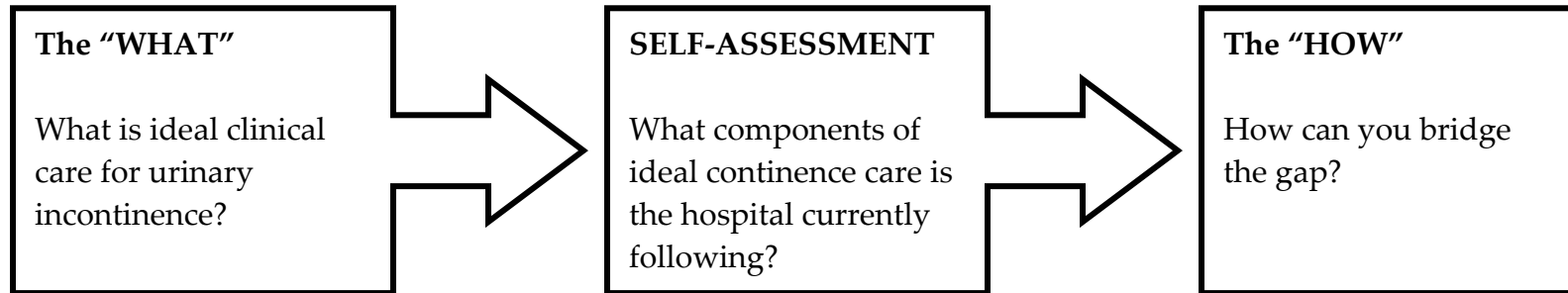
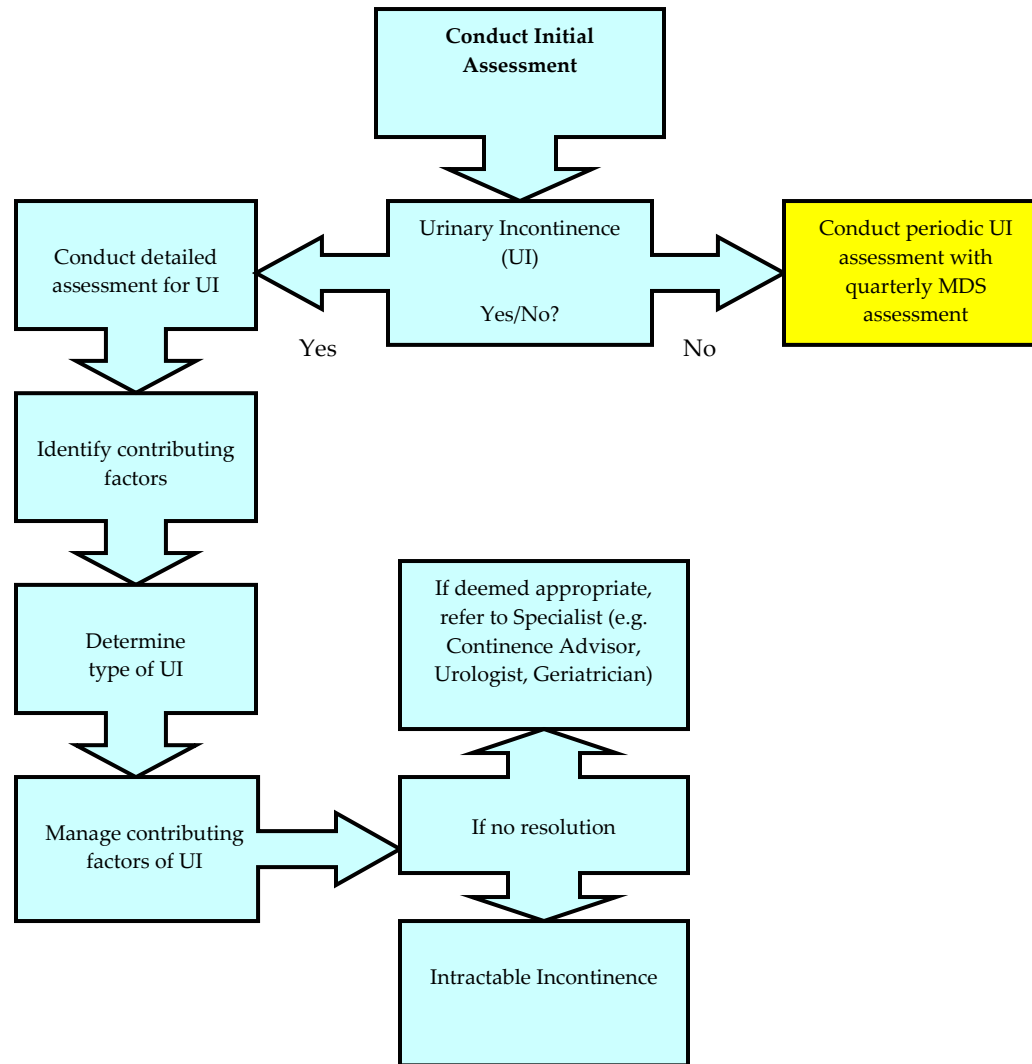


