the DRYeR Kit

Doing Right by Your Residents

An Incontinence Train the Trainer Toolkit for DONs

Developed by:

RA Chidester CONSULTING LLC

NADONALTC

The National Association of Directors of Nursing Administration in Long Term Care

Background & Foreword

NADONA, The National Association of Directors of Nursing of America, teamed up with RA Chidester Consulting, LLC to develop this robust resource about incontinence management, quality assurance and performance improvements within Skilled Nursing. During the recent pandemic, the safety of residents was compromised due to the nature of the tragedy that biologically targeted the older population. Time is now to upgrade our knowledge, our training and our actions as it relates to managing incontinence, which so discreetly lies beneath quality metrics of falls, injuries, pressure ulcers, antipsychotic medication use, infections, loss of functioning and more.

60-70% of nursing home residents are living with Incontinence. Over 56% of a nursing aide's shift in skilled nursing accounts for incontinence care. New studies are starting to research the current standard of practice for incontinence management as it is widely used, yet falls short of providing the older adult a dignified way of handling the condition. It has been calculated with the old standard of practice of changing resident's every 2 hours, can still put the older adult at risk for being exposed to their own waste for 36 hours or more. Overall, the management of incontinence care is a major pillar in providing quality care to older adults. Incontinence is not a normal part of aging and as a society, we must acknowledge this and provide older adults with the most dignified means possible in which to regain control of their functioning or at minimum, how to have a happy healthy life living with the condition. Research suggests the management of incontinence can "significantly impact" CMS Quality Indicators in areas of falls with major injury (47%), Urinary Tract Infections (47%) and Pressure Ulcers (41%).*

This training is an updated, modern handbook for Directors of Nurses to be able to share with staff, families and/or residents in order to improve quality of care. Included with this guide is a presentation and handouts for the most effective teaching experience. You have taken the first step by reading this message and now is the time to join the movement to better continence health for our older adults.

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Amy is a proud graduate of the Virginia Tech's Center for Gerontology, located in beautiful Blacksburg, Virginia. As a Fellow Alumni of the LeadingAge Leadership Academy, an original member/founder of the Geriatric Mental Health Partnership, a former Adjunct Professor of Long-Term Care for South University and a Certified Gerontologist, Amy has spent the last 20 plus years as a respected senior living executive managing multiple levels of senior living to include skilled nursing, assisted living, memory support, CCRC's (Continuing Care Retirement Communities) and independent living. She is licensed as a Nursing Home Administrator, Preceptor and Assisted Living Administrator in both Virginia and Texas. Amy served as the Director of The Birdsong Initiative, giving her 3 plus years of experience in formal, medical research in technology and aging studies. Currently, Amy owns and manages RA Chidester Consulting that is working with clients in Agetech and senior care services to help revolutionize the incontinence industry by transforming the way we monitor and manage care to positively impact quality among America's senior services. Amy is the Founder of the Global Agetech International Laboratory (G.A.I.L.), www.rachidester.com, a virtual, matchmaking space for everyone in the aging ecosystem to collaborate and work together as a force to improve the speed and efficacy of the services and products made for seniors. She is extremely proud of her two daughters that she has with her husband Russell Chidester. She resides in Austin, Texas and has had experience as an informal caregiver on multiple situations throughout her life. She has a passion for helping others who care for people, pets and children.

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Cindy Fronning

Cindy has over 40 years of experience in long-term care as a DON / Multi Facility Organization consultant and a National Clinical Consultant specializing in clinical reimbursement. Cindy's experience includes education of nursing home personnel, mentoring of nurses and Directors of Nursing, clinical systems and form development, department restructuring, and mock surveys. As a respected professional in the industry she has developed a comprehensive understanding of the State and Federal regulations impacting long term care. Currently, Cindy is the Director of Education for NADONA. Her role is responsible for the planning, direction and implementation of all educational projects and pursuits within NADONA. She created and is the instructor for the NADONA Certification courses and exams for Nurse Leaders, Infection Preventionists and Antibiotic Stewardship initiatives.

Instructions for Directors of Nursing

1. Familiarize yourself with the training materials
2. Assess where your incontinence program is currently with our self assessment form in "Attachments".
3. Plan how you will train your staff with the information provided and when. Schedule it and make it a priority!
4. Engage with conversation and interaction among staff during your training.
5. Re-assess where your incontinence program is with the same form as before the training to determine how effective your training program was.
6. Monitor by implementing a QAPI Incontinence Program Action Plan. See Attachments for a template.

Table of Contents

Section A:
What is Incontinence, causes, symptoms and types
Overview of the Urinary System

Incontinence is not a normal part of aging.


Incontinence is...

Incontinence is...

- At least 10 million Americans suffer from incontinence, which means that they are not able to control the times when they urinate.
- In some cases, the loss of urine is so small that people are hardly aware of it.
- In other cases, the amount of leakage is quite large.
- Only about 10 percent of people who suffer from incontinence seek treatment.
- Without treatment, many of these people stay at home and withdraw from life unnecessarily.
- Incontinence is not a disease, but it can be a symptom of disease.

Incontinence is...

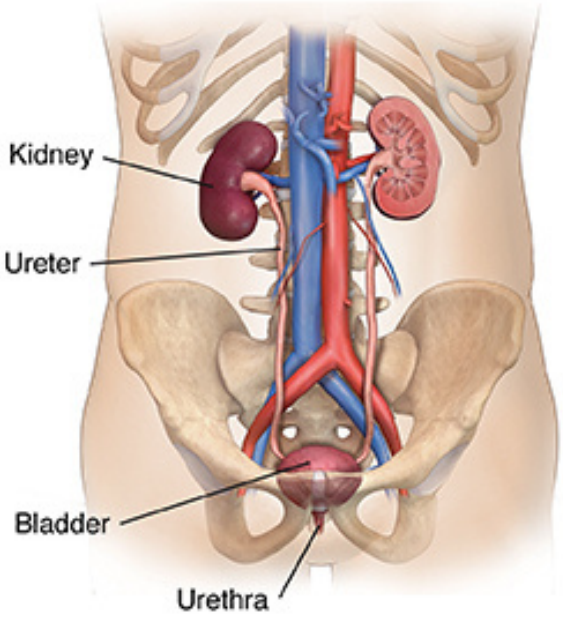
“Lack of voluntary control over urination"
(Oxford Languages)

“Inability of the body to control the evacuative functions of urination or defecation : partial or complete loss of bladder or bowel control”
(https://www.mayoclinic.org/diseases-conditions/urinary-incontinence/symptoms-causes/syc-20352808)

Also know as Overactive Bladder

Common & Embarrassing condition–
Can happen when muscles and nerves that help the bladder hold or release urine weaken

Symptoms
•May occur (leak urine) when you cough or sneeze
•May have a sudden urge to void but can’t get to the bathroom in time.



The Urinary System

What happens in the body to cause bladder control problems?

Located in the lower abdomen, the bladder is a hollow organ that is part of the urinary system, which also includes the kidneys, ureters, and urethra. During urination, muscles in the bladder tighten to move urine into the tube-shaped urethra.

At the same time, the muscles around the urethra relax and let the urine pass out of the body.

When the muscles in and around the bladder don't work the way they should, urine can leak, resulting in urinary incontinence.

CAUSES

Females

- urinary tract infections
- vaginal infection or irritation
- constipation
- medications
- weak bladder or pelvic floor muscles
- overactive bladder muscles
- damage to nerves that control the bladder from diseases such as multiple sclerosis, diabetes or Parkinson's disease.
- diseases such as arthritis may make it difficult to get to the bathroom in time
- pelvic organ prolapse, which is when pelvic organs (such as the bladder, rectum, or uterus) shift out of their normal place into the vagina or anus. when pelvic organs are out of place, the bladder and urethra are not able to work normally, which may cause urine to leak.

Males

- prostatitis, a painful inflammation of the prostate gland
- injury or damage to nerves or muscles from surgery
- an enlarged prostate gland, which can lead to benign prostate hyperplasia, a condition in which the prostate grows as men age
- medications
- urinary tract infections
- overactive bladder

5 Types of Incontinence

1)Stress incontinence

- Urine leaks when you exert pressure on your bladder by coughing, sneezing, laughing, exercising or lifting something heavy
- These actions cause a small amount of urine to leak from the urethra (tube that the urine passes through)
- Most common type of incontinence suffered by women
- Can affect women of all ages
- Most vulnerable are older women
- Women that have given birth more likely to have it

2) Urge Incontinence

Also known as overactive bladder(OAB)

- sudden, intense urge to urinate followed by an involuntary loss of urine
- having to go void eight or more times a day and/or more than once at night
- getting the urge to go when you touch or hear running water
- there’s also a dry form of OAB: You get the urge to go even if your bladder is empty
- may be caused by a minor condition, such as infection, or a more severe condition such as a neurological disorder or diabetes.

3) Overflow incontinence

- experience frequent or constant dribbling of urine due to a bladder that doesn't empty completely.

4) Functional incontinence

- a physical or mental impairment keeps you from making it to the toilet in time. For example, if you have severe arthritis, you may not be able to unbutton your pants quickly enough.

5) Mixed incontinence

- experience more than one type of urinary incontinence
- most often this refers to a combination of stress incontinence and urge incontinence
- more common in women.

Symptoms of Incontinence

The following are common symptoms of urinary incontinence.

However, each individual may experience symptoms differently.
The symptoms of urinary incontinence may resemble other conditions or medical problems.
Always consult a physician for a diagnosis.

Symptoms may include:

- needing to rush to the restroom and/or losing urine if not reaching the restroom in time
- urine leakage with movements or exercise
- leakage of urine that prevents activities
- urine leakage with coughing, sneezing or laughing
- leakage of urine that began or continued after surgery
- leakage of urine that causes embarrassment
- constant feeling of wetness without sensation of urine leakage
- feeling of incomplete bladder emptying

Section B: Disease States and Infection Control

#1 reason for hospitalization is Septicemia with 31% originating from UTI

Source: AHRQ

Disease States: Alzheimer's Disease

People in the later stages of Alzheimer’s disease often have problems with urinary incontinence.

This can be a result of not realizing they need to urinate, forgetting to go to the bathroom, or not being able to find the toilet.

These tips may help:

- avoid drinks like caffeinated coffee, tea, and sodas, which may increase urination. But don’t limit water
- keep hallways clear and the bathroom clutter-free, with a light on at all times
- provide regular bathroom breaks
- use underwear that is easy to get on and off, and absorbent briefs or underwear for trips away from home.

Disease States: Diabetes, Stokes and Other Nerve Diseases

These diseases in addition to other nerve diseases can damage the nerves that control the bladder which is where urine is stored before it leaves the body.

These diseases can also weaken the "sphincter," a ring of muscle around the opening of the bladder. This ring usually keeps urine from leaking out.

Men can have incontinence from problems such as overgrowth of the prostate gland or cancer of the prostate gland, both of which can block the flow of urine. In these cases, urine leaks out when the bladder becomes too full.

Risk Factors for Incontinence

Residents who are at risk for incontinence due to having at least one of these risk factors:

- Dementia
- Limited functioning
- Bedfast
- Pressure ulcers / Hx.
- Falls
- Catheter
- Wheelchair bound
- Limited engagement
- Frequent UTIs
- Poor nutritional health
- Dehydration / Hx.
- Obesity
- Diabetic
- Arthritis, back pain or injury
- Hearing or visual impairment
- High caffeine intake or alcohol, smoking and/or drug abuse

INFECTION CONTROL
Complications of Incontinence- Infection Considerations

Urinary Tract Infections

Limiting fluids

Can cause dehydration and a concentration of urine within the bladder leading to development of bacteria & infection

Peri Care

Potential for contamination/infection if frequent peri-care not provided correctly

Cystitis

Inflammation of the bladder caused by a UTI

Wound Infections

Pressure Injury wounds often become soaked for periods of time with urine saturated incontinent briefs if not changed frequently enough. This can worsen or cause new wounds or infections to develop.

Sepsis

Often infections get into the blood stream and infect the whole body

Section C: Treatment and Management

Studies show that that skin can start to breakdown in as fast as 15 seconds of exposure to a single void.

Source: AHRQ

Treatment of Incontinence

What is the treatment for urinary incontinence?

Specific treatment for urinary incontinence will be determined by a doctor based on:

- age, overall health and medical history
- type of incontinence and extent of the disease
- tolerance for specific medications, procedures or therapies
- expectations for the course of the disease
- personal opinion or preference

Treatment of Incontinence

These are some examples for the treatment of multiple types of incontinence:

•**Pelvic muscle rehabilitation** (to improve pelvic muscle tone and prevent leakage)

•**Kegel exercises:** Regular, daily exercising of pelvic muscles can improve, and even prevent, urinary incontinence

•**Biofeedback:** Used with Kegel exercises, biofeedback helps people gain awareness and control of their pelvic muscles

•**Vaginal weight training:** Small weights are held within the vagina by tightening the vaginal muscles

•**Pelvic floor electrical stimulation:** Mild electrical pulses stimulate muscle contractions

Treatment of Incontinence

These are some examples of behavioral interventions for the treatment of incontinence:

•**Bladder training programs:** teaches people to resist the urge to void and gradually expand the intervals between voiding

•**Toileting assistance**: uses routine or scheduled toileting, habit training schedules and prompted voiding to empty the bladder regularly to prevent leaking.

Treatment of Incontinence

Other treatments could include:

- **diet modifications:** Eliminating bladder irritants, such as caffeine, alcohol and citrus fruits

- **medications**: anticholinergic medications or vaginal estrogen

- **Pessary** (small rubber device that is worn inside the vagina to prevent leakage)

- **Office procedures:**
  - Botox injections into bladder
  - urethral bulking agents
  - peripheral nerve stimulation
  - surgery
  - slings (may be made from synthetic mesh or your own tissue)
  - bladder suspension

Clinicians should be knowledgeable on the types, symptoms and treatments of the many types of incontinence.

Incontinence Awareness

The regulations require several areas of awareness and knowledge for CNAs in long term care. <u>At any point an inspector can and should be asking you these questions about programs that impact your incontinence care procedures and practice.</u>

<u></u>These elements are a part of the clinical pathways or critical elements developed and published by CMS (links in appendix)*

Let's discuss the following:

- Inspectors will ask to observe your incontinence care given to someone who wears a brief. Be sure to know all the steps and make sure you are aware of the procedures within your particular organization.

- How do you know what care to provide? How are care plans communicated to you?
    a. Is this a book? a kiosk in the hallway? a handheld device?

- What do you look for when caring for someone who is incontinence?
    - Risk factors for infection, pain, hydration needs available, repositioning, nutritional needs, or any other unmet needs?
    - These needs should be addressed immediately while you are in the room and reported as appropriate (DONs give some examples here)

- In what ways do you allow the resident to be as independent as possible during incontinence care?

- How has the family and resident been involved in the care planning for the resident's individualized incontinence care? Care plan meetings?

- Inspectors will also look for you to explain what you will do with the resident BEFORE you do it during incontinence care and other care provided. (DONs give examples and maybe role plays here)

The DRGs of Managing Incontinence for the CNA

D=Dignity

- All residents deserve dignity whether or not they are living with incontinence. They are people too.
- Depending on the choice of treatment or management, providing the care in a way that provides privacy and dignity for the individual is key.
- Be discreet with communications to the resident and their caregivers as well as when to provide care as much as possible.

R=Respect

All residents deserve to have their individually desired treatment choices provided in a non-judgmental manner.

G=Grace

- All residents should be equally provided assessments, choices, professional evaluations, treatments and attention to their incontinence needs because it is not a normal part of aging.
- Our older adults deserve fair chances to make choices as they age.

Section D: Interventions for quality improvement and standards of practice

More than 1/3 of falls in long term care are related to going to the bathroom

Source: Stefanacci

Interventions for Quality Improvements

Incontinence is a pillar of high quality care. In other words, if you are not managing incontinence well; the overall health and wellbeing of the individual will suffer.

Incontinence is associated with the following conditions and adverse events:

- depression and other psychological conditions
- social isolation
- reduced engagement
- pressure ulcers and other skin breakdown
- urinary tract infections and sepsis
- increased confusion and/or cognitive impairment
- falls and falls with major injury
- negative behaviors and antipsychotropic medication use
- dehydration
- odor
- strained caregiver relationships
- increased preventable hospitalizations and ER visits
- decreased functioning
- institutionalization
- death

Interventions for Quality Improvements

Putting Incontinence into Perspective

Within 15 minutes of a single void, a resident's skin can start to degrade and breakdown.

56% of all shifts in long term care are associated with incontinence care.

