CAET 37th National Conference 2018

Turn Knowledge into Action

Promoting Continence Using Prompted Voiding in Acute Care

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MAY 5TH 2018, 0930-1020, OAK BAY ROOM
DATE, TIME, ROOM

Nurse Specialized in Wound, Ostomy & Continence (NSWOC)

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Urinary Incontinence

Promoting Continence Using Prompted Voiding in Acute Care

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Conflict of Interest Disclosure Statement

I sit on the Board of Directors for The Canadian Association for Enterostomal Therapy

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RNAO Best Practice Guideline

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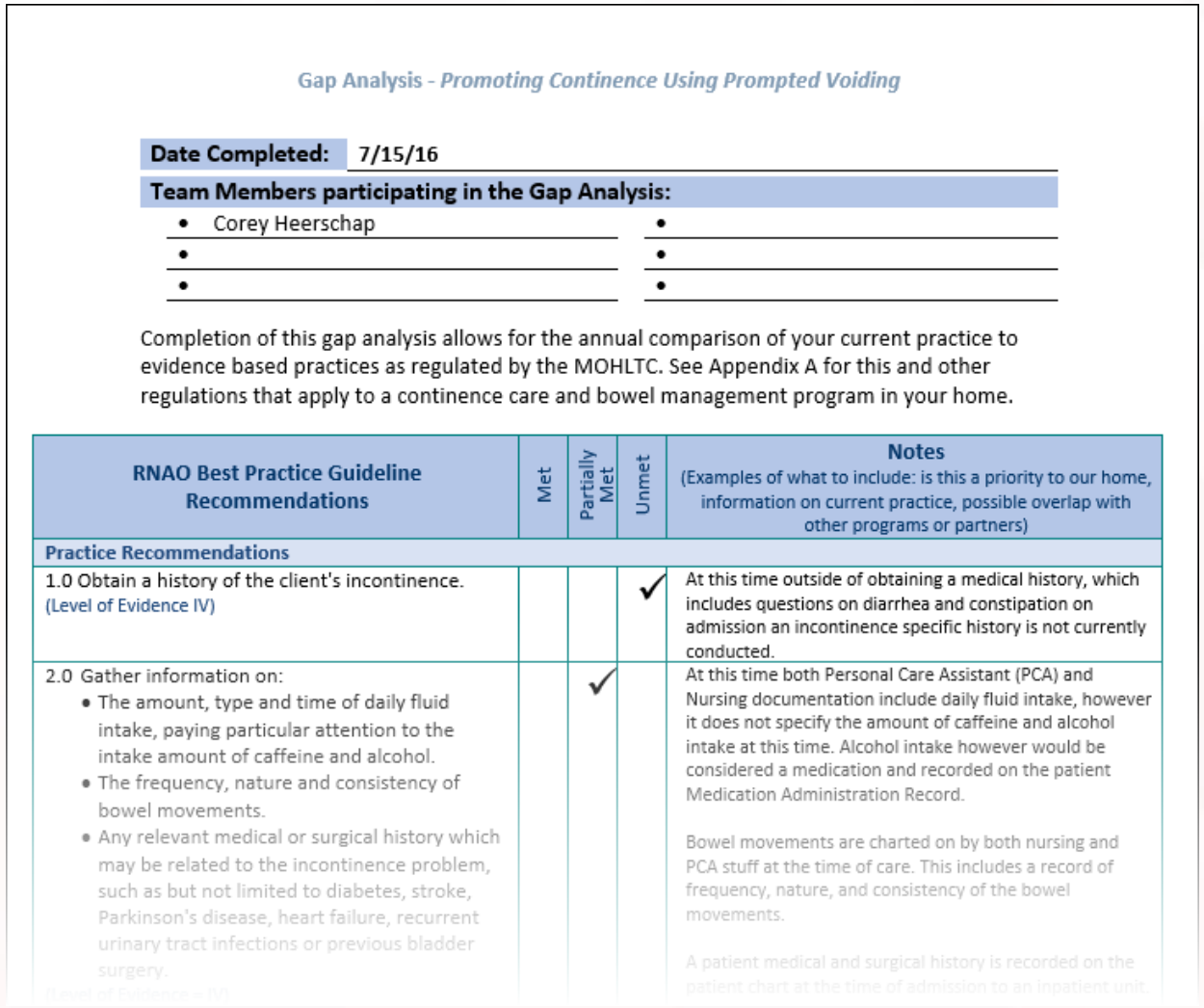
Gap Analysis



