Step 1: Conduct a Basic Resident Evaluation

Learn about the benefits of and procedures for conducting this critical first step in managing urinary incontinence in nursing home residents

COMPREHENSIVE ASSESSMENT IDENTIFIES CAUSE OF AND TREATMENT FOR URINARY INCONTINENCE

There are many potential causes of urinary incontinence. Consequently, there are many potential treatments. Determining the first so that you can decide upon the second is the primary goal of a basic resident evaluation, a first step recommended in all best-practice guidelines for managing urinary incontinence.

Though this first step is clearly a cornerstone for effectively managing incontinence, even nursing homes that purportedly provide quality services in this area often fail to follow through with recommended assessment procedures (1). In one study conducted in 30 nursing homes, we found that the staff (and here we include physicians) had obtained targeted histories for most incontinent residents, but had performed comprehensive physical exams for less than 14% of these residents (1). Rarer still were recommended dip stick urinalyses, post-void residual measurements, and 24-hour voiding records.

BENEFITS OF COMPREHENSIVE ASSESSMENT

There may be several reasons for skipping critical assessment tasks, including lack of time, staff inexperience, and unfamiliarity with recommended guidelines, but if you give this first step the attention it deserves, your facility, residents, and staff will reap the benefits:

- Residents with reversible causes of urinary incontinence will get proper treatment, which in turn will help them maintain their independence.
- Staff will be able to better target time-consuming toileting assistance to residents who truly need it.
- And your facility may score better on publicly reported quality measures that reflect the quality of incontinence care.

INDICATORS OF A QUALITY ASSESSMENT

What exactly does a basic resident assessment of urinary incontinence entail? We at the Vanderbilt Center for Quality Aging worked with UCLA colleagues and researchers at RAND, a southern California think tank, to develop a series of quality indicators (QI) related to incontinence care for nursing home residents. Of the nine QIs we generated, three pertain to the assessment process. Presented as a series of if/then statements (so there's no mistaking your obligations), these QIs outline the assessment process:

Urinary Incontinence Assessment Quality Indicators

1. IF a nursing home resident has urinary incontinence on admission or the new onset of urinary incontinence that persists for over one month,

THEN a targeted history should be obtained that documents each of the following:

- **Mental status**
- **Characteristics of voiding**
- **Ability to get to the toilet**
- **Prior treatment for urinary incontinence**
- **Importance of the problem to the residents**

2. IF a nursing home resident has new urinary incontinence that persists for over one month or urinary incontinence on initial assessment,

THEN a targeted physical should be performed that documents:

- **Rectal exam**
- **Skin exam**
- **Genital system exam (including a pelvic exam for women)**

3. IF a nursing home resident has new urinary incontinence that persists for over one month or urinary incontinence on initial assessment,

THEN the following tests should be obtained or there should be documentation explaining why the test was not completed:

- **Dipstick urinalysis**
- **Post-void residual**
- **24-hour voiding record**

It should be noted that these QIs are not, technically speaking, practice guidelines, though they are based closely on existing guidelines. Practice guidelines, such as those available from the American Medical Directors Association, "aim to define optimal or ideal care in the context of complex decision-making," writes RAND. In most nursing homes, however, optimal care is virtually synonymous with impossible care; it simply cannot—and almost certainly will not—be implemented under usual conditions. So with a nod to real life, the QIs lower the bar. Explains RAND: They "set a minimal standard for acceptable care—standards that, if not met, almost ensure that the care is of poor quality (emphasis is ours)."

Based on expert opinion and existing best-practice guidelines, all of our QI-associated assessment tasks are *both* related to positive outcomes for residents *and* feasible for nursing home staff to implement.

TREATMENTS FOR URINARY INCONTINENCE

Depending on the outcomes of the basic evaluation, four broad types of treatment and several combinations of treatments may be justified. These include:

Treatments for Urinary Incontinence

Drug Therapy

Surgery

- **Bladder neck suspension and repair of the pelvic prolapse for women with stress incontinence**
- **Insertion of artificial urinary sphincters**
- **Removal of anatomical obstructions**

Behavioral Interventions

- **Bladder retraining**
- **Pelvic muscle rehabilitation (Kegel exercises)**
- **Biofeedback**
- **Vaginal weights to strengthen pelvic muscles**
- **Toileting assistance protocols, including prompted voiding**

Other interventions

- **Electrical stimulation**
- **Intermittent catheterization**
- **Chronic indwelling catheters**
- **Intravaginal supportive devices (e.g., pessary)**

Although there are few comprehensive studies on the prevalence of incontinence treatment strategies for nursing home residents, existing data suggests that indwelling urethral catheters are used by 4% to 12% of residents (2) and medications by 3% to 10% (3—unpublished data from the pharmaceutical industry), with the remaining majority using diapers with some form of toileting assistance. As a general rule, incontinent nursing home residents are considered poor candidates for the other behavioral interventions largely because most of them have cognitive impairments that prevent them from following complex instructions (3).

MANAGEMENT OPTIONS FOR CHRONICALLY INCONTINENT RESIDENTS

Now is the time to mention the next incontinence QI in our series of nine:

- **IF a nursing home resident remains incontinent after transient causes are treated,**
- **THEN the resident should be placed on a 3-day toileting assistance trial to assess responsiveness to prompted voiding.**

While some residents may improve continence through other treatments, the vast majority, because of their cognitive and physical impairments, will need some type of staff assistance to stay dry. Of the staff management options currently available—prompted voiding, scheduled toileting, habit training, and use of incontinence briefs—only prompted voiding has been shown in a controlled trial—the gold standard for research studies—to significantly improve continence. And the only way to reliably identify the 40% to 60% of incontinent residents who respond well to prompted voiding is to offer all otherwise untreated incontinent residents a trial run of the intervention (4). The *next step* presents procedures for this run-in trial.

REFERENCES

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