1/3 of falls and falls with major injury account for the leading cause of preventable ER visits in long term care residents

Incontinence is the #1 predictor of institutionalization for those living with Dementia

Urosepsis accounts for 31% of the leading cause for hospitalization

During the pandemic, wounds and falls exponentially worsened in long term care communities

Myths About Incontinence

1. ***Incontinence is a normal part of aging....FALSE!***

Incontinence is not a rite of passage for becoming older. Incontinence is a symptom of other underlying conditions, most that are more prevalent as you age, therefore creating this myth.

If goes largely unresearched and underestimated when training medical professionals and determining the impacts of it on society at large. As we get older, it gets hard to be able to "fix" these conditions causing incontinence therefore it is something that some individuals will have to live with, but there are many ways of managing it effectively to keep an individual clean and dry, which is the only way to prevent other chronic conditions and adverse events.

It is important however for incontinence to be explored for an individual by their team of physicians in order to see if any treatment is appropriate before making assumptions about incurability.

2. Incontinence is not able to be reversed....FALSE!

Lots of types of incontinence can be reversed and/or cured but it depends on the reason behind the condition. A physician can work with an individual to determine 1) the cause 2) if there are any steps to take to try and reverse the condition and 3) can assist in determining ways to manage the incontinence if the condition is not reversable or too risk adverse.

It is important to note:

- Product matters-it is important to be educated in the many products that exist for management of incontinence. There are pull-ups, tabbed briefs, pads, reusable underwear and bedpans and urinals. For a whole listing of the types of products available to men and women living with incontinence, visit the National Association For Continence (https://nafc.org/incontinence-products-for-adults/)
- Size matters-sizing someone into the right size brief is important. The size does not have anything to do with the absorbency of the brief. If the brief is too large, it can leak around the legs or over the top creating an uncomfortable situation for the individual and a mess for the caregiver to clean up.
- Amount matters-It does not increase absorbency by applying more than one pad or one brief at a time. This can create other additional conditions and is not safe nor healthy for the individual.

3. Limiting water can make incontinence better because you won't have to pee as much...FALSE!

First of all, limiting water on purpose in dangerous in older adults due to risk of dehydration being higher than a younger individual.

Second, limiting water will cause urine to be more concentrated, which irritates the bladder and it can cause problems and issues to get worse, not better.

Third, the best is to drink proper fluid to be healthy and then to establish and maintain a realistic toileting schedule.

4. There is no valuable information in voiding patterns....FALSE!

On the contrary you can tell a lot about an individual by the schedule in which they void. It can be particularly helpful to know schedules because it can help care teams make better decisions when determining the cause, the treatment and the management of the incontinence. The only way to keep an accurate account of voiding patterns and determine schedules is by documentation. Some communities have electronic documentation and some have other means for documenting. The important part is that you find and maintain the way to document this information timely and accurately.

Voiding patterns can lead to insights about the risk for the following:

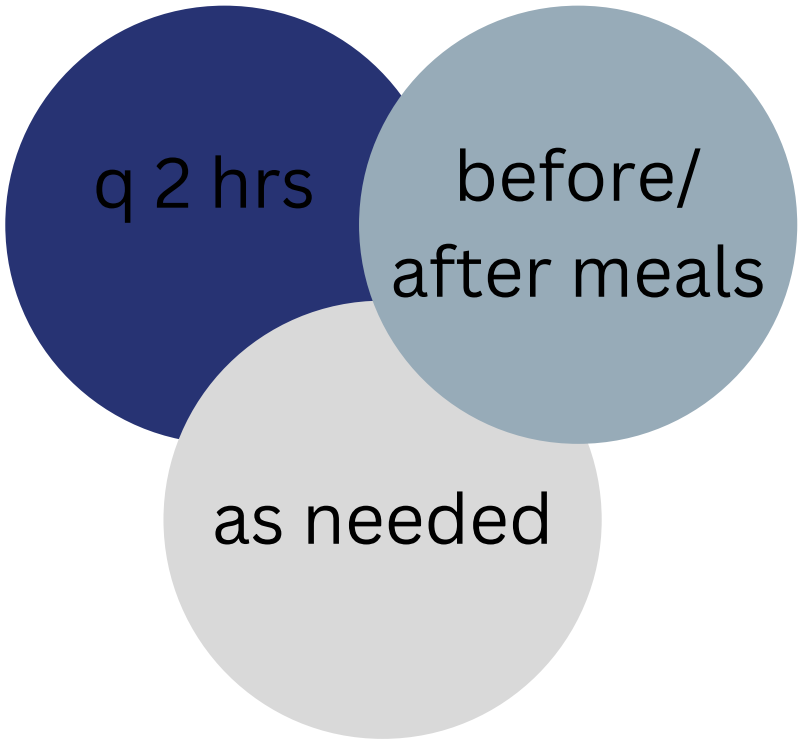
- dehydration
- urinary tract infection and/or urosepsis
- exacerbation of congestive heart failure
- diabetes
- overactive bladder
- kidney infection
- kidney stones
- stroke
- other neurological disorders
- weight loss
- falls and falls with major injury
- agitation, negative behaviors and/or psychotropic medication use

5. ***If someone is incontinent only some of the time, it means they are doing it on purpose...FALSE!***

Intermittent incontinence is completely possible and should still be treated, managed, respected and evaluated like anyone else living with incontinence.

Standards of Practice

Historical practice in rounding



Many problems with this:

- Not individualized, may not work for everyone
- Disruptive to sleep, activities and other hobbies
- At best, every two hours can still expose a resident to skin breakdown and infection
- cause behaviors
- not physically possible with staffing levels

Standards of Practice

Why strive for more?

Expectations of Regulations/Survey Compliance

- Individualization of care plans
- Professional assessment and evaluation for incontinence
- Increase quality and reduce accidents/incidents
- Providing care as ordered by physician and care planned

5 star ratings by CMS

- Improve exposure times by changing as frequently as possible can help improve quality which increases the ratings in areas of Quality metrics and Inspections that formulate the overall ratings
- Improves marketability for community to increase census
- Increases chances of participating with more insurance companies so that you can care for more older adults with various payers.
- Could provide better revenues, which could lead to continued wage increases and investment in additional staff

Standards of Practice
Why strive for more?

Maintaining Health and Wellbeing

- Knowing what to look for, reporting when necessary and helping maintain dry, happy residents will lighten burden of caregiving
- ***Research shows incontinence impacts falls with major injury (47%), UTIs (47%) and Pressure Ulcers (41%) and has been shown to be linked to Increased need for help with activities of daily living, worsened ability to move independently, catheter use, and antipsychotic medication use***.

Empowerment

- Managing multiple residents at once, if you and your team can individualize their voiding schedules, you can prioritize those that need changing more frequently than others, empowering you to take control of your daily routines

Standards of Practice

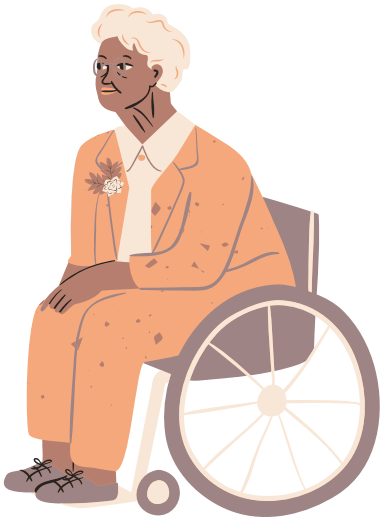
How to move above the standard?

- Know the signs and symptoms of complications from this training
- Increase observations and be vigilant of small changes-utilize your INTERACT tools
- Do not just start using incontinence products without consultation with nursing
- When in doubt, report
- Schedule your time, individualized voiding schedules are easier to plan for
- Know your residents' care plans or ask
- Document, Document, Document

Standards of Practice

Elevating Quality and Transform Incontinence Management

How I impact quality?



Good incontinence management

- Vigilant staff
- Changed at least every 2 hours or when notified when wet
- No grievances about slow or poor changes to briefs
- Staff communicate together to provide he is dry and comfortable at all times
- Stays hydrated routinely and encouraged to drink, always has access to water
- Participates in activities often

Poor incontinence management

- Busy staff
- Has dermatitis and the start of pressure wounds
- Not engaged in activities
- Doesn't drink water so he doesn't have to sit a wait to be changed
- Appears sleepy often and can sometimes be dizzy with headaches
- Frequent ER visits for UTIs
- Falls often trying to get to the bathroom on his own

Considerations for QAPI Action Plans

If you identify ways in which your community and team can help improve incontinence care or management, please inform your DON. The most important initiatives come from those on the frontlines, all of the hard working CNAs.

Please include ways you would like your staff to engage with you regarding QAPI ideas/thoughts.

Some examples could include:

- *Comment Boxes*
- *Surveys*
- *Polls*
- *Competitions*
- *Anonymous submissions*

Section E:
Using Technology in Incontinence Monitoring and Management

56%+ of each shift accounts for incontinence care

Source: Stefanacci

Technology and Incontinence for CNAs

Technology has slowly evolved over time to tackle the challenges with incontinence. However, incontinence has not quite made it to the attention of innovators and researchers as an area of need.

Today, more studies are appearing that are starting to recognize the power of innovation for incontinence and that it is a large crisis impacting the entire aging ecosystem.

Some of the technology we are seeing today

- More absorbent briefs
- Briefs with odor control
- Sizes, shapes and material to be more like underwear for dignity
- Smaller padding to not mimic infant diapers
- Colors and patterns to products
- Indicator lines to detect and communicate moisture
- Smart briefs using technology to report moisture
- Electronic Medical Records and ADL recording software
- Handheld devices for call bells
- ipads and iphones for documenting

Technology to Monitor and Management

When we think of more transparency, we think negative thoughts of how leadership may use the data or information punitively, but...

Innovation has a lot of benefits for frontline staff:

- Streamlining work, creating better work schedules and assignments
- Allowing time for breaks with less interruptions
- Reduces or eliminates time to document and proves your hard work caring for the resident
- Helping families understand the hard work you are doing for their loved one when they are not present, especially if their loved one has Dementia and cannot tell the family all you do for them
- Reduces behavior in residents that can lead to longer tasks than normal
- Allowing you more time to connect with the person and not just performing care for them
- Allows for more ability for flexible shift scheduling
- Could limit or reduce end or beginning of shift incontinence rounding

Embracing Technology

It seems like such a hassle....Why embrace innovation?

Up to 40% of residents in US nursing home residents face a potential displacement with nursing home financial strains that could cause closure of their home

Wages have doubled since before the pandemic due to demand of staff and vacancies while income (margin) has reduced

63% of LTC communities have talent vacancies

98% of LTC communities have asked staff to work overtime, double shifts, or called in to cover vacancies

AHCA.org

Overall health of operations=ability to give raises, pay better and include better benefits for all

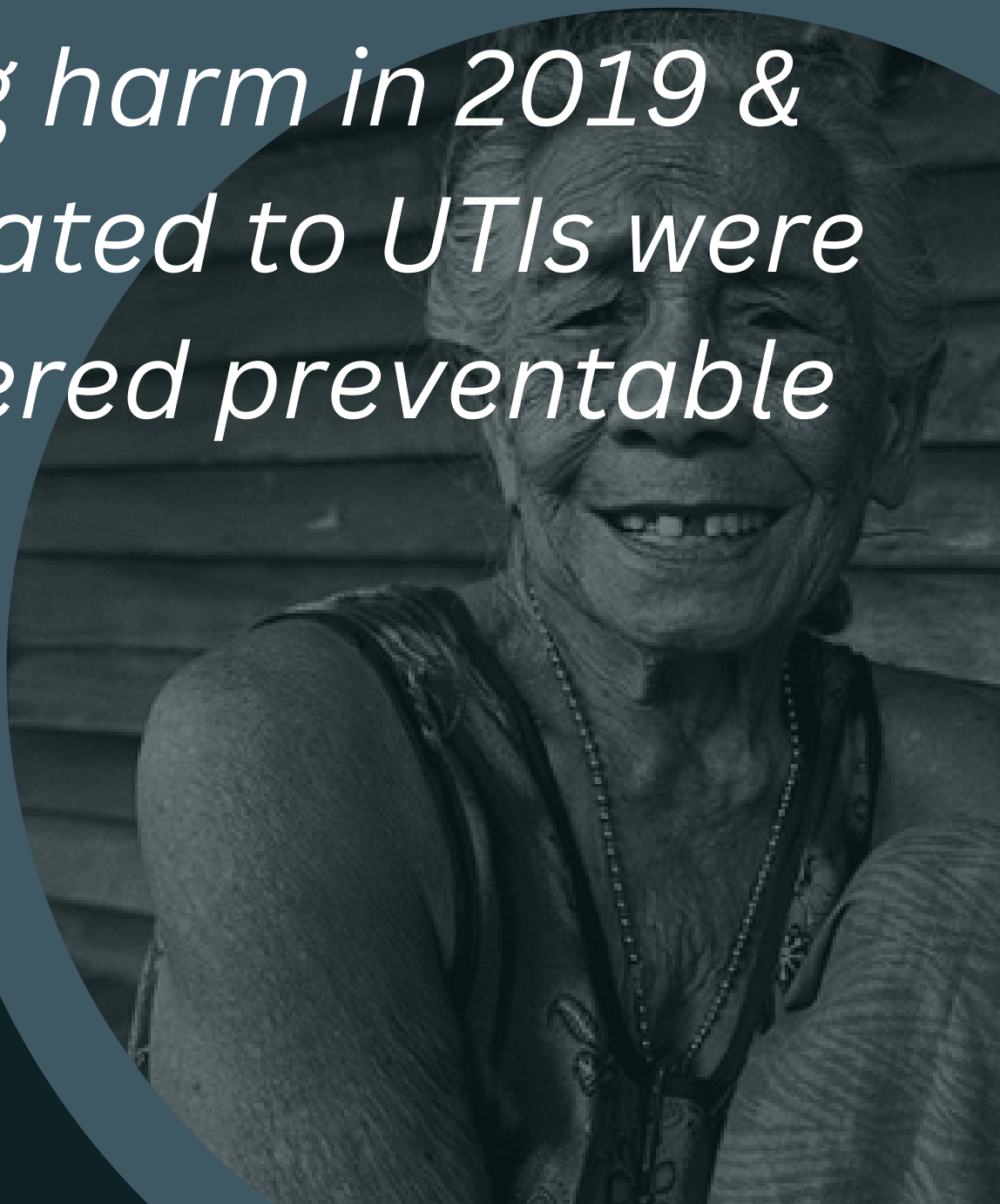
LTC is hard work, but we know you are in it to make a difference.

Knowing the status of the industry as a whole; chances are:

you WILL work short staffed
you WILL have a shift after yours not show up
you WILL be asked to juggle many things
you WILL need the help of a team
you WILL want to show the hard work you have done
you WILL want to work smarter not harder
you WILL want what is RIGHT for Your Resident

Due to this, embracing technology can only help us Do Right by Your Resident and keep them "DRYeR"

Infections in general accounted for 26% of adverse events found causing harm in 2019 & 71% related to UTIs were considered preventable



Source: CDC

Observations

As a CNA, what can I DO about incontinence?