Gap Analysis - *Promoting Continence Using Prompted Voiding*

Date Completed: 7/15/16

Team Members participating in the Gap Analysis:

- Corey Heerschap
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Completion of this gap analysis allows for the annual comparison of your current practice to evidence based practices as regulated by the MOHLTC. See Appendix A for this and other regulations that apply to a continence care and bowel management program in your home.

RNAO Best Practice Guideline Recommendations	Met	Partially Met	Unmet	Notes (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners)
Practice Recommendations				
1.0 Obtain a history of the client's incontinence. (Level of Evidence IV)			✓	At this time outside of obtaining a medical history, which includes questions on diarrhea and constipation on admission an incontinence specific history is not currently conducted.
2.0 Gather information on: • The amount, type and time of daily fluid intake, paying particular attention to the intake amount of 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, such as but not limited to diabetes, stroke, Parkinson's disease, heart failure, recurrent urinary tract infections or previous bladder surgery. (Level of Evidence – IV)		✓		At this time both Personal Care Assistant (PCA) and Nursing documentation include daily fluid intake, however it does not specify the amount of caffeine and alcohol intake at this time. Alcohol intake however would be considered a medication and recorded on the patient Medication Administration Record. Bowel movements are charted on by both nursing and PCA stuff at the time of care. This includes a record of frequency, nature, and consistency of the bowel movements. A patient medical and surgical history is recorded on the patient chart at the time of admission to an inpatient unit.

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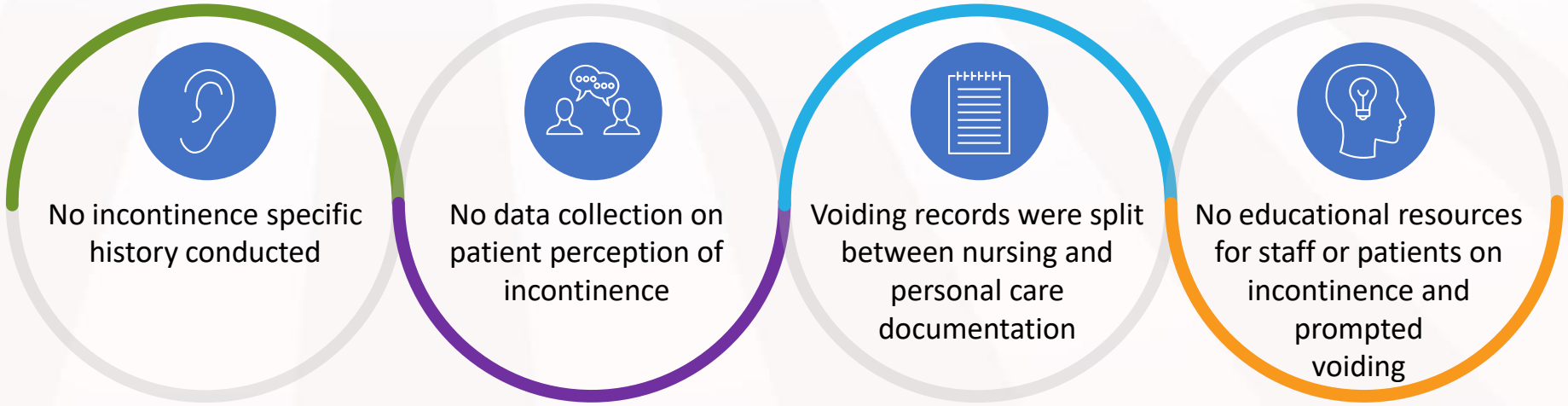
Areas for Improvement



