what barriers incontinence presents to being able to participate in the activities they enjoy. Care plans should reflect those important times of day for the resident to be assisted for toileting or incontinence cares prior to those activities. In the STREAM program, it was recognized that while the residents were interviewed about many things (like pain, mood, etc.) no department specifically asked if incontinence prevents them from doing the things they enjoy. This was then built in to the bowel and bladder assessment or care conference template.

Activities should be offered that move the body, expend physical energy, and engage the core and lower body. These simple movements, by adding physical activity, can strengthen the muscles in the pelvic floor that control the bladder and bowel.

Interdisciplinary teams must also consider environmental barriers that inhibit restrooms from being accessible, comfortable, safe for residents.

Considerations:

- Activity Schedule
- Resident's preferred activities to attend
- Visitors
- Meal times
- Preferred wake and sleep times
- What matters most to the resident
- Toileting prior to events and outings
- Mobility Status
- Where are bathrooms in the buildings residents can use

"All the kegels in the world won't help if someone just lays in bed all day." Dr. Laird

TR/Activities Impact

Activities that Move the Body
Community Walk Inspire residents to walk by initiating fun community walking events, competitions, walk for a cause, or walk to certain daily functions like meals or activities.
Physical Exercise Whether in a group on 1:1, exercising has numerous health benefits. Maintaining functional mobility may decrease the likelihood of functional or stress incontinence. Exercise can also boost endorphins, the brain's "feel good" neurotransmitters.
Chair exercises Seated chair exercise groups can be offered daily, and are tailored to moving the whole body while seated. Marching in place and Kegel exercises are most effective in engaging the pelvic floor while seated.
Yoga/stretching Breathing and relaxation techniques promote physiological quieting. Stretching and posing engages muscles of the body and improves range of motion, flexibility, functional abilities, and core strength.
Games Offer games that move the body like balloon volleyball, or try standing for BINGO.
Opportunities to Stand Standing for groups like baking, choir, crafts, gardening, games, concerts, parties, etc.
Go Outside Spending time outdoors has physical and mental benefits. Many people enjoy hobbies outside that also move the body, such as planting/gardening, games, feeding animals, nature walks, etc. Getting direct sunlight can set the circadian rhythm and promote better sleep at night.

Things to remember:

Stress and anxiety can exacerbate bowel and bladder issues- including difficulty with bowel movements, and urgency of urination due to muscle tension. Stress increases antidiuretic hormone and can cause frequent urination.

Complementary techniques like aromatherapy, deep breathing, massage, soft music, visual diversions, etc. can benefit residents.

Mobility and Exercise

Mobility Interventions for Incontinence
PT/OT Therapy can address many functional barriers to continence, such as mobility, ambulation, transfers, ADL's, routine modification, adaptive equipment, pelvic floor and core exercise, balance, breathing techniques, e-stim, and more.
Kegel Exercises Pelvic floor muscle strengthening can improve stress incontinence. Using the right muscles is important, and these exercises can be done 2-3 times a day while sitting, standing, or lying down.
Ambulation Even walking short distances engages the pelvic floor and can improve incontinence, especially functional and stress. Walking can also promote bowel movements.
Standing Programs For those unable to ambulate but can bear weight to stand, standing also engages the pelvic floor and can improve stress incontinence.
Marching in place One of the most effective exercises for engaging the pelvic floor from a seated position is marching in place.
Yoga Yoga incorporates breathing coordination with movement, stretching, and posing that engages the core and pelvic floor. It also can be relaxing, boost mood, focus, and inner peace.
Pain management Control pain so the resident is able to comfortably participate in activities and exercise. Pain creates tension in the body that can inhibit bowel elimination and bladder control.
Encourage Independence Allow residents to assist in their cares as much as possible. Resist doing it for them because it may be faster for staff but can lead to functional decline for the resident. Wheeling your own wheelchair engages most muscles in the body, as does getting dressed.

Environmental Considerations

Equipment

Having the right equipment to facilitate independence and comfortable bathroom usage was found to be critical for improvement of continence for residents. For example, a STREAM resident became completely continent by simply placing more urinals in his room that he could get to easily during the day and night. Our collaborative members also found female urinals to be a best option for some male residents because the handle is longer and the opening is smooth and wider for better comfort against the skin.

Various members of the collaborative utilized the following equipment items:

Toilet seat raiser

Soft toilet seats

Female urinals

Anti-spill urinals

Black toilet seat for contrast

External catheter

Bariatric Bedpans

Squatty potty

Bedside commodes

Osteoarthritis clothing

Urinals – adding more to room

Toilet tongs

Reacher device

Cornerstone

Restorative Sleep

Incontinence and nocturia is a common barrier.

- STREAM Best Practice: Night time care plan addresses preferences
- STREAM Best Practice: Design toileting plans to protect and consolidate sleep
- STREAM Best Practice: Overnight products are used when appropriate

Restorative Sleep Importance

Poor sleep can lead to physical and cognitive decline and puts residents at risk for other care concerns such as falls. Incontinence can be a barrier to restorative sleep. Design toileting plans to protect sleep as much as possible. Waking people at night at times that are not indicated by an assessment is disruptive to quality sleep.

Restorative Sleep is essential for overall health and wellbeing.

What is Restorative Sleep?

One continuous significant sleep period in 24 hour day, ideally lasting 7-9 hours, and occurring at night.

Uninterrupted Sleep = Restorative Sleep

Nocturia

What is Nocturia?

Waking more than 1 time per night to urinate.

