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Reducing Urinary Incontinence

Communication and quality improvement are key to the effective assessment, prevention, and improvement of this costly and complex issue.

URINARY INCONTINENCE (UI) HAS long plagued nursing facilities, with prevalence rates as high as 50 percent in the United States. Although there has been little success in improving the rate of UI among residents over the years, recent research and analyses have yielded some compelling recommendations for effectively tackling this conundrum.

Among the most convincing proposals are those found in a recent article by Mary H. Palmer, RN, as published in the Dec. 2008 *Journal of Urologic Nursing*. She argues that nurse leadership and effective quality improvement efforts are vital to alleviating UI.

The article examines the epidemiology of UI, the evidence for behavioral interventions, and the types of quality improvement strategies currently used.

Perceptions Pose Barriers

A 2008 study in the *Journal of the American Medical Directors Association* reveals a notable divergence of perceptions among nursing facility clinicians' attitudes about how UI impacts residents' quality of life. For example, results of surveys given to physicians, geriatric nurse practitioners (GNPs), and directors of nursing (DONs) reveal that these three groups are more likely to evaluate and manage other geriatric syndromes before UI.

In contrast, the nurse assistant (NA) respondents were more likely to be involved in UI care than in care provided for residents with any of five other syndromes: behavioral symptoms of dementia, falls, unintended weight loss, pain, and delirium. The study

also found that only 22 percent of the physician respondents reported that their facilities have a process improvement team activity in place to address incontinence. Similarly, 26 percent of DONs and 16 percent of GNPs reported the existence of such a team in

■ NAs rated UI second only to pain with regard to its impact on quality of life.

their facilities. Conversely, 57 percent of NA respondents were aware of a UI team in their facilities.

Physicians, GNPs, and DONs rated UI as fourth or fifth with respect to effect on quality of life.

NAs, on the other hand, rated UI second only to pain with regard to its impact on quality of life.

"This leaves nurse assistants as the first-line managers for a condition that they perceive, and in fact does, have an important impact on quality of life," the researchers conclude.

Since the perceived barriers to improving UI care differ among the four groups, approaches to overcoming them should be multifaceted, the study recommends.

The study's authors assert that given the increasingly limited resources in the nursing facility setting, UI may remain the neglected geriatric syndrome. "If this is the case, what should physicians,

GNPs, DONs, and NAs do to relieve symptoms and improve quality of life for residents with incontinence?"

The answer, according to the study, may be found in the newly revised interpretive guidelines for incontinence and medical directors. "State surveyors may focus on the interface between these two F Tags in an effort to foster improvement in the recognition, assessment, and management of [UI]."

With this in mind, they reason that medical directors can take a leading role in improving continence care by encouraging great specificity of treatment orders for toileting, developing and implementing policies that call for a search for remediable contributors, and proposing policies that all new admissions with incontinence or residents with new incontinence receive a two- to three-day trial of toileting assistance.

Palmer, who is the Helen W. and Thomas L. Umphlet distinguished professor in aging at the University of North Carolina, Chapel Hill, regards these results as evidence that health care professionals need to understand each other's perspective and respect it.

"They also need to understand what information is needed to make informed clinical decisions and to relay information about patient responses to interventions, including satisfaction with care," she says.

Treatments Examined

In her article, Palmer outlines the recent history of multiple treatments designed to improve incontinence in nursing facility residents, including prompted voiding, habit training,

scheduled voiding, pharmacological therapies, and absorbent products.

Palmer notes that while pharmacological therapies are popular, their success is limited due to concerns about side effects and interaction with other medications. Anti-cholinergics, for example, have been shown to impair memory and, in turn, worsen incontinence.

F Tag 315 requires that long-term management of UI with absorbent products should only occur after an appropriate evaluation and after alternative treatments were considered.

What The Studies Found

A recent systematic review of UI studies in nursing facilities examined the benefits and adverse reactions associated with the following treatment interventions: antimuscarinic medications, oral estrogen plus progesterone, and behavioral interventions, such as prompted voiding and prompted voiding with exercise.

Published in the Dec. 2008 issue of *Mayo Clinical Proceedings*, the results show that neither prompted voiding plus exercise nor prompted voiding plus oral estrogen and progesterone were more effective than prompted voiding alone. Prompted voiding plus oxybutynin slightly reduced incontinence compared with prompted voiding plus placebo.

Residents who had at least a minimum level of cognitive function demonstrated modest short-term improvement in daytime UI with prompted voiding alone and with prompted voiding with exercise. However, the study found no trial evidence for the long-term effectiveness of prompted voiding plus exercise.

