Good morning. Thank you for joining us. I'm Pam Heckman from the New England QIN-QIO. I will be moderating today's webinar. Thank you for joining today’s webinar, A New Look at Incontinence. Today we will hear how one of the nursing homes participating in the New England Nursing Home Quality Care Collaborative addressed incontinence care challenges by bringing in outside support from advanced practice RNs to provide urology services. Before we get started I will review housekeeping items. This webinar will be recorded and the presentation will be available in a few business days. I will provide details on accessing the recording at the end of the webinar. Phone lines will be on mute for the duration of the presentation. We will be monitoring questions and comments and will address them at the end of the presentation. I would like to remind everyone about your monthly affinity group calls. These topics are intended to provide you with an opportunity to share, request suggestions or ask questions. We will provide this forum as long as the group has a need and provides -- finds value. Please visit our website to sign up to receive notifications about future calls. I am happy to once again introduced Gail Harbour. Gail is a registered nurse with over 35 years of experience in nursing and extensive experience in the long-term care setting.

Thank you, Pam. Welcome, everyone. I wanted to start by addressing concerns that were brought up after the first webinar. There was a question about Medicare reimbursement for rehab for incontinence. It needs to be a restorative program with a supporting diagnosis and contain a clear plan -- plan and goal. There were questions about interpreting an avoiding diary and interpreting it. I encourage you to involve the resident in the toileting plan and in some cases extending the diarrhea period from three full days, 25 full days -- to 5 full days. Reassess the number of incontinent episodes including a few weeks after the plan was initiated. There were general questions and Allison has agreed to touch on that topic. If you have a specific case to discuss, please join in at the end of her presentation. There were comments about toileting residents with dementia. We will share a few slides that you may be able to share with caregivers. It might be old information to the slides are designed to post as reminders, use them as handouts. Your direct caregivers are probably the best source of approaches to patients with dementia for individualizing care. Here is a quick look. You can get them from our website. The first slide is to slow yourself down before you present yourself to a resident with dementia.

Incontinence usually occurs early, mid-stage but can be managed with visual reminders. We need to keep in mind that direct caregivers are rushing around all day
long. Stopping and taking a moment to get that eye level look and engaging their eyes, and of course, with a smile.

Make your request as you would an invitation. Reach out and offer physical cueing. Don't rely only on words. Verbal requests may get a no even if you use toileting words. Toileting words vary from one culture to another. You may know the resident's vocabulary from previous work with them or by asking family members. Visuals, sounds, bathroom, toilet, running water may get a more positive result even if they verbalize they do not need to go. Think about a long car trip. We may not feel like we have to empty air bladders, but if we sit, we can empty. At least that is the hopeful plan.

Respect privacy. Lower voice tones are better received. The more steps for toileting the more confusing it can get. Keep it to a minimum and think about appropriate clothing. Make sure the bathroom is a comfortable environment. Avoid unnecessary help. Privacy matters. Always be prepared. Sometimes you will need to do incontinent care because not every toilet attempt will be in time. Sometimes a raised toilet seat helps. We asked them to sit and get a smile back but no response. We gently tugged their middle and say, please sit. Physically they may not need a raised seat but they may need to fill it for reassurance. A higher seed may be helpful. Your best sources are your LNAs and CNAs. Adjust bathroom anxiety. Some residents balk about walking into that enclosed space. Think about what might work better. Commode at the bedside, larger bathroom, urinal, a sign on the door directly across from the resident. Remember, their back is to the toilet and if they face you. Sometimes a picture on that wall may help. Actions speak louder than words. Encourage voiding by running water, or for a drink -- offer a drink. Watch for the nonverbal messages. Talking on closing, touching genitals, wandering aimlessly, do they look uncomfortable? They may move away from others to isolate themselves, general restlessness. If you're resident cannot follow any instructions and never avoids -- voids one encourage, talk to the team. Talk about what is being coded. Thank you for this and all that you do every day. I want to introduce Teresa Skinner and Alison Gorman.

This is Teresa Skinner. Touch points at Farmington is a 120 bed, four-star SNF. Restraint and alarm free, memory care community. We started looking at incontinence management for a variety of reasons but we were looking at the electronic medical record, some inconsistencies and documentation. If you have a change in incontinence and you haven't put in systems to address that, is another reason. How marketable our way? How do we beat our competition? We came up with ideas which are our trade secrets which we are now looking -- giving away. There is a change in incontinence. Nurses would fill out assessments and not always know what to do with that.
information other than a bladder diary or incontinence management program. We wanted to get more sophisticated in what to do with that information. Lucia worked with Urocare.

