Nurse Specialist Role in Older Adult Continence Management

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What kind of specialist nurse is needed?

- Continence nurse specialist
- Gerontological nurse specialist
What continence nursing knowledge contributes

Assessment

- Focused history and physical exam, specific evaluation strategies (e.g. bladder diaries)
- Order lab/DI - *Advanced practice nurses (Nurse Practitioners, Prescribing Nurse)*

Conservative Management

- E.g. fluid management, PFME, toileting strategies, bladder retraining, IC/indwelling catheter management, pessaries, containment products, bowel management
- Patient teaching/continence promotion

Pharmacological management

- *Advanced practice nurses (Nurse Practitioners, Prescribing Nurse)* - Scope varies with legislation
What gerontological nursing knowledge contributes

Assessment
Cognitive and physical function of older adults
Order lab/DI - *Advanced practice nurses (Nurse Practitioners, Prescribing Nurse)*

Management
Communication strategies (dementia, hearing/vision loss)
Strategies for management of dementia related behaviours
Strategies to reduce incontinence related falls risk
Medication review – identification of potentially problematic medications
  ◦ prescribing/deprescribing - *advanced practice, scope varies*
Liaison with case managers in home care/assisted living/nursing home
Multidisciplinary focus
Case

83 year old female brought to continence clinic for recurrent urinary tract infections

• Multiple visits to family physician and EDs for UTI
• Very recent move from apartment to assisted living dementia unit
• Medical hx: Depression, anxiety disorder (long standing), cognitive impairment, GERD, hypertension, hypothyroidism
• Surgical history: cholecystectomy, hysterectomy (both remote)
• Obs hx: G3 P3 – vaginal deliveries, no other information
• Medications: citalopram, zopiclone at hs, pantoprazole, ramipril, levothyroxine, lorazepam
Case

Assessment

- Little evidence in lab results (“mixed cultures” or “no growth”), but multiple courses of Abx
- Difficulty responding to questions about LUTS
- Daughter reports daily UI (urgency?), no fever/delirium with frequent complaints of UTI
- Using paper towels for containment
- PE – perineum red, no leak on cough, grade 1 anterior prolapse, urogenital atrophy, no stool in rectum
- Required significant reassurance from continence NP, daughter to complete the PE
- Unable to void in clinic, PVR > 350ml

Initial Impression

- Urogenital atrophy, query overflow UI, query urgency UI - DHIC?
Could she be mistaking Sx of urogenital atrophy for UTI?

Possibly – symptoms can overlap

Email survey post-menopausal women 55-65 in Great Britain, the United States, Canada, Sweden, Denmark, Finland, or Norway

- 45% reported vaginal discomfort (83% vaginal dryness, 42% pain during intercourse, 30% involuntary urination, 27% soreness, 26% itching, 14% burning, and 11% pain when touching the vagina)
- Knowledge of urogenital atrophy low – only 4% attributed symptoms to vaginal atrophy

Nappi & Kokot-Kierepa 2012

Cross sectional data from US Women’s Health Study, 50-79 years

- Symptom prevalence: 27% dryness, 27% irritation/itching, 11.1% discharge, 5.2% dysuria
- No relationship of time since menopause and moderate/severe symptoms

Pastore et al 2004
What would you do?

1. Put in an indwelling urinary catheter
2. Start intermittent catheterization
3. Fit with a pessary
4. Toileting schedule
5. Treat the urogenital atrophy with vaginal estrogen
6. Get a bladder diary

Other ideas?
Guidance: Improving continence care for people with dementia living at home (Alzheimer Europe)

- Embarrassment/stigma, lack of knowledge or perception that incontinence is a normal part of dementia/aging may make people with dementia/carers reluctant to seek help
  - ask about continence issues and refer for continence assessment
  - Stepwise process to management
Don’t just blame the dementia: Types of UI in AD

Na et al 2015
As dementia progresses

Functional issues make the incontinence more complicated

• Visual/Spatial Disorientation— can’t find the bathroom

• Apraxia - tasks such as dressing/undressing, hygiene become more difficult

• AGNOSIA – Difficulty recognizing objects such as the toilet

• Recognizing the need to go to the toilet

• Recognizing they have wet or soiled themselves
Conservative management strategies

Systematic review of conservative treatment in older and frail older people (Stenzelius et al 2015)