CNAs are the eyes and ears of the clinicians and nurses
We depend on YOU to observe and report changes

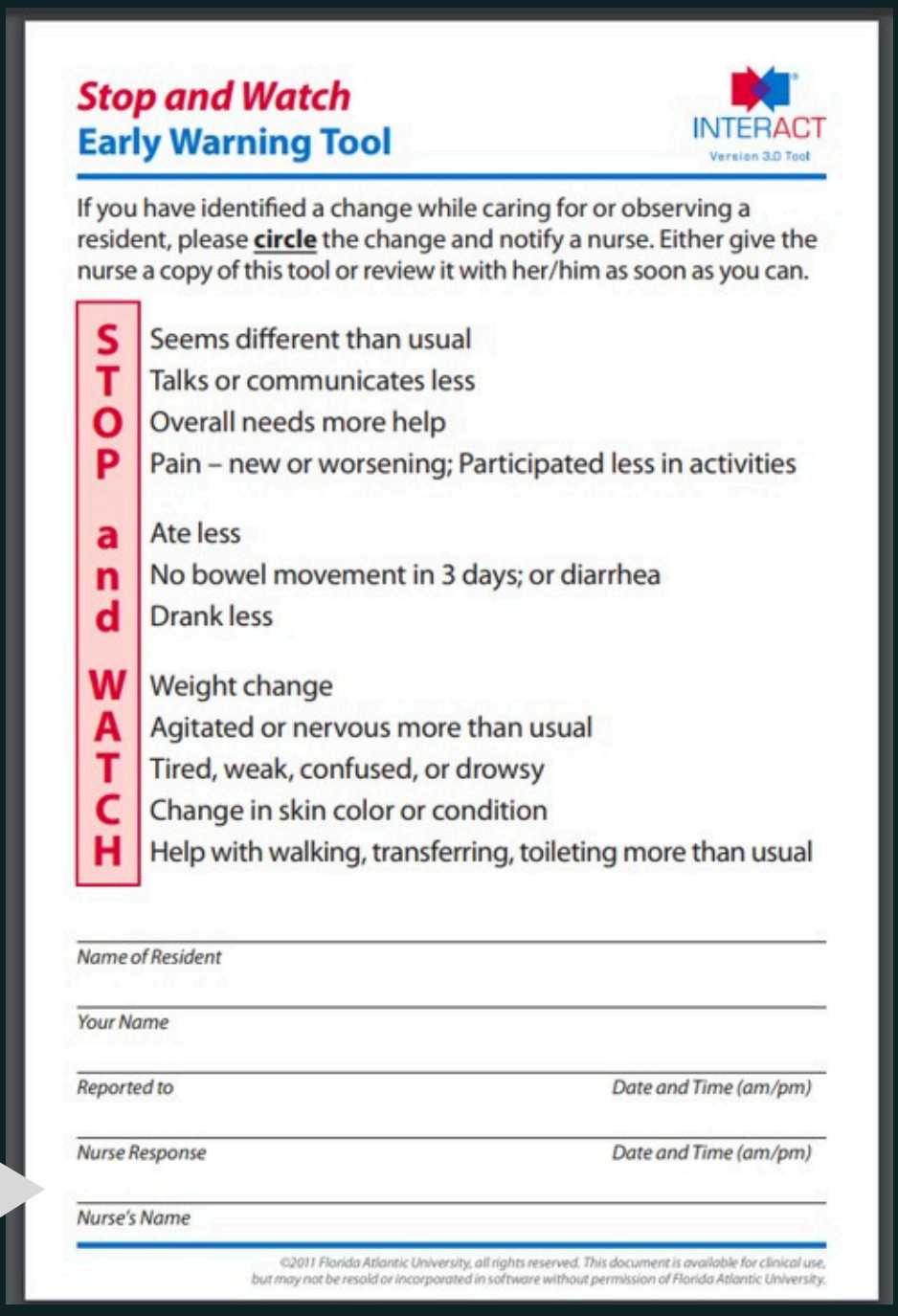
When providing care these areas should be observed and reported if identified:

- changes in urinary habits
- new incontinence
- rushing to the bathroom
- incontinence preventing activities
- increasing frequency of incontinence
- bladder program not working
- pain or trouble urinating
- incontinence with movement
- incontinence with coughing, sneezing or laughing
- incontinence that began or continued after surgery
- incontinence that causes embarrassment
- complaints of constant feeling of wetness without sensation of urine leakage
- complaints of feeling that didn't bladder empty completely

Observations

What do I look for when caring for an older adult?

Some organizations have integrated the process of stop and watch.
Others have integrated questions regarding changes in condition into their computer documentation that reflect the content of the Stop and Watch program.



Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
Seems different than usual
Talks or communicates less
Overall needs more help
T
O
P
Pain – new or worsening; Participated less in activities

a
Ate less
n
No bowel movement in 3 days; or diarrhea
d
Drank less

W
Weight change
A
Agitated or nervous more than usual
T
Tired, weak, confused, or drowsy
C
Change in skin color or condition
H
Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Documentation

Recording the observations is as important as noticing them and reporting them to the nurse.

- This might be technologically done through a Point of Care software
- Might be paper driven
- Regardless of method the info needs to provide a documentation trail.
- It also need to be reported to the team nurse
- You have the responsibility to assess, call the clinician and pass along to the next shift

ASSESS

REPORT TO NURSE

REPORT TO NEXT SHIFT

Documentation

What needs to be documented?

- If measuring I&O
  - Amount
- Color
- Density (Thick)
- Clear
- Sediment
- Odor
- Blood
- When changing incontinent pads or underwear
- Odor
- Signs of Bleeding
- Frequency
- Type of Incontinent Pad used (Brief/pad etc.)
- Resident Distress
- Complaints of Pain, frequency, inability to hold it
- Refusal to attend activities or be mobile due to incontinence

You have the ability to impact the overall health and wellness of your residents.

One observation,

one note,

one report,

one concern

can make the difference in someone's life.

Attachments

1. Training Powerpoint
2. Training Powerpoint Handouts
3. PostTest
4. PostTest Answer Key
5. Incontinence Program Self Assessment Tool
6. 3-day Voiding Record
7. Continence Promotion Care Plan
8. Bladder Assessment Example

Developed by:

RA Chidester
CONSULTING LLC

NADONALTC
The National Association of Directors of Nursing Administration in Long Term Care


NADONALTC
The National Association of Directors of
Nursing Administration in Long Term Care

MISSION

The mission of NADONA is to be the leading professional organization for current and aspiring nursing leaders through professional development, board certification, and clinical expertise related to the promotion of health and wellness of individuals in the long term care and post-acute care continuum.

VISION

NADONA envisions a global environment where the individual's health and wellness goals are met by diverse healthcare professionals committed to clinical excellence and population health management, leadership, and advocacy in the speciality of long term care and post-acute care through board certification, professional development, and the advancement of evidence based practice.

CORE VALUES:

Become a member today!


RA
Chidester
CONSULTING LLC

RA Chidester Consulting LLC is a consulting company owned and operated by Amy Chidester, MS, LNHA and Certified Gerontologist, Caregiver Advocate. Amy provides consulting to many Agetech companies helping to acknowledge and focus their innovative products and services towards older adults, families and/or caregivers they serve.

As a skilled former operator of over 20+ years as an executive in senior living, Amy specializes in quality improvement initiatives, innovation, problem-solving, assessing and strategizing to get new products and services impacting older adults earlier and more effectively to make a positive impact on their lives and the lives of their caregivers.

ADDRESSING THE VOID

Amy has published an industry informational series of articles around quality of care and how incontinence remains a pillar to all initiatives to enhance it. Check it out today at:

www.rachidester.com

Please feel free to reach out to Amy with any questions or if you are interested in her consulting services at:

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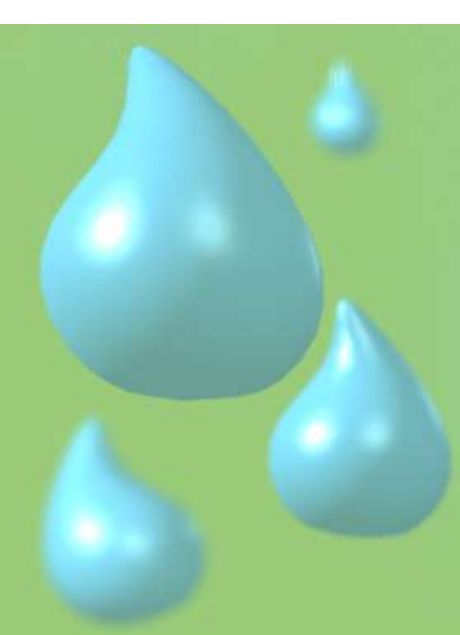
Consulting services include:

Operational Improvements for providers or services
Agetech Innovation analysis and review
Strategy and Subject Matter Expertise in senior services/caregiving
Project Management for pilots/research
Systems reviews and procedural development
Audit/Quality Reviews



Incontinence and the CNA

Amy Chidester MS, LNHA, Certified Gerontologist
Cindy Fronning, RN, GERO-BC, IP-BC, AS-BC, RAC-CT, CDONA, FACDONA, EFLA, CALN
Master Trainer
Director of Education

What is incontinence?

- At least 10 million Americans suffer from incontinence, which means that they are not able to control the times when they urinate.
- In some cases, the loss of urine is so small that people are hardly aware of it.
- In other cases, the amount of leakage is quite large.
- Only about 10 percent of people who suffer from incontinence seek treatment.
- Without treatment, many of these people stay at home and withdraw from life unnecessarily.
- Incontinence is not a disease, but it can be a symptom of disease.

Urinary Incontinence

Incontinence

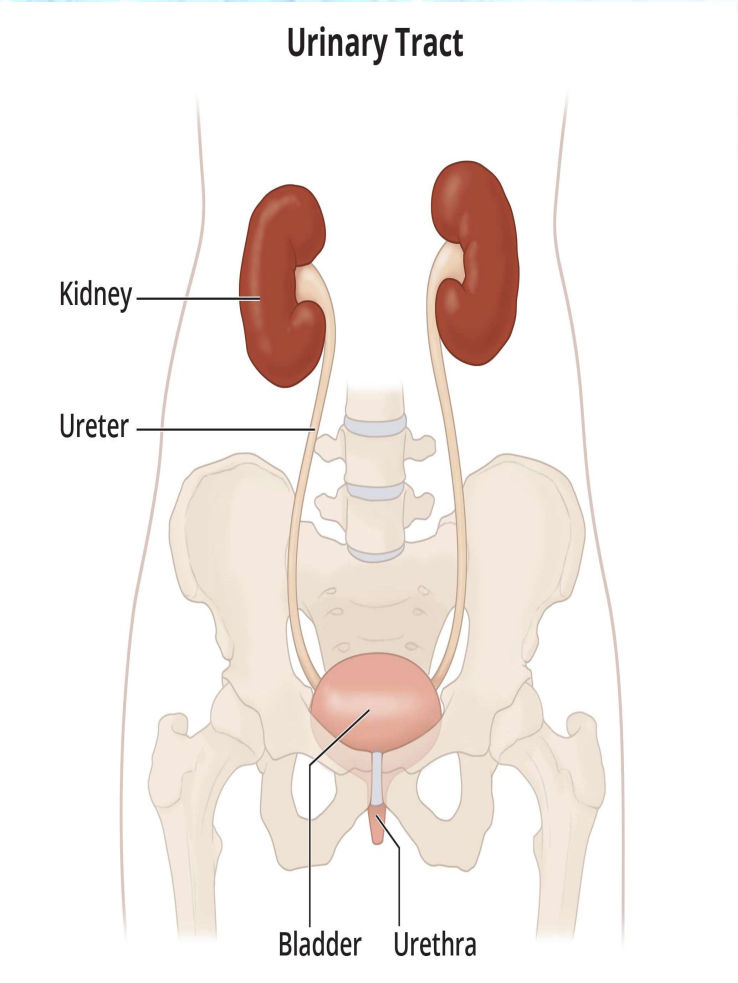
- "Lack of voluntary control over urination (Oxford Languages)"
- "Inability of the body to control the evacuative functions of urination or defecation : partial or complete loss of bladder or bowel control" (https://www.mayoclinic.org/diseases-conditions/urinary-incontinence/symptoms-causes/syc-20352808)
- Also know as Overactive Bladder

Urinary Incontinence cont.

- Common & Embarrassing condition–
  - Can happen when muscles and nerves that help the bladder hold or release urine weaken
- Symptoms
  - May occur (leak urine) when you cough or sneeze
  - May have a sudden urge to void but can’t get to the bathroom in time.

How Does the Urinary System work?

What happens in the body to cause bladder control problems?



- Located in the lower abdomen, the bladder is a hollow organ that is part of the urinary system, which also includes the kidneys, ureters, and urethra.
- During urination, muscles in the bladder tighten to move urine into the tube-shaped urethra.
- At the same time, the muscles around the urethra relax and let the urine pass out of the body.
- When the muscles in and around the bladder don't work the way they should, urine can leak, resulting in urinary incontinence.

Causes of Incontinence

What Causes Urinary Incontinence?

In Women

•Incontinence can happen for many reasons, including urinary tract infections, vaginal infection or irritation, or constipation.

•Some medications can cause bladder control problems that last a short time. When incontinence lasts longer, it may be due to:

- Weak bladder or pelvic floor muscles
- Overactive bladder muscles
- Damage to nerves that control the bladder from diseases such as multiple sclerosis, diabetes or Parkinson's disease.
- Diseases such as arthritis may make it difficult to get to the bathroom in time
- Pelvic organ prolapse, which is when pelvic organs (such as the bladder, rectum, or uterus) shift out of their normal place into the vagina or anus.
  - When pelvic organs are out of place, the bladder and urethra are not able to work normally, which may cause urine to leak.

What Causes Urinary Incontinence? cont.

In Men

- Most incontinence in men is related to the prostate gland.
- Male incontinence may be caused by:
  - Prostatitis, a painful inflammation of the prostate gland
  - Injury or damage to nerves or muscles from surgery
  - An enlarged prostate gland, which can lead to benign prostate hyperplasia, a condition in which the prostate grows as men age

Risk Factors For Incontinence

Risk Factors

- Residents who are at risk for incontinence due to having at least one of these risk factors
  - Dementia
  - Limited functioning
  - Bedfast
  - Pressure ulcers / Hx.
  - Falls
  - Catheter
  - Wheelchair bound
  - Limited engagement
  - Frequent UTIs
  - Poor nutritional health
  - Dehydration / Hx.
  - Obesity
  - Diabetic
  - Arthritis, back pain or injury
  - Hearing or visual impairment
  - High caffeine intake or alcohol, smoking and/or drug abuse

Types of Incontinence

What are the different kinds of urinary incontinence?

There are five basic types.

1. **Stress incontinence.**
   - Urine leaks when you exert pressure on your bladder by coughing, sneezing, laughing, exercising or lifting something heavy.
   - These actions cause a small amount of urine to leak from the urethra (tube that the urine passes through).
   - Most common type of incontinence suffered by women
   - Can affect women of all ages
   - Most vulnerable are older women
   - Women that have given birth more likely to have it

Different kinds of urinary incontinence cont.

2. Urge Incontinence

- Also known as overactive bladder(OAB)
- You have a sudden, intense urge to urinate followed by an involuntary loss of urine.
- You may have OAB if you have to go eight or more times a day and more than once at night.
- Or you may feel the urge to go when you touch or hear running water.
- There's also a dry form of OAB: You get the urge to go even if your bladder is empty.
- Urge incontinence may be caused by a minor condition, such as infection, or a more severe condition such as a neurological disorder or diabetes.

Different kinds of urinary incontinence cont.

3. Overflow incontinence.

- You experience frequent or constant dribbling of urine due to a bladder that doesn't empty completely.

4. Functional incontinence.

- A physical or mental impairment keeps you from making it to the toilet in time.
- For example, if you have severe arthritis, you may not be able to unbutton your pants quickly enough.

Different kinds of urinary incontinence cont.

5. Mixed incontinence.

- You experience more than one type of urinary incontinence —
- Most often this refers to a combination of stress incontinence and urge incontinence.
- This is more common in women.

Symptoms of Urinary Incontinence

Symptoms of Urinary Incontinence

- What are the symptoms of urinary incontinence?
  - The following are common symptoms of urinary incontinence.
  - However, each individual may experience symptoms differently.
  - Symptoms may include:
    - Needing to rush to the restroom and/or losing urine if not reaching the restroom in time
    - Urine leakage with movements or exercise
    - Leakage of urine that prevents activities
    - Urine leakage with coughing, sneezing or laughing

Symptoms of Urinary Incontinence cont.

- Leakage of urine that began or continued after surgery
- Leakage of urine that causes embarrassment
- Constant feeling of wetness without sensation of urine leakage
- Feeling of incomplete bladder emptying

- The symptoms of urinary incontinence may resemble other conditions or medical problems.
- Always consult your doctor for a diagnosis.

Disease States

Alzheimer's

- People in the later stages of Alzheimer's disease often have problems with urinary incontinence.
- This can be a result of not realizing they need to urinate, forgetting to go to the bathroom, or not being able to find the toilet.
- These tips may help:
  - Avoid drinks like caffeinated coffee, tea, and sodas, which may increase urination. But **don't limit water**.
  - Keep hallways clear and the bathroom clutter-free, with a light on at all times.
  - Provide regular bathroom breaks.
  - Use underwear that is easy to get on and off, and absorbent briefs or underwear for trips away from home.

Diabetes, strokes and nerve diseases, such as multiple sclerosis.

- These diseases can damage the nerves that control the bladder which is where urine is stored before it leaves the body.
- These diseases can also weaken the "sphincter," a ring of muscle around the opening of the bladder.
- This ring usually keeps urine from leaking out.
- Men can have incontinence from problems such as overgrowth of the prostate gland or cancer of the prostate gland, both of which can block the flow of urine.
- In these cases, urine leaks out when the bladder becomes too full.