No prompted voiding

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Planned Intervention

Promoting Continence Using Prompted Voiding Best Practice Guideline Implementation Pilot Project on Geriatric Inpatient

Task	Target Date	Date Completed	Status	Comments
Conduct a gap analysis for the Promoting Continence Using Prompted Voiding Best Practice Guideline	July 17th, 2016	July 15th, 2016		A gap analysis was conducted for the Geriatric Unit at the Royal Victoria Regional health Centre
Review with the unit resource nurses and the manager the logistics behind which patients would be candidates for prompted voiding, how education should be disseminated, and which staff will be involved in the project	August 10th, 2016	August 10th, 2016		Spoke with unit resource nurses about best times to complete in-services. Provided staff and unit manager with an overview of the program. Identified three patients who may be appropriate to trial prompted voiding with. Began development of documentation for the project.
Begin development of a presentation for staff on promoting continence	August 10th, 2016	August 10th, 2016		Began development of a power point presentation of prompted voiding for staff education on the program. Also developed a bladder diary document, and created identifiers for patients on the unit who are taking part in the project.
Develop and/or package documentation necessary for the project and prepare it for roll out on the unit	August 11th, 2016	August 11th, 2016		I completed the power point presentation for staff and determined which assessment tool will be utilized for staff to determine the type and underlying cause of the patients' incontinence.
Complete presentation development for the promoting continence educational materials	August 17th, 2016	August 17th, 2016		An education sheet to provide to staff on the many possible causes of urinary incontinence was completed. Development was started on a patient information package using the RNAO patient information booklet. In servicing to

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Patient History

Bladder & Bowel Continence Assessment

Date Assessment Initiated: _____
Information Source *(please circle)* – Resident (R), Family (F) _____, Chart (C), RN, RPN, PSW, other.

Addressograph

A. RELEVANT MEDICAL &/OR SURGICAL CONDITIONS
(From Resident, Family, Chart)

- ☐ **Immobility Issues**
- ☐ Arthritis
- ☐ Other_____
- ☐ **Neurological Conditions**
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Spinal Cord injury
- ☐ Other_____
- ☐ **Medical Conditions**
- ☐ Diabetes
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Heart Problems

Weight : _____ (kg)

- ☐ **Cognitive Problems**
- ☐ Dementia
- ☐ Other_____
- ☐ **Genito-Urinary (GU) Problems**
- ☐ Recurrent Urinary Tract Infections
- ☐ Previous G/U Surgery or Injury
- ☐ Prostate Problems
- ☐ Other_____
- ☐ **Gastro-Intestinal (GI) Problems**
- ☐ Chronic constipation
- ☐ Diverticular disease
- ☐ Hemorrhoids/fissures
- ☐ Previous colon surgery
- ☐ Irritable bowel syndrome
- ☐ Other_____

B. MEDICATIONS

See over	Y	N	Comments
Antacids with aluminum			
Analgesics/NSAIDS			
Anticholinergic/ Antispasmodic/ Anti-emetics			
Antidepressants			
Antihistamines			
Anti-hypertensives			
Anti-Parkinson agents			

D: SYMPTOMS ASSOCIATED WITH URINARY INCONTINENCE

Type of Urinary Incontinence	Symptoms	Y	N	N/A	*Total number of "yes" answers
Stress UI	Leakage with cough, sneeze, physical activity				
	UI in small amounts (drops, spurts)				
	UI during daytime only				
	Fecal incontinence may be present				
Urge UI	Strong, uncontrolled urge prior to UI				
	UI moderate/large volume (gush)				
	Frequency of urination				
	Nocturia > 2 times				
	Nocturnal enuresis – bedwetting				

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Staff Education & Choosing Participants

