Continence Management Program
ACE Program

Purpose:
The purpose of this program is to create an interdisciplinary approach to managing the generic client in a skilled nursing facility to address deficits in continence through interventions within the scope of practice for therapy services. The prevalence of urinary incontinence is widespread in skilled nursing facilities, being the second most common reason for nursing home placement behind dementia.

The state survey process has identified incontinence as a deficiency that must be addressed comprehensively to ensure the resident is able to function at their highest functional level for voiding. Managing incontinence is a collaborative effort of therapy and nursing. Therapy plays an important role in addressing the resident's functional ability to ambulate, transfer, manage clothing and perform the self care task for the toileting routine. The cognitive aspect of toileting can also be addressed by therapy to ensure a program is designed taking the cognitive level of the resident into account.

Patient Identification
There are several ways to identify residents who may benefit from therapy services to address deficits in continence.

> ***Observation*:** Observe residents in the facility. Do you see residents are having new incidents of incontinence? Is there anyone who has had a fall while trying to get to the bathroom? Is there anyone who is having increased problems with dexterity managing their clothing?
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> ***Interview of Staff*:** Talk with facility staff to see if they think they have seen anyone in particular is having increased problems with incontinence. Ensure nurses, nursing assistants, activity staff, and dietary staff are all interviewed.
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> ***Educational Opportunities*:** Don't miss an opportunity to educate! If there is a small group of nursing assistants, talk with them for a few minutes and briefly explain some of the criteria you are looking for to see if there is a change in continence status. If they know what therapy can do to help a resident, they may be more likely to help generate referrals.
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> ***MDS 3.0:*** The new MDS requires documentation if a resident has incontinence and if intervention of a program has been initiated (section H). Therapy intervention would be included in this section, thus MDS

coordinators should be notified and our interventions should be care planned on the CAA, as part of the interdisciplinary team.

Types of Incontinence

Stress Incontinence: Leakage of urine during normal activity, such as coughing, laughing, sneezing or exercise which may place pressure on the bladder. This is due to muscle weakness and sphincter insufficiency.

Urge Incontinence: Occurs when the brain signals the bladder to empty, even though it may only contain a small amount of urine, also called “overactive bladder”. Symptoms: Frequent urination, worrying about leaking, voiding just in case, limiting water intake to avoid problems. This is more of a nervous system response and is often a "learned" response rather than from weakness.

Mixed Incontinence: A combination of stress and urge incontinence

Functional Incontinence: Inability to void urine in proper place (i.e. toilet) due to physical limitations or barriers

Overflow Incontinence: When the bladder has become flaccid. This is seen in more neurological patients such as Parkinsons, MS and CVA where there may be a delay or decrease in sensation that the bladder can become "too full"

Criteria for Patient Identification

There are several triggers that may indicate therapy services are appropriate for the resident to provide an evaluation and treatment activity designed to address incontinence:

- New development of incontinence (therapy limitations)
- Withdrawing from activities or socialization due to embarrassment
- Removal of catheter
- New issues with urgency to use the bathroom and “accidents”
- Acute illness such as MI, CVA, or new onset of a confusional state
- UTI or frequency UTIs
- Presence of some medications including sedatives, hypnotics, loop diuretics, anticholinergic agents, alpha-adrenoceptor agonists and antagonists, calcium channel entry blockers
- Presence of depression or similar psychological disorders
- Presence of endocrine disorders including hypercalcemia or hyperglycemia
- Impaired mobility or decline in mobility
- Stress – stress incontinence is caused by a weakening of the muscles and sphincters that control output. This is commonly manifested by leakage with sneezing, coughing, laughing or lifting heavy objects.
- Sensory impairment (sight, hearing, communication) that inhibits their ability to communicate their needs to caregivers.
- Environmental obstacles that hinder them from reaching the bathroom safely and timely
- Decreased sensation in hands that affect undressing to toilet
- Declining cognitive status
- Decreased strength and mobility skills or incidence of falls

- Impairments in coordination and use of upper extremities affecting clothing
- Perceptual dysfunction
- Increased depression related to embarrassment or lack of independence

MDS (2.0)

When providing therapy services to long term residents of a skilled nursing facility, there are a couple key areas on the MDS (Minimum Data Set) to check to see if there has been a change. The presence of a change in score or a difference in current status to previous status will signify a change in the condition of the resident and help support the intervention of therapy services.