Incontinence in the elderly is very close to my heart. Generally speaking, incontinence is defined as the inability to control urination or defecation. Historically it has been a difficult problem to study. It is difficult to get a true definition. Studies are usually conducted on individuals in the community and not patients in hospitals or long-term care. They often ask the patient how much satisfaction or dissatisfaction and they are incontinence -- the incontinence care gives them also comparing oranges to apples in studies. Don't take all problems into consideration. The scope of the problem is huge. Is a significant financial burden is approximately $22 billion including home and facilities. It is the number one reason for admission to long-term care and often the cause of hospitalization. They are more than 25 million Americans with incontinence.

I think the problem is far greater due to underreporting. On an individual level, there are problems causing isolation, distress, depression and a significant cause of injuries, false, sepsis, skin breakdown. This is such a far-reaching, complicated program different problem but we still lack whether a patient is hospitalized comment rehab, long-term care community. These are types of incontinence. Stress incontinence is intermittent leakage which affects about one third of women. Urge is the sudden, urgent need to urinate with no access to toilet with various causes. You might be familiar with the ads where they have patients not being able to find a bathroom if there are side effects with medications. They decrease cognition, increase dehydration. Overflow is when there is more urine created within the bladder can hold. Causes include constipation, enlarged prostate and medication. Fecal is when the patient is unable to control bowel, neurological D/O. these are barriers to improve incontinence. It is a chronic problem with very little to -- change in management. We need to get away from the one diagnosis fits all approach. There is a lack of robust evaluation. We need to individualize the evaluation across the board in all healthcare settings. Multiple times a patient will be started on a medication for leaking, incontinence. Actually the patient has urinary retention or incomplete bladder emptying problems. The patient needs a robust evaluation to determine what is going on. There is a lack of proper diagnosis. It is often undertreated. There is poor recognition and very little staff buy-in. I have had patients who have had problems with prolapse or hydro-seal and have needed an elevated toilet seat. If there is a lack of interest or resignation mindset. There is inaccurate or inadequate documentation. Licensed staff should be checking in when patients have diarrhea. We should be checking hygiene on independent patients. We really have to know what is going on with them. Health trajectory of patients in the LTC setting shows they will need help and we need to act appropriately. We have a task oriented approach to care. Caregivers are often resistant to new approaches. There are thin staffing numbers or
float staff. Facilities today have been using a basic tool for identifying UI involving asking questions such as, is the patient incontinent? You will see a chart for one hour for each 24 hour time slot. Everybody feels they have to fill in every slot. The caregiver should be taking this with them when the patient is on the bladder diary. Every time they evaluate the patient whether it be 2 AM, 7 AM, 3:00 P.M., 11:00 P.M., was the patient continent or were you able to take them to the bathroom. That is the basic premise for failing in the diary. You should get three days’ worth of data. It doesn't have to be back-to-back. It can be once a week. Especially when you have new patient. The patient is trying to get accustomed to new surroundings. You don't really know what is what with the patient. I suggest doing it initially been repeated -- then repeat. Find if the patient is incontinent and check yes or no. Improving or preventing incontinence in the bladder and bowels is a significant way to improve quality of life in decreased morbidity and save healthcare dollars. Urinary incontinence is a symptom which results from multiple factors. Patients need a more holistic evaluation, physical exam, bladder scan and also talking with caregivers and nursing to get a good book as to what is going on with the patient. We can come up with a diagnosis. Is it urine retention, shy bladder, depression? When you have a practical plan of care, you can follow up and see what is going on, what works, do you need to try something else? It is also important to identify comorbidity issues such as retention, UTI, constipation, especially with diabetes. Poorly controlled diabetes needs to be addressed. You need to look at dietary intake. Does the patient take a lot of caffeine, soda? Cranberry can cause bladder irritation. It is good if the patient is a chronic UTI sufferer. With incontinence, I would not actually give cranberry. It is applied irritant -- a blood irritant. As a nurse practitioner, I like to be a resource for the facility. We also need to educate the patient. If they are alert and oriented, we need to talk about what we're doing for them. Refer out to urology if everything I tried fails. If recurring continues, that needs to be documented. This is a tool that nursing can use on a daily basis. I think of it as the six vital signs. We added oxygen saturation as the fifth vital sign. I like to think of this as the sixth. I have an example of aggressive hospice patients. The patient was restless and now has urinary retention due to opioids. You can obtain a refurbished blood scanner for approximately $250,000 -- up to $12,000. These individuals require a history and PE to determine underlying causes before POC can be determined. Causes include chronic diarrhea, constipation, diabetes, diet changes, mobility changes. Keep a watch for changes in bowel patterns and act on those as soon as possible. The bladder is a trainable organ. If you get patients on a schedule, it is amazing how well it helps. Especially for patients who are impaired but ambulatory. Ask then take the patient. If you ask, they will say no. If you bring them along, they will come. Prompting. Check in with them. We have to avoid and treat constipation. Constipation is very often responsible for incomplete voiding. We don't want to over hydrate but patient need to be appropriately hydrated. We need to observe for new symptoms. UTIs can trigger new or increased UI. Review
medications, reduce polypharmacy as able. Especially medications with urinary tract side effects, sedating medications, hypnotics. Avoid bladder irritants. Adding low dose estrogen for female UI plumps up the tissues or topical estrogen is not systemic and very low chance of increasing cancer. Control diabetes. It provides food for bacteria already present.