Clinical Model for "IC 5"



The “WHAT”

What is Optimal Continence Care? (details for each component are on the following pages)



The “WHAT” continued

Conduct Initial Assessment	<ul style="list-style-type: none"> • Presence of UI • When person was last continent • Patient’s continence goals
Conduct Detailed Assessment for UI (include patients with catheters)	<ul style="list-style-type: none"> • History of patient’s UI • Presence of delirium (part of MDS assessment) • Type, amount and time of fluid intake • Frequency of BMs • Relevant and related medical or surgical history • Medications • Cognitive awareness of voiding • Environmental barriers (e.g. access to toilet, privacy, toilet height and comfort etc.) • Rule out urinary retention <ul style="list-style-type: none"> • Functional ability • 3-day voiding record to determine pattern of incontinence • Urinalysis and urine culture • In/out catheter to evaluate post-void residual urine • Presence of vaginal prolapse (should be referred to NCA or Physician) • Appropriateness of indwelling catheter, if present (refer to intractable incontinence section for indications for indwelling catheter use) • Patient’s goals and motivation
Identify Contributing Factors	<ul style="list-style-type: none"> • Mobility • Environmental Factors (different from those that might restrict mobility) • Infection • Delirium • Constipation • Fluid Intake (amount, timing and type with attention to caffeine) • Urinary retention • Urinary Tract Infection (UTI) <ul style="list-style-type: none"> • Pharmaceuticals (e.g. meds causing polyuria – diuretics; constipating medications – codeine, iron: retention-causing meds – antidepressants)
Determine type of UI	<ul style="list-style-type: none"> • Assess for type of urinary incontinence: <ol style="list-style-type: none"> a) Transient b) Functional c) Overflow d) Stress or e) Urge

**Manage
Contributing
Factors of UI**

Conservative Management of UI: These strategies should be applied to patients with **any type of incontinence** (global strategies)

- Adjust fluid intake: increase fluid to 1500 to 2000 mL/day; eliminate caffeine; address timing of fluid intake (i.e. consider restriction after 1800 to address nocturia)
- Treat constipation (increased fluid, fibre, exercise, routine, positioning)
- Product selection while working on management strategies: size and fit; absorbent for correct volume; wick moisture away; comfort; patient ease of use (i.e. can pull up and down themselves if toileting); day versus night needs for absorbency.

Plus UI type specific interventions

(a) Transient UI

- Treat constipation
- Treat delirium
- Treat UTI
- Review medications that may impact incontinence (i.e., diuretics, anticholinergics, antidepressants, sedatives etc.)

