

Giving Voice to Quality

*The National Citizens' Coalition for Nursing Home Reform consumer education project;
Funded by the Retirement Research Foundation*

**FOLLOW-UP CALL #6 IN OUR SERIES:
“Incontinence and Quality Care”
THURSDAY, NOVEMBER 30, 2006 – 3PM (ET) [2PM CT / 1PM MT / 12PM PT]**

EDUCATIONAL CONFERENCE CALL MINUTES

Welcome & Project Overview

- This call series, on issues of quality in nursing homes, has been funded by the Retirement Research Foundation. The project began centered around the concept that while staff and professionals have access to information about nursing home quality care issues, family and residents often do not.
- This project is helping to educate people by tapping into a national pool of experts. It is helping to inform families and residents on how to improve the quality of life and care in nursing homes they (or their family members) are in.
- The calls have been successful. For example, we have seen people make connections across the country with others whom have similar questions and issues. People are beginning to understand that they are not alone, and what type of progress is possible, and is being made on issues.
- If you have not received a packet of materials for this call, please call us at: 202-332-2275.

Introduction of Robyn Grant, Conference Call Special Facilitator

Conference Call Overview – Robyn Grant

- The title of this call is “Incontinence and Quality Care.”
- I want to take a moment now to go over the agenda and logistics of the call:
 - Following a brief reminder/introduction of the speaker we have available on the call, Annemarie Dowling-Castronovo will spend a few minutes sharing with us some specific case examples and the measures taken to improve residents’ incontinence status.
 - Following Annemarie’s presentation, we will entertain questions and stories from those of you on the line.
 - Your line is muted. When we open the call for questions and comments, the operator will tell you what to do.
 - We only have 60 minutes, so we ask that folks please be as brief as possible with their questions.
- Web site: www.nccnhr.org/consumervoice - all information resources for this call series are available at this website.

Speaker Introduction (Annemarie Dowling-Castronovo, PhD(c), RN, Adjunct Faculty at The College of Staten Island, and College of Nursing, NYU, Nurse consultant, and Doctoral Candidate at Rutgers)

Expert Speaker Presentation: Annemarie Dowling-Castronovo, PhD(c), RN

- It makes a huge difference when there is a continence specialist available at a

home.

- Review: Barriers: workload issues, communication among team members, and among residents and family members.
 - There was a question in the previous session about an 8 hour diaper. I researched this, and I do not know of it's existence. Individualization appears on absorbent product website – and indicates that the time you can leave a product on an individual depends on that individual.
 - Discussion of specific case examples and the measures taken to improve residents' incontinence status:
 - Specific Case Example: Francis, who was on the report log for being aggressive to staff. She had history of dementia or Alzheimer's type, and was in a wheelchair. Francis used a toilet and adult briefs, and only occasionally had accidents in the diapers. Her incontinence was managed to the best that it could be. When the problem became known as a problem to the staff, it came to my attention.
 - Prior to the episode, Francis had a poor appetite, and more wet diapers than usual (increase in urine incontinence).
 - Francis had a UTI
 - 3-4 months later, Francis started to exhibit poor appetite and increased leakage again – the staff notified me of the change in status – we were able to treat her and avoid another hospital visit.
- You need to see if something else is causing urinary issues.
- Specific Case Example: Mary, who had dementia, Diabetes, and Heart Disease. She only wore diapers at night, occasionally leaked, and wore underwear during the day. Mary was on a toileting schedule. I noticed that after lunch and sometimes before, she would be toileted, but ½ an hour after the lunch toileting she would yell to go to the bathroom, and the staff would say that they just had just taken her.
 - I took to the bathroom again, and noticed that she would go to the bathroom, but not very much. I decided that the assessment piece was critical. I needed to look at her abdomen, and determine how much urine was left in her bladder after she went to the bathroom. I found that she had a lot left in her bladder after she went to the bathroom. Diabetes is not just a sugar problem –it also affects how nerves transmit messages to the brain. Mary was unable to empty her bladder all the way, and she leaked. The treatment: a catheter schedule to reduce the feeling of bladder pressure.
- Urinary incontinence is marker of increased frailty.
 - My Mother has Alzheimer's. She fell down steps, fractured her hip, and had to go to hospital. I advocated for as quick a removal as possible of catheters, as they irritate and cause problems with continence status after they are taken out, and they can cause UTIs. After the catheter was taken out, a diaper was put on. People should not assume that just because someone has gray hair, that they need a diaper. My Mother had diarrhea due to the antibiotics. I didn't want my Mother to have a diaper – I was afraid that she wouldn't go back to using the toilet. But my Mother wanted the diaper, to be decent. There is a place for absorbent

products. Luckily, there was a one-on-one companion hired. There needs to be a mindset shift to educate healthcare staff. My Mother's diarrhea should have been managed not by using an anti-diarrheal, but specific antibiotics.

- You need to know how to work the chain of command. Medication nurse → charge nurse → physician → Administrator on call. Even when you have the knowledge, you still have to educate up the chain of command.
- Once my Mother was discharged, I wrote a 2 page letter to the administrator, cc'ing it to an eldercare attorney and the homecare agency that provided the 24 hour coverage. The letter wasn't all about complaining. It noted the exceptional nursing assistance and the exceptional care that was beyond the culture of the facility. I celebrated that work.
- I did my Mother's laundry, which allowed me to monitor how her incontinence status was worsening or improving without stepping on anyone's toes.

Participant Question and Answers

Q Have you ever come across instances of residents using incontinence as an attention-seeking device?