Nocturia is a common barrier to restorative sleep. When residents are wakening >1 time per night to use the bathroom, this is an abnormal finding that requires further analysis. The amount of urine produced at night should also be measured during this analysis, as urinating more than 33% of the daily fluid intake overnight indicates a condition known as Nocturnal Polyuria.

Consider assessing the amount and type of fluid intake in a typical day, and at what time. Tapering fluids after supper is a common approach that can promote better sleep, and may be important for older adults with nocturia. With the aging process, the antidiuretic hormone is less effective and the body continues creating urine overnight.

Nocturia can also be caused by medication side effects, urinary tract infections, and overactive bladder (OAB). The clinical team should review all possible contributing factors to nocturia and consult with medical providers as needed. The interdisciplinary team should also evaluate safety measures to keep the resident from falling at night in transit to the bathroom.

***See education tab for micro learning: Nocturia

Restorative Sleep interventions
Individualized Toileting schedule Plan the overnight schedule for toileting care based on resident's unique voiding pattern, and based on resident's personal preferences for sleep.
Taper fluids before bedtime Drink the bulk of fluids during the day, tapering in the evening/after suppertime to reduce incontinence overnight and minimize disruptions.
Avoid bladder irritants and caffeine Beverages that irritate the bladder can increase urgency and frequency, and should be avoided especially after suppertime.
Right product to wear overnight Assess/determine what type and absorbency product best suits the overnight needs, considering level of output and resident's sleep preferences.
Double void Incorporate double voiding into the resident's bedtime/HS care routine, to void as much as possible (remove residual urine) and allow for a longer sleep period.
Sleep Environment Create a space for deeper uninterrupted sleep. Consider measures such as Aromatherapy, white noise, warm blankets, amber lighting vs blue light.
Night time care plan Residents have a separate nighttime care plan, differentiating preferences and cares from day and night.
Equipment Adaptive equipment may lead to safer and easier elimination overnight, for example: bedside commode, urinal at bedside, bedpan.
Medication Timing Review the timing of medication administration, the number of bedtime medications and amount of fluids given, and timing of laxatives and diuretics.
Urinate right before Bed In some cases, bedtime cares are done earlier than the resident's actual bedtime. A resident may need to urinate just before going to bed, to prolong their sleep period.

Actigraphy

Assessing sleep quality and efficiency is an important part of understanding the impact of incontinence on a resident's quality of life. Utilizing a sleep study device, such as an Actigraphy Watch or similar tool, will give a detailed report analyzing a person's 24-hour sleep/wake cycle. This can provide information about:

- sleep efficiency and quality
- restlessness at night
- number of night time awakenings
- time of sleep onset and morning awakening
- waking after sleep onset
- light exposure at night and day
- napping- length and time
- activity level
- time it takes to fall asleep
- and more!

Incontinence and/or toileting needs is one of the top disturbers of sleep. Comparing a sleep report to a bladder diary will give the best picture of the relationship between elimination needs and sleep quality. Toileting plans can be designed to limit disruptions, bundle cares, and provide toileting assistance at the right time for the individual to preserve their sleep.

STREAM Audit: Night Time Practices

STREAM- OVERNIGHT Continence Audit

Site: _____ **Date completed:** _____

Purpose of the Audit: To determine current practices that effect the restorative sleep and continence needs, and to address action items. Interview IDT members.

Operational Practices:				Who is responsible
Do we practice standard rounding at NOC? Every 2 hours (10p, 12am, 2am,4am,6am).	Yes/ No	If yes, why?	Action Plan:	
Do we use overnight incontinent products?	Yes/ No	If yes, how is do you determine the need for a resident? If no, why?	Action Plan:	
Do we practice optimizing consolidated sleep time with individualized overnight continence care needs and preferences?	Yes/ No	If yes, how is this shared? Is it shared consistently? If no, why?	Action Plan:	
Do we practice "bundling of cares" to decrease disruptions?	Yes/ No	If yes, how is this shared? Is it shared consistently? If no, why?	Action Plan:	
Do we use Actigraphy to understand individual sleep patterns and to determine if poor sleep is a root cause of other care concerns?	Yes/ No	If yes, who do we communicate the results of the report to? If no, why not?	Action Plan:	
Do we individualize night time care plans to indicate when best to assist resident with toileting needs?	Yes/No	If yes, how are night time continence cares communicated to staff? If no, why not?	Action Plan:	

NOTES:

STREAM

Cornerstone

Medication Alignment

Avoid cascading effects of polypharmacy

- STREAM Best Practice: Review medications that affect elimination
- STREAM Best Practice: Preventative nutritional interventions for healthy elimination
- STREAM Best Practice: Dietaty intervention prior to day 3 BM protocol
- STREAM Best Practice: Observe dietary intake that exacerbates elimination issues

Review Medications

Nursing bowel and bladder assessments address medications that affect bowel and bladder. It is important for a thorough analysis of medications to be completed, noting cause and effect of symptom management. Bowel and bladder medications should be routinely reviewed, with interview of the resident, to determine effectiveness, comfort, and therapeutic intent.

Medication alignment is an approach to ensure the medication regimen aligns with what matters most to the resident and their wishes/priorities.

Polypharmacy (taking more than five medications daily) can lead to what is known as geriatric syndrome: cognitive decline, falls, and incontinence. The more medications a person takes, the more likely it is they experience side effects or drug interactions. Look for possibilities replace bowel medications with non-pharmacologic interventions and lifestyle changes such as diet and exercise.

