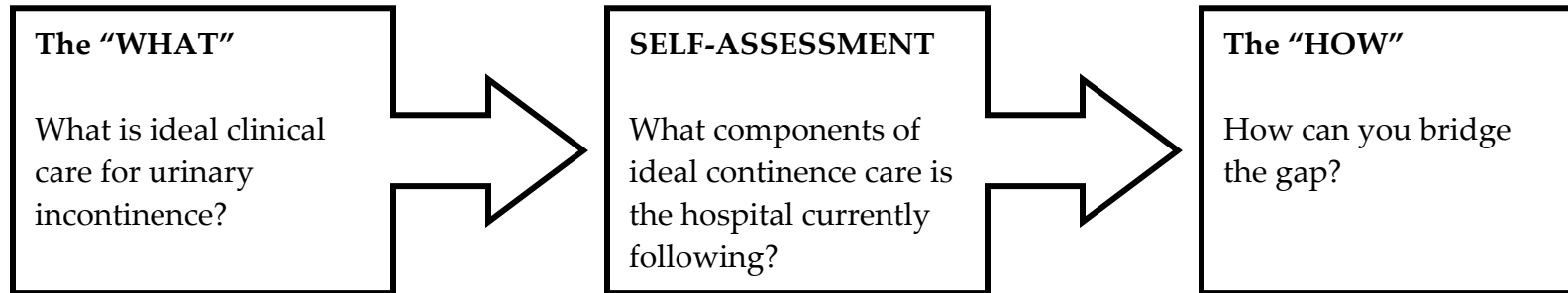
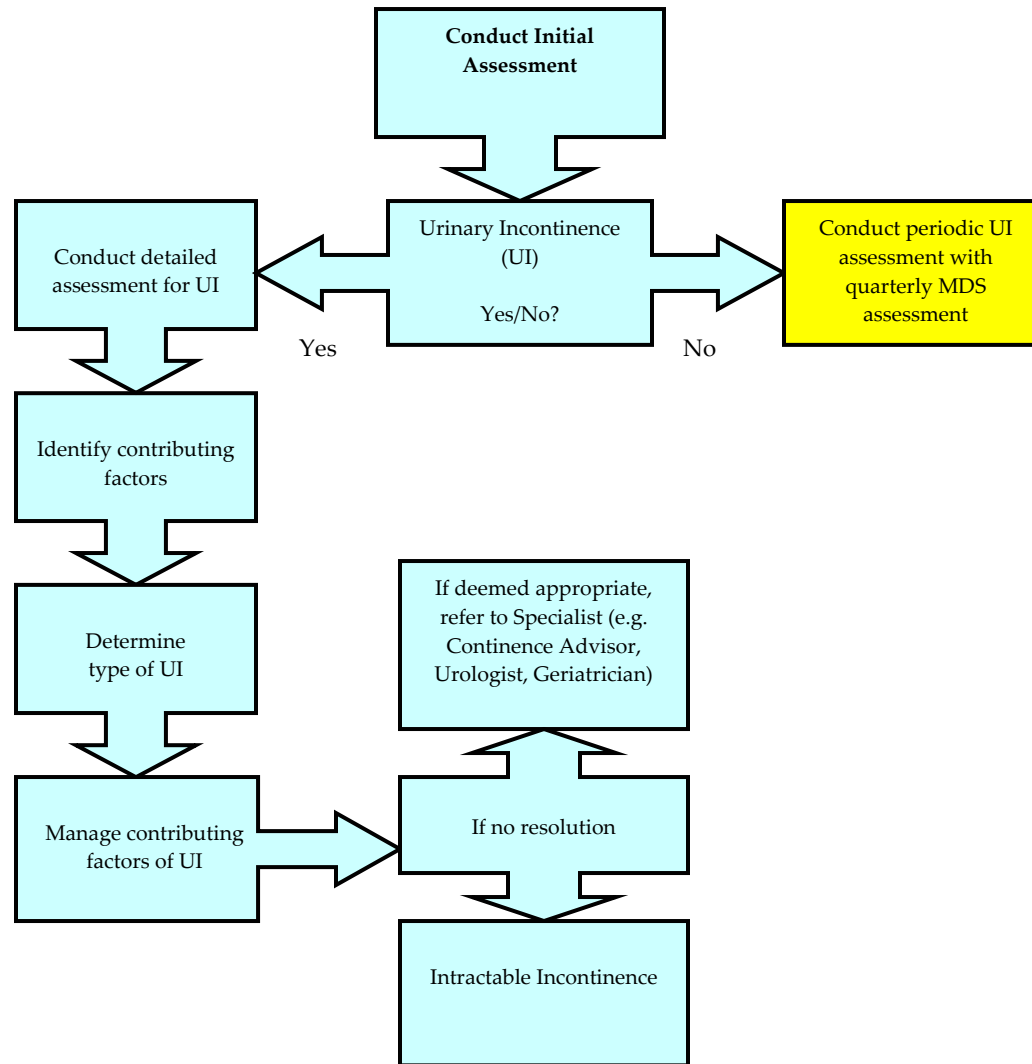


