Geriatric Nursing 40 (2019) 648–650

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

AALNA Section

The impact of a resident's occasional incontinence: The under-recognized incontinence

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On admission to an assisted living community, Connie was 82 years old with two children, diabetic with poor eyesight and no other known health problems. She was overweight and generally physically inactive. She loved caffeinated drinks such as coffees or sodas and did not care much about healthy eating. She had no history of incontinence; however, was physically inactive. Two months after admission, she began to experience occasional wetness. When she notified her caregiver for aid and she was given protective undergarments for her occasional incontinence. She began to limit her liquids, thinking it would prevent urinary incontinence (UI). She became more irritable, anxious and angry from the leakage and odor she experienced. She withdrew from activities and often refused to eat in the dining room or go out with her family because of embarrassment. Seven months later, she began to experience heavier and more frequent wetness. She was unable to control her urgency as she waited for the aide to help. She experienced her first urinary tract infection (UTI) in many years. Her UTI was successfully treated with antibiotics. Her continence had deteriorated, and she now evidenced moderate to severe incontinence. She was assessed to see whether she was at higher risk of incontinence, day or night or both. Results showed she was at higher risk of night-time incontinence. She was given incontinence products to wear at night. Even with the incontinence garments in place she was awakened every two hours at night for toileting to reduce her risk of night-time incontinence, fragmenting her sleep and making her over tired, agitated and irritable.

After two years, Connie began to experience symptoms of dementia. Her scheduled toileting continued, as her cognitive status began to decline. She began to feel more agitated as she was woken from her sleep to toilet every two hours, until one of the nights, she lost her balance and fell. Fortunately, she had no fractures, but had bruising and pain which took two months of recovery time. With her cognitive decline, physical therapy was a challenge as she could not retain the exercises and hints for improved function. She was given a walker. She could not sleep well because of her pain and UI, and continued to feel agitated. She struggled to maintain her toileting regimen and became used to feeling wet and not alerting the caregiver of wetness, only to result in another UTI and Incontinence Associated Dermatitis (IAD). Residents should not get used to "wet comfort" which can lead to significant increase in risk of incontinence associated complications.[1] As her cognitive status continued to decline, Connie became more incontinent, agitated and aggressive, developing resistance and confusion to toileting. It became a constant struggle for Connie, her family, and her caregivers as Connie's cognitive status declined and became fully/chronically incontinent.

Why did Connie begin to experience UI? There are several possible risk factors for Connie's UI, such as pelvic floor atrophy commonly caused by pregnancy, bladder or sphincter dysfunction or a combination of both, a history of UTI's/Bladder infections, diabetes, reduced mobility, a long history of poor bladder habits, poor eyesight, age, inadequate fiber and water intake. Such risk factors more commonly than others, can play a significant role for incontinence and cause adverse negative outcomes for residents.

What could staff have done differently for Connie as she began to experience occasional incontinence? How could they have reduced her risk of becoming fully incontinent as her physical function and cognitive status began to decline? Occasional incontinence is an under-recognized, under treated issue in most post-acute care settings yet it is a very important stage because early assessment and risk reducing protocols can slow the decline and improve the quality of life. In most settings the resident with occasional incontinence is not checked on and no assessment or plan is put into place until the individual becomes frequently incontinent. Once the resident is frequently incontinent mitigating the risk factors to slow the progression of incontinence or reducing the level of incontinence is more difficult. At the early stage, UI risk reduction steps may slow down progression before it becomes chronic. The assessment of occasionally incontinent individuals should be individually-based, since there can be several risk factors that can contribute

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https://doi.org/10.1016/j.gerinurse.2019.11.006
0197-4572/$ – see front matter

to UI. Medical evaluation and patient history are the most important factors in identifying the type, severity and burden of incontinence.[1] The first step in evaluation is to identify transient or reversible causes of UI.[2] Reversible incontinence usually has a sudden onset and has been present for less than six weeks at the time of evaluation.[3] The pneumonic DIAPPERS can be used as a quick evaluation tool to bring to mind some of the reversible causes of UI:

Delirium, Infection, Atrophic vaginitis, Pharmaceuticals, Psychological disorder (e.g., depression), Excessive urine output (e.g., hyperglycemia), Reduced mobility (e.g., functional incontinence or reversible urinary retention), and Stool impaction.

If two or more of these factors are present further investigation and interventions should be explored. Simple questionnaires can be useful for UI evaluation.[4] A voiding diary asks resident to record the frequency of incontinence episodes as well as the situations in which incontinence occurs helping to clarify the type and severity of incontinence and the possible causes such as medications or prior surgeries. The diary may also provide indications for resident specific relief for the situations-two-hour toileting, casual offers to assist to the bathroom when a staff member passes the resident. If we understand when and where we maybe able to ascertain the why and mitigate the situation.

Caregivers must be educated and equipped with tools to slow down the progression of UI and reduce the risk of frequent incontinence, with tools such as journaling to assess the resident's toileting pattern, hydration level and programs, diet, mood and sleeping patterns, normal resident circadian rhythms, involvement of physical therapy and restorative nursing programs to promote continence. In the beginning, this may seem as extra work for the caregivers; however, may result in reducing the risk of UI progression, skin infections, UTI's, sleep fragmentation, and falls is the key to maintaining continence and improving resident quality of life and staff satisfaction. Falls, UI, and cognitive impairment are among the most common and important conditions affecting older persons,[5] yet the care processes to diagnose and treat these conditions effectively are sometimes poorly implemented in clinical practice.[6] Staff education and implementation of effective incontinence care management tools can decrease the burden for caregivers, strengthen caregiver-resident trust as well as improve the residents' quality of life.