Considerations:

- Side effects
- Timing of medication Ex: diuretics, bowel medications
- Therapeutic effect
- Non pharm strategies
- Resident goals and preferences
- Appropriate diagnosis for meds
- Scheduled vs. PRN
- Standing orders
- House protocol for no BM

**Supporting Education: See Nurse Incontinence Course module 5: Medication Impacts for Bowel and Bladder*

Nutrition:

Food before Medicine

Food Before Medicine

Ultimately, what a person eats and drinks directly affects elimination. Making dietary modifications is a non-pharmacological approach to improve elimination. A STREAM best practice is to incorporate preventative measures for bowel and bladder concerns, using food and fluids to influence healthy elimination. Food before medicine.

Historically, medications have been the first line of defense for managing bowel and bladder concerns. Side effects, especially of rescue laxatives, can be uncomfortable and lead to incontinence of loose stools. Avoiding constipation is essential for not only bowel health but also bladder incontinence. Constipation puts pressure on the bladder, and can actually worsen urinary incontinence. The dietary and clinical teams should consult to come up with long-term solutions to managing constipation based on the causes. Initiate nutritional and hydration interventions to promote bowel regularity and decrease the reliance on rescue medicines.

Urinary incontinence symptoms can be impacted by dietary intake as well. For example, residents with overactive bladder symptoms should consider limiting certain beverages (ex: coffee, soda) that are known bladder irritants.

Considerations:

- Review standing orders bowel protocol
- Review house protocol for no BM (day 2, 3, etc.)
- Review EMR for administration records of PRN bowel medication usage
- Audit snack offerings
- Review meals/menus
- Hydration strategies
- Ask residents what healthy snacks they enjoy
- Involve Resident Council
- Involve Dietician and Culinary

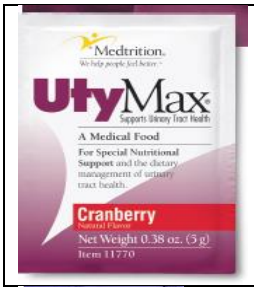
This section will share numerous food before medicine strategies for bladder and bowel health that had successful outcomes when implemented in the STREAM communities. Additionally, a dietary audit to evaluate current menu offerings and opportunities for change.

**Supporting education: see education tab "Food for your Gut"*

Food before Medicine Interventions: Hydration
High fiber juices Whether administered by dining room staff per the diet slip, or by nursing during med pass, high fiber juices (apple, orange, cranberry) add fiber and fluid to diets, avoiding need for medication.
Sugar free flavored water Offering sugar-free flavored water (such as mango or strawberry kiwi) is a delicious way to get residents to drink more water and avoid sugar intake.
Avoid Caffeine Caffeine is a bladder irritant and should be limited to avoid urgency and frequency. Ideally, caffeine intake is in the morning only.
Cup holders Cup holders can be secured to resident chairs/wheelchairs to provide for fluids to be nearby and travel with the resident.
Warm or Cold beverages Warm beverages in cold weather or cold beverages in hot weather provide comfort and may increase fluid intake.
Hidden fluids Remember there are hidden fluids in some foods like popsicles, watermelon, Jell-O, and soups.
Taper Fluids in the Evening For residents that experience nighttime awakenings to toilet, tapering fluids in the evening/after supper can ward off excessive urinary output overnight and allow better sleep.
Add Water Serve a glass of water with every meal (unless contraindicated) similar to restaurants. Pour a glass while waiting before the meal arrives. Offer a glass after exercise groups or therapy sessions. Bring water to outside activities during hot weather. Water may be more appealing if lemon is added. Consider fruit diffused water dispensers for common areas, as allowed.
Avoid Other Bladder Irritants Acidic beverages like tomato juice, sugary drinks like soda, and alcohol are known bladder irritants. Overactive bladder symptoms worsen when drinking these beverages. For a full list of bladder irritants see www.nafc.org

Food before Medicine Interventions: Nutrition
Snack offerings Review current snacks available, both prepared snacks and pantry snacks, adding fiber rich snacks into the rotation.
Limit Sugar Sugar is a bladder irritant, and can exacerbate urgency, frequency, and urinary tract infections. It can also lead to kidney problems, diabetes, and weight gain, which worsen urinary incontinence.
Prunes A staple for bowel regimens, prunes can be given as is, or blended into a pudding/whip. Prune juice is another alternative.
Bran Bran is great for digestion, increases transit time and bulks stool, and can help relieve constipation. Offer bran muffins or cereal for breakfast/snacks. There are recipes for bran balls, similar to energy bites, which mix bran with raisins peanut butter and other ingredients.
Smoothies Offering smoothies as a breakfast or snack item is an effective way to deliver a highly nutritional drink (incorporate greens, fruits, fiber, and yogurt) that tastes great and can be switched up with many appealing recipes.
Food diary Keeping track of intake with a food diary can reveal any dietary coincidence with bowel and bladder challenges, so modifications can be made accordingly.
Probiotics Found in yogurt, lactobacillus drinks, tempeh, miso, pickled vegetables, kombucha and other fermented foods, probiotics protect and restore the flora/biome in the gut, alleviating some GI symptoms.
Seasonings Consider adding no-salt seasoning, or other flavors like lemon, garlic, ginger to enhance the flavor of vegetables to promote intake.
Fruits and Vegetables Include fresh fruits and vegetables with meals and snacks. A few menu items shared by Passion for Dining and Nutrition: spinach salads topped with strawberry and cucumber, sliced apples with dip, apple and butternut squash soup.