- Section B 4
- Section G 1, b, c, d, e, f, g, I, j
- Section G 8, 9
- Section H 1 a, b
- Section H 2, 3, 4

Quality Indicators

Review the following quality indicators:

- Incidence of decline in late loss ADLs
- Prevalence of daily physical restraints
- Prevalence of bladder or bowel incontinence
- Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan
- Incidence of new fractures
- Prevalence of falls (trying to get up to the toilet, walking too fast to toilet)

Potential Interventions and Plan of Care

The plan of care for each resident is individualized to their own deficits and impairments. The following are possible interventions that could be utilized when addressing incontinence. Occupational and physical therapists and assistants specialize in the treatment of incontinence.

- Assess tone and determine its impact upon function.
- Assess the strength of the pelvic floor muscles used to control urine flow
- Educate resident in Kegel and pelvic floor exercises, including accessory muscle (hip flex, ex, rotators, gluteus) to increase strength of muscles and sphincter.
- Consider use of bedside commode or other environmental adaptations to facilitate independent toileting.
- Utilize training exercises for bladder such as consciously override bladder signals to delay voiding and increase bladder capacity.
- Drink adequate fluids and monitor fluid intake.
- Avoid caffeinated beverages such as coffee, tea and alcohol. Other foods/beverages that may contribute to bladder leakage include: colas, milk

products, citrus juice and fruits, tomatoes/tomato based products, spicy foods, sugar, honey, chocolate, corn syrup.
- Address mobility issues including balance and strength that may be affecting ability to reach bathroom in time.
- Develop FMP for accessory muscle strengthening to maintain pelvic strength
- Address communication impairments to create a system for resident to notify caregiver of their need to use the bathroom.
- Use electrical stimulation or biofeedback (when therapist is proficient in these interventions) to retrain the muscles used for controlling continence. PENS for stimulation of the muscle, reeducation or neuro-modulation to calm urgency
- Address ADL and self care skills to maximize independence with toileting tasks.
- Avoid nocturnal fluids
- Reduce body weight if overweight
- Utilize bladder re-training techniques
- Restore normal pattern of urination
- Resist the sensation of urgency
- Postpone voiding
- Lengthen the distance between voiding
- Develop a toileting schedule with nursing to anticipate incontinence

Training Accessory Muscles

The muscles which control continence can be affected through "overflow" from activation of the accessory muscles in the surrounding areas. Positive changes in continence should be visible after about two to three weeks. Some effective exercises to positively impact continence are as follows:

- Abdominal brace: Lie on your back with your knees bent and feet flat on surface. Locate the neutral spine position, tighten your abdominal muscles to maintain the neutral position.
- Single leg slides: Lie on back with knees bent and feet on surface. Slide one foot away from body while maintaining neutral spine position, return to starting position. Alternate movement with other leg.
- Abdominal brace with leg lift: On back with knees bent and feet flat on surface. Maintain neutral position, lift foot from surface brining knee towards head until hip is at 90°, return to starting position. Alternate movement with other leg.
- Bridging: On back, knees bent with ball between them, spin in neutral position. Maintain lower spine in stable position. Using buttock muscles, raise body from surface. Can also perform with single leg.
- Bridging with tiny steps: Start with body in bridged position. Maintaining neutral position, lift feet from surface a small distance in tiny marching steps.

- Bridging with leg extension: Start in bridged position. Lift one foot from surface and straighten leg (terminal knee extension) while maintaining a stable, neutral spine.
- Hip rotation: Variety of rotational exercises to improve pelvic floor strength
- Ball and Band: Therapy ball and theraband for resisted leg abd/adduction with rotation (point toes in when doing the ball, point toes out when doing the banc)
- Clam shells: Sidelying rotation by rolling top knee toward ceiling. Keep feet down and together, do not lift leg, but rotate it up
- Standing plie: Stand with feet point out, make a small dip with bent knees to plie'
- Elevator: Complete Kegel but try to segment the contraction and relaxation by thinking of an elevator and stopping at each floor up and down to progressively activate Kegel rather than a quick contract and relax

Bladder Irritants

The follow is a guide to help identify foods that may irritate the bladder, causing the signal that it needs to be emptied more frequently.