A You need someone qualified to come in and look at it individually and see the meaning, why the attention seeking behavior is occurring. It needs to be looked at as an individual case.

Q I worked with staff to develop a behavior change intervention. We used treats for each shift that the resident was not incontinent, and did ask to go to the bathroom. She responded very well - in a month to 6 weeks. We treated other behaviors the same way with the behavior modification. Staff did a great job – had to keep watching her, and keeping track, etc.

A That's a great thing to celebrate. What was the relationship between the nursing assistants and the professional staff?

Q I worked with the CNAs and nursing staff. We dealt with problems when they came up, developed a behavior modification program.

A Highlight the workload and team dynamics, and your role in breaking the status quo, and working with staff and implementing different strategies. You don't always need to be an incontinence expert.

Q Regarding the example you gave earlier of the resident, Francis – was there a connection between her “abusiveness” and her incontinence and UTI?

A Yes, when older adults have an infectious process, they don't respond like younger adults do. They often have a mental status change, that can come out as aggression, or become more sleepy, less talkative, etc. Changes are cause for a medical workup and an assessment and evaluation. Leaking urine can be a sign of a UTI in an adult. Sometimes the staff doesn't have the necessary knowledge to know what to report to the “expert.”

Q Without substantial do-it-yourself background or medical training, hardly anyone can do the extent of oversight that you've been describing. What are some extremely basic tips of how to proceed given that most people wouldn't be able to do what you can, especially if they are trying to look after someone they don't have any authority over (i.e.: no power of attorney)?

A This is an issue beyond just residents. It's about being a patient anywhere. Most people tend to take things as they are delivered by powers of authority.

- Q** If we don't know what we don't know, how do we know what to ask? We are not in a position to give more education and information than the person providing the care.
- A** For the regular person, the questions are: is this person incontinent? Is it old or new? (did they enter the facility with it?) What type of incontinence is it? Has anything been tried to restore their continence? Has it been successful?
This puts most healthcare providers on the spot. People now have a heightened awareness of incontinence just from this call. This doesn't mean that we can make every resident dry.
- Q** We need to have a handy decision tree like under the CAG toolkit.
- A** I will look for a consumer friendly decision-tree.
- Q** My Mother is a resident in a long-term care facility. She is incontinent, but goes to the bathroom some. Sometimes when she's in bed and has to go to the bathroom, they tell her to just go in her diaper if they don't want to get her out of bed and into the bathroom. This bothers me. Where do I start in the chain of command?
- A** There is a formal and informal chain of command. To understand, you usually have to spend time on the unit to understand the culture. Find out what your Mother's relationship is with the nursing assistant. One of the biggest fears is retaliation. I agree - I think it is unacceptable to tell someone to just use a diaper. If you don't know of an individual, call a team meeting and express this concern.
- Q** I thought about having a team meeting, but I wasn't sure if I should start there or with the nurse who gives her care.
- A** Check for the charge nurse or the social worker to get the team meeting together. Sometimes the nursing assistant is more receptive than the charge professional nurse.
- A** Be careful to do it in a positive way. Most staff, if I blow my lid and then apologize later, will couch my behavior in the concerned family member role that it comes from.
- Q** I spent time in a hospital with a catheter. You need to consider that some people have latex allergies. And if so, they can be ulcerated inside and out. You also need to be aware of impaction – this can alter mental status and staff may not notice.
- A** If you feel that you know that resident the best, a change in mental status is key.
- Q** I developed a Stage 4 bedsore on my hip – from not being able to get to the bathroom and not being clean.
- Q** Can you talk about C-dif?
- A** C-dif is short for c-dif–bacteria that is in intestines. When people are on antibiotics, that bacteria can get wiped out. They then can get profuse diarrhea which can cause dehydration and be debilitating. Signs: Copious amounts of diarrhea with a distinct odor to it. Don't give the anti-diarrheal because it can lead to further damage. Let the diarrhea run its course, and there are specific antibiotics prescribed for this. You need to wash hands well because it is easily transmitted. Someone with C-dif might need to be isolated so as not to share commodes, etc.
- Q** You had spoken about a champion. Who would you recommend that person be, in a typical nursing home?
- A** Ideally, someone who wants to do it. It would be good if it was a professional staff, or maybe train one person to be a continence nurse for the facility as a resource person. Get someone to learn about basic evaluations.... It doesn't always have to be a continence expert. There seems to be trends of people going to incontinence

seminars to learn more – it's on the radar screen in a new way.

Q What are the signs of a UTI in an older adult?

A Change in mental status, increased confusion, agitated, violent, more quiet, abdominal discomfort or pain, fever, changes in lab values, change in odor, change in appetite.

Q 315 survey tag – I am not familiar with this tag. Is this CMS?

A Yes, it's CMS. Might be on CMS website. Looks at what surveyors should be coming in and looking for regarding evidence based assessment and management for residents with incontinence. Are specific triggers that they look for. Get in touch with your MDS person and see if they have the information.

A The interpretive guidelines that go with the F-tag are online. Will email the link to Jessica to put on the NCCNHR website.

Announcements

- Action Steps – We want to challenge all of you, the participants, to get involved in your own or your loved ones' incontinence and quality care issues.
- We look forward to hearing from you on the follow-up call so that we can celebrate together, and make additional suggestions as necessary.

Closing, Wrap up

- Thank you to Annemarie, Robyn, and all of you who have participated in this call.
- Please, if you have not already done so, fill out an evaluation form about this sixth call, and return it to us at NCCNHR.
- This is the last educational conference call. We have been thrilled with the turnout, the great content presented by our experts and our best practice providers, and by the terrific questions and input from our call participants.