Tools/Resources “Food before Medicine”

	Medtrition- UtyMax https://www.medtrition.com/product/utymax/
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	Medtrition: Expedite https://www.medtrition.com/product/expedite/
	Lyons: High Fiber Apple Juice (+other flavors) https://lyonsreadycare.com/products/apple-juice-with-fiber

Prune Pudding recipe

1 1/2 c. pitted prunes
1 c. unsweetened applesauce
1/2 c. All-Bran
3/4 c. prune juice

Put in blender. Blend well.

Optional: add sprinkles, cinnamon, or whipped cream for presentation

Refrigerate. Can be kept in the fridge for 1 week, or frozen.

Serving size: ¼ cup

Serve once daily, or per request/need

STREAM Audit: Dietary

STREAM Dietary Audit

Audit question	*Who you interviewed*	*Notes*
What food and beverage items are on the snack cart (differentiate AM, afternoon, PM, HS)		
What does the kitchen offer, for residents who are having problems with constipation?		
What are your site recipes you currently offer for constipation (ex: power ball, power pudding, BM cocktail) and how can staff access it/order it		
Pull standing house orders for bowel and bladder. What non-pharm interventions are there (prior to or along with meds)		
What can you access in the pantry to promote bowel/bladder health	*Nurses* *Nursing assistants*	
You often have residents struggling with bowel movements. What can you do?	*Nursing assistants*	
What departments receive education regarding hydration and foods to promote good digestion?		
Dietary Manager		
What are some things you do to support resident bowel and bladder health and function? Give some specifics.		
What else could be done to promote bowel and bladder health/function?		
What education would your staff benefit from the most, related to elimination		

Summary of findings:

Cornerstone

Quality Data Implications

- STREAM Best Practice: MDS and Nursing Collaboration
- STREAM Best Practice:Understand Quality Indicators for Continence
- STREAM Best Practice: Monthly QI Audits

MN Quality Indicator Scores

The STREAM program targeted 3 of the Minnesota Quality Indicator Scores in the Incontinence Domain (LS)

Continence	Incidence of Worsening or Serious Bowel Incontinence
Continence	Incidence of Worsening or Serious Bladder Incontinence
Continence	Prevalence of Occ to Full Bladder Incontinence w/o a Toileting Plan

If the community has a goal to improve these QI scores, start by:

1. Deciphering the QI score
    a. Numerator, Denominator, Excluders, Risk Adjustors. In order to impact the QI, it's important to know which residents trigger the QI and why.
2. Where does the score come from?
    a. MN QI scores are derived from the MDS coding. The continence domain QI scores pull directly from section H of the MDS. Learn which questions of section H are tied to the QI.
3. RAI Manual definitions
    a. Review the RAI manual for section H to find what program criteria entails. What goals, assessment components, verbiage, evaluations will need to be present in the nursing documentation for MDS to credit the program.
    b. Review current existing bowel and bladder documentation templates for these components.
    c. Determine what education gaps can be supported with education in this manual (ex: micro learning NAR documentation importance, nurse incontinence course).

Toileting Programs

Toileting Programs (MDS)

The information provided is as of June 15th, 2023.

MDS Criteria for an individualized toileting program:

Documentation must include:

- ✓ Implementation of an individualized, resident specific toileting program.
  …That was based on resident's unique voiding pattern
- ✓ The program was communicated to staff and resident through ___ verbally and through a care plan
- ✓ Evaluation - Document resident's response to the program and re-evaluate periodically (quarterly at minimum). Current interventions, Effectiveness, progress towards goal, writer's reasoning to continue or change plan.

Toileting Program must be addressed on the Care Plan & has to include:

- ✓ A problem/focus statement (resident's starting point)
- ✓ A measureable GOAL directly related to incontinent episodes
  - ✓ Urinary incontinence goal DAILY, bowel incontinence 4/7 days/wk
- ✓ Interventions, promoting continence , specific to type

- Bladder Program Strategies accepted by MDS: Timed/Scheduled, Habit Training, Bladder Retraining, Prompted Voiding

- Bowel Program Strategies accepted by MDS: Individualized Schedule, plus other interventions

MDS Coding- Urinary Frequency

MDS will review a 7-day look back period of incontinence documentation from NAR charting. The MDS coding guidance is as follows:

- Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, **without any episodes of incontinence.**
- Code 1, occasionally incontinent: if during the 7-day look-back period the resident **was incontinent less than 7 episodes**. This includes incontinence **of any amount of urine sufficient to dampen undergarments**, briefs, or pads during daytime or nighttime.
- Code 2, frequently incontinent: if during the 7-day look-back period, the resident was **incontinent of urine during seven or more episodes but had at least one continent void.** This includes incontinence of any amount of urine, daytime and nighttime.
- Code 3, always incontinent: if during the 7-day look-back period**, the resident had no continent voids**.
- Code 9, not rated: if during the 7-day look-back period the resident **had an indwelling bladder catheter**, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

STREAM QI Management Advice

Action items suggested by STREAM consortium members:

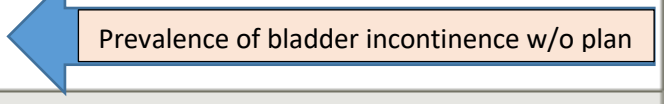
- Stay in close communication with MDS nurse.
- Discuss residents who are/will be coded always incontinent in IDT. IDT must agree this is accurate before it is coded that way.
- Review all new admissions for incontinence.
- Residents who use full lift - consider option to use bedpan or urinal.
- Add custom tasks for NARs to capture documentation of continence.
- Observe resident toileting during ARD window.
- Use technology and use it timely to give objective data.
- Add a calendar reminder to review section H coding and complete QI audit every month.
- Alert MDS nurse if needing to change frequency coding (ex: coded always, change to frequent).
- Add a progress note in the ARD to capture new level of continence for MDS nurse to read.
- There may be other EMR specific reports that can inform of declining residents (ex: ADL significant change report) to review for programs.
- Add/update residents to program as incontinence changes.
- Request feedback from MDS nurse if program could not be credited.
- Educate staff on accurate documentation of incontinence (ML 10). Educate nurses on documentation criteria and expectations.
- RN clarification notes can override nursing assistant charting.