(b) Functional UI

- Individualized prompted voiding schedule to assess, plan and monitor individual prompted voiding (based on needs and determined by assessment); 3-day voiding record after prompted voiding initiated (use briefs and pay attention to skin integrity if applicable during this process)
- Involve the interdisciplinary team members:
 - i. OT for assistive devices aids – commode, modified/adaptive clothing, cognitive aids (i.e., signage), environmental barriers in bathroom
 - ii. PT for mobility aids/mobility enhancement
 - iii. Speech/Language pathologist for communication strategies/aids (i.e., if patient has aphasia)

(c) Overflow UI

- Evaluate impact of medications
- Liaise with MD for treatment of overflow incontinence with intermittent catheterization or indwelling catheter or suprapubic catheter
- Referral to specialist if overflow related to vaginal prolapse or to check for enlarged prostate

(d) Stress UI

- Consider referral to specialist if related to vaginal prolapse (i.e., pessary or surgery)

(e) Urge UI

- Evaluate impact of medications
- Prompted voiding
- Management of conditions that cause polyuria (i.e., diabetes, CHF)
- If nocturia is related to cardiac status, consider elevating legs above level of the heart for 2 hours/day or compression stockings

<p>No resolution (i.e. actions to be taken after there is no initial resolution to the UI)</p>	<ol style="list-style-type: none"> 1) Refer to one of the following specialist(s): Nurse Continence Advisor, Urologist, Urogynecologist, Geriatrician 2) Intractable Incontinence <ul style="list-style-type: none"> • Refer to “product selection” under conservative management • Catheterization is indicated as a last resort in the following situations: <ol style="list-style-type: none"> a) Urinary retention that is characterized by: persistent overflow incontinence, symptomatic infections, or renal dysfunction; cannot be corrected surgically or medically; patient prefers not to be managed with intermittent catheterization. b) Skin wounds, pressure sores, or irritations that are being contaminated by incontinent urine that cannot be managed with briefs or condom catheters c) Care of terminally ill or severely impaired for whom bed and clothing changes are uncomfortable or disruptive d) Preference of patient when patient has not responded to more specific treatments • Best practice guidelines for intermittent catheterization: <ol style="list-style-type: none"> a) Use <u>Modified Sterile</u> technique (i.e. one sterile glove) • Best practice guidelines to prevent blockage of indwelling catheters: <ol style="list-style-type: none"> a) Use a lubricous or hydrogel catheter. A hydrogel silastic catheter can last up to 3 months. A hydrogel latex catheter requires changing every 2-4 weeks. b) Select the smallest French size (12 or 14) of catheter as possible as the smaller the size, the less irritating it is to the urethra and bladder. c) Inflate the balloon per the manufacturer’s guidelines. Select a catheter with a smaller balloon size (i.e., 10cc) as the larger the size, the more irritating it is to bladder and urethra.
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The “HOW”

How to achieve Optimal Continence Care

Project Team Success Factors

Implementing change at the bedside

- Using decision aids, algorithms and/or reminders for continence care practices and processes that will help to increase the likelihood of implementing the clinical model
- Educating providers on the following:
 - Risk factors for incontinence
 - How to do a proper continence assessment
 - Various approaches to treatment and
 - Optimal use of catheters

Measuring and Monitoring

- Collecting and using baseline data about: patients, resources, existing knowledge, practice, process and outcomes
- Provide and help teams use regular, timely and easy access data on quality improvement initiatives and potentially better practices and clinical processes and outcomes
- Provide senior management timely and useful information on progress and barriers to successful implementation of optimal continence care practices

Corporate Success Factors

Strategic/Organizational

- Positioning continence as a strategic (and improvement) priority for the organization
- Having visible organizational leadership support for continence care
- Making continence care multidisciplinary/team-based
- Providing resources (time, \$) and opportunities for education and training
- Having a central continence advisor and educator with specialist training and knowledge for the organization
- Implementing staffing models and scheduling to promote optimal continence care
- Creating an optimal physical environment (layout, availability of equipment/devices and specific types of products)

Educational

- Providing educational programs that are structured, organized, comprehensive and directed at all levels of providers, patients and families
- Including guidelines as part of active educational and training programs, and using tips from RNAO toolkit to facilitate implementation