Infection Control Considerations

Infections Related to Incontinence

- UTIs
  - Limiting fluids
    - Can cause dehydration and a concentration of urine within the bladder leading to development of bacteria & infection
  - Peri Care
    - Frequent need for Peri Care
    - Potential for contamination/infection if peri-care not provided correctly
  - UTIs can cause Cystitis in women
    - Inflammation of the bladder
- Wound Infections
  - Pressure Injury wounds often become soaked for periods of time with urine saturated incontinent briefs
- Sepsis
  - Often infections get into the blood stream and infect the whole body

Incontinence Management

Incontinence Management

- What is the treatment for urinary incontinence?
  - Specific treatment for urinary incontinence will be determined by your doctor based on:
    - Age, overall health and medical history
    - Type of incontinence and extent of the disease
    - Tolerance for specific medications, procedures or therapies
    - Expectations for the course of the disease
    - Personal opinion or preference

Treatment for urinary incontinence cont.

- **Pelvic muscle rehabilitation** (to improve pelvic muscle tone and prevent leakage):
  - **Kegel exercises:** Regular, daily exercising of pelvic muscles can improve, and even prevent, urinary incontinence.
  - **Biofeedback:** Used with Kegel exercises, biofeedback helps people gain awareness and control of their pelvic muscles.
  - **Vaginal weight training:** Small weights are held within the vagina by tightening the vaginal muscles.
  - **Pelvic floor electrical stimulation:** Mild electrical pulses stimulate muscle contractions.

Treatment for urinary incontinence cont.

Treatment may include:

- **Behavioral therapies**:
  - **Bladder training:** Teaches people to resist the urge to void and gradually expand the intervals between voiding.
  - **Toileting assistance:** Uses routine or scheduled toileting, habit training schedules and prompted voiding to empty the bladder regularly to prevent leaking.
- **Incontinent Products**
  - **Pads**
  - **Briefs**
- **Diet modifications:** Eliminating bladder irritants, such as caffeine, alcohol and citrus fruits.

Treatment for urinary incontinence cont.

- **Medication** :
  - **Anticholinergic medications**
  - **Vaginal estrogen**
- **Pessary** (small rubber device that is worn inside the vagina to prevent leakage)
- **Office procedure**
  - **Botox injections into bladder**
  - **Urethral bulking agents**
  - **Peripheral nerve stimulation**
- **Surgery**
  - **Slings** (may be made from synthetic mesh or your own tissue)
  - **Bladder suspension**
  - **Peripheral nerve stimulation**

Clinicians should be approached with questions regarding the and treatment of urinary incontinence of various residents.

Incontinence Awareness

- ***The regulations require several areas of awareness and knowledge for CNAs in long term care.***

- ***<u>At any point, an inspector can and should be asking you these questions about programs that impact your incontinence care procedures and practice.</u>***

Let's discuss the following:

Inspectors will ask to observe your incontinence care given to someone who wears a brief.

Be sure to know all the steps and make sure you are aware of the procedures within your particular organization.

Let's discuss the following:

How do you know what care to provide?

How are care plans communicated to you? Is this a book? a kiosk in the hallway? a handheld device?

Let's discuss the following:

What do you look for when caring for someone who is incontinence?

- Risk factors for infection, pain, hydration needs available, repositioning, nutritional needs, or any other unmet needs?
- These needs should be addressed immediately while you are in the room and reported as appropriate (DONs give some examples here)

Let's discuss the following:

In what ways do you allow the resident to be as independent as possible during incontinence care?

Let's discuss the following:

How has the family and resident been involved in the care planning for the resident's individualized incontinence care? Care plan meetings?

Let's discuss the following:

Inspectors will also look for you to explain what you will do with the resident BEFORE you do it during incontinence care and other care provided.

(DONs give examples and maybe role plays here)

Clinical Pathways Impacted by Incontinence

Pathways Link to CMS

- Accidents and Incidents
- Activities
- ROM
- Rehab
- ADL
- Catheter
- Communication Deficits
- Environmental
- Hydration
- Incontinence
- Pressure Ulcer
- Restraints
- Staffing
- Unnecessary Medication Use

The DRGs of Managing Incontinence for the CNA

- ***D=Dignity***
- All residents deserve dignity whether or not they are living with incontinence. They are people too.
- Depending on the choice of treatment or management, providing the care in a way that provides privacy and dignity for the individual is key.
- Be discreet with communications to the resident and their caregivers as well as when to provide care as much as possible.

The DRGs of Managing Incontinence for the CNA

- ***R=Respect***

- All residents deserve to have their individually desired treatment choices provided in a non-judgmental manner.

The DRGs of Managing Incontinence for the CNA

- ***G=Grace***
- All residents should be equally provided assessments, choices, professional evaluations, treatments and attention to their incontinence needs because it is not a normal part of aging.
- Our older adults deserve fair chances to make choices as they age.

Interventions for Quality Improvement

Incontinence is a pillar of high-quality care. In other words, if you are not managing incontinence well, the overall health and wellbeing of the individual will suffer. Incontinence is associated with the following conditions and adverse events:

- depression and other psychological conditions
- social isolation, reduced engagement
- pressure ulcers and other skin breakdown
- urinary tract infections and sepsis
- increased confusion and/or cognitive impairment
- falls and falls with major injury negative
- behaviors and antipsychotropic medication use
- dehydration
- odor
- strained caregiver relationships
- increased preventable hospitalizations and ER visits
- decreased functioning
- institutionalization
- death

Putting Incontinence into Perspective

- Within 15 minutes of a single void, a resident's skin can start to degrade and breakdown.
- 56% of all shifts in long term care are associated with incontinence care.
- 1/3 of falls and falls with major injury account for the leading cause of preventable ER visits in long term care residents
- Incontinence is the #1 predictor of institutionalization for those living with Dementia
- Urosepsis accounts for 31% of the leading cause for hospitalization
- During the pandemic, wounds and falls exponentially worsened in long term care communities

Myths About Incontinence

1. Incontinence is a normal part of aging....FALSE!

Incontinence is not a rite of passage for becoming older. Incontinence is a symptom of other underlying conditions, most that are more prevalent as you age, therefore creating this myth. If goes largely unresearched and underestimated when training medical professionals and determining the impacts of it on society at large. As we get older, it gets hard to be able to "fix" these conditions causing incontinence therefore it is something that some individuals will have to live with, but there are many ways of managing it effectively to keep an individual clean and dry, which is the only way to prevent other chronic conditions and adverse events. It is important however for incontinence to be explored for an individual by their team of physicians in order to see if any treatment is appropriate before making assumptions about incurability.

2. Incontinence is not able to be reversed....FALSE!

Lots of types of incontinence can be reversed and/or cured but it depends on the reason behind the condition. A physician can work with an individual to determine 1) the cause 2) if there are any steps to take to try and reverse the condition and 3) can assist in determining ways to manage the incontinence if the condition is not reversable or too risk adverse.

It is important to note:

- Product matters-it is important to be educated in the many products that exist for management of incontinence. There are pull-ups, tabbed briefs, pads, reusable underwear and bedpans and urinals. For a whole listing of the types of products available to men and women living with incontinence, visit the National Association For Continence (https://nafc.org/incontinence-products-for-adults/)
- Size matters-sizing someone into the right size brief is important. The size does not have anything to do with the absorbency of the brief. If the brief is too large, it can leak around the legs or over the top creating an uncomfortable situation for the individual and a mess for the caregiver to clean up.
- Amount matters-It does not increase absorbency by applying more than one pad or one brief at a time. This can create other additional conditions and is not safe nor healthy for the individual.

3. Limiting water can make incontinence better because you won't have to pee as much...FALSE!

First, limiting water on purpose in dangerous in older adults due to risk of dehydration being higher than a younger individual. Second, limiting water will cause urine to be more concentrated, which irritates the bladder, and it can cause problems and issues to get worse, not better. Third, the best is to drink proper fluid to be healthy and then to establish and maintain a realistic toileting schedule.

4. There is no valuable information in voiding patterns....FALSE!

On the contrary you can tell a lot about an individual by the schedule in which they void. It can be particularly helpful to know schedules because it can help care teams make better decisions when determining the cause, the treatment and the management of the incontinence. The only way to keep an accurate account of voiding patterns and determine schedules is by documentation. Some communities have electronic documentation, and some have other means for documenting. The important part is that you find and maintain the way to document this information timely and accurately.

Voiding patterns can lead to insights about the risk for the following:

- dehydration
- urinary tract infection and/or urosepsis
- exacerbation of congestive heart failure
- diabetes
  overactive bladder, kidney infection, kidney stones
- stroke other neurological disorders
- weight loss
- falls and falls with major injury
- agitation, negative behaviors and/or psychotropic medication use

5. If someone is incontinent only some of the time, it means they are doing it on purpose...FALSE!

Intermittent incontinence is completely possible and should still be treated, managed, respected and evaluated like anyone else living with incontinence.

Standards of Practice

Problems with this:

- Not individualized, may not work for everyone
- Disruptive to sleep, activities and other hobbies
- At best, every two hours can still expose a resident to skin breakdown and infection
- cause behaviors
- not physically possible with staffing levels

Why strive for more?

Expectations of Regulations/Survey Compliance:

- Individualization of care plans
- Professional assessment and evaluation for incontinence
- Increase quality and reduce accidents/incidents
- Providing care as ordered by physician and care planned

5-star ratings by CMS

- Improve exposure times by changing as frequently as possible can help improve quality which increases the ratings in areas of Quality metrics and Inspections that formulate the overall ratings
- Improves marketability for community to increase census
- Increases chances of participating with more insurance companies so that you can care for more older adults with various payers.
- Could provide better revenues, which could lead to continued wage increases and investment in additional staff

Why strive for more?

Maintaining Health and Wellbeing

- Knowing what to look for, reporting when necessary and helping maintain dry, happy residents will lighten burden of caregiving

Empowerment

- Managing multiple residents at once, if you and your team can individualize their voiding schedules, you can prioritize those that need changing more frequently than others, empowering you to take control of your daily routines

How to move above the standard?

- Know the signs and symptoms of complications from this training
- Increase observations and be vigilant of small changes-utilize your INTERACT tools
- Do not just start using incontinence products without consultation with nursing
- When in doubt, report
- Schedule your time, individualized voiding schedules are easier to plan for
- Know your residents' care plans or ask
- Document, Document, Document

How I impact quality?

Good incontinence management

- Vigilant staff
- Changed at least every 2 hours or when notified when wet
- No grievances about slow or poor changes to briefs
- Staff communicate together to provide he is dry and comfortable at all times
- Stays hydrated routinely and encouraged to drink, always has access to water
- Participates in activities often

Poor incontinence management

- Busy staff
- Has dermatitis and the start of pressure wounds
- Not engaged in activities
- Doesn't drink water so he doesn't have to sit a wait to be changed
- Appears sleepy often and can sometimes be dizzy with headaches
- Frequent ER visits for UTIs
- Falls often trying to get to the bathroom on his own

Considerations for QAPI Action Plans

If you identify ways in which your community and team can help improve incontinence care or management, please inform your DON. The most important initiatives come from those on the frontlines, all of the hard working CNAs.

Please include ways you would like your staff to engage with you regarding QAPI ideas/thoughts. Some examples could include:

- Comment Boxes
- Surveys
- Polls
- Competitions
- Anonymous submissions

Technology for Incontinence Management

Technology has slowly evolved over time to tackle the challenges with incontinence. However, incontinence has not quite made it to the attention of innovators and researchers as an area of need.

Today, more studies are appearing that are starting to recognize the power of innovation for incontinence and that it is a large crisis impacting the entire aging ecosystem.

Technology Today

- More absorbent briefs
- Briefs with odor control
- Sizes, shapes and material to be more like underwear for dignity
- Smaller padding to not mimic infant diapers
- Colors and patterns to products
- Indicator lines to detect and communicate moisture
- Smart briefs using technology to report moisture
- Electronic Medical Records and ADL recording software
- Handheld devices for call bells ipads and iphones for documenting

When we think of more transparency, we think negative thoughts of how leadership may use the data or information punitively, but...

Innovation has a lot of benefits for frontline staff:

- Streamlining work, creating better work schedules and assignments
- Allowing time for breaks with less interruptions
- Reduces or eliminates time to document and proves your hard work caring for the resident
- Helping families understand the hard work you are doing for their loved one when they are not present, especially if their loved one has Dementia and cannot tell the family all you do for them
- Reduces behavior in residents that can lead to longer tasks than normal
- Allowing you more time to connect with the person and not just performing care for them
- Allows for more ability for flexible shift scheduling
- Could limit or reduce end or beginning of shift incontinence rounding

It seems like such a hassle to change the way I have always done it. Why embrace innovational changes?

- Up to 40% of residents in US nursing home residents face a potential displacement with nursing home financial strains that could cause closure of their home
- Wages have doubled since before the pandemic due to demand of staff and vacancies while income (margin) has reduced 63% of LTC communities have talent vacancies
- 98% of LTC communities have asked staff to work overtime, double shifts, or called in to cover vacancies
- Overall health of operations=ability to give raises, pay better and include better benefits for all

LTC is hard work, but we know you are in it to make a difference.

Knowing the status of the industry, chances are:

you WILL work short staffed
you WILL have a shift after yours not show up
you WILL be asked to juggle many things
you WILL need the help of a team
you WILL want to show the hard work you have done
you WILL want to work smarter not harder
you WILL want what is RIGHT for Your Resident Due to this,

Embracing technology can only help us Do Right by Your Resident and keep them "DRYeR"

CNAs ‘ Observations and Documentation

Why and What does a CNA Need to DO Regarding Resident Incontinence

- CNAs are the eyes and ears of the clinicians and nurses
- We depend on them to observe and report changes
- When providing care these areas should be observed:
  - Changes in urinary habits
  - New incontinence
  - Rushing to the bathroom
  - Incontinence preventing activities
  - Increasing frequency of incontinence
  - Bladder program not working
  - Pain or trouble urinating
  - Incontinence with movement

Why and What does a CNA Need to DO Regarding Resident Incontinence cont.

- When providing care these areas should be observed: cont.
  - Incontinence with coughing, sneezing or laughing
  - Incontinence that began or continued after surgery
  - Incontinence that causes embarrassment
  - Complaints of constant feeling of wetness without sensation of urine leakage
  - Complaints of feeling that didn't bladder empty completely

Some facilities have integrated the process of stop and watch. Others have integrated questions regarding changes in condition into their computer documentation

Stop and Watch
Early Warning Tool

INTERACT
Version 3.0 Tool

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S
- Seems different than usual

T
- Talks or communicates less

O
- Overall needs more help

P
- Pain – new or worsening; Participated less in activities

a
- Ate less

n
- No bowel movement in 3 days; or diarrhea

d
- Drank less

W
- Weight change

A
- Agitated or nervous more than usual

T
- Tired, weak, confused, or drowsy

C
- Change in skin color or condition

H
- Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

Why and What does a CNA Need to DO Regarding Resident Incontinence cont.

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    - Who has a responsibility to:
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What Needs To Be Documented

- CNA Documentation
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one note,

one report,

one concern

can make the difference in someone's life.

Resources

- https://www.webmd.com/urinary-incontinence-oab/stress
- https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-tract-how-it-works
- https://www.mayoclinic.org/diseases-conditions/urinary-incontinence/symptoms-causes/syc-20352808
- https://www.nia.nih.gov/health/urinary-incontinence-older-adults

Resources cont.

- https://www.depend.com/en-us/incontinence-help?&msclkid=5e9cfd9b366a10c7d59599bf88724c90&utm_source=bing&utm_medium=cpc&utm_campaign=Info_Women%27s%20Support&utm_term=female%20incontinence&utm_content=Core&gclid=5e9cfd9b366a10c7d59599bf88724c90&gclsrc=3p.ds
- https://www.health.com/condition/incontinence/10-things-that-can-make-incontinence-worse
- https://www.hopkinsmedicine.org/health/conditions-and-diseases/urinary-incontinence/urinary-incontinence-in-women
- https://www.kidney.org/atoz/content/incontinence

Resources cont.

- www.ahrq.com
- www.cdc.gov
- www.cms.gov
- www.sepsis.org
- www.ncbi.nlm.nih.gov
- www.nafc.org
- www.webmd.com
- www.mcknightsseniorliving.com
- www.vumc.org
- https://www.scopus.com/record/display.uri?eid=2-s2.0-85133980947&origin=inward&txGid=d4fdcaa358f308c638116ddf67ad5dba

Incontinence and the CNA

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Master Trainer
Director of Education

1

What is incontinence?