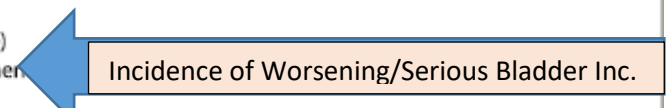
- Residents trigger the QI when >100 days of stay, be aware of LOS.

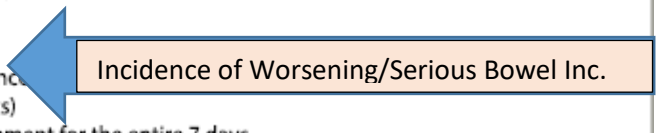
MDS Section H

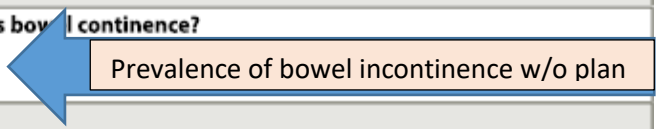
MN Quality Indicator scores come directly from the following MDS Section H questions:

Section H	Bladder and Bowel
H0100. Appliances	
↓ Check all that apply	
☐	**A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☐	**B. External catheter**
☐	**C. Ostomy** (including urostomy, ileostomy, and colostomy)
☐	**D. Intermittent catheterization**
☐	**Z. None of the above**
H0200. Urinary Toileting Program	
Enter Code ☐	**A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. **No** → Skip to H0300, Urinary Continence 1. **Yes** → Continue to H0200B, Response 9. **Unable to determine** → Skip to H0200C, Current toileting program or trial
Enter Code ☐	**B. Response -** What was the resident's response to the trial program? 0. **No improvement** 1. **Decreased wetness** 2. **Completely dry** (continent) 9. **Unable to determine** or trial in progress
Enter Code ☐	**C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. **No** 1. **Yes**
H0300. Urinary Continence	
Enter Code ☐	**Urinary continence** - Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (less than 7 episodes of incontinence) 2. **Frequently incontinent** (7 or more episodes of urinary incontinen 3. **Always incontinent** (no episodes of continent voiding) 9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days
H0400. Bowel Continence	
Enter Code ☐	**Bowel continence -** Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (one episode of bowel incontinence) 2. **Frequently incontinent** (2 or more episodes of bowel incontinenc 3. **Always incontinent** (no episodes of continent bowel movements) 9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days
H0500. Bowel Toileting Program	
Enter Code ☐	**Is a toileting program currently being used to manage the resident's bow l continence?** 0. **No** 1. **Yes**
H0600. Bowel Patterns	
Enter Code ☐	**Constipation present?** 0. **No** 1. **Yes**









Incidence of Worsening or Serious Bladder Incontinence QI Audit

Facility name _____ Date _____

We are doing this audit to/because:
To take measures to improve the Incidence of Worsening or Serious Bladder Incontinence QI.

Instructions for audit:
Review the following:

1. Pull List of residents coded as "Always Incontinent" on their last MDS. (always = serious)
    a. Exclusions are: ostomy, para/quadriplegia, comatose, end stage prognosis, hospice care, short stay.
2. Routinely and often- review section H of the MDS for accurate coding of residents.
3. Ongoing – review section H of the MDS BEFORE the MDS closes. See if coding is reflecting accurate picture.
4. Worsening: compare most recent MDS to prior MDS, urinary frequency coding

Audit:
How many residents in the last month were coded as always incontinent? _____
How many residents in the last month were coded as worsening incontinence? _____

How many of those residents are on STREAM/Toileting Program? _____

Resident Initials:	Always Or Worsening	Toileting Program Resident Y or N	Does IDT agree always inc. of urine? Y or N	Will this resident be added to Program?	If no, explain reason(s).

Bowel and Bladder Plan QI Audit

Facility name _____Date _____

We are doing this audit to/because: ___

This audit will verify toileting plans are credited on the MDS and help with RCA to discover why if not. This audit is to be completed then reviewed in depth monthly with MDS nurse.

Instructions for audit:

Review the following:

1. Current residents on toileting program/STREAM caseload
2. Residents you believe should have a bowel or bladder program credited on MDS
3. Last MDSs completed for those residents – review section H coding

Audit:

How many toileting programs do you have in place- Bowel _____ Bladder _____

How many of those programs were credited (yes) on section H of MDS – Bowel _____ Bladder _____

Resident Room # or Initial	Bowel program?	Was it credited on last MDS?	Bladder program?	Was it credited on last MDS?	If No – Why not?

