Bowel and Bladder Function

HOW TO DEVELOP AN EFFECTIVE SCHEDULED TOILETING PROGRAM AS A FALL REDUCTION PROGRAM
Objectives

• Participants will be able to verbalize understanding of how development of effective toileting plans can reduce fall risks

• Participants will be able to verbalize how to conduct a Bowel and Bladder Assessment and 3-day Elimination Assessment and development of an effective toileting schedule from gathered data

• Participants will be able to verbalize understanding of Bladder Habit Training, Prompted Toileting and Scheduled Voiding Protocols
Incontinence and/or Urgency

• “While urinary incontinence is more prevalent with age, it is not a natural part of aging,” says Liz Jensen, RN, MSN, RN-BC, clinical director at Direct Supply. “Comprehensive, person-centric assessments and an interprofessional approach to care planning can help many residents who experience incontinence either reduce the number of episodes per day or restore continence altogether, while reducing risk of falls.”

• Studies show almost 50% of falls are related to toileting

• Common urologic conditions associated with falls include:
  • Lower UTIs
  • Urinary incontinence
  • Overactive bladder
  • Prostatic diseases
  • Lower urinary tract tumors
The Relationship Between Incontinence & Accidental Falls

- Incontinence episodes may lead to slips on wet floor surfaces
- Urge incontinence may increase fall risk when a person hurries to the toilet, especially in unfamiliar, cluttered or dark areas
- Episodes of urinary incontinence may be transitory and often related to acute illness, such as urinary tract infections that can cause incontinence, delirium, drowsiness and hypotension
- Medications used to treat incontinence, such as anticholinergics or alpha blockers, can cause postural hypotension
- Waking up to urinate at night can result in poor sleep, which is associated with increased fall risk
- Making frequent bathroom trips at night, through a poorly lit or obstructed pathway, may increase fall risk
F690 Incontinence

- The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

- §483.25(e)(2) For a resident with urinary incontinence, based on the resident’s comprehensive assessment, the facility must ensure that—
  
  (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary;

  (ii) A resident who enters the facility 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 demonstrates that catheterization is necessary and

  (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

- §483.25(e)(3) For a resident with fecal incontinence, based on the resident’s comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
F690 Intent

- The intent of this requirement is to ensure that:

- Each resident who is continent of bladder and bowel receives the necessary services and assistance to maintain continence, unless it is clinically not possible.

- Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible;

- A resident who is incontinent of bowel is identified, assessed and provided appropriate treatment and services to restore as much normal bowel function as possible;

- An indwelling catheter is not used unless there is valid medical justification for catheterization and the catheter is discontinued as soon as clinically warranted;

- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the indwelling catheter; and

- A resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible.
Definitions

• “Urinary Incontinence” is the involuntary loss or leakage of urine.

• There are several types of urinary incontinence, and the individual elder may experience more than one type at a time. Some of the more common types include:
  • Functional Incontinence: urinary tract intact but resident cannot remain continent because of external factors
  • Mixed Incontinence: combination of urge incontinence & stress incontinence
  • Overflow Incontinence: associated with leakage of small amounts of urine when bladder has reached capacity
  • Stress Incontinence: Outlet incompetence; associated with impaired urethral closure
  • Transient Incontinence: temporary or occasional incontinence that may be related to a variety of temporary causes (i.e., medications, delirium, infection, vaginitis, restricted mobility, fecal impaction)
  • Urge Incontinence: Associated with detrusor muscle over activity: abrupt urgency, frequency & nocturia
F690 Interventions

- Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc.;

- Removing or improving environmental impediments that affect the resident’s level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet);

- Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion);

- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and

- Implementing a fluid and/or bowel management program to meet the assessed needs.
F690 Interventions: Behavioral Programs

• **NOTE:** It is important for the comprehensive assessment to identify the essential skills the resident must possess, *such as* the resident’s ability to: comprehend and follow instructions; identify urinary urge; control the urge to void until reaching a toilet; and/or respond to prompts to void. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate planning care to avoid or reduce the frequency of episodes.

• Bladder Rehabilitation /Bladder Retraining

• Pelvic Floor Muscle Rehabilitation

• Prompted Voiding

• Habit Training/Scheduled Voiding
Other Potential Interventions

- **Toilets/Commodes**
  - Correct height
  - Have grab bars
  - Close as possible to bed
- Arrange room to facilitate safe independence as appropriate
- Floors dry & pathway is uncluttered & unobstructed
- Eliminate tethers
  - Oxygen
  - Catheter tubing (Consider leg bags during day)
  - IV tubing
  - Feeding tube cords

- **Medical Treatments**
  - Pessary
  - Hormone therapy
  - Surgery
  - Anticholinergics or alpha-agonists

- **Therapy Services**
  - Have OT make recommendations for structural updates
  - Have all incontinent residents evaluated by PT to determine if neuromuscular retraining is possible
  - Pelvic floor exercises
  - Electro-stimulator therapy
Assessment documentation

- Specific designation of type of incontinence
- Substantiation of elder’s fluid & hydration status

Documentation substantiating risks &/or conditions affecting incontinence:

- Neurological
- Sensory impairments
- Stroke
- History of UTI
- Obesity
- History of fecal impaction
- End of life

- Cognitive
- Resisting care
- Diabetes
- Prolapsed uterus
- History of urinary retention
- Pain
- Presence of pressure ulcer(s)

- Physical function
- Depression
- Parkinson’s disease
- BPH
- Dietary Factors
Assessment documentation (cont)