Hydration is an extremely important step in reducing the risk of UI. Many people with bladder control problems reduce the amount of liquids they drink in the hope that they will urinate less. This can create highly concentrated, irritating urine which can make a person go to the bathroom more often, encouraging the growth of bacteria, which can lead to UTI's or bladder infections. Lack of hydration can also cause constipation which is also irritating, and can cause UI. Since the thirst mechanism in the elderly may be dysfunctional, caretakers should help focus on drinking small, frequent amounts of fluid throughout the day rather than waiting to feel thirsty. Hydration stations throughout the community may provide untargeted access to liquids destigmatizing the resident with the occasional incontinence as all residents would be encouraged to drink frequent small amounts all day. Hydration can also be encouraged by caregivers by facilitating activities such as a Wake-Up Morning Drink or an Afternoon Happy Hour for Hydration, given in wine glasses! Keep in mind that by the time the resident feels thirst they are already on their way to dehydration. Make sure the residents diet includes enough fiber to stimulate healthy bowel movements without mechanical or chemical stimulants. Caffeinated drinks are diuretics. Limiting caffeine intake, reduces the urgency to urinate, decreasing the risk of dehydration, UI, UTI's, and falls. Malnutrition including hydration impact the fragility of the skin.[10] Good nutrition and hydration will help make skin more resistant to breakdown and skin will be more likely to heal and fight off infections, such as IAD, should it occur.

Unfortunately, for Connie, her occasional incontinence progressed to frequent incontinence. To make matters worse, the onset of dementia progressed her UI to being fully incontinent. Rates of UI are higher among persons with dementia (53%) than those without dementia (13%).[6] The primary reasons for incontinence in dementia patients are not because of pathology in the urinary system,[7] rather, it is due to functional incontinence. Functional incontinence risk factors led to Connie's full incontinence. Cognitive decline, in Dementia residents, impairs mobility, manual dexterity, lack of motivation and pupillary responses. As a result, people with dementia are more vulnerable to bed-wetting, UTI's, IAD and other skin infections, as well as falls. Falls, UI and cognitive impairment are among the most important conditions affecting older persons.[8] There is a direct correlation between sleep fragmentation, nocturnal agitation and UI in Dementia/AD patients.[6] Decreasing urgency with prompted voiding, good nutrition and hydration can help control UI and awakening from sleep with subsequent agitation, reducing the risk of falling. Individualized toileting plans are paramount o managing occasional incontinence to slow the decline, but once full incontinence occurs toileting should still be done based on the individual resident patterns of wetness.

Wetness causes bacterial overgrowth and contact with the urethra, leading to UTI's or bladder infections. Often, due to wet comfort, residents do not realize the degree to which they are wet and if they suffer from memory or musculoskeletal disease, they have limited self-awareness for the severity of wetness to alert caregivers. At this point, the already-vulnerable aging skin is exposed to wetness and odor, making the patient feel uncomfortable, embarrassed and agitated. To reduce wetness and odors and keep the skin dry, the right products need to be used in the correct way. Caregivers/staff should be educated to assess residents' incontinence and maintain reasonable prompted voiding schedules following their voiding pattern, to reduce urgency, prevent sleep fragmentation and subsequent agitation. Prompted voiding can also cause sleep fragmentation. Caregivers must be cautious to not wake them too often. A reasonable number of times for night-time voiding along with the correct use of incontinence products should keep the resident as comfortable and dry as possible. As the visual pupillary responses decline, soft lighting should always be present while the resident sleep. Soft lighting will allow their eyes to adjust slowly, maintain better balance by reducing startle responses from sudden bright lights, reduce the risk of toilet confusion and potentially reduce falling. Other considerations to reduce the risk of incontinence include effective rounding- at all encounters to assure all needs are met before leaving the resident, the distance to the bathroom, wearing resident specific adaptable clothing, maintaining calm and quiet uncluttered environment, assessing the need for assistive devices for walking or toileting, or identifying other physically barriers.

In this case study, when Connie became frequently incontinent, in addition to her physical and cognitive decline, her incontinence had progressed to the point of irreversibility. However, with a good incontinence care management protocol, her incontinence, could have been managed once she started to have "occasional incontinence". With proper staff education, timely assessment and intervention for UI, Connie's occasional incontinence could have been managed and reduced the risk of UI progression. During her cognitive decline, an effective toileting and total incontinence management program could have affected her mobility, behavior, skin integrity, UTI, fluid intake in addition to her continence status.[9] This would have ultimately improved her quality of life and reduced caregiver's burden. Dr. Ara Sayabalian, Ed.D. and his team specialize in implementing total incontinence care programs for assisted living and memory care communities. The focus of the programs revolve around risk reducation, caregiver education, and cost control. Fo questions, Dr. Sayabalian can be reached at drara@sayabalian.com.

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