Education

Educational Resources

The following educational topics were created through the learnings from the STREAM program. Micro learnings (ML) are designed to be approximately 15 minutes and include a lesson plan, slides, and quiz. While some topics are designed specifically for nurses or nursing assistants, numerous topics apply to all disciplines. The presenters in the STREAM program found that small group settings were most effective, followed by individual 1:1 teaching. Each educational topic in this manual includes a lesson plan, describing the intended outcome, targeted audience, materials needed, learning evaluation, and which phase of implementation the topic is recommended for.

For Licensed Nurses:

- Nurse Incontinence Course
- Bladder Scanner Indications (ML)
- Parkinson's and Incontinence
- Bariatric Considerations
- Moisture Associated Skin Dermatitis

For Nursing Assistants:

- NAR Documentation Importance (ML)

For all Direct Care Staff:

- Food for your Gut (ML)
- Functional Incontinence (ML)
- Intro to Incontinence (ML)
- Strategies (ML)
- Nocturia (ML)
- Urinary Tract infections (ML)
- STREAM Bingo
- STREAM Game Show

Micro Learning: Intro to Incontinence

Topic: **Intro to STREAM and Incontinence**

Audience: **all disciplines, NAR, non-licensed**

Implementation Phase: Recommended for Phase 1

Objectives: Learner will

- ☐ **increase awareness of STREAM**
- ☐ **identify prevalence and significance of UI**
- ☐ **match types of UI with symptoms**

Materials/Equipment:

Power point slides

Quiz (handout)

Sign-in sheet

Tasks/Actions:

Date, Time?

Location?

Advertise?

Summary of Learning:

- ✓ **Plant the Seed** 

  This starter session will get the wheels spinning… and open the door for the next topic re: strategies.

- ✓ **STREAM overview**
- ✓ **Incontinence 101**
- ✓ **Types of incontinence**

Assessment of Learnings:

QUIZ (collect at end of training)

Staff may now recognize symptoms in their residents.

Micro Learning: Effective Strategies

Topic: **Effective Strategies for Improving Incontinence**

Audience: **nursing assistants/ direct caregivers**

Implementation Phase: Recommended for Phase 1

Objectives: Learner will:

- ☐ **define strategies**
- ☐ **practical application thru resident scenario**
- ☐ **enhance practice to improve incontinence for unique type**

Materials/Equipment:

Rolled hand towels

Power point slides

Quiz (handout)

Sign-in sheet

Tasks/Actions:

Date, Time?

Location?

Advertise?

Summary of Learning:

- ✓ **STREAM awareness**
- ✓ **Incontinence can be improved/ managed with these strategies, you can help keep residents dry and sleep better**
- ✓ **Prompted voiding**
- ✓ **Scheduled/timed voiding**
- ✓ **Double Voiding**
- ✓ **Kegel exercise awareness**
- ✓ **Empowering nursing assistants to carry out these methods effectively**

Assessment of Learnings:

QUIZ (collect at end of training)

Staff can demonstrate and carry out these strategies that may be part of resident's bladder plans.

Micro Learning: Bladder Scan Indications

Topic: **Bladder Scanner Indicated Uses**

Audience: **Nurses**

Implementation Phase: Recommended phase 1 or 2

Objectives:

- ☐ **Increase knowledge of bladder scanner use**
- ☐ **Improved critical thinking skill for urinary assessment**
- ☐ **Increase use of the new bladder scanner beyond the usual PVR/straight Cath order**

Materials/Equipment:

Your Bladder Scanner

Micro learning #3 Hand out

Sign in sheet

Tasks/Actions:

Date? Location?

Advertise:

Educate nurses on the indicated uses for the bladder scanner and evaluate competency

Hands on Training with the bladder scanner

Summary of Learnings:

Historically, the primary and sometimes only use of the bladder scanner in LTC has been for this scenario "straight Cath resident if PVR is greater than 250cc"

Through our learnings from Dr. Laird, and the VitaScan company, we have identified several indicated uses of the bladder scanner for clinical assessment. The bladder scanner can inform your assessment and drive clinical decisions. It is a valuable tool for root cause analysis.

Sources:

Dr. Laird

AMN Health care Edu. Services rn.com

Assessment of Learnings:

Hands-on training

Sign in sheet

Auditing of learning via observation and questioning on the floor

Bladder Scan : Indicated Uses

Bladder scanners are innovative tools that utilize technology to safely and accurately evaluate urinary conditions.

Here are several indicated uses of the bladder scanner for clinical assessment. The bladder scanner can inform your assessment and drive clinical decisions. It is a valuable tool for root cause analysis.

For residents with incontinence, urinary urgency, frequency, bladder irritability, voiding difficulty, or who use a catheter; consider how this tool could help collect more information to determine the cause behind the resident's symptoms.

Bladder Capacity
✓ Identify bladder distention or full bladder ✓ Determine Individual Bladder Capacity ✓ At what volume does the resident feel the urge to urinate, how much can they hold?
Retention
✓ Assess f0r Urinary Retention ✓ Monitor Post Void Residual (PVR) ✓ Overflow incontinence
Catheter
✓ Bladder function after removing an indwelling urinary catheter ✓ Useful tool in bladder retraining (Biofeedback) ✓ Identify a blocked catheter
Clinical Assessment
✓ Accurate assessment of a resident's hydration status ✓ Abdominal or bladder pain ✓ Bladder outlet obstruction or suspected voiding dysfunction

Bladder Scan

3- day baseline	Individualized Bladder Capacity (IBC)
• **URINE VOLUME** • Collect urine in hat • + weighed pads* • + • **URINE RETAINED** • POST-VOID RESIDUAL	Average Volume + Average PVR = **IBC**