## Clinical Model for “IC 5”



## The “WHAT”

What is Optimal Continence Care? (details for each component are on the following pages)



## The “WHAT” continued

<b>Conduct Initial Assessment</b>	<ul style="list-style-type: none"> <li>• Presence of UI</li> <li>• When person was last continent</li> <li>• Patient’s continence goals</li> </ul>
<b>Conduct Detailed Assessment for UI</b> (include patients with catheters)	<ul style="list-style-type: none"> <li>• History of patient’s UI</li> <li>• Presence of delirium (part of MDS assessment)</li> <li>• Type, amount and time of fluid intake</li> <li>• Frequency of BMs</li> <li>• Relevant and related medical or surgical history</li> <li>• Medications</li> <li>• Cognitive awareness of voiding</li> <li>• Environmental barriers (e.g. access to toilet, privacy, toilet height and comfort etc.)</li> <li>• Rule out urinary retention</li> </ul> <ul style="list-style-type: none"> <li>• Functional ability</li> <li>• 3-day voiding record to determine pattern of incontinence</li> <li>• Urinalysis and urine culture</li> <li>• In/out catheter to evaluate post-void residual urine</li> <li>• Presence of vaginal prolapse (<b>should be referred to NCA or Physician</b>)</li> <li>• Appropriateness of indwelling catheter, if present (refer to intractable incontinence section for indications for indwelling catheter use)</li> <li>• Patient’s goals and motivation</li> </ul>
<b>Identify Contributing Factors</b>	<ul style="list-style-type: none"> <li>• Mobility</li> <li>• Environmental Factors (different from those that might restrict mobility)</li> <li>• Infection</li> <li>• Delirium</li> <li>• Constipation</li> <li>• Fluid Intake (amount, timing and type with attention to caffeine)</li> <li>• Urinary retention</li> <li>• Urinary Tract Infection (UTI)</li> </ul> <ul style="list-style-type: none"> <li>• Pharmaceuticals (e.g. meds causing polyuria – diuretics; constipating medications – codeine, iron: retention-causing meds – antidepressants)</li> </ul>
<b>Determine type of UI</b>	<ul style="list-style-type: none"> <li>• Assess for type of urinary incontinence:             <ol style="list-style-type: none"> <li>a) Transient</li> <li>b) Functional</li> <li>c) Overflow</li> <li>d) Stress or</li> <li>e) Urge</li> </ol> </li> </ul>

**Manage  
Contributing  
Factors of UI**

**Conservative Management of UI:** These strategies should be applied to patients with **any type of incontinence** (global strategies)

- Adjust fluid intake: increase fluid to 1500 to 2000 mL/day; eliminate caffeine; address timing of fluid intake (i.e. consider restriction after 1800 to address nocturia)
- Treat constipation (increased fluid, fibre, exercise, routine, positioning)
- Product selection while working on management strategies: size and fit; absorbent for correct volume; wick moisture away; comfort; patient ease of use (i.e. can pull up and down themselves if toileting); day versus night needs for absorbency.

**Plus UI type specific interventions**

**(a) Transient UI**

- Treat constipation
- Treat delirium
- Treat UTI
- Review medications that may impact incontinence (i.e., diuretics, anticholinergics, antidepressants, sedatives etc.)