Nurse assistants provide the "Lion's Share" of incontinence care. I was once in charge of hiring nurse assistants for facilities I was working at as an RN. My modus operandi was a five-step approach. I would collect applications and go over them. If they were written in crayon or incomplete or poor English or language, I would dismiss them. If they can't communicate when applying for a job, they will not be good communicators with other team members. It was thank you, but no thank you. I would call the people I would select. They have good telephone manners, polite, excited to hear from us. I would invite them to interview. As I meet the person, I like them to be on time, well presented. They don't have to be wearing an interview suit but no jeans, no piercings. We are dealing with elderly people who want to have people they recognize. If they are pleasant and talking with them and assess their conversation skills -- they may be nervous -- that is a good thing. We will sit and talk. I start by asking why they applied for the job. There better be something in what they say about them liking looking after patients. They want to go to nursing school or they like elderly or have looked after elderly family members or they feel elders need really good care. I might prompt them. I have been a nursing 30 years. I love it. My mother was a nurse. I get a feel if they really want to do the job. I give them a tour. If they are smiling and conversing I hired them on the spot. We need to build, develop and value quality care. We need to support person with education. Praise jobs well done and successes demonstrated. Encourage supervision of nurse assistants. Check work and documentation. Check in with patients and families. That is always known to improve patient satisfaction. Reports and documentations need to be complete, meaningful and useful. When we see patients with liquid stool and assessing for frequent UTI, make sure staff know what the norms are. I can't tell you how many patients are you evaluate for recurrent UTI and they have liquid stool. If you don't deal with that, they will keep getting those UTIs.

These are a few case studies I have come across. Number one, 82-year-old female, dementia, independently amply toward. Never married, no children. Suddenly developed bowel incontinence. The bathroom was a mess. The patient was mortified. She had a small weight loss. Dietary added a protein shake at bedtime. She had the protein shake which was causing her to defecate largely through the night. We change the time of the protein shake and continence was restored. Number two, 42-year-old male. Family member would take the patient out and he would involuntarily urinate in the car or theater. He turned out to have urinary retention. Bladder scanner was
reading greater than 1000. I had realized he was on a lot of antipsychotics. Feet a PRN -- they had added oxybutynin. We switched his medications. The sister can take him out and it has improved his situation. Third, 39-year-old male. His problem was constipation. He had a bowel movement every day but was not emptying enough. We aggressively maintained bowel emptying. I added a weekly fleet enema. The fourth patient was 80, forgetful, new onset dementia but able to self-toilet, self-care. She had swirled clothing. With prompting toileting she was able to maintain continence. That is the end of my presentation. Thank you very much for attending. I can entertain any questions. Here is one last slide.