- At least 10 million Americans suffer from incontinence, which means that they are not able to control the times when they urinate.
- In some cases, the loss of urine is so small that people are hardly aware of it.
- In other cases, the amount of leakage is quite large.
- Only about 10 percent of people who suffer from incontinence seek treatment.
- Without treatment, many of these people stay at home and withdraw from life unnecessarily.
- Incontinence is not a disease, but it can be a symptom of disease.

2

Urinary Incontinence

Incontinence

- "Lack of voluntary control over urination (Oxford Languages)"
- "Inability of the body to control the evacuative functions of urination or defecation : partial or complete loss of bladder or bowel control" (https://www.mayoclinic.org/diseases-conditions/urinary-incontinence/symptoms-causes/syc-20352808)
- Also know as Overactive Bladder

3

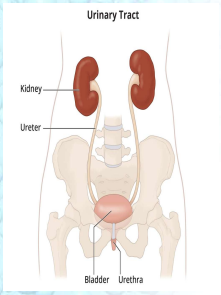
Urinary Incontinence cont.

- Common & Embarrassing condition–
  - Can happen when muscles and nerves that help the bladder hold or release urine weaken
- Symptoms
  - May occur (leak urine) when you cough or sneeze
  - May have a sudden urge to void but can't get to the bathroom in time.

4

How Does the Urinary System work?

What happens in the body to cause bladder control problems?



- Located in the lower abdomen, the bladder is a hollow organ that is part of the urinary system, which also includes the kidneys, ureters, and urethra.
- During urination, muscles in the bladder tighten to move urine into the tube-shaped urethra.
- At the same time, the muscles around the urethra relax and let the urine pass out of the body.
- When the muscles in and around the bladder don't work the way they should, urine can leak, resulting in urinary incontinence.

5

Causes of Incontinence

6

What Causes Urinary Incontinence?

In Women

•Incontinence can happen for many reasons, including urinary tract infections, vaginal infection or irritation, or constipation.

•Some medications can cause bladder control problems that last a short time. When incontinence lasts longer, it may be due to:

- Weak bladder or pelvic floor muscles
- Overactive bladder muscles
- Damage to nerves that control the bladder from diseases such as multiple sclerosis, diabetes or Parkinson's disease.
- Diseases such as arthritis may make it difficult to get to the bathroom in time
- Pelvic organ prolapse, which is when pelvic organs (such as the bladder, rectum, or uterus) shift out of their normal place into the vagina or anus.
  - When pelvic organs are out of place, the bladder and urethra are not able to work normally, which may cause urine to leak.

7

What Causes Urinary Incontinence? cont.

In Men

- Most incontinence in men is related to the prostate gland.
- Male incontinence may be caused by:
  - Prostatitis, a painful inflammation of the prostate gland
  - Injury or damage to nerves or muscles from surgery
  - An enlarged prostate gland, which can lead to benign prostate hyperplasia, a condition in which the prostate grows as men age

8

9

Risk Factors

- Residents who are at risk for incontinence due to having at least one of these risk factors
  - Dementia
  - Limited functioning
  - Bedfast
  - Pressure ulcers / Hx.
  - Falls
  - Catheter
  - Wheelchair bound
  - Limited engagement
  - Frequent UTIs
  - Poor nutritional health
  - Dehydration / Hx.
  - Obesity
  - Diabetic
  - Arthritis, back pain or injury
  - Hearing or visual impairment
  - High caffeine intake or alcohol, smoking and/or drug abuse

10

Types of Incontinence

11

What are the different kinds of urinary incontinence?

There are five basic types.

1. **Stress incontinence**.
   - Urine leaks when you exert pressure on your bladder by coughing, sneezing, laughing, exercising or lifting something heavy.
   - These actions cause a small amount of urine to leak from the urethra (tube that the urine passes through).
   - Most common type of incontinence suffered by women
   - Can affect women of all ages
   - Most vulnerable are older women
   - Women that have given birth more likely to have it

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Different kinds of urinary incontinence cont.

2. Urge Incontinence

- Also known as overactive bladder(OAB)
- You have a sudden, intense urge to urinate followed by an involuntary loss of urine.
- You may have OAB if you have to go eight or more times a day and more than once at night.
- Or you may feel the urge to go when you touch or hear running water.
- There's also a dry form of OAB: You get the urge to go even if your bladder is empty.
- Urge incontinence may be caused by a minor condition, such as infection, or a more severe condition such as a neurological disorder or diabetes.

13

Different kinds of urinary incontinence cont.

3. Overflow incontinence.

- You experience frequent or constant dribbling of urine due to a bladder that doesn't empty completely.

4. Functional incontinence.

- A physical or mental impairment keeps you from making it to the toilet in time.
- For example, if you have severe arthritis, you may not be able to unbutton your pants quickly enough.

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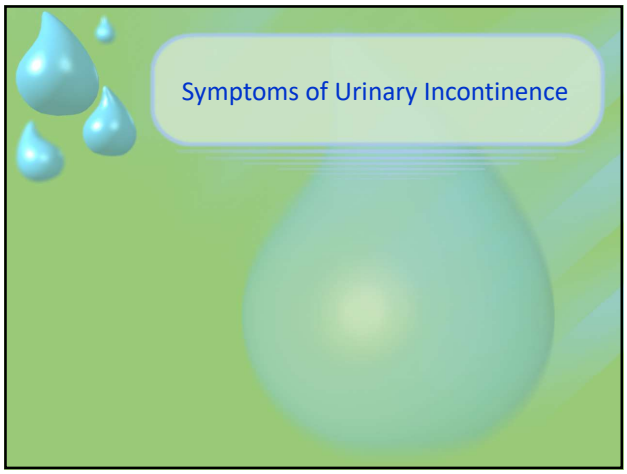
Different kinds of urinary incontinence cont.

5. Mixed incontinence.

- You experience more than one type of urinary incontinence —
- Most often this refers to a combination of stress incontinence and urge incontinence.
- This is more common in women.

15



16

Symptoms of Urinary Incontinence

- What are the symptoms of urinary incontinence?
  - The following are common symptoms of urinary incontinence.
  - However, each individual may experience symptoms differently.
  - Symptoms may include:
    - Needing to rush to the restroom and/or losing urine if not reaching the restroom in time
    - Urine leakage with movements or exercise
    - Leakage of urine that prevents activities
    - Urine leakage with coughing, sneezing or laughing

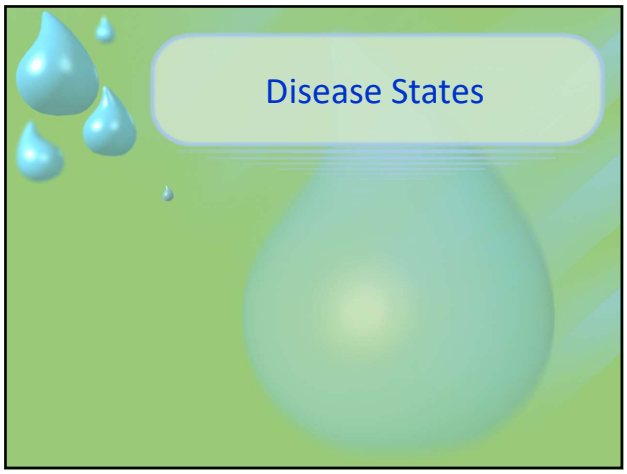
17

Symptoms of Urinary Incontinence cont.

- Leakage of urine that began or continued after surgery
- Leakage of urine that causes embarrassment
- Constant feeling of wetness without sensation of urine leakage
- Feeling of incomplete bladder emptying

- The symptoms of urinary incontinence may resemble other conditions or medical problems.
- Always consult your doctor for a diagnosis.

18



19

Alzheimer's

- People in the later stages of Alzheimer's disease often have problems with urinary incontinence.
- This can be a result of not realizing they need to urinate, forgetting to go to the bathroom, or not being able to find the toilet.
- These tips may help:
  - Avoid drinks like caffeinated coffee, tea, and sodas, which may increase urination. But **don't limit water**.
  - Keep hallways clear and the bathroom clutter-free, with a light on at all times.
  - Provide regular bathroom breaks.
  - Use underwear that is easy to get on and off, and absorbent briefs or underwear for trips away from home.

20

Diabetes, strokes and nerve diseases, such as multiple sclerosis.

- These diseases can damage the nerves that control the bladder which is where urine is stored before it leaves the body.
- These diseases can also weaken the "sphincter," a ring of muscle around the opening of the bladder.
- This ring usually keeps urine from leaking out.
- Men can have incontinence from problems such as overgrowth of the prostate gland or cancer of the prostate gland, both of which can block the flow of urine.
- In these cases, urine leaks out when the bladder becomes too full.

21

Infection Control Considerations

22

Infections Related to Incontinence

- UTIs
  - Limiting fluids
    - Can cause dehydration and a concentration of urine within the bladder leading to development of bacteria & infection
  - Peri Care
    - Frequent need for Peri Care
    - Potential for contamination/infection if peri-care not provided correctly
  - UTIs can cause Cystitis in women
    - Inflammation of the bladder
- Wound Infections
  - Pressure Injury wounds often become soaked for periods of time with urine saturated incontinent briefs
- Sepsis
  - Often infections get into the blood stream and infect the whole body

23

Incontinence Management

24

Incontinence Management

- What is the treatment for urinary incontinence?
  - Specific treatment for urinary incontinence will be determined by your doctor based on:
    - Age, overall health and medical history
    - Type of incontinence and extent of the disease
    - Tolerance for specific medications, procedures or therapies
    - Expectations for the course of the disease
    - Personal opinion or preference

25

Treatment for urinary incontinence cont.

- **Pelvic muscle rehabilitation** (to improve pelvic muscle tone and prevent leakage):
  - **Kegel exercises:** Regular, daily exercising of pelvic muscles can improve, and even prevent, urinary incontinence.
  - **Biofeedback:** Used with Kegel exercises, biofeedback helps people gain awareness and control of their pelvic muscles.
  - **Vaginal weight training:** Small weights are held within the vagina by tightening the vaginal muscles.
  - **Pelvic floor electrical stimulation:** Mild electrical pulses stimulate muscle contractions.

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Treatment for urinary incontinence cont.

Treatment may include:

- **Behavioral therapies**:
  - **Bladder training:** Teaches people to resist the urge to void and gradually expand the intervals between voiding.
  - **Toileting assistance:** Uses routine or scheduled toileting, habit training schedules and prompted voiding to empty the bladder regularly to prevent leaking.
- **Incontinent Products**
  - **Pads**
  - **Briefs**
- **Diet modifications:** Eliminating bladder irritants, such as caffeine, alcohol and citrus fruits.

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Treatment for urinary incontinence cont.

- **Medication** :
  - **Anticholinergic medications**
  - **Vaginal estrogen**
- **Pessary** (small rubber device that is worn inside the vagina to prevent leakage)
- **Office procedure**
  - **Botox injections into bladder**
  - **Urethral bulking agents**
  - **Peripheral nerve stimulation**
- **Surgery**
  - **Slings** (may be made from synthetic mesh or your own tissue)
  - **Bladder suspension**
  - **Peripheral nerve stimulation**

Clinicians should be approached with questions regarding the and treatment of urinary incontinence of various residents.

28

Incontinence Awareness

- ***The regulations require several areas of awareness and knowledge for CNAs in long term care.***
- ***At any point, an inspector can and should be asking you these questions about programs that impact your incontinence care procedures and practice.***

29

Let's discuss the following:

Inspectors will ask to observe your incontinence care given to someone who wears a brief.

Be sure to know all the steps and make sure you are aware of the procedures within your particular organization.

30

Let's discuss the following:

How do you know what care to provide?

How are care plans communicated to you? Is this a book? a kiosk in the hallway? a handheld device?

31

Let's discuss the following:

What do you look for when caring for someone who is incontinence?

- Risk factors for infection, pain, hydration needs available, repositioning, nutritional needs, or any other unmet needs?
- These needs should be addressed immediately while you are in the room and reported as appropriate (DONs give some examples here)

32

Let's discuss the following:

In what ways do you allow the resident to be as independent as possible during incontinence care?

33

Let's discuss the following:

How has the family and resident been involved in the care planning for the resident's individualized incontinence care? Care plan meetings?

34

Let's discuss the following:

Inspectors will also look for you to explain what you will do with the resident BEFORE you do it during incontinence care and other care provided.

(DONs give examples and maybe role plays here)

35

Clinical Pathways Impacted by Incontinence

Pathways Link to CMS

- Accidents and Incidents
- Activities
- ROM
- Rehab
- ADL
- Catheter
- Communication Deficits
- Environmental
- Hydration
- Incontinence
- Pressure Ulcer
- Restraints
- Staffing
- Unnecessary Medication Use

36

The DRGs of Managing Incontinence for the CNA

D=Dignity

- All residents deserve dignity whether or not they are living with incontinence. They are people too.
- Depending on the choice of treatment or management, providing the care in a way that provides privacy and dignity for the individual is key.
- Be discreet with communications to the resident and their caregivers as well as when to provide care as much as possible.

37

The DRGs of Managing Incontinence for the CNA

R=Respect

- All residents deserve to have their individually desired treatment choices provided in a non-judgmental manner.

38

The DRGs of Managing Incontinence for the CNA

G=Grace

- All residents should be equally provided assessments, choices, professional evaluations, treatments and attention to their incontinence needs because it is not a normal part of aging.
- Our older adults deserve fair chances to make choices as they age.

39

Interventions for Quality Improvement

Incontinence is a pillar of high-quality care. In other words, if you are not managing incontinence well, the overall health and wellbeing of the individual will suffer. Incontinence is associated with the following conditions and adverse events:

- depression and other psychological conditions
- social isolation, reduced engagement
- pressure ulcers and other skin breakdown
- urinary tract infections and sepsis
- increased confusion and/or cognitive impairment
- falls and falls with major injury negative
- behaviors and antipsychotropic medication use
- dehydration
- odor
- strained caregiver relationships
- increased preventable hospitalizations and ER visits
- decreased functioning
- institutionalization
- death

40

Putting Incontinence into Perspective

- Within 15 minutes of a single void, a resident's skin can start to degrade and breakdown.
- 56% of all shifts in long term care are associated with incontinence care.
- 1/3 of falls and falls with major injury account for the leading cause of preventable ER visits in long term care residents
- Incontinence is the #1 predictor of institutionalization for those living with Dementia
- Urosepsis accounts for 31% of the leading cause for hospitalization
- During the pandemic, wounds and falls exponentially worsened in long term care communities

41

Myths About Incontinence

42

1. Incontinence is a normal part of aging....FALSE!

Incontinence is not a rite of passage for becoming older. Incontinence is a symptom of other underlying conditions, most that are more prevalent as you age, therefore creating this myth. If goes largely unresearched and underestimated when training medical professionals and determining the impacts of it on society at large. As we get older, it gets hard to be able to "fix" these conditions causing incontinence therefore it is something that some individuals will have to live with, but there are many ways of managing it effectively to keep an individual clean and dry, which is the only way to prevent other chronic conditions and adverse events. It is important however for incontinence to be explored for an individual by their team of physicians in order to see if any treatment is appropriate before making assumptions about incurability.

43

2. Incontinence is not able to be reversed....FALSE!

Lots of types of incontinence can be reversed and/or cured but it depends on the reason behind the condition. A physician can work with an individual to determine 1) the cause 2) if there are any steps to take to try and reverse the condition and 3) can assist in determining ways to manage the incontinence if the condition is not reversable or too risk adverse.

It is important to note:

- Product matters-it is important to be educated in the many products that exist for management of incontinence. There are pull-ups, tabbed briefs, pads, reusable underwear and bedpans and urinals. For a whole listing of the types of products available to men and women living with incontinence, visit the National Association For Continence (https://nafc.org/incontinence-products-for-adults/)
- Size matters-sizing someone into the right size brief is important. The size does not have anything to do with the absorbency of the brief. If the brief is too large, it can leak around the legs or over the top creating an uncomfortable situation for the individual and a mess for the caregiver to clean up.
- Amount matters-It does not increase absorbency by applying more than one pad or one brief at a time. This can create other additional conditions and is not safe nor healthy for the individual.

44

3. Limiting water can make incontinence better because you won't have to pee as much...FALSE!

First, limiting water on purpose in dangerous in older adults due to risk of dehydration being higher than a younger individual. Second, limiting water will cause urine to be more concentrated, which irritates the bladder, and it can cause problems and issues to get worse, not better. Third, the best is to drink proper fluid to be healthy and then to establish and maintain a realistic toileting schedule.