• Limited evidence with regards to those living with cognitive impairment
• Community - Patient education/PFME studies – excluded those with CI
• In NH – toileting, physical exercise - results variable, staff availability an issue
MANAGEMENT OF URINARY INCONTINENCE IN FRAIL OLDER MEN & WOMEN

Active case finding in all frail elderly people

Assess, treat and reassess potentially treatable conditions, including relevant comorbidities and ADLS (see text)
Assess QoL, desire for Rx, goals of Rx, pt & caregiver preferences
Targeted physical examination (cognition, mobility, neurological and digital rectal examination)
Urinalysis
Consider bladder diary or wet checks, especially if nocturia is present
PVR in specific patients (see text)

UI associated with:
- Pain
- Haematuria
- Recurrent symptomatic UTI
- Pelvic mass
- Pelvic irradiation
- Pelvic/LUT surgery
- Prolapse beyond introitus (women)
- Suspected fistula

Clinical diagnosis

* These diagnoses may overlap in various combinations, eg, Mixed UI, DHIC (see text)

Urgency UI*

Significant PVR*

Stress UI*

Other*

Initial management

Lifestyle interventions
Behavioural therapies
consider trial of antimuscarinic drugs

Treat constipation
Review medications
Consider trial of alpha-blocker (men)
Catheter drainage if PVR 200-500 ml, then reassess (see text)

Lifestyle interventions
Behavioural therapies
(See text)

If insufficient improvement, reassess for and treat contributing comorbidity +/- functional impairment

If continued insufficient improvement, or severe associated symptoms are present, consider specialist referral as appropriate per patient preferences and comorbidity (see text)

Wagg et al 2015/2012
Environmental changes and lifestyle measures

• Low tech
  • urinals, commodes
  • Cues to finding the bathroom

• Hi Tech - wetness sensors
  • Can be part of a home wireless sensing system (Gong et al 2015)

• Fluid management
  • 6-8 cups of fluid/24 hours
  • Take most during the day, restrict in evening
Toileting and bowel management

Toileting strategies
• Regular toileting, prompting (cueing), scheduled/timed (Wagg et al 2015/2012)
• Remove barriers to the bathroom
• Make it part of preparation for a pleasurable activity e.g. stop into to the bathroom on the way to watching a favourite tv show (Francis et al 2015)

Bowel management
Lifestyle – Good bowel habits

• Maintain hydration

• Eat a diet with adequate fibre
  • Adults - 21-38 grams of total dietary fibre each day

• Exercise – walking is excellent

• Take advantage of the gastrocolic reflex – eating stimulates movement of the gut and emptying of the bowels
  • After breakfast for many

• Get in the right position to poo
The right position to poo

https://s-media-cache-ak0.pinimg.com/736x/d0/d3/9f/d0d39f2d35511f231859acd9cd5e0fa.jpg
Conservative Management Strategies

Containment products
• Variety of absorbent products available – pads/liners, all in ones, pull up style, male pouches
• Bed/chair protectors
• Pads for bladder leakage are different than menstrual pads!

Local policies re: subsidies

Continence Product Advisor Website
• Not for profit, University of Southampton, UK Research Unit
• http://www.continenceproductadvisor.org/
Case

Minimize anxiety provoking stress
• Decide not to catheterize in clinic (risk/harm)

Initial management - Contact by phone with Case Manager (engage the caregivers)
• staff to assist with a bladder diary (intake and output)
• daytime toileting program (timed toileting, coaching to double void)
• assistance with vaginal estrogen
• treatment for incontinence dermatitis, continence pads, control access to paper towels
• One week follow up to reassess PVR (<200 ml) – some improvement with regular toileting

2 month follow-up
• PVR < 200ml, no “UTI” treatment, contact with Case Manager – reported patient less fixated on UTI (especially on days with diversionary activity), cooperative with toileting (familiar staff)
• Taking her out of the care unit provoked severe anxiety (and family distress too), follow-up with Family Physician who did site visits
What do patients think of specialist continence nurse services?

Little research

Evaluation of nurse-led continence service in the UK (part of the Leicestershire Medical Research Council Incontinence Study

- Qualitative, n= 23 patients who had undergone 8 week treatment with a *Continence Nurse Practitioner*
- Interpersonal as well as technical skills (thoroughness, specialization, knowledge) important to satisfaction

Shaw et al 2000

*Knowledge is key – continence nurses working with frail older adults need both continence and gerontological nursing knowledge*
References


References