When Lucia first decided to have the Urocare -- I think she had some of the same findings when she first introduced the concept. She did not expect resistance from the medical staff. They thought it would add another layer and more medications. Lucia had Urocare present at the staff meeting so they could hear about the philosophy of the Company which is about individualized diagnosis and an individual treatment plant and not just more medication. Next the Urocare APRNs came in to talk with the staff. They would speak to them about the resident and what staff knew about that resident and what had worked and had not worked. Also providing education around incontinence. This would make things easier if we could maintain continence. Another aspect was to involve MGS -- MDS coordinators. Urocare asked for the CASPER reports. The interventions that the APRNs came up with -- can they be rolled into a better plan? The first person to realize that there is a change in incontinence is by CNA’s. After review of CNA documentation, it can help identify residents appropriate to be seen. They also contacted the rehab department. Some residents are already on program and made -- may be seen. Lucia talked about celebrating outcomes, no matter how small! We may not see a cure, but that is not how we celebrate successes. It may be they will continue to be incontinent but instead of five we go to for -- four. That is success. Instead of several times we go down to twice a year. That is success. They also looked at as a measure of success, falls. We have had good success with decreasing falls by incontinent management. Celebrate successes no matter how small.

These are our contact numbers.

Thank you so much, Teresa and Alison. We are open to take questions.

Could you describe your incontinence assessment and describe how it differs from assessment done by a unit nurse.

A unit nurse will either find if the patient is continent or not from the diary or transfer or if it has been noted when the nurse assistants are doing documentation. I don't
know if they reported to the house APRN for attending. It is a significant change, so it should be addressed. When I asked to see a patient, I always ask chief complaint. Is it for incontinence, falling, frequent UTIs? I review notes and become familiar with the patient's history. Often times I don't know why the patient first came in. I like to know how the patient has been then get an idea of decline up to the point of our meeting. I review medications, allergies, vitals. I see if there has been recent changes in care. Half they recently had a UTI -- have they've recently had a UTI? I look at the labs. It gives you an idea of whether it could be hygiene, diarrhea issue. It starts to narrow targets. I collect that data. I do a head to toe assessment. How they look. To they look chronically ill? Do they look well? Pulmonary, mobility, are that currently incontinent? Do they have Foley? Why? Have they tried to get it out? Goal of that is important. I always do -- I always do a pelvic or rectal exam. They get a physical exam every year and never get a pelvic or rectal exam. I find foreign bodies, nobody knows they are there. It is amazing what is found. I talked to the nurses. Unfortunately, nurses don't know a lot of what is going on with the patient when it comes to incontinence. It usually comes from nurse assistants. I always praise them for their care and thanked them for the useful information. I also ask how they hydrate. Are they good at taking fluids? What is their diet like? I write very comprehensive notes, formulate information, diagnose and write a plan of care. I follow-up with the patient. If I implement a plan of care, I follow-up with the patient in a month. If they are stable and fairly young -- in their 70s -- I will see them again in three months then every patient every six months. Unless it is a psychiatric patient who has incontinence due to psychological issues but not having UTIs or incomplete bladder emptying or retention issues. I will see those patients annually. I can always be called back to see a patient.

That was very comprehensive.

Most patients with a UTI have confusion. Why does it affect mental status?

Because these patients are frail -- we tend to forget that. We see them every day breathing, easing eating.-- all of a sudden they become confused and they often become confused because their body is trying to fight infection. Elders fight infection differently from a younger person. ABB -- a baby will go from eight normal temperature to 104 and they behave typically. An elderly person might present a change in mental status. Fact is usually evidenced by sleepiness, can't hold head up, don't eat or drink. You still need to look carefully. When you see mental status changes, -- as long as the patient isn't looking septic -- the nurse has to do manual vita signs, blood pressure, heart rate, temperature. If they can't close their mouth, it needs to be done rectally. Oxygen saturation. Quite often in septic patients, temperatures will be low. You may see shaking, chills. That needs to be called into a doctor. If the
patient is stable and they have a mental status change, I recommend putting the patient on a 72 hour UTI tracking pathway. You are watching them for three days, watch vital signs, push fluids, start IV hydration. Quite often mental status changes will be due to under hydration. Notice I do not use the word dehydration. We do not want to see that anywhere in the documentation. That is a trigger for the state. They are putting the patient on an antibiotic, flying blind, not knowing what they are treating. All of that poor treatment is adding to resistance to antibiotics. In about 10 years we will be up the creek without a paddle because there is nothing new coming up the Pike.

There is an evaluation that will automatically show up. Please complete that. You should receive a link to that evaluation and the webpage tomorrow. The website is in the chat. The PowerPoint presentation is posted on our website. A recording and transcript will also be added to our website as soon as it is available.

Thank you to Teresa and Alison for a wonderful presentation and Gail for bringing forward information on her wonderful program.

Thank you.

[ Event Concluded ]