Long-Term Care Survey Alert

Put Your Continence Program On The Fast Track To Success

If managing urinary incontinence seems like a constant battle in your facility, it might be time to regroup the troops and decide how youre going to define victory.

You dont have to help a resident become 100 percent dry to claim success, emphasized **Mary Palmer**, associate professor of nursing at the **University of North Carolina at Chapel Hill**, speaking at the June 2003 **National Association of Directors of Nursing Administration in Long Term Care** (NADONA) conference in Cincinnati.

Assessment is the key to developing a realistic plan of care that will allow you to target staffing most effectively and keep surveyors happy.

What surveyors expect to see and will ask staff about is how the facility determined which resident is on what program, says **B.J. Collard**, a restorative nurse with **CTS Inc.** in Denver.

To answer that question, staff can keep a careful bladder diary for several days where they record each time the resident voids and, if possible, the amount. Within three days, you will see a pattern, Palmer says.

Not only can the diary detect residents with urinary frequency or urgency that may be contributing to toileting accidents or falls, it provides the fork in the road by identifying those residents who have a chance to regain bladder control. The more severely incontinent the person, the less likely a trial of behavioral [bladder] retraining will work, Palmer said.

Cognitively impaired residents may also have trouble with bladder retraining, which requires a person to follow the programs instructions and consciously delay voiding for increasing intervals. In Collards view, candidates for such programs should have a score on the MDS for cognitive skills for daily decision making (Section B4) of 0 (independent) or 1 (some difficulty with decisions in new situations only).

Tip: The bladder diary will show whether the resident is improving and its a great way to show surveyors that youre monitoring outcomes.

Those residents who arent good candidates for bladder retraining or those who dont improve on such regimens go on a regular toileting schedule. Some facilities automatically toilet residents every two hours. But the bladder diary and ongoing assessment by regular caregivers can help staff individualize the schedule to each residents own voiding pattern. **Tip:** Eighty-two percent of voiding episodes occur during the same hourly blocks of time upon arising is one. So staff accordingly, Palmer said.

Check and change programs are appropriate for residents who have no potential to be toileted or bladder trained and are so debilitated that they are unable to use the toilet. You can still use a bladder diary to determine wet and dry patterns that will help staff keep these residents dry and avoid skin breakdown.

Think DRIP

In addition to using the bladder diary, the handy DRIP acronym can help staff hone in on common causes of incontinence:

D: Dementia. To help cognitively impaired residents find their way to the bathroom, place large footsteps on the floor that lead the way to the bathroom. (Glow-in-the-dark footsteps can help the resident with nocturia.) Mark bathrooms with large signage and picture symbols, which also helps your residents with low vision.

Steer clear of common triggers known to worsen a cognitively impaired residents disorientation, which can lead to more toileting accidents. For example, avoid over-stimulation, changes in caregivers and routine, and anticholinergic drugs. Nursing homes have to be careful with anticholinergic drugs, including drugs like Detrol used to treat overactive bladder, cautions **Sam Kidder**, a pharmacy consultant and long-term care ombudsman in Silver Spring, MD. Too much anticholinergic effect can produce mental/behavioral changes.

R: Restricted mobility. Assess and address the underlying causes of decreased mobility (pain, arthritis, low vision, Parkinsons disease) that make it difficult for residents to use the toilet independently. Muscle-strengthening exercises can help residents whose arms are too weak to get up and down from the toilet, Collard suggests. Do task segmentation (see Section G7 of the MDS) to break down all the steps required to toilet independently so youll know where the resident needs assistance and/or restorative interventions.

I: Infection and impaction. Urinary tract infection can cause incontinence, so check for bacteriuria, especially with new onset incontinence or a changing pattern of incontinence, suggested NADONA presenter **Theodore Johnson II**, assistant professor of medicine at the **Emory University School of Medicine** in Atlanta.

Fecal impaction may cause urge or overflow incontinence and can usually be detected with a digital rectal exam. **Tips:** Studies confirm that cranberry juice reduces bacteriuria. A dietary bowel regimen (more fiber, natural food laxatives and fluid) can really improve urinary incontinence.

P: Pharmaceuticals and Polyuria. Consult with the pharmacist to see if medications might be causing or contributing to a residents incontinence. Common culprits include diuretics and medications that cause constipation or sedation. One case study showed that altering anti-anxiety agents reduced incontinence, according to NADONA presenter **Diane Newman**, co-director of the **PENN Center for Continence and Pelvic Health at the University of Pennsylvania** in Philadelphia. Refer residents with unexplained polyuria to the physician to rule out endocrine or kidney disease.