**(b) Functional UI**

- Individualized prompted voiding schedule to assess, plan and monitor individual prompted voiding (based on needs and determined by assessment); 3-day voiding record after prompted voiding initiated (use briefs and pay attention to skin integrity if applicable during this process)
- Involve the interdisciplinary team members:
  - i. OT for assistive devices aids – commode, modified/adaptive clothing, cognitive aids (i.e., signage), environmental barriers in bathroom
  - ii. PT for mobility aids/mobility enhancement
  - iii. Speech/Language pathologist for communication strategies/aids (i.e., if patient has aphasia)

**(c) Overflow UI**

- Evaluate impact of medications
- Liaise with MD for treatment of overflow incontinence with intermittent catheterization or indwelling catheter or suprapubic catheter
- Referral to specialist if overflow related to vaginal prolapse or to check for enlarged prostate

**(d) Stress UI**

- Consider referral to specialist if related to vaginal prolapse (i.e., pessary or surgery)

**(e) Urge UI**

- Evaluate impact of medications
- Prompted voiding
- Management of conditions that cause polyuria (i.e., diabetes, CHF)
- If nocturia is related to cardiac status, consider elevating legs above level of the heart for 2 hours/day or compression stockings

<p><b>No resolution</b> (i.e. actions to be taken after there is no initial resolution to the UI)</p>	<ol style="list-style-type: none"> <li>1) Refer to one of the following specialist(s): Nurse Continence Advisor, Urologist, Urogynecologist, Geriatrician</li> <li>2) Intractable Incontinence <ul style="list-style-type: none"> <li>• Refer to “product selection” under conservative management</li> <li>• Catheterization is indicated as a last resort in the following situations: <ol style="list-style-type: none"> <li>a) Urinary retention that is characterized by: persistent overflow incontinence, symptomatic infections, or renal dysfunction; cannot be corrected surgically or medically; patient prefers not to be managed with intermittent catheterization.</li> <li>b) Skin wounds, pressure sores, or irritations that are being contaminated by incontinent urine that cannot be managed with briefs or condom catheters</li> <li>c) Care of terminally ill or severely impaired for whom bed and clothing changes are uncomfortable or disruptive</li> <li>d) Preference of patient when patient has not responded to more specific treatments</li> </ol> </li> <li>• <b>Best practice guidelines for intermittent catheterization:</b> <ol style="list-style-type: none"> <li>a) Use <u>Modified Sterile</u> technique (i.e. one sterile glove)</li> </ol> </li> <li>• <b>Best practice guidelines to prevent blockage of indwelling catheters:</b> <ol style="list-style-type: none"> <li>a) Use a lubricous or hydrogel catheter. A hydrogel silastic catheter can last up to 3 months. A hydrogel latex catheter requires changing every 2-4 weeks.</li> <li>b) Select the smallest French size (12 or 14) of catheter as possible as the smaller the size, the less irritating it is to the urethra and bladder.</li> <li>c) Inflate the balloon per the manufacturer’s guidelines. Select a catheter with a smaller balloon size (i.e., 10cc) as the larger the size, the more irritating it is to bladder and urethra.</li> </ol> </li> </ul> </li> </ol>
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## The “HOW”

### How to achieve Optimal Continence Care

#### Project Team Success Factors

##### Implementing change at the bedside

- Using decision aids, algorithms and/or reminders for continence care practices and processes that will help to increase the likelihood of implementing the clinical model
- Educating providers on the following:
  - Risk factors for incontinence
  - How to do a proper continence assessment
  - Various approaches to treatment and
  - Optimal use of catheters

##### Measuring and Monitoring

- Collecting and using baseline data about: patients, resources, existing knowledge, practice, process and outcomes
- Provide and help teams use regular, timely and easy access data on quality improvement initiatives and potentially better practices and clinical processes and outcomes
- Provide senior management timely and useful information on progress and barriers to successful implementation of optimal continence care practices

#### Corporate Success Factors

##### Strategic/Organizational

- Positioning continence as a strategic (and improvement) priority for the organization
- Having visible organizational leadership support for continence care
- Making continence care multidisciplinary/team-based
- Providing resources (time, \$) and opportunities for education and training
- Having a central continence advisor and educator with specialist training and knowledge for the organization
- Implementing staffing models and scheduling to promote optimal continence care
- Creating an optimal physical environment (layout, availability of equipment/devices and specific types of products)

##### Educational

- Providing educational programs that are structured, organized, comprehensive and directed at all levels of providers, patients and families
- Including guidelines as part of active educational and training programs, and using tips from RNAO toolkit to facilitate implementation