The analyses also revealed that there were no benefits associated with oral estrogen in UI treatment. “Future research should focus on long-term clinical trials of prompted voiding alone, prompted voiding with exercise, and antimuscarinic medications on targeted nursing facility residents who have UI,”

the study’s authors recommend. Palmer says that nurses should take a more central role in leading quality improvement programs in nursing facilities in order to reduce the prevalence of UI.

Geriatric advance practice nurses, for example, can act as change agents—or “continence champions”—making people aware of the need for timely access to toileting and the dignity issues involved, she suggests. “Because any one of us can be incontinent—just

remove our toilet access long enough—we are all stakeholders,” Palmer says. “Holding a health fair in a nursing home and addressing continence as a lifelong issue can help people see the importance to their lives, and the quality of their lives.”

Palmer also stresses the importance of quality improvement as an effective tool in managing and reducing UI. “Waiting until quarterly reports are reviewed to discover that a nurse has

Questions To Consider In Tackling Urinary Incontinence

System-level change is necessary to sustain practice change, and clinicians are much less likely to address the systems issues than they are the clinical issues, according to a new guide aimed at helping long term care providers implement change in their facilities.

Below are selected system-level questions that are important to consider in the improvement of UI in nursing facilities, as found in the guide. Following the questions, in parentheses, are suggested worker types who have been identified as most likely to be interested and able to address a particular question.

The Physical Environment

- Is access to bathrooms blocked? (maintenance, housekeeping)
- Are hallways cluttered? Are hallways more cluttered at certain times of the day? Are the hallways on certain units more cluttered than others? (maintenance, housekeeping)
- Are handrails accessible and secure? (maintenance)

Assessment And Care Planning

- Is continence assessed when a change in clinical status occurs? (director of nursing [DON], minimum data set facilitator, nurses)
- When developing incontinence assessments and care plans, are nurses

directly available to consult with direct care staff on all units and all shifts? (DON, nurses)

- Are residents with mobility limitations that affect independent toileting assessed to determine if therapy or restorative services might improve walking, transfer, or dressing ability? (restorative staff, nurses, therapy)

Facility-Wide Prevention

- How many residents with functional incontinence related to weakness and immobility are receiving therapy or restorative services? (nurses, nurse assistants [NAs], restorative staff, therapy)
- Are any residents with UI being treated with medications that are not recommended for the elderly? (DON, pharmacist)
- How is the administrator involved in incontinence programs? (Administrator, DON, NAs)

Source: “Implementing Change in Long-Term Care: A Practical Guide To Implementation,” prepared by researchers at the University of Wisconsin–Madison, School of Nursing, with a grant from The Commonwealth Fund. For a copy of the manual, go to the Advancing Excellence for America’s Nursing Homes Web site at: www.nhqualitycampaign.org/files/Implementation_Manual_ChangeInLongTermCare.pdf.

stopped performing comprehensive assessments or that staff members did not receive orientation about the toileting protocols is too late,” she says.

“Without intervention to address discrepancies among stakeholders and active interdisciplinary collaboration to embed quality improvement activities

into the structure and culture of nursing homes, quality improvement efforts will have limited success.”

Preventing incontinence in low-risk residents can be accomplished through primary prevention strategies at the organizational level, she suggests. Such strategies may include assisting resi-

dents to maintain mobility and transfer abilities and facilitating cognitive functioning by creating triggers, such as prompting the resident to void and helping the resident to sit on the toilet.

Palmer also points to the Centers for Medicare & Medicaid Services Nursing Home Quality Initiative, quality improvement organizations, and the revised F Tag 315 as “powerful allies in the quest for the appropriate assessments and treatments that their residents require.”

Another quality improvement campaign—Advancing Excellence in America’s Nursing Homes—does not directly address UI, but Palmer says she believes UI treatment and management are embedded in the campaign’s goals.

“With reduction of pressure ulcers, use of physical restraints, and management of pain, UI should also reduce,” she says. “Remission of incontinence should be evident. That is, as evidence-based interventions are used to promote skin integrity, allow freedom of movement, and pain relief, attention will be paid to elimination needs. Improved continence should also be an outcome of these interventions.”

A Dignity Issue

Nursing facility residents deserve to be treated with dignity, and Palmer argues that continence should be viewed as a dignity issue. In her paper, she cites a 1948 declaration by the United Nations that dignity is a human right, and notes that almost 60 years later, a human rights complaint on behalf of incontinent nursing facility residents was filed by the Ontario Federation of Labour to the Human Rights Commission.

“Although this case was later dismissed, it started a dialogue about the link between continence and dignity,” Palmer notes. “Continence should be viewed as a dignity issue, especially when nursing home residents express preference for care that promotes comfort, does not depend on staff, and is not embarrassing.” ■

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