Acknowledgements

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Objectives

• Discuss factors that impact continence
• Review recommendations from Promoting Continence Best Practice Guideline
• Share ideas for developing Individualized toileting/prompted voiding schedules
• Share tips for implementing prompted voiding
• Discuss ways to overcome barriers and challenges
Promoting Continence Using Prompted Voiding BPG

- Provides information on implementing a prompted voiding program
- Practice Recommendations:
  - Assessment
  - Planning
  - Implementation
  - Evaluation
Assessment Recommendations

1.0 Obtain a history of the resident's incontinence.

2.0 Gather information on:
   - The amount, type and time of daily fluid intake including caffeine and alcohol.
   - The frequency, nature and consistency of bowel movements.
   - Any relevant medical or surgical history which may be related to the incontinence problem eg. diabetes, stroke, Parkinson's disease, heart failure, recurrent urinary tract infections or previous bladder surgery.
Types of Urinary Incontinence

Physical:
- Stress: cough, laugh, etc.
- Urge: need to go now…
- Overflow: leaks out

Functional:
- Person needs help

Transient
- Short term problem
Overview of Continence Factors

- Current Medical Problems
- Cognitive Impairment
- Past Medical/Surgical History
- Overweight
- Aging: Loss of pelvic muscle tone & atrophic changes
- Urinary Tract Infections
- Low Fluid Intake
- Caffeine / Alcohol Intake
- Constipation
- Decreased Mobility
- Environmental Factors
- Medications
Assessment Recommendations

- 3.0 - Review the client's medications that may have an impact on incontinence.
- 4.0 - Identify the client's functional and cognitive ability.
- 5.0 - Identify attitudinal and environmental barriers to successful toileting.
Medications That Impact Continence

- **Anti-hypertensives** - Postural hypotension leads to functional urinary incontinence (UI).
- **Diuretics** - Diuresis causes overflow incontinence
- **Calcium Channel Blockers** - Constipation, diarrhea
- **Antacids with aluminum** - Laxative effect, can cause diarrhea or loose stools
- **Laxatives** - Diarrhea, intestinal cramping, fecal incontinence.
- **Antidepressants** - Constipation, especially in elderly. Contribute to overflow and functional UI. Problems with urination and loss of bladder control.
- **Monoamine oxidase inhibitors (MAO’s)** - Urinary retention.
- **Anti-psychotics** - Constipation, confusion, sedation, rigidity and immobility leading to overflow and functional UI.

More Meds That Impact Continence

- **Sedative/Hypnotic/ Barbiturate** - Can cause excessive sedation and decreased mobility in elderly people predisposing them to functional UI. Not commonly used in long term care.

- **Narcotics** - Constipation and confusion leading to overflow and functional urinary incontinence.

- **NSAIDS** – Urinary retention in elderly and/or arthritic patients (in large doses)

- **Anticholinergic/ Antispasmodic/ Antiemetics** - Constipation and urinary retention leading to overflow and functional UI

- **Cholinergic** - Cause urge incontinence due to bladder relaxation. Not commonly used in long term care.

- **Anti-Parkinson agents** - Constipation, diarrhea

Resident Capabilities

Functional Barriers
• Affect resident's ability to get a toilet on time:
  – Access to bathroom
  – Ambulation assistance
  – Wheelchair
  – Transfer aids
  – Adaptive clothing/environment

Cognitive Capacity
• awareness of urge to void
• able to get to the bathroom
• able to suppress the urge until resident reaches the bathroom
• able to void when resident gets to the BR
Planning Recommendations

6.0 Check urine to determine if infection is present. Urine testing is controversial. Follow recommendations in PIDAC standards

8.0 Ensure that constipation and fecal impaction are addressed.

9.0 Ensure an adequate level of fluid intake (1500 - 2000 ml per day), and minimize the use of caffeinated and alcoholic beverages where possible.