Cause Worsening of Symptoms in Most People:

- Coffee (even decaffeinated for some people)
- Caffeinated soda (even decaffeinated for some people)
- Alcoholic beverages
- Medicines with caffeine (Excedrin)
- Tea
- Chocolate
- Carbonated beverages
- Smoking

Cause Worsening of Symptoms in Some People:

- Milk and milk products
- Artificial sweeteners
- Citrus fruits and juices
- Tomato and tomato based products
- Highly spiced foods
- Sugar and honey
- Corn syrup

Often Not Irritating to the Bladder:

- Grape juice
- Cranberry juice
- Cherry juice
- Apple juice
- Water
- Prunes
- Plums

Reducing fluid intake will result in a concentration of urine. This irritates the bladder and results in more symptoms of frequency and urgency. Fluid intake is individualized for each patient. Gradually you should be drinking six (6) to eight (8) oz. glasses of fluid each day. Caffeinated drinks and alcohol dehydrate the body. These drinks are not counted as fluid intake towards the total required 48 to 64 oz. per day, as long as you are not under fluid restriction for another medical condition. Fluid intake should be spaced throughout the day. Coordinate with nursing, dietary and the physician if recommending any changes to a resident's diet. Decreasing bladder irritants and obtaining the proper amount of fluid intake will enhance your overall bladder function and decrease your symptoms.

Inservices

Therapy services usually provide inservices to nursing and other facility staff to raise their awareness of incontinence and to help generate appropriate referrals for therapy programs. These inservices are usually done around the change of shift in order to catch more caregivers. The following is a sample outline of an inservice program that could be provided regarding incontinence.

Inservice Outline
Incontinence Program

What are the signs that a patient may be having problems with incontinence?
New onset of incontinence –

- Withdrawing from activities or socialization due to embarrassment
- New issues with urgency to use the bathroom
- Presence of depression or similar psychological disorder
- Difficulty with mobility, needing more assist with toileting
- Stress incontinence – leakage with sneezing, coughing, or laughing
- Declining cognition affecting toileting
- Problems with decreased coordination and sensation in hands affecting clothing management.

What can you do if you think a resident may be having trouble with incontinence?

- Tell the nurse the problems you observed and ask them to document it in medical record
- Tell a member of the therapy team or leave a note in their mailbox
- Write what you saw on the 24 hour report
- Bring it up for discussion at morning report or other patient related meeting
- Coordinate with MDS intervention team

What can therapy do to help these residents?

- Evaluate the resident to see what they are able to do
- Provide treatment and interventions to improve continence, including ACE modality interventions or exercise based interventions
- Develop recommendations that can be integrated into a restorative program
- Rehab can identify adaptive equipment for clothing management to assist in toileting
- Make recommendations for specific setup and assist strategies to help the resident do as much for themselves as they can
- Make recommendations for adaptation to the environment to help the resident perform toileting easier
- Recommend adaptive equipment that can help the resident with toileting or clothing management.
- Rehab can help address any mobility issues that are hindering their ability to successfully toilet themselves.
- Rehab can provide training and therapy techniques to help retrain and strengthen the muscles directly responsible for controlling urine flow to help with incontinence.
- Rehab can help with re-education of the bladder to help decrease urgency and incidents of incontinence.

What can be done every day to help with continence problems?

- If a resident voices the need to use the bathroom, help them as soon as possible.
- Respond quickly to call lights and requests for help.
- If a resident with cognitive impairment is showing behavioral or non-verbal signs of discomfort, they may need to use the bathroom.
- If adaptive equipment has been recommended for the resident, ensure that they use it during toileting.
- Ensure the items used routinely in toileting are easily within reach.
- If a resident is having a new problem with incontinence, notify a member of the rehab team.
- Recognize the normal gastric reflex to toilet 20 min after toileting. Residents may also void more often after medications.
- Assure residents can sit supported and relaxed on the toilet (not too high or unsupported) to assure proper pelvic relaxation to fully void

Any questions?

Quiz for Incontinence

1. True or False (Circle one)
Incontinence is a normal part of aging. It will happen to everyone.

2. True or False (Circle One)
Once a resident begins to be incontinent, they can never be continent again. There is nothing that can be done.

3. If a resident asks to go to the bathroom after eating, it may be necessary to toilet again even if they went to the toilet prior to the meal. What is the reason?

4. What should you do when you suspect that a resident is having new trouble with continence?

a. Wait and see if it continues
b. Let the next shift take care of it
c. Take immediate action and notify the unit nurse as well.
d. Notify therapy if it continues to be a pattern
e. All the above

Name:_____ Shift:_____