45

4. There is no valuable information in voiding patterns....FALSE!

On the contrary you can tell a lot about an individual by the schedule in which they void. It can be particularly helpful to know schedules because it can help care teams make better decisions when determining the cause, the treatment and the management of the incontinence. The only way to keep an accurate account of voiding patterns and determine schedules is by documentation. Some communities have electronic documentation, and some have other means for documenting. The important part is that you find and maintain the way to document this information timely and accurately.

Voiding patterns can lead to insights about the risk for the following:

- dehydration
- urinary tract infection and/or urosepsis
- exacerbation of congestive heart failure
- diabetes
  overactive bladder, kidney infection, kidney stones
- stroke other neurological disorders
- weight loss
- falls and falls with major injury
- agitation, negative behaviors and/or psychotropic medication use

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5. If someone is incontinent only some of the time, it means they are doing it on purpose...FALSE!

Intermittent incontinence is completely possible and should still be treated, managed, respected and evaluated like anyone else living with incontinence.

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Standards of Practice

Problems with this:

- Not individualized, may not work for everyone
- Disruptive to sleep, activities and other hobbies
- At best, every two hours can still expose a resident to skin breakdown and infection
- cause behaviors
- not physically possible with staffing levels

48

Why strive for more?

Expectations of Regulations/Survey Compliance:
- Individualization of care plans
- Professional assessment and evaluation for incontinence
- Increase quality and reduce accidents/incidents
- Providing care as ordered by physician and care planned

5-star ratings by CMS
- Improve exposure times by changing as frequently as possible can help improve quality which increases the ratings in areas of Quality metrics and Inspections that formulate the overall ratings
- Improves marketability for community to increase census
- Increases chances of participating with more insurance companies so that you can care for more older adults with various payers.
- Could provide better revenues, which could lead to continued wage increases and investment in additional staff

49

Why strive for more?

Maintaining Health and Wellbeing
- Knowing what to look for, reporting when necessary and helping maintain dry, happy residents will lighten burden of caregiving

Empowerment
- Managing multiple residents at once, if you and your team can individualize their voiding schedules, you can prioritize those that need changing more frequently than others, empowering you to take control of your daily routines

50

How to move above the standard?

- Know the signs and symptoms of complications from this training
- Increase observations and be vigilant of small changes-utilize your INTERACT tools
- Do not just start using incontinence products without consultation with nursing
- When in doubt, report
- Schedule your time, individualized voiding schedules are easier to plan for
- Know your residents' care plans or ask
- Document, Document, Document

51

How I impact quality?

Good incontinence management

- Vigilant staff
- Changed at least every 2 hours or when notified when wet
- No grievances about slow or poor changes to briefs
- Staff communicate together to provide he is dry and comfortable at all times
- Stays hydrated routinely and encouraged to drink, always has access to water
- Participates in activities often

Poor incontinence management

- Busy staff
- Has dermatitis and the start of pressure wounds
- Not engaged in activities
- Doesn't drink water so he doesn't have to sit a wait to be changed
- Appears sleepy often and can sometimes be dizzy with headaches
- Frequent ER visits for UTIs
- Falls often trying to get to the bathroom on his own

52

Considerations for QAPI Action Plans

If you identify ways in which your community and team can help improve incontinence care or management, please inform your DON. The most important initiatives come from those on the frontlines, all of the hard working CNAs.

Please include ways you would like your staff to engage with you regarding QAPI ideas/thoughts. Some examples could include:

- Comment Boxes
- Surveys
- Polls
- Competitions
- Anonymous submissions

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Technology for Incontinence Management

Technology has slowly evolved over time to tackle the challenges with incontinence. However, incontinence has not quite made it to the attention of innovators and researchers as an area of need.

Today, more studies are appearing that are starting to recognize the power of innovation for incontinence and that it is a large crisis impacting the entire aging ecosystem.

54

Technology Today

- More absorbent briefs
- Briefs with odor control
- Sizes, shapes and material to be more like underwear for dignity
- Smaller padding to not mimic infant diapers
- Colors and patterns to products
- Indicator lines to detect and communicate moisture
- Smart briefs using technology to report moisture
- Electronic Medical Records and ADL recording software
- Handheld devices for call bells ipads and iphones for documenting

55

When we think of more transparency, we think negative thoughts of how leadership may use the data or information punitively, but...

Innovation has a lot of benefits for frontline staff:

- Streamlining work, creating better work schedules and assignments
- Allowing time for breaks with less interruptions
- Reduces or eliminates time to document and proves your hard work caring for the resident
- Helping families understand the hard work you are doing for their loved one when they are not present, especially if their loved one has Dementia and cannot tell the family all you do for them
- Reduces behavior in residents that can lead to longer tasks than normal
- Allowing you more time to connect with the person and not just performing care for them
- Allows for more ability for flexible shift scheduling
- Could limit or reduce end or beginning of shift incontinence rounding

56

It seems like such a hassle to change the way I have always done it. Why embrace innovational changes?

- Up to 40% of residents in US nursing home residents face a potential displacement with nursing home financial strains that could cause closure of their home
- Wages have doubled since before the pandemic due to demand of staff and vacancies while income (margin) has reduced 63% of LTC communities have talent vacancies
- 98% of LTC communities have asked staff to work overtime, double shifts, or called in to cover vacancies
- Overall health of operations=ability to give raises, pay better and include better benefits for all

57

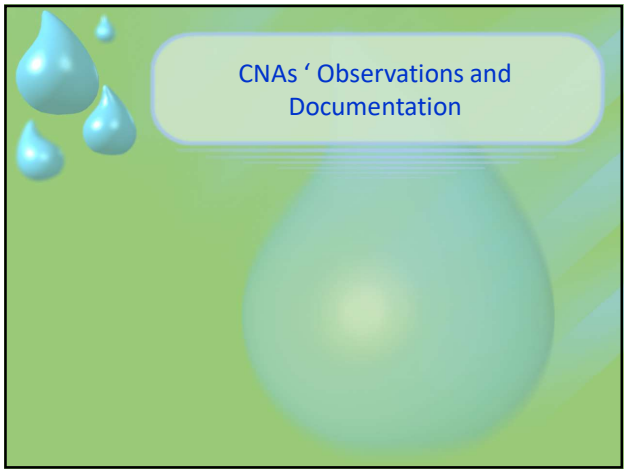
LTC is hard work, but we know you are in it to make a difference.

Knowing the status of the industry, chances are:

you WILL work short staffed
you WILL have a shift after yours not show up
you WILL be asked to juggle many things
you WILL need the help of a team
you WILL want to show the hard work you have done
you WILL want to work smarter not harder
you WILL want what is RIGHT for Your Resident Due to this,

Embracing technology can only help us Do Right by Your Resident and keep them "DRYeR"

58



59

Why and What does a CNA Need to DO Regarding Resident Incontinence

- CNAs are the eyes and ears of the clinicians and nurses
- We depend on them to observe and report changes
- When providing care these areas should be observed:
  - Changes in urinary habits
  - New incontinence
  - Rushing to the bathroom
  - Incontinence preventing activities
  - Increasing frequency of incontinence
  - Bladder program not working
  - Pain or trouble urinating
  - Incontinence with movement

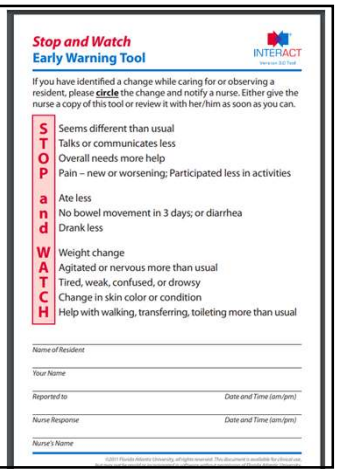
60

Why and What does a CNA Need to DO Regarding Resident Incontinence cont.

- When providing care these areas should be observed: cont.
  - Incontinence with coughing, sneezing or laughing
  - Incontinence that began or continued after surgery
  - Incontinence that causes embarrassment
  - Complaints of constant feeling of wetness without sensation of urine leakage
  - Complaints of feeling that didn't bladder empty completely

61

Some facilities have integrated the process of stop and watch. Others have integrated questions regarding changes in condition into their computer documentation



Stop and Watch
Early Warning Tool

INTERACT

If you have identified a change while caring for or observing a resident, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

Name of Resident

Your Name

Reported to — Date and Time (am/pm)

Nurse Response — Date and Time (am/pm)

Nurse's Name

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Why and What does a CNA Need to DO Regarding Resident Incontinence cont.

- Recording the observations is as important as noticing them and reporting them to the nurse.
  - This might be technologically done through a Point of Care software
  - Might be paper driven
  - Regardless of method the info needs to provide a documentation trail.
- It also need to be reported to the team nurse
  - Who has a responsibility to:
    - Assess,
    - Call clinician and
    - Pass along to the next shift

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What Needs To Be Documented

- CNA Documentation
  - If measuring I&O
    - Amount
    - Color
    - Density (Thick)
    - Clear
    - Sediment
    - Odor
    - Blood
  - When changing incontinent pads or underwear
    - Odor
    - Signs of Bleeding
    - Frequency
    - Type of Incontinent Pad used (Brief/pad etc.)
    - Resident Distress
      - Complaints of Pain, frequency, inability to hold it
      - Refusal to attend activities or be mobile due to incontinence

64

You have the ability to impact the overall health and wellness of your residents.

One observation,
one note,
one report,
one concern
can make the difference in someone's life.

65

Resources

- https://www.webmd.com/urinary-incontinence-oab/stress
- https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-tract-how-it-works
- https://www.mayoclinic.org/diseases-conditions/urinary-incontinence/symptoms-causes/syc-20352808
- https://www.nia.nih.gov/health/urinary-incontinence-older-adults

66

Resources cont.

- https://www.depend.com/en-us/incontinence-help?&msclkid=5e9cfd9b366a10c7d59599bf88724c90&utm_source=bing&utm_medium=cpc&utm_campaign=Info_Women%27s%20Support&utm_term=female%20incontinence&utm_content=Core&gclid=5e9cfd9b366a10c7d59599bf88724c90&gclsrc=3p.ds
- https://www.health.com/condition/incontinence/10-things-that-can-make-incontinence-worse
- https://www.hopkinsmedicine.org/health/conditions-and-diseases/urinary-incontinence/urinary-incontinence-in-women
- https://www.kidney.org/atoz/content/incontinence

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Resources cont.

- www.ahrq.com
- www.cdc.gov
- www.cms.gov
- www.sepsis.org
- www.ncbi.nlm.nih.gov
- www.nafc.org
- www.webmd.com
- www.mcknightsseniorliving.com
- www.vumc.org
- https://www.scopus.com/record/display.uri?eid=2-s2.0-85133980947&origin=inward&txGid=d4fdcaa358f308c638116ddf67ad5dba

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CNA AND Incontinence Post-test

1. Incontinence is a disease.
    A. True
    B. False

2. Which of the following is not connected with stress incontinence?
    A. Urine leaks when you exert pressure on your bladder by laughing.
    B. Most common type of incontinence suffered by women.
    C. Women that have given birth more likely to have it.
    D. Caused by a minor condition, such as infection,
    E. Can affect women of all ages.

3. Which of the following describes urge incontinence
    A. . A physical or mental impairment keeps you from making it to the toilet in time.
    B. These actions of lifting or exercising can cause a small amount of urine to leak from the urethra.
    C. A sudden, intense urge to urinate followed by an involuntary loss of urine.
    D. Constant dribbling of urine.

4. Mixed incontinence is when you experience more than one type of incontinence.
    A. True
    B. False

5. The symptoms of incontinence include which of the following: (pick all that apply):
    A. Needing to rush to the restroom.
    B. Urine leakage with movements or exercise.
    C. Leakage of urine that prevents activities.
    D. Constant feeling of wetness without sensation of urine leakage.

6. There are diseases that can damage the nerves that control bladder function. Which of the following is not one of these diseases?
    A. Alzheimer's
    B. Nerves
    C. High Blood Pressure
    D. MS
    E. Stroke

7. Which of the following infections could be caused by incontinence?
    A. Pneumonia
    B. Dehydration
    C. COVID 19
    D. Sepsis
    E. Candidiasis

8. Which of the following treatments is most often used in nursing homes
    A. Pelvic muscle rehabilitation
    B. Bladder training
    C. Toileting assistance
    D. Incontinent Products
    E. Surgery

9. CNAs do not have to document regarding incontinence.
    A. True
    B. False

10. CNAs should look for all but one of the following when providing care
    A. Changes in urinary habits
    B. New incontinence
    C. Rushing to the bathroom
    D. Incontinence preventing activities
    E. None of the above.

11. Incontinence is a part of aging?
    A. True
    B. False

12. Incontinence is associated with the following conditions except:
    A. Depression
    B. Death
    C. Pressure Ulcers
    D. UTIs
    E. Cancer

13. Incontinence can be reversed?
    A. True
    B. False

14. One way to NOT treat incontinence is?
    A. Assess for any voiding disfunction by professional
    B. Allow resident to drink adequate of fluids
    C. Medication
    D. Provide the right sized incontinence product
    E. Limit water intake

15. All of the following CAN be detected by monitoring voiding habits <u>except</u>?
    A. Dehydration
    B. Urinary Tract Infection
    C. Exacerbation of congestive heart failure
    D. Overactive Bladder
    E. None of the above

16. As a CAN, I cannot directly impact the health and wellness of my residents?
    A. True
    B. False

17. What benefits can technology have on incontinence care?
    A. Automate documentation
    B. Streamline tasks so that CNAs have more time for other care
    C. Allowing knowledge about someone's voiding habits to better provide care
    D. Help families understand the amount of care I am providing my residents
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CNA AND Incontinence Post test ANSWER KEY

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Incontinence Program Self Assessment-
Attachment to DRYeR Incontinence Training Toolkit Manual
Updated 2024

Assessment Question	Yes	No	Further information/Instructions
Do you provide training on incontinence on a routine basis for all employees no less than annually and incoming new employees during orientation?			Incontinence care should be taught at least annually to all staff, at orientation and anytime as needed when indicated by low performance identifiers such as increase in UTIs, Pressure Wounds, Falls, Catherter use and/or minimally engaged residents.
Does the training include the following:			
What incontinence is, types and causes			
Disease states and infection control			
Treatments and management techniques			
Interventions for Quality Improvement and Standards of Practice			
Technology and incontinence			
Observations and Documentation			
Do you have a falls prevention program that includes incontinence?			1/3 of falls occur in the bathroom or related to bathroom use and 1 out of 5 falls causes serious injury.
Do you have technology deployed to create efficiencies for your staff?			Deploying and implementing the right technology in the right places can create substantial efficiencies that will give time back to frontline staff.
Do you have an incontinence product sizing program in place that includes documentation and communciation to all staff how to check and monitor sizes accurately and easy?			Sizing is very important in incontinence care. Leaks occur if not sized right, which create a lot of extra labor, shame and social isolation if not addressed. Double briefing also will not increase absorbancy. Each manufacturer has their own sizing resources, so contact the makers of the products that you use and obtain a copy of the guide.
Is your total (voluntary and involuntary) turnover at 30% or below?			To calculate your turnover rate: You will need your 1) count how many employees left in 1 year 2) the number of total employees at the beginning of that one year period and 3) the number of total employees at the end of that one year period.Take the number of the employed at the beginning of the period and add it to the number of the employed at the end of the period. Divide that figure by 2 will give you the average number of employees. You can then calculate your turnover with this simple formula: Turnover % = (Employees who left ÷ Average number of employees) x 100
Do you engage with your therapy provider regarding bladder retraining programs and other pelvic exercise programs available to your residents?			There is evidence that combining continence care with functionally oriented exercise improves continence and other functional outcomes among long-term care residents. Therapy programs are trained and available for use of Medicare funds to help someone re-train their bladder under certain circumstances. Speak with your therapy provider team to determine the best way to communicate, refer and assess for the need and availability of them to assist you with bladder re-training programs. While this may not translate into direct payments from Medicare, it can be some reimbursement in the therapy sessions as well as it will have an ROI built into the improved quality it can enhance.
What does your weight monitoring system look like? Is it being done as needed/ordered, is it consistently being done, are the values consistent from week to week/month to month, and is the documentation being done and completed timely? Is it automated in any ways?			Weight monitoring processes, in order to be effective, must be done on a routine cadence as indicated medically, consistently and using the same equipment (ie scale, wheelchair, chair, standing), documented and monitored for blind charting or missing and inaccurate information. Automations created by technology would prove to be extremely helpful in order to improve this area to then trickle into the overall incontinence health of your community. Oversight of these processes is essential to ensure compliance and interdisciplinary involvement in the weight monitoring processes.
What does your vital signs monitoring system look like?			Vital signs are incredibly important to the care team to make the best diagnostic decisions possible. Complications surrounding incontinence management are not always easily identified, but can be caught early if the resident is being monitored closely to include vital signs. The system that you use (automated or not) needs to include equipment calibration and checks, consistent use of equipment and training of use, consistent gathering, documentation of results, monitoring for anomolies (as indicated by policy and procedures) and repeat entries (copying) as well as reporting of such to the physician and/or care team. If you have not already, consider technology and automation in any parts of this process and think systematically about the process to make sure that it is impactful and working to support your team's medical decisions.
CMS Quality Measures: For instructions on how to pull your QM for review, download the technical manual.			