Causes of Urinary Incontinence

Remember TOILETED

Thin, dry vaginal and urethral epithelium (Atrophic urethritis or vaginitis)
Obstruction (Stool Impaction/Constipation)
Infection
Limited mobility (Restricted mobility)
Emotional (Psychological, Depression)
Therapeutic medications (Pharmacological)
Endocrine disorders (Uncontrolled Diabetes)
Delirium

Medications leading to incontinence:

- Anti-hypertensives – May lead to functional urinary incontinence
- Diuretics – May lead to overflow incontinence
- Calcium Channel Blockers – May lead to constipation of diarrhea
- Antacids with aluminum – Can cause diarrhea
- Laxatives – May lead to fecal incontinence
- Antidepressants – May lead to constipation, overflow, and functional urinary incontinence
- Monoamine oxidase inhibitors (MAO's) – May lead to urinary retention
- Anti-psychotics – May lead to constipation, overflow, and functional urinary incontinence
- Sedatives – May lead to functional incontinence
- Narcotics – May lead to constipation, overflow, and functional urinary incontinence
- NSAIDS – May lead to urinary retention in large doses
- Anticholinergic/Antipasmodic/Antiemetics – Constipation and urinary retention leading to overflow and functional urinary incontinence

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Implementation

Patient Name:
Date:

Bladder Diary/Record

	Time Interval	Urinated in toilet	Incontinent Episode	Reason for Episode	Liquid intake	Bowel Movement	Produce Use
A.M. HOURS	12:00-01:00 AM						
	01:00-02:00 AM						
	02:00-03:00 AM						
	03:00-04:00 AM						
	04:00-05:00 AM						
	05:00-06:00 AM						
	06:00-07:00 AM						
	07:00-08:00 AM						
	08:00-09:00 AM						
	09:00-10:00 AM						
	10:00-11:00 AM						
	11:00-12:00 PM						
P.M. HOURS	12:00-01:00 PM						
	01:00-02:00 PM						
	02:00-03:00 PM						
	03:00-04:00 PM						
	04:00-05:00 PM						
	05:00-06:00 PM						
	06:00-07:00 PM						
	07:00-08:00 PM						
	08:00-09:00 PM						
	09:00-10:00 PM						
	10:00-11:00 PM						
	11:00-12:00 AM						

[1]**Incontinent episodes:** (++) = SMALL: did not have to change pad/clothing; (+++) = LARGE: needed to change pad/clothing
[2]**Examples of reasons for incontinence episodes:** leaked while sneezing; leaked while running to the bathroom
[3]**Examples of type and amount of liquid intake:** 12oz can of cola, 2 cups regular coffee
[4]**Examples of product use:** pad, undergarment; track times you changed

Possible Causes of Transient Urinary Incontinence
TOILETED Mnemonic

Initial 3 Day Assessment

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Implementation

Implementation

Applied to chart spines and in patient rooms to remind staff of who is participating in the program

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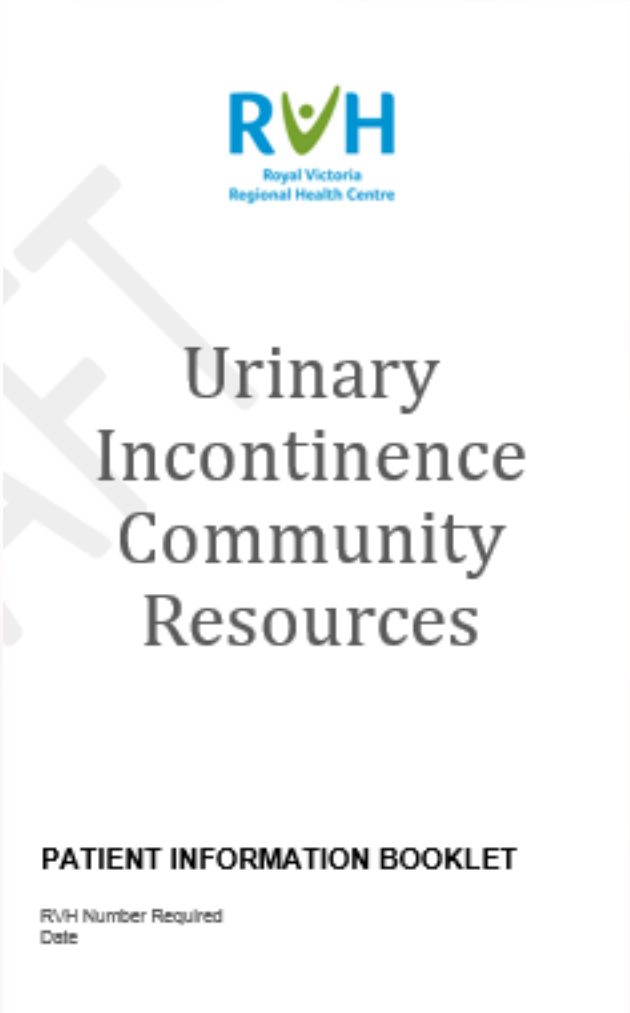
Education