*1 Liter = 1 Kilogram; 33 ounces = 2.2 pounds

Bladder Scanner Indicated Uses:

- Prevent catheter associated Urinary Tract Infections (CAUTI)
- Identify Post-operative Urinary Retention (POUR)
- Post Void Residual (PVR)
- Identify Bladder Outlet Obstruction (BOO)
- Identifying full bladder when Foley catheter is not draining
- Bladder function after removing an indwelling urinary catheter
- Identify bladder distention
- Identify causes of urinary frequency and bladder irritability
- Accurate assessment of a patient`s hydration status
- Useful tool in bladder retraining (Biofeedback)

Micro Learning: Functional Incontinence

Topic: Functional incontinence

Audience: All staff

Date:

Objectives:

- Identify functional incontinence
- Apply RCA to recognize individual, environmental and/or operational causes for functional incontinence
- Align meaningful interventions to address root cause/s of functional incontinence

Materials/Equipment:

What you will need:

PowerPoint slides

Quiz

Tasks/Actions:

Date, Time?

Location?

Advertise?

Summary of Learning:

See power point: Know Better/ Do Better

Functional incontinence – definition

Not a normal part of aging

Match intervention to cause

Environmental cueing

Medication alignment

Know the Resident

Physical, cognitive and operational causes

Assessment of Learnings:

Post quiz and consideration of implementing answers to post quiz question # 3

Micro Learning: Dietary Impact: Food for your Gut (PDN)

Topic: Dietary Education "Food for your Gut"

Audience: Dietary Department, Dieticians, Diet Techs, Activities, NAR

Implementation recommendation: Phase 2

Objectives:

- Become familiar with the USDA Dietary Guidelines and the overall approach to eating for health.
- Learn the daily recommendation for fiber and sources of fiber in food.
- Identify ways to incorporate fiber rich food into meals and snacks.
- Explore ideas for creating a partnership with Culinary Service departments.

Materials/Equipment:

PowerPoint slides

Tasks/Actions:

Date, Time?

Location?

Advertise?

Assessment of Learnings:

Quiz questions

Summary of Learning:

This micro-learning addresses the highlights from the ***Passion for Dining & Nutrition*** presentation from 11.18.21

Including:

- ✓ My Plate Guide
- ✓ Highest- fiber grains, fruits, veggies
- ✓ Creative ways to offer snacks
- ✓ Menu suggestions
- ✓ Recipes from PDN

Nutrition improvements are part of our PIPP (bowel and bladder) and can also be part of a site QAPI plan, working on improvement as a community initiative.

Micro Learning: Nocturia

Topic: **Nocturia**

Audience: **nursing assistants/ direct caregivers, Night Shift.**

Implementation Recommendation: Phase 2

Objectives:

- ☐ Recognize nocturia as a particular type of incontinence
- ☐ Be able to recognize nocturia in residents
- ☐ How to approach treatment of nocturia

Materials/Equipment:

Power point slides

Quiz (handout)

Sign-in sheet

Tasks/Actions:

Date, Time?

Location?

Advertise?

Other topics to address with night shift:

Summary of Learning:

- ✓ **STREAM awareness**
- ✓ **Defining Nocturia**
- ✓ **Risk factors for Nocturia**
- ✓ **Individualized night time care plans**
- ✓ **Root cause analysis of Nocturia**
- ✓ **Promoting restorative sleep**

Assessment of Learnings:

QUIZ (collect at end of training)

Staff can recognize Nocturia in residents and understand the importance of individualized care.

Micro Learning: Urinary Tract Infections

Topic: **Urinary Tract Infections**

Audience: **Families, Residents, Direct Care Staff**

Implementation Recommendation: hase 2

Objectives:

- ☐ **Identify symptoms of UTI**
- ☐ **Understand implications for antibiotics for UTI in LTC**
- ☐ **Understand treatment of symptoms**

Materials/Equipment:

Power point slides

Quiz (handout)

Sign-in sheet

Optional- Loebs or McGeers criteria

Tasks/Actions:

Date, Time?

Location?

Advertise?

Upcoming family or resident council meetings?

Summary of Learning:

- ✓ **This training includes highlights from the TENA CEU training Jan 2022**
- ✓ **This micro learning will benefit residents and family as well as staff.**
- ✓ **STREAM awareness**
- ✓ **Defining UTI**
- ✓ **Risk factors for UTI**
- ✓ **Preventative Care**
- ✓ **Criteria for treating UTI**
- ✓ **How STREAM and staff can help**

Assessment of Learnings:

Discuss with infection control nurse if they see criteria being followed.

Follow up audit could include peri care, toileting, hydration practices, etc.

Micro Learning: NAR Documentation Importance

Topic: **Documentation Importance, NAR**

Audience: **Nursing assistants**

Implementation Recommendation: Phase 1

Objectives:

- ☐ Understand the bigger picture importance of NAR documentation
- ☐ Define continent and incontinent with examples
- ☐ Inspire timely, accurate, effective charting

Materials/Equipment:

Power point slides

Quiz (handout)

Sign-in sheet

Optional- POC charting pulled up

Tasks/Actions:

Date, Time?

Location?

Advertise?