In LTC, follow your registered dietitian’s fluid intake recommendations for individualized plan of care.
Urinary Tract Infections (UTI’s)

- Assess UTI’s using your LTC Home’s or another protocol
- UTI treatment is controversial
- Avoid creating Antibiotic Resistant Organisms with overuse of Antibiotics
- Consult with your Regional Infection Control Network (RICN) Coordinator

Constipation and Fecal Impaction

- Pushing too hard and too often when having a bowel movement can weaken pelvic floor muscles
  - Stool “impaction” adds to urinary incontinence
  - “Smearing” or “staining” of stool can be as a result of constipation

Consult Dietitian
- Ensure adequate fluid intake,
- Increase fiber
- Encourage and assist with mobility
- Stool softeners and laxatives as required
Dehydration can cause:

• More concentrated urine which is irritating to the bladder
• Urinary frequency
• UTI’s
• Nocturnal leg cramps
• Delirium

Solutions:

• Track fluid intake for all residents
• Review fluid intake reports daily
• Encourage fluids with residents who have not drunk enough

Source: http://www.liversupport.com/for-your-livers-sake-the-best-times-to-drink-water/
Implementation Recommendations

7.0 Determine how the resident perceives their urinary incontinence and if they will benefit from prompted voiding. Before initiating prompted voiding, identify the resident's pattern of incontinence using a 3-day voiding record.

10. Initiate an individualized prompted voiding schedule based on the resident's toileting needs, and as determined by a 3-day voiding record.

11.0 Initiate a 3-day voiding record, a minimum of 3 weeks and a maximum of 8 weeks, after the prompted voiding schedule.
Approaches to Reduce Incontinence

- Prompted voiding
- Habit retraining
- Fluid management
- Pelvic floor muscle rehabilitation (Stress Incontinence)
- Lifestyle modifications, and
- Urge inhibition techniques

10.0 Prompted Voiding Approach

- Changes staffs’ response to urine loss rather than resident’s response.
- Staff prevents undesired urine loss from occurring before the resident would be incontinent.
- Staff adjusts their routine to accommodate residents’ voiding patterns.
- Residents are toileted based on their individualized voiding plan rather than routine or scheduled toileting (e.g. q2H).
7.0 Start with a Voiding Record

Do a three-day **observation** period of the resident’s incontinence pattern

Voiding record/diary are tools to track:

- Fluid intake
- Time and amount voided
- Times and number of incontinence episodes
7.0 Implementing a Voiding Diary

- Determine sequential documentation and communication for at least 3 days/9 shifts for data collection
- Remind staff to do the diary on shift report sheets
- Communicate between shifts during shift-to-shift report
  - Example: case-based huddles each shift change
10.0 Take a closer look:

- Review diary after completion:
  - Number of times voided
  - Number of times wet
  - Fluid intake
  - Times identified when Resident was wet/soiled

- Look for possible patterns for a toileting plan – time of day
- Note signs of need to void
Engage Personal Support Workers (PSW’s)

• Track fluid intake and urinary output
• Identify residents on prompted voiding by using a logo (i.e. waterdrop-logo)
• Use a laminated ‘clock’ at the bedside. Mark toileting times identified.
• Assigned PSW keeps the clock updated.
• Put toileting schedule on care carts with resident specific toileting times or signals.
Engage the Resident

Approach Resident at the time when he/she would normally void or is showing signs of needing to void:

• **Monitor** - Ask the resident if he/she needs to use the toilet.

• **Prompt** - Remind the resident to use the toilet and try not to void between prompted voiding sessions.

• **Praise** - Give positive feedback to resident to reinforce dryness and appropriate toileting
Helpful Hints for Encouraging Voiding

• Physical surroundings may need to be adapted. Resident may need cues like signs. Ask residents and family for suggestions on the best approach.

• Ask resident “Can I take you to the **toilet?**” rather than “Can I take you to the **bathroom?**”.

• Ask the resident to come back to their room to “check them”.

• Standing a resident up and walking to the bathroom often triggers the need to void.