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Education

RVH
Royal Victoria Regional Health Centre

At Royal Victoria Regional Health Centre (RVH) we work to provide care that includes our patients and their family.

WHAT IS URINARY INCONTINENCE?

Urinary incontinence is the accidental release of urine or leaking urine. It may occur when sneezing, coughing, laughing, or jogging. It may also occur as a sudden urgent need to urinate. Urinary incontinence can occur for a short period of time, due to acute medical issues, or over a long period of time due to an underlying issue with the body.

URINARY INCONTINENCE FACTS

- Urinary incontinence is caused by an underlying condition, it is a symptom not a disease itself.
- Urinary incontinence can affect anyone at any age, however it is more common in those over 65 years of age.
- Urinary incontinence is NOT a natural part of aging
- Urinary incontinence can be due to a number of issues such as difficulty getting to the toilet, drinking caffeinated beverages, constipation, not drinking enough fluids, a bladder infection, and more.

URINARY INCONTINENCE ORGANIZATIONS

Canadian Continence Foundation
www.canadiancontinence.ca
c/o Jacqueline Cahill, Executive Director
P.O. Box 417
Peterborough, ON, K9J 6Z3
1-800-265-9575 or 705-750-4600

Canadian Nurse Continence Advisors
www.cnca.ca
905-573-4823

National Association for Continence
www.nafc.org

Continence Product Advisor
www.continenceproductadvisor.org

Financial Supports & Incontinence Care Professionals Within the Region

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Myths & Facts

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Education

RNAO Recommends education programs include information on the following:

- Incontinence Myths
- Defining Incontinence
- Assessment
- Prompted Voiding
- Individualized Plans
- Impact of cognitive impairment and managing behaviours
- Relation of bowel hygiene to healthy bladder
- Use of a toileting Record

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What is Urinary Incontinence?

- Accidental release of urine or leaking urine
- May occur when sneezing, coughing, laughing, or jogging
- May also occur as a sudden urgent need to urinate
- Can be short term caused by medical issues such as a urinary tract infection, constipation, or medication
- It can also be long term due to physiological issues

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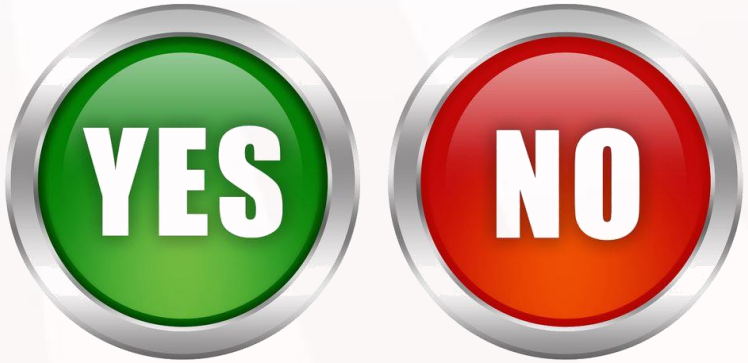
Is incontinence expected in the elderly?