Is your QM for hospitalizations at or below the national average %?			Sepsis is the number one reason for hospitalization and 31% of sepsis originates from urosepsis/urinary tract infections. When caught early enough, one can avoid the hospitalization which often times comes when early signs and symptoms are missed by the care team. Hospitalization rates not only can indicate a systematic breakdown in processes, but it also can create major financial and operational challenges for your community as a consequence. Payers review this statistic and hold it at high regard when determining participation in ACOs, HMOs and other coverage entities. It can also have a negative impact on whether hospitals will refer patients to your community, because high re-hospitalization rates also have a financial and operational challenge for the hospital with regards to their quality indicators. This QM could indicate a problem within your incontinence program if staff are having challenges with the observation techniques recommended.
Is your QM for ER visits at or below the federal average %?			When trying to understand this QM, it is important to note that the number one reason for ER visits among those living in long term care is injury from falls. However, it is important to look deep and trend those cases that are triggering the visits specifically for your community. Identify if there are any similarities in the person(s) having the visits, the diagnosis most frequently visiting the ER, location of rooms and/or same staff assignments, and/or the symptoms of which phases of the illness present (too frequently sending people or not sending them fast enough). This QM could indicate a problem within your incontinence program if staff are having challenges with the observation techniques recommended. Those that would trigger inclusion in this figure would be nursing home stays for beneficiaries who: a)met the inclusion criteria for the denominator; AND b)were admitted to an emergency department within 30 days of entry/reentry to the nursing home, regardless of whether they were discharged from the nursing home prior to the emergency department visit. Outpatient emergency department visits are identified using Medicare Part B claims; AND c)were not admitted to a hospital for an unplanned inpatient stay or observation stay immediately after the visit to the emergency department. Inpatient and observation stays are identified using Medicare Parts A and B claims. (Planned inpatient stays are identified using principal discharge diagnosis and procedure codes on Medicare claims for the inpatient stay) Denominator includes:Included in the measure are stays for residents who: a)entered or reentered the nursing home within one day of discharge from an inpatienthospitalization (note that inpatient rehabilitation facility and long-term carehospitalizations are not included). Hospitalizations are identified using Medicare Part Aclaims; AND b)entered or reentered the nursing home within the 12-month target period Short-stay residents are excluded if: a)the resident did not have fee-for-service parts A and B Medicare enrollment for theentire risk period (defined as the calendar month of the index hospitalization through thecalendar month that follows the month during which the resident was discharged fromthe nursing home); OR b)the resident was ever enrolled in hospice care during their nursing home stay; OR c)the resident did not have an initial MDS assessment (within 14 days of entry/reentry) touse in constructing covariates for risk-adjustment; OR d)the resident was comatose or missing data on comatose on the first MDSassessment after the start of the stay; OR e)data were missing for any of the claims or MDS items used to construct the numeratoror denominator, or for risk-adjustment.
Do you have any falls with major injury within the last year from today?			According to the CDC, falls account for the most prevalent reason for preventable hospital visits. Understanding root causes for all your falls should be an ongoing endeavor among a team of interdisciplinary professionals. 1/3 of all falls involve residents and going to the bathroom. (Stefanacci) 95% of all hip fractures are caused by falls (CDC) It is our responsibility to determine what part of that process can be addressed with a more robust incontinence program. Every major injury with a fall should be dissected as soon as possible to determine root cause and to put interventions as well as preventative measures into place for any other resident with the same risk factors as the individual who experienced the injury. i.e. if someone became confused due to an onset of a missed UTI and then experienced a fracture trying to get to the bathroom, then it is important to take a look at the incontinence program, UTI prevention measures as well as how or why initial signs may have been missed.
Is the QM regarding falls of long term care residents (per their episode of care) at or below the federal average %?			1/3 of falls involve going to the bathroom. It is important to review falls, interventions and prevention measures no less than weekly from a high level leadership team. This QM could indicate a need to have better incontinence observations and documentation or other gaps in incontinence management.

Is the QM that captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers at or below the federal average %?			Proper sizing of products may impact on potential for skin breakdown i.e., blister formation. It is important that residents using absorbent products be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations. Products may contain urine but check and changes are still needed due to an increased risk of MASD. Residents are defined as high-risk if they meet one or more of the following three criteria on the target assessment: 1.Impaired bed mobility or transfer indicated, by either or both of the following: a)Bed mobility, self-performance b)Transfer, self-performance 2.Comatose 3.Malnutrition or at risk of malnutrition Exclusions 1.Target assessment is an OBRA Admission assessment or a PPS 5-Day assessment Incontinence can play a very large role in pressure ulcers and skin integrity. Skin can start to break down within 15 minutes of exposure to one single void. Having efficiencies to be able to address incontinence as soon as possible after it has occured as well as being compliant and dedicated to the voiding schedule to keep them healthy.
Is the QM that reports the percent of long-stay residents who frequently lose control of their bowel or bladder at or below the federal average %?.			Numerator Long-stay residents with a selected target assessment that indicates frequently or always incontinence of the bladder or bowel from one assessment to the next. Denominator All long-stay residents with a selected target assessment, except those with exclusions. Exclusions 1.Target assessment is an admission assessment or a PPS 5-Day assessment 2.Residents who have any of the following high-risk conditions: A)Severe cognitive impairment on the target assessment B) Totally dependent in bed mobility self-performance C)Totally dependent in transfer self-performance D)Totally dependent in locomotion on unit self-performance E) Resident is comatose or comatose status is missing on the target assessment F)Resident has an indwelling catheter or indwelling catheter status is missing on the target assessment G)Resident has an ostomy or ostomy status is missing on the target assessment.
Is the QM that reports the percentage of long stay residents who have a urinary tract infection at or below the federal average %?.			Review and update your definitions of UTI in accordance with CMS guidelines:The CMS guidance defines symptomatic urinary tract infections, in noncatheterized residents, as a positive urine culture in the presence of at least three of the following: 1) fever; 2) new or increased burning on urination, frequency, or urgency; 3) new flank or suprapubic pain or tenderness; 4) change in character of urine; 5) worsening of mental or functional status. The definition and criteria utilized in the facility's policy and procedure manual must be adhered to in practice for compliance. Numerator: Long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days Denominator: All long-stay residents with a selected target assessment, except those with exclusions. Exclusions: Target assessment is an admission assessment (A0310A) or Urinary tract infection value is missing (I2300
Is the QM that reports the percentage of residents who have had an indwelling catheter in the last 7 days at or below the federal average %?.			Intermittent catheterization may be an appropriate intervention for some residents. If the resident self-performs the task, make sure there is documentation to support ongoing ability and use of acceptable infection control practices. Long-stay residents with a selected target assessment that indicates the use of indwelling catheters Denominator All long-stay residents with a selected target assessment, except those with exclusions. Exclusions 1.Target assessment is an admission assessment or a PPS 5-Day assessment 2.Target assessment indicates that indwelling catheter status is missing 3.Target assessment indicates neurogenic bladder or neurogenic bladder status is missing 4. Target assessment indicates obstructive uropathy or obstructive uropathy status is missing

Is your QM that measures the percent of "long-stay residents who need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment" at or below national average %?			Numerator Long-stay residents with selected target and prior assessments that indicate the need for help with late-loss Activities of Daily Living (ADLs) has increased when the selected assessments are compared. The four late-loss ADL items are self-performance bed mobility (G0110A1), self-performance transfer (G0110B1), self-performance eating (G0110H1), and self-performance toileting (G0110I1). An increase is defined as an increase in two or more coding points in one late-loss ADL item or one point increase in coding points in two or more late-loss ADL items. Note that for each of these four ADL items, if the value is equal to [7, 8] on either the target or prior assessment, then recode the item to equal [4] to allow appropriate comparison. Residents meet the definition of increased need of help with late-loss ADLs if either of the following are true 1.At least two of the following are true (note that in the notation below, [t] refers to the target assessment, and [t-1] refers to the prior assessment): 1.1Bed mobility: ([Level at target assessment (G0110A1[t])] - [Level at prior assessment (G0110A1[t-1])]) > [0], or 1.2Transfer: ([Level at target assessment (G0110B1[t])] - [Level at prior assessment (G0110B1[t-1])]) > [0], or 1.3Eating: ([Level at target assessment (G0110H1[t])] - [Level at prior assessment (G0110H1[t-1])]) > [0], or 1.4Toileting: ([Level at target assessment (G0110I1[t])] - [Level at prior assessment (G0110I1[t-1])]) > [0]. 2.At least one of the following is true: 2.1 Bed mobility: ([Level at target assessment (G0110A1[t])] - [Level at prior assessment (G0110A1[t-1])]) > [1], or 2.2Transfer: ([Level at target assessment (G0110B1[t])] - [Level at prior assessment (G0110B1[t-1])]) > [1], or 2.3Eating: ([Level at target assessment (G0110H1[t])] - [Level at prior assessment (G0110H1[t-1])]) > [1], or 2.4Toileting: ([Level at target assessment (G0110I1[t])] - [Level at prior assessment (G0110I1[t-1])]) > [1]. Exclusions 1.All four of the late-loss ADL items indicate total dependence on the prior assessment, as indicated by: 1.1.Bed Mobility (G0110A1) = [4, 7, 8] and 1.2.Transferring (G0110B1) = [4, 7, 8] and 1.3.Eating (G0110H1) = [4, 7, 8] and 1.4.Toileting (G0110I1) = [4, 7, 8]. 2.Three of the late-loss ADLs indicate total dependence on the prior assessment, as in #1 AND the fourth late-loss ADL indicates extensive assistance (value 3) on the prior assessment. 3.If resident is comatose on the target assessment. 4.Prognosis of life expectancy is less than 6 months (J1400 = [1, -]) on the target assessment. 5.Hospice care on the target assessment. 6.The resident is not in the numerator and 6.1.Bed Mobility (G0110A1 = [-]) on the prior or target assessment, or 6.2.Transferring (G0110B1 = [-]) on the prior or target assessment, or 6.3.Eating (G0110H1) = [-]) on the prior or target assessment, or 6.4.Toileting (G0110I1 = [-]) on the prior or target assessment.

Is the QM that reports the percent of long-stay residents who experienced a decline in independence of locomotion during the target period at or below the federal average %?			Numerator Long-stay residents with a selected target assessment and at least one qualifying prior assessment who have a decline in locomotion when comparing their target assessment with the prior assessment. Decline identified by: 1.Recoding all values (G0110E1 = [7, 8]) to (G0110E1 = [4]). 2.An increase of one or more points on the “locomotion on unit: self-performance” item between the target assessment and prior assessment (G0110E1 on target assessment – G0110E1 on prior assessment ≥1). Denominator Long-stay residents who have a qualifying MDS 3.0 target assessment and at least one qualifying prior assessment, except those with exclusions. Exclusions Residents satisfying any of the following conditions: 1.Comatose or missing data on comatose (B0100 = [1, -]) at the prior assessment. 2.Prognosis of less than 6 months at the prior assessment as indicated by: 2.1.Prognosis of less than six months of life (J1400 = [1]), or 2.2.Hospice use (O0100K2 = [1]), or 2.3.Neither indicator for being end-of-life at the prior assessment (J1400 ≠ [1] and O0100K2 ≠ [1]) and a missing value on either indicator (J1400 = [-] or O0100K2 = [-]). 3.Resident totally dependent during locomotion on prior assessment (G0110E1 = [4, 7, or 8]). 4.Missing data on locomotion on target or prior assessment (G0110E1 = [-]). 5.Prior assessment is a discharge with or without return anticipated (A0310F = [10, 11]). 6.No prior assessment is available to assess prior function.
Is the QM that reports the percentage of short-stay residents who are receiving an antipsychotic medication during the target period but not on their initial assessment at or below the federal average %?			Numerator Short-stay residents for whom one or more assessments in a look-back scan (not including the initial assessment) indicates that antipsychotic medication was received: 1.N0410A = [1, 2, 3, 4, 5, 6, 7]. Note that residents are excluded from this measure if their initial assessment indicates antipsychotic medication use or if antipsychotic medication use is unknown on the initial assessment (see exclusion #3, below). Denominator All short-stay residents who do not have exclusions and who meet all of the following conditions: 1.The resident has a target assessment, and 2.The resident has an initial assessment, and 3.The target assessment is not the same as the initial assessment. Exclusions 1.The following is true for all assessments in the look-back scan (excluding the initial assessment): 1.1.For assessments with target dates on or after 04/01/2012: (N0410A = [-]). 2.Any of the following related conditions are present on any assessment in a look-back scan: 2.1.Schizophrenia (I6000 = [1]). 2.2.Tourette’s syndrome (I5350 = [1]). 2.3.Huntington’s disease (I5250 = [1]).
Whether environmental accommodations have been made to promote continence, such as:			https://www.cms.gov/files/document/cms-20125-urinary-incontinencepdf
Placing the call bell within reach and responding to the call bell promptly			
Maintaining a clear pathway and ready access to bathroom facilities. Bathroom free of hazards lighting, flooring, no throw rugs, close prox to bed and bedroom			
Toilet paper hanger close to toilet			
Providing adaptive equipment or devices, based on resident identified needs, such as elevated toilet seats, grab bars, urinals, bedpans, or commodes; and assuring adequate lighting and assistance as needed to use devices such as urinals, bedpans and commodes.			
Have 100% of your female, incontinent residents had a recent pelvic exam within the past year and documentation can be located in medical record regarding such?			Research suggests that females with incontinence when indicated safe and physically possible, that help practitioners identify pelvic disorders that can cause or lead to incontinence, treatment options as well as prognosis.

Have 100% of your male, incontinent residents had a recent rectal exam within the past year to evaluate prostate and documentation can be located in the medical record regarding such?			Most incontinence in males is a result of prostate concerns. Research suggests that males with incontinence when inidcated safe and physically possible, that help practitioners identify prostate concerns that can cause or lead to incontinence, treatment options as well as prognosis.
Have 100% of your residents with a UI diagnosis had their treatment preferences documented in care plan or either in medical record?			Care plan (e.g., scheduled toileting or restorative program based on the type of incontinence [retraining, habit training, scheduled voiding, prompted voiding, toileting devices], environment or assistive devices, promotes choice and dignity, psychosocial concerns [social withdrawal or embarrassment], skin integrity, UTI prevention, incontinence products, hydration/nutrition needs).
Have 100% of your residents had documentation of an assessment to determine a resident's suitability for prompted voiding?			Behavioral programs such as bladder rehab/bladder retraining, pelvic floor muscle rehab require the resident's cooperation and motivation. Prompted voiding and scheduled voiding are more staff-directed programs rather than dependent on resident function. Scheduled voiding is not considered to be a bladder retraining /rehab program. Research suggests that these programs can be extremely beneficial for those living with incontinence.
Does each resident with an in-dwelling catheter have a documented care plan, an appropriate diagnosis and have a plan for removing the catheter unless otherwise indicated?			A resident who is admitted with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible, unless the resident's clinical condition necessitates continued catheterization
Do 100% of your incontinent residents wearing a brief have:			
A care plan for incontinence?			One example: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/QMP/ContinencePromotionCarePlan.pdf An example provided by the Texas Department of Health and Human Services is included in the Training Manual Appendix for your reference.
A bladder assessment in their medical record and does it include the following:			CMS requires a bladder assessment to be completed upon admission, re-admission and any time a resident's status changes. Once determined, care planned and thoroughly documented, quarterly assessments can be stopped if the condition causing the incontinence is determined to be irreversible. An example of a comprehensive bladder assessment is included in the Training Manual Appendix for your reference.
The resident's prior history of bladder functioning – i.e., were they continent prior to hospitalization?			It is important to use many sources to determine this information. Family and caregivers can be extremely beneficial with giving input into this determination.
Pertinent diagnosis – DM, CHF, CVA?			
Voiding patterns – i.e., frequency, nocturnal voiding?			Voiding patterns can tell a lot about someone wo may be reliant on a caregiver for assistance.
Medication use – i.e., diuretics, narcotics?			Certain medications can have side effects of incontinence as well as some medications when used together can create incontinence. It is recommended that a review not only be taken by the pharmacists, but a physician review as well for a different perspective. It is also suggested that it is communicated to the practitioner that the review is being requested in order to determine the impact one's medications might have on their incontinence.
Patterns of fluid intake i.e., consider limiting fluids after a certain hour?			
Use of stimulants/irritants – caffeine?			
Physical exam – enlarged prostate, prolapsed uterus?			
Functional and cognitive needs – manual dexterity, need for task segmentation, pain?			
Environmental factors – lighting, distance to the bathroom, use of bedside commodes?			
Potential for or actual skin breakdown?			A skin integrity assessment could be useful along with skin assessments for determining whether or not the individual is at high risk for breakdown or if they currently have skin integrity issues that need to be addressed aggressively and quickly.
A 3 day voiding record?			One example: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/QMP/voidingrecord-1c5project.pdf An example from the Texas Department of Health and Human Services is located in the Training Manual Appendix.
A documented determination of whether or not a bladder re-training program is appropriate or warranted?			
Does your therapy provider screen residents for the potential of therapies related to incontinence on a quarterly basis and as needed or at risk?			Screening on a quarterly basis can determine if any changes have taken place in the above information to warrant bladder retraining or scheduled voiding exercises to improve their incontinence.