- History of incontinence
- Accommodations used
- Dialysis if applicable including diagnosis for dialysis
- Urology consult notes if applicable
- Medications to enhance bladder control?
- Documentation that incontinence is unrelated to adverse effects of other meds ordered
- History of restorative b/b program & effectiveness
Bowel assessment

- Continence status
- History of bowel patterns and history of bowel incontinence
- Usual patterns
- Dietary factors
- Medications/elimination tools &/or medication side effects
The plan for care, treatment and services identifies

- Measurable goal
- Specific toileting schedule (times) based on 3 day voiding diary
- Environmental factors impeding elder’s ability to maintain bowel and/or bladder function
- Type & frequency of physical assistance to facilitate toileting
- Appropriate monitoring schedule
- **Appropriate revision if/when incontinence noted**
# Three Day Elimination Pattern Tool

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**Codes:**
- **S** = TOILETED + SUCCESS
- **L** = LAXATIVE
- **U** = URINARY INCONTINENCE
- **B** = BOWEL INCONTINENCE
- **M** = TOILETED − SUCCESS
- **E** = SUPPOSITORY
- **R** = RESIDENT REFUSED
- **A** = ENEMA
- **N** = SMALL

**REVIEW**
- POST-VOID RESIDUAL AMOUNT
- DATE OF PVR
- CALCULATION, PERCENTAGE OF INCONTINENT EPISODES: INCONTINENT EPISODES / TOTAL EPISODES

**RECOMMENDATIONS FOR TOILETING PROGRAM:**

_Signature_ ___________________________  _Date_ ___________________________
Continence Care Management Program

- Bladder Retraining
  - Aware of need to void
  - Aware of need to use toilet
  - Able to delay voiding
  - Able to disrobe for toileting
  - Able to transfer to toilet
  - Able to void

- Scheduled Voiding
  - Able to be toileted
  - Able to understand & follow simple directions
  - Willing to cooperate with care partners
  - Able to delay voiding for a short time
  - Able to initiate voiding when taken to toilet
Continence Care Management Program

• Habit Toileting
  • Able to transfer with assistance
  • Willing to cooperate with care partners
  • Able to initiate voiding when taken to toilet

• Prompted Voiding
  • Willing to use toilet on a regular basis
  • Willing to cooperate with care partners when asked to toilet
  • Able to initiate voiding when taken to toilet
  • Able to recognize own name when asked
  • Able to understand & respond to simple directions
Continence Care Management Program

• Check and Change Program
  • Persons who do not meet any other criteria should be checked and changed based on 3-day voiding diary and according to comprehensive, individualized care plan
  • Resident may wear incontinence protective products per care plan
  • Skin protocol should be included in the resident’s care plan
When?

- On admission: suggest start 3 day assessment not before day 3 post-admission (hospitalization hydration diuresis)

- The Nurse will complete a Bladder Assessment on admission, quarterly & with any change in elder’s continence, other change in condition, or relevant med regimen change to determine the elder’s bladder status, define the elder’s incontinence, determine the elder’s goals for improving incontinence, and develop an individualized toileting plan
Bladder retraining protocol

• The Nurse will meet with each elder who meets the criteria for bladder retraining to determine if the elder is willing to participate in a bladder retraining protocol
  • In the event the elder decides not to participate in a bladder retraining protocol, the Nurse will explain the benefit of improved incontinence and the risk for not participating in a toileting plan and other programs related to assisting the elder to be continent
  • The reasons for the elder’s refusal of this program should be documented in the elder’s clinical record
Bladder retraining protocol (cont)

- Voiding schedule developed based on assessment & 3-day voiding pattern WITH the elder/rep including the resident’s stated goals for incontinence
  - Should be encouraged to void at least every 4 hours while awake
  - Should include night time uninterrupted sleep intervals of 4-5 hours if at all possible (keep skin risk in mind)
  - Scheduled times should be based on the voiding diary results

- Encourage elder to drink at least 1500-2000cc/day (unless ordered fluid restriction)
  - Fluids should be encouraged wake up time to 7pm then restrict fluids after 7pm
  - Avoid caffeinated & carbonated drinks during retraining period if acceptable to resident’s preferences & prior routines

- Staff encouraged to toilet within 15-30 minutes of scheduled voiding times as care planned

- Encourage resident to dress in clothing that will promote independence in dressing/undressing

- Success/lack of success must be documented in clinical record
  - Reviewed weekly by Restorative Nurse Coordinator
  - Plan modified as indicated
Bladder Retraining Protocol (cont)

• The schedule and diary should be placed in the resident’s care plan

• Direct care staff and neighborhood nurses providing direct care to the resident should review the plan and record when the resident voids or is incontinent

• The plan shall also include:
  • The word or words the elder uses or used in the past related to toileting
  • Environmental modifications such as seat risers or use of a mechanical lift
  • Skin care to be provided as care planned
Bladder Retraining Protocol (cont)

- Once a week for six weeks, the Nurse Coordinator should review with the resident and the team, the progress the resident has made with the protocol
  - A summary of that review should be documented in the resident’s clinical record
  - The care plan should be amended as appropriate to assist the resident to reach the resident’s stated/documented goal
- Six weeks after instituting the toileting program, the Nurse Coordinator with the resident and the interdisciplinary team should evaluate and record the effectiveness of the program
  - The care plan should be amended if needed.
- A voiding diary should be completed for a three day period to provide information on the resident’s continence status prior to each reassessment
- The effectiveness of the continence protocol should be evaluated with each assessment to determine if it continues to be an appropriate program for the resident
Resources

• https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4859925/
• https://www.nursingtimes.net/clinical-archive/continence/incontinence-and-falls-in-older-people-is-there-a-link/203525.article
Thank you!

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