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What types of urinary incontinence are there?

Physical:

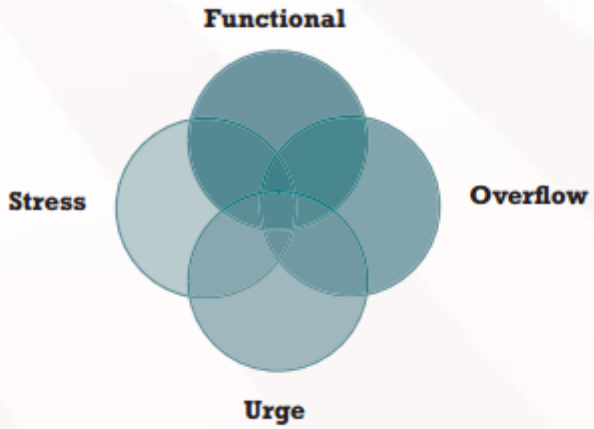
- **Stress**: Coughing, laughing, etc.
- **Urge**: The sudden need to go immediately
- **Overflow**: Leaking

Functional:

- Patient needs assistance (ie. Ambulating)

Transient:

- Short term incontinence issues



RNAO, 2006

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What can affect urinary incontinence?

- Medical pathology
- Cognitive impairment
- Medical & surgical history
- Obesity
- Aging which leads to a loss of pelvic muscle tone and atrophic changes

- Urinary tract infections
- Decreased fluid intake
- Caffeine and alcohol intake

- Constipation
- Decreased mobility
- Environmental factors
- Medications

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How can we assess the cause?

Use of the TOILETED Mnemonic

Thin, dry vaginal and uretheral epithelium (Atrophic urethritis or vaginitis)
Obstruction (Stool impaction/Constipation)
Infection
Limited mobility (Restricted mobility)
Emotional (Psychological, Depression)
Therapeutic medications (Pharmacological)
Endocrine disorders (Diabetes)
Delirium

Take an Interprofessional approach

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How can we reduce urinary incontinence?

- Prompted voiding
- Habit retraining
- Fluid management
- Pelvic floor training for stress incontinence
- Lifestyle modifications
- Urge inhibition techniques

Turn Knowledge into Action

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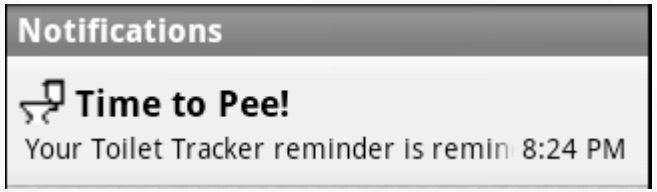
What is the prompted voiding approach?

Prompted voiding is a behavior therapy approach, which places the patient on an individualized voiding plan. Staff toilet the patient on a schedule made specifically for their patient at specific times during the day. These times are strategically chosen to reduce the occurrence of incontinence episodes.



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Completing a voiding record

Patient Name:

Date:

Bladder Diary/Record

	Time Interval	Urinated in toilet	Incontinent Episode	Reason for Episode	Liquid intake	Bowel Movement	Produce Use
A.M. HOURS	12:00-01:00 AM						
	01:00-02:00 AM						
	02:00-03:00 AM						
	03:00-04:00 AM						
	04:00-05:00 AM						
	05:00-06:00 AM						
	06:00-07:00 AM						
	07:00-08:00 AM						
	08:00-09:00 AM						

A bladder diary should be completed each day for a minimum of three days prior to determining the best times of the day for patient toileting

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Review the voiding record

On review of the bladder diary a number of variables can be determined:

- How often the patient is toileted
- How often the patients incontinence products are changed
- The amount of liquid intake during the day
- Bowel issues such as constipation
- Possible reasons for the incontinence episode

Based on review of this document, individualized set times throughout the day and night should be determined that the patient should be brought to the bathroom to void.