• Moving resident may work better than asking the resident while sitting in a chair whether they need to go to the toilet.
7.0 Residents who benefit most from prompted voiding:

- Most successful with residents who are mobile or able to follow simple instructions.
  - Start with ambulatory residents or one person transfers
- New Admissions who have previously been continent or have not had an continence assessment.
- Useful with residents having physical/mental/cognitive impairments
- Try not to exclude residents without a trial of prompted voiding.
Common Challenges - Prompted Voiding

- Incomplete voiding diaries
- Getting staff 'buy-in' to adjust their schedules to toilet resident at the appropriate times
- Staff unable/unwilling to follow the specific times of the voiding diary
- Keeping the scheduled voiding times updated
- Communicating the scheduled voiding times to all staff
- Myth that residents cannot become continent
Prompted Voiding Challenges – Resident:

- Fails a 2-3 week trial of prompted voiding
- Unable to safely sit on toilet/commode even with a toileting sling
- Unwilling to cooperate
- Condition does not allow continence ie. Neurogenic bladder, continuous incontinence, etc.
- Has extreme cognitive impairment
- Chooses to be incontinent and wants to wear a product
- Feels that reminders to void, challenges their dignity
Evaluation Recommendations

14.0 Successful implementation of prompted voiding requires:

- Management support;
- Opportunities for education and training;
- Active involvement of key clinical staff;
- Gradual implementation of the prompted voiding schedule;
- Collection of baseline information about clients, resources and existing knowledge;
- Interpretation of this data and identification of problems;
- Development of implementation strategy; and
- Monitoring of the program.
Resident Success Indicators

Dignity and Self Esteem:
• Toileted at specific times
• Sustained continence for many months
• Appropriate products – ie Pad in the am (dry throughout the day) and a night brief at bedtime

Safety:
• Reduced falls
• No Urinary Tract Infections
• Skin clear and intact

Hydration:
• Fluid intake is increased during waking hours

Pain:
• Free of pain related to continence-associated dermatitis

Activity:
• Participating in programs and activities
• LOA visits

Outcome:
• Family and Resident Satisfaction
Staff Success Indicators

- Decreased workload – spending more quality time with the residents
- Decreased WSIB related to transferring and toileting
- Time saved
- Staff workplace satisfaction
- Increased productivity
Staff Workload Indicators

Change time Vs. Toilet Time

**TIME SAVED**

- Time to Change: 15 – 20 minutes
- Time to Toilet – 5-7 minutes
Organization Success Indicators

- Reduction in cost for continence products – Budget alignment
- Reduced falls
- Reduced incontinence-associated dermatitis (IAD)
- Decreased supplies & laundry
- Reduced UTI’s
- Reduced episodes of Delirium
- Resident taking more part in programs/activities
- No odours

- Improved Quality of Life for Residents
- Improved staff workload balance
- Reduction in product utilization
- Impact on compliance
- Impact on accreditation
- Impact of RAI and other quality indicators
- Decreased medication utilization
Quality Improvement Monitoring

Pre-implementation
- 4-5 changes of briefs
- Costs 2.72-3.40

Post Implementation
- 1 day-light pad for a waking hours (dry) and brief overnight
- Costs 1.07
Overview - Prompted Voiding

- Collect baseline information about resident.
- Plan a gradual implementation. Start 1-2 residents on the protocol at one time.
- Involve front line clinical staff.
- Try out the approach, then revise it.
- Tell everyone about your successes.
- Get management support.
- Monitor prompted voiding indicators.
Questions?
Resources

• RNAO Promoting Continence Using Prompted Voiding: A PDA Guide. 
  http://www.rnao.org/pda/void - Condensed version of the Continence BPG. Excellent summary in English and French.

• RNAO BPG – Promoting Continence Using Prompted Voiding. 

• Anna and Harry Borun Center for Gerontological Research. Incontinence Management Training Module. 
  http://www.geronet.med.ucla.edu/centers/borun/modules/Incontinence_management/about.htm. A clearly written, self-learning package that breaks the process into steps: assessment, responsiveness, maintenance and audits. Includes voiding records, monitoring forms, MDS subscales, etc. Highly recommended.