Prior review of NAR documentation for trends, patterns, knowledge gaps

Summary of Learning:

- ✓ **This training emphasizes the importance of NAR documentation from a big picture stand point**
- ✓ **Baseline questions**
- ✓ **STREAM awareness**
- ✓ **Defines continent and incontinent**
- ✓ **Examples and scenarios**
- ✓ **Importance of following the toileting care plan**
- ✓ **Who needs to see the charting (Nurses, MDS) and why**

Assessment of Learnings:

QUIZ (collect at end of training)

Audit NAR documentation for more accuracy

Coaching as needed

Clinical Nurse Incontinence Course

Topic: ***Clinical Nurse Incontinence Course***

Audience: Licensed Nurses (RN, LPN) in any role

Length: 3 hours, 3.0 CEU

Implementation Recommendation: Phase 1, 2, and 3 continued. 80% of nurses trained.

Objectives:

- ☐ Increase clinical competency for incontinence assessment and management for nursing staff.
- ☐ Learn the importance of root cause analysis of incontinence before creating a plan
- ☐ Dispel the myths surrounding aging and incontinence.

Materials/Equipment:

- Class Flyer
- Power point slides
- Work book handout
- Sign in sheet
- Evaluations
- CEU Certificates

Tasks/Actions:

- ☐ Post flyer and manage registration
- ☐ Arrange for light food/snack items and coffee/water.
- ☐ Ensure 80% of primary nurses attend
- ☐ Keep a folder of class materials (handouts, sign in sheet, evals)

Summary of Learning:

STREAM has created an Advanced Education module to increase clinical competence for incontinence assessment and management, for nursing staff.

Dispel the myths surrounding aging and incontinence

Teach the importance of root cause analysis

Use "Mabel" scenario for practical application

Use Dr. Laird's care plan table for practical application

Diffuse learnings from the STREAM program to all nurses

Assessment of Learnings:

- Course Evaluations know better do better section
- Competency Quiz
- See it in practice – documentation, care plans

;Special Considerations:

Bariatric Incontinence

Audience: Nurse, Therapy, Dietician

Implementation recommendation: Phase 2 or 3

Objectives:

- Learn interventions and strategies to reduce the negative effects of incontinence related to bariatric status
- Discuss risk factors presented by bariatric status and other co-related morbidities
- Inform on best practices in bariatric incontinence related care

Parkinson's and Incontinence

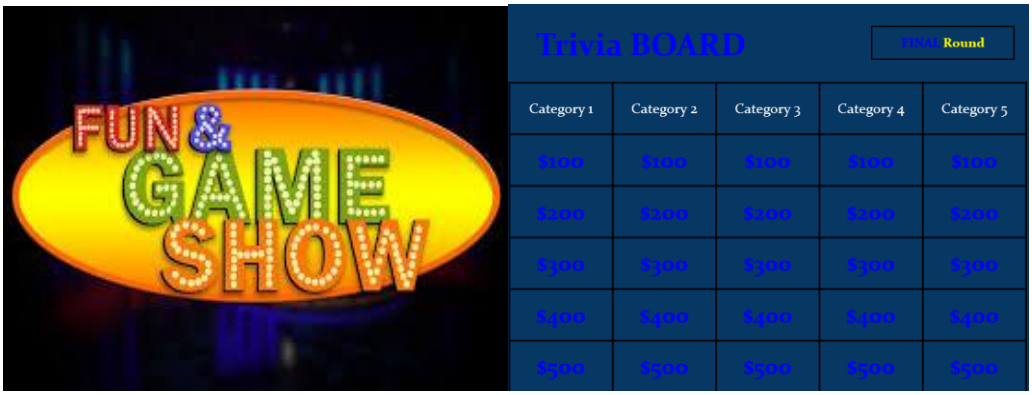
Audience: Nurse, Therapy, Other IDT

Implementation recommendation: Phase 2 or 3

Objectives:

- Basic understanding of Parkinson's disease (PD) and draw connections between PD and Bladder/Bowel concerns
- Understand how a normal bladder functions vs. Parkinson's disease process
- Learn effective treatment strategies for PD and Urinary Incontinence (UI).
- Apply critical thinking to real life case studies

STREAM Trivia Game Show



Audience: All staff

Implementation Recommendation: Phase 3

Objectives:

- ☐ Audit knowledge retention of previous learnings
- ☐ Provide on the spot education
- ☐ Present education/audit in a fun engaging way.

Materials/Equipment:

Trivia Game (ex: Jeopardy Template) PowerPoint slides. Example above found on creative commons

Tablet or Lap Top

Candy or some kind of prize for playing

Tasks/Actions:

Date, Time?

Location?

Advertise?

Summary of Learning:

This micro-learning addresses knowledge retention of previous staff who should have attended/received micro learning education.

It covers myths, practices, interventions, strategies, etc. It reflects both the T/F questions and written response questions from micro-learnings 1, 2, and 4. Also covers some basic product knowledge (ex: identifi) that should be known to all staff.

This game offers the opportunity to provide new education for new staff as well.

It may reveal areas where the education did or did not stick with recipients. It may shed light on education gaps you can follow up on.

Assessment of Learnings:

Correct / incorrect responses will be known on the spot. Please explain correct answers if staff answer incorrectly.

STREAM BINGO

This is an example of a BINGO game for a holiday staff gathering, using terminology and concepts from the micro-learnings previously shared with staff. This is a method to evaluate knowledge retention, and provide on the spot education where terms are not well understood.

**Bingo cards can be created online at: myfreebingocards.com

Resources

Resources

Links to credible online resources leveraged for this program:

National Association for Continence www.nafc.org

Wound Ostomy Continence Nurse Society www.wocn.org

Urology Care Foundation www.urologyhealth.org

Subject Matter Experts

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