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Implementing Prompted Voiding

- Nursing staff and PCAs will track fluid intake and urinary output using the bladder diary

- Patients who are participating in prompted voiding will have a symbol on the spine of their chart

- There will be a laminated clock found in the patients room on their whiteboard, which will be completed by the assessing nurse who determines the toileting schedule

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Work with the patient

When the patient would normally void the nurse or PCA should:

- **Monitor** - Ask the patient if he/she needs to use the toilet
- **Prompt** - Remind the patient to use the toilet and try not to void between prompted voiding sessions
- **Praise** - Give positive feedback to patient to reinforce dryness and appropriate toileting

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Encouraging Voiding

Tips & Tricks

- Use terms such as toilet instead of bathroom
- Ask the patient to return to their room to “check them”
- Walking towards the bathroom can trigger the need to void
- If the patient is in a wheel chair it may work better to tell them your bringing them to the toilet and begin to bring them rather than asking them if they need to go to the toilet. This will vary by patient.

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Who will benefit the most?

- Patients who are mobile
- Patients who can follow simple instructions
- Newly incontinent patients
- May be beneficial with those who have physical, mental, and cognitive impairments
- All patients who are incontinent may benefit from prompted voiding and can be trialed

- YOU! It is faster for staff to assist with voiding rather than completing a brief change

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Successes

Patient success:

- Increased dignity and self esteem
- Reduced falls, urinary tract infections, and continence associated dermatitis
- Increased fluid intake during the day

Staff Success:

- Decreased workload

Organization Success:

- Decreased use of continence products
- Improved patient quality of life and satisfaction

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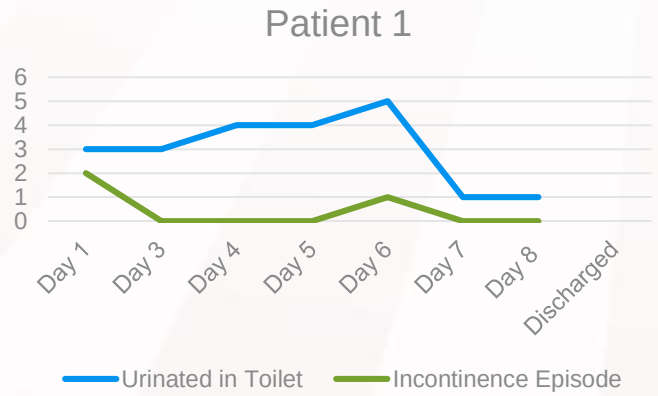
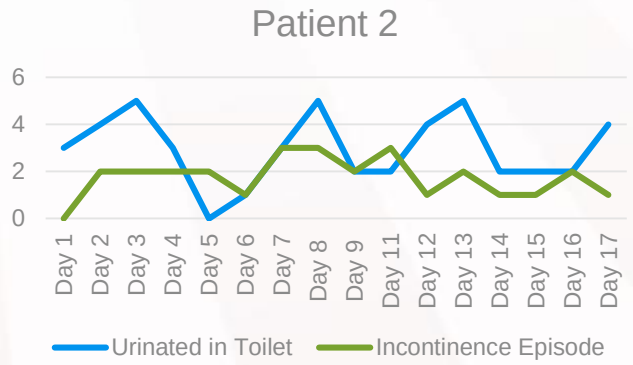
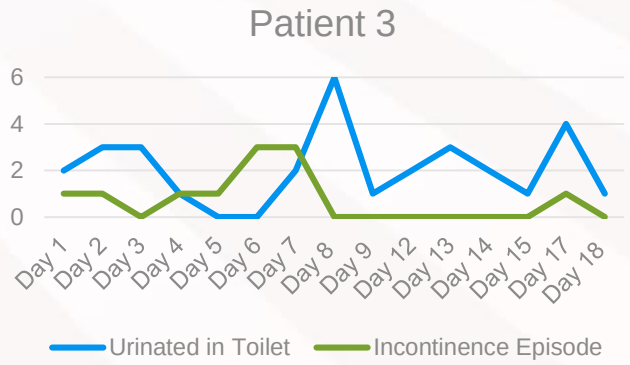
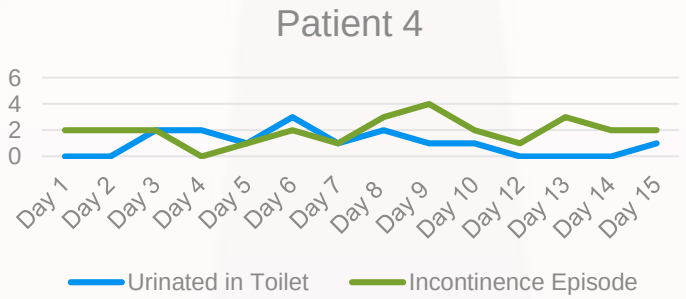
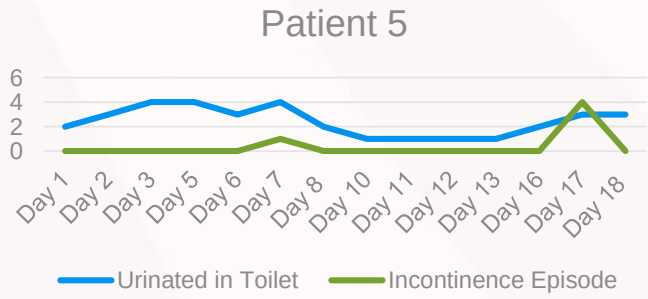
Outcomes