Are all newly incontinent residents discussed in your weekly at risk meetings?			This is important. Incontinence has not been historically, clinically nor scientifically directly linked to higher risk, however it can be suggested that due to particular conditions, circumstances and deficits that can cause or lead to incontinence, it adds a layer of risk that can be prevented, monitored closer and/or reversed. It is important to identify and implement appropriate interventions that can be used to reduce risk based on incontinence.
Do you have an incontinence qapi action plan that has input by your medical director and nursing leadership?			An example is located in the appendix of the DON Guidebook, however it is imperative to formalize a QAPI action plan, work group and goals with steps to take to reach these goals
Are you still waking residents up in the middle of the night for incontinence care?			Consider the DREAM kit from CMS: https://www.cms.gov/files/zip/developing-restful-environment-action-manual-dream-toolkit.zip Also the toolkit will be included in the Training Manual Appendix for your review and use.
Have 100% of your incontinent residents had a medication review by their attending physician as well as the consulting pharmacist quarterly to look for side effects that could cause the incontinence?			Medications can be the cause of incontinence as well as can be the treatment for it as well so it is important to get practitioner's assessment of their medication use quarterly as it relates to incontinence.
Is education being provided to 100% of the incontinent residents and their families related to incontinence and their treatment plans?			It is mentioned in the CMS guidelines that residents and their families receive education to themselves and their caregivers for a more thorough observation. The guidebook sections can also be broken down and utilized with families and/or caregivers.
Do residents who are at risk for incontinence due to having at least one of these risk factors have a care plan to prevent incontinence?			
Dementia?			
Limited functioning?			
Bedfast?			
History of Pressure ulcers?			
History of Falls?			
Catheter?			
Wheelchair bound?			
Limited engagement?			
frequent UTIs?			
History of vaginal child birth?			
Hisotry of prostate issues or concerns?			
Autoimmune disorders?			
IC, OAB or other diagnosis?			
Medication use of over 2 medications daily, especially diuretics, tranquilizers, antidepressants, antipsychotic medications, and hypnotics?			
Poor nutritional health?			
history of dehydration?			
obesity?			
diabetic?			
chf?			
delirium?			
systolic hypertension?			
Parkinsons Disease or ALS?			
constipation or IBS?			
pelvic floor muscle disfunction?			
arthritis, back pain or injury?			
hearing or visual impairment?			
high caffiene intake or alcohol, smoking and/or drug abuse?			

Are you aware of and have you reviewed, used and educated your staff on the incontinence critical element pathway devleoped and released by CMS?			The pathway includes 12 areas that surveyors will include incontinence as a potential violation. Review here: https://www.cms.gov/files/document/cms-20125-urinary-incontinencepdf You can also locate a copy of the critical element pathway in the Training Manual Appendix for use.

If you answered no to any item, see the "further information/instructions" collumn in order to determine your next steps and to start your QAPI action plan today.

Bowel & Bladder Screening (3-day Void)

❑ Annual ❑ Admission ❑Readmission ❑ New Onset Incontinence

	NAR Initials	Time	Toileted			Pad		Resident Requested toileting	Bowel Movement
			When placed on toilet/commode, did res. void?	Refused by Res.	Not able by Res.	Dry or Wet	Approx amt of urine		
Date: _____ (day1) Am Q 2 hrs		6:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		7:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		8:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		9:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		10:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		11:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		12:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		1:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		2:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									
Date: _____ (day 1) Pm Q 2 hrs		3:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		4:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		5:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		6:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		7:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		8:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		9:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		10:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									
Date: _____ (day 1) NOC Q 2 hrs		11:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		12:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		1:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		2:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		3:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		4:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		5:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									
Date: _____ (day 2) Am		6:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		7:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		8:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
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		9:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		10:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									

Resident Name:_____MR#_____ Room#_____

	NAR Initials	Time	Toileted			Pad		Resident Requested toileting	Bowel Movement
			When placed on toilet/commode did res. void?	Refused by resident	Not able by resident	Dry Or Wet	Approx amt of urine		
Date: _____ (day 2) NOC		11:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		12:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		1:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
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		3:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		4:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		5:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									
Date: _____ (day 3) Am		6:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		7:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		8:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		9:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
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		1:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		2:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									
Date: _____ (day 3) Pm		3:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		4:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
		5:_ _pm	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
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		5:_ _am	Voided Not voided	Refused	Not able	Dry Wet	S M L	Yes No	Cont. Inc.
Licensed staff reviewed:									
Comments:									

Additional Comments: _____

Resident Name:_____MR#_____ Room#_____

Sample Care Plan: Urinary Incontinence

Mrs. Fuller is an 84 year old widow, who recently came to live at Northland Nursing Facility, after her husband's death. Her daughter lives in the area and visits regularly. Mrs. Fuller has Osteoarthritis, clinical depression, and approximately eight episodes of incontinence daily. She takes Celebrex for arthritis, Lexapro for depression, and Benadryl as a sleep aid. Mrs. Fuller has an order for Tylenol and Hydrocodone as needed, for pain. Mrs. Fuller eats a regular diet. She drinks coffee with each meal. On assessment, Mrs. Fuller has a stage I pressure ulcer on her sacrum. She reports she has a "moderate" amount of pain, but prefers not to take medication. "I do not want to get hooked." Regarding episodes of incontinence Mrs. Fuller tearfully states, "It is just easier to wear these diapers. It is difficult to get to the bathroom in time. I am not as quick as I use to be." Mrs. Fuller's progress notes document wandering at night with disorientation to place. She is often wet.

Nursing Diagnosis: Functional Incontinence related to impaired mobility

Goal	Expected Outcome	Intervention	Rationale
Mrs. Fuller will have reduced episodes of incontinence within one week.	Mrs. Fuller will report a 50% decrease in episodes of incontinence within the first week of the plan.	Nurse will assess barriers to successful implementation of plan, including appropriateness and side effects of medications	Inadequate lighting, inaccessibility to bathroom, inaccessibility to bathroom modifications, pain medications and knowledge deficits may contribute to episodes of incontinence.
		A 3-day voiding record will be completed for Mrs. Fuller.	A 3-day voiding pattern will establish Mrs. Fuller's normal voiding pattern.
		An educational program for Mrs. Fuller, her caregivers and her family will be implemented.	Information on myths related to incontinence, pain management, and best practice guidelines on continence promotion will facilitate and interdisciplinary approach. .

TEXAS Department of Aging and Disability Services

Quality Monitoring Program

www.dads.state.tx.us/providers/qmp/evidence-based-best-practices/continence-promotion.html

Goal	Expected Outcome	Intervention	Rationale
Mrs. Fuller will have reduced episodes of incontinence within one week.	Mrs. Fuller will report a 50% decrease in episodes of incontinence within the first week of the plan.	Implement an individualized prompted voiding schedule based on Mrs. Fuller's needs, and as determined by the 3-day voiding record. Nurse will educate Mrs. Fuller about behavior modification. The interdisciplinary team will evaluate the effectiveness of the prompted voiding program and other interventions, modifying when appropriate.	Prompted voiding schedules will encourage Mrs. Fuller to empty her bladder before the usual; "need" to go, and avoid the fear of not getting to the bathroom in time. Correct practice of pelvic floor muscle exercises, re-training the bladder and decreasing caffeine intake are noninvasive treatments for urinary incontinence. Continuous documentation and monitoring of voiding records and input from Mrs. Fuller, family and staff will be necessary to track and trend voiding patterns and measure outcomes/progress toward goals.

Please note: This is not an actual care plan. The purpose of this care plan is to capture key elements of best practice regarding an individualized approach to implementation. This information can be used in the development of individualized care plans for continence promotion; additional columns may be helpful to evaluate the effectiveness of interventions and progress toward goals.

Bladder Data Collection & Assessment

❒ Initial ❒ Annual ❒ Significant change ❒ New onset incontinence

Catheter: (care plan for catheter care)

❒ Catheter reason/dx and type:_____ Size:_____ D/C Plan_____

❒ Discontinuation attempted date:_____ MD order ❒Yes Catheter change frequency_____

Cognitive Awareness

Does the resident display any of the following: ❒ Short term memory loss ❒ Long term memory loss
Can the resident identify the need or urge to void/defecate? ❒ Yes ❒ No ❒ Some of the time
Is the resident able to use the call light? ❒ Yes ❒ No ❒ Some of the time
Is the resident able to ask to go to the toilet? ❒ Yes ❒ No ❒ Some of the time

Elimination History (Include resident and family/representative)

Bladder: How long has the resident been incontinent of bladder? _____ ❒ Since admit ❒Unknown
❒ Wakes at night to void How many times?_____ Other significant patterns:_____
❒ Has problems "leaking" urine Precipitating factors:_____
Any incontinent episodes with: ❒ Laughing ❒ Coughing ❒ Changing positions ❒ Sneezing ❒ Exercising

Symptoms Affecting Elimination Patterns

❒ Voids often and in small amounts	❒ Unable to void	❒ Urgency ❒ Dysuria
❒ Difficulty stopping stream	❒ Difficult starting stream	❒ Bladder spasms ❒ Mood/Behavior
❒ Dribbles while coughing/standing up	❒ Burning pain	❒ Hematuria
❒ Dribbles after voiding	❒ Distended bladder	❒ Polyuria
❒ Dribbles constantly	❒ Fever	❒ Urinary retention (inability to empty bladder)
❒ Unable to feel urge sensation	❒ Functionally disabled	❒ Psychological impact from incontinence

Diagnosis and Medications Affecting Elimination Patterns

Does the resident have any of the following diagnosis? *(Check all that apply)* ❒ CVA ❒ CHF ❒ Delirium
❒ Urinary disorders ❒ Edema ❒ Diabetes ❒ Atrophic Urethritis/Vaginitis ❒ Kidney disease ❒ UTI's ❒ M.S.
❒ Dehydration ❒ Prostate problems ❒ Depression ❒ Parkinson's ❒ Recent surgery ❒ Bowel obstruction
❒ Dementia/Alzheimer's ❒ Pelvic organ prolapse ❒ Cancer ❒ Obesity ❒ Mental illness ❒ Behaviors

Taking one or more of the following medications influencing *Lower Urinary Tract Functioning*?

❒ Diuretics ❒ Hypnotic/Sedative ❒ Antipsychotics ❒ Calcium Channel Blockers (*Verapamil, Cardizem, Nifedipine)*
❒ Parkinson's Meds ❒ Ace Inhibitors *(captopril, lisinopril)* ❒ Narcotics ❒ Caffeine ❒ Antispasmodics
❒ Antihistamines ❒ Tricyclic Antidepressants *(Amitriptylline etc.)* ❒ Beta Blockers (*Metoprolol etc.)* ❒ Stimulants
❒ History of multiple antibiotic use

Mobility /Environmental Limitations Which Could Affect Elimination

❒ Requires assist with ambulation ❒ Requires assist to transfer ❒ Fear of falling ❒ Requires mechanical lift
❒ Confined to chair ❒ Bed rest ❒ BR is not easily accessible ❒ Lighting ❒ Use of physical devices
❒ Uses adaptive equipment *(Hi/low toilet seat, bars, commode etc..)* List:_____

Pain *(Refer to Pain Assessment)*

Is pain or discomfort affecting elimination patterns ❒Yes ❒ No Comments:_____

Labs (Abnormal values in past 30 days or abnormal baselines)

❒ Elevated BUN:_____ ❒ Low B12 ❒ High creatinine:_____ ❒ Elevated blood glucose ❒ High blood calcium
❒ TSH ❒ Elevated WBC

Possible Reversible Causes for the Incontinence

❒ History of UTI (s) Usual symptoms (if any) _____ Last UTI_____

Resident Name:_____ MR#_____ Room_____

Toileting –Resident Self Performance (How resident uses the toilet/commode/bedpan and transfers on/off toilet, cleanses, changes pad, , adjust clothes)

❑ Independent ❑ Supervision, encouragement or cueing ❑ Requires non-weight bearing assist, resident highly involved
❑ Requires weight bearing assist, resident somewhat involved ❑ Resident requires total assist

Elimination Patterns

Urinary Patterns from 3-day void:

Resident shows **patterns of urinary continence** ❒ **Less than 2 hours** *or* ❒ **Greater than 2 hrs**

Comments on urinary patterns:_____

- Resident has patterns reflecting dribbling of urine ❒ Yes ❒ No
- Resident able to use the toilet majority of time ❒ Yes ❒ No
- Resident does NOT display elimination patterns ❒
- Resident has voluntary leakage of urine (behavior-refuses toileting) ❒ AM ❒ PM ❒ NOC

Suspected Type(s) of Incontinence ❒ **Urge** (sudden urgency) ❒ **Stress** (leaks with cough/ sneeze)
❒ **Mixed** (combination of both urge and stress)
❒ **Overflow** (leakage of small amounts of urine when bladder is full -frequent dribbling, bladder "fullness")
❒ **Functional** (decreased mental awareness/decreased or loss of mobility or personal unwillingness)
❒ **Transient** (temporary episodes of urinary incontinence that are reversible once casual factors are treated

Skin Integrity

Does resident have current skin breakdown in perineal/sacral areas? ❒ Yes ❒ No Hx of breakdown ❒ Yes ❒ No
Is current elimination plan effective as evidenced by clear skin integrity? ❒ Yes ❒ No

Patterns of Fluid Intake

❒ WNL Describe alterations in fluid intake:_____
LPN Signature: _____ Date: _____
Analysis of Assessment Data:_____

_____

_____

_____

Treatment Plan

Elimination Plan	Bladder	Product
❒ **Scheduled toileting plan** • Cognitively Impaired • Functionally disabled • Caregiver dependent ❒ **Check and change program** (Designed for residents who are physically unable to sit on toilet or have cognitive impairment or behaviors that make it difficult to use) • Cognitive impairment • Functionally disabled ❒ **Training to return to previous pattern/retraining** • Oriented • Able to feel sensation • Able to understand and learn to inhibit the urge • Toilet Ind. or with minimal assist ***Involve resident/representative in condition and treatment options and outcomes of refusal of treatments***	**Assistance/Mode of Elimination** ❒ Assist to use toilet ❒ Assist to use commode ❒ Assist to use bedpan ❒ Check and change **Frequency:** ❒ Upon arising ❒ After meals ❒ Before bed ❒ Before and after meals ❒ With NOC Rounds ❒ Scheduled Q _____hrs ❒ Provide assist to toilet PRN ❒ Assist Q _____hrs ❒ Reminders Frequency:_____ ❒ Other: _____ ❒ Provide teaching for retraining ❒ Intermittent catheterization __	❒ Brief ❒ Pull-up ❒ Pads ❒ Snap pants with liner ❒Panty liner ❒ Other : _____ Size: ❒ Small ❒ Medium ❒ Large ❒ External collection system ❒ Pessary
❒ **Prompted voiding** (Scheduled toileting that requires the caregivers prompting) • Able to use toilet - Feel sensation • Able to request toileting	Ask Q ____hrs if need to use BR ❒ Prompt _____	**PVR =** _____ cc
If continence cannot be maintained is this resident candidate for incontinence product or device? ❒ Yes ❒ No Comments:_____		

RN Signature: _____ Date: _____

Resident Name: _____ MR#_____ Room_____