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Staff Evaluation

1 What do you feel worked well with this pilot project?

2 What difficulties did you experience during this pilot project?

3 Do you have any recommendations for future implementation of this Best Practice Guideline or any further comments you would like to make note of?

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Staff Evaluation

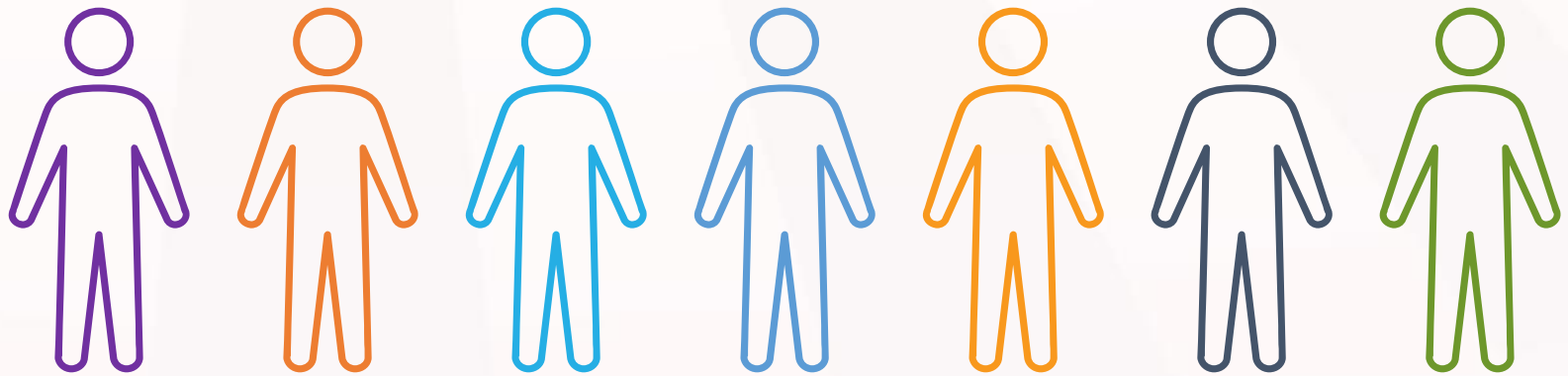
I didn't have time to complete the documentation and some staff didn't know about the program

Those who most benefitted were patients who were mobile and understood commands

Even with less incontinence episodes the patients mood didn't improve

Fecal incontinence needs to be addressed

The toileting wasn't time consuming it was the extra documentation



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