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CNA TRAINING ADVISOR From HCPro

Incontinence

Contrary to popular belief, incontinence—the loss of bladder or bowel control—is not normal. Although the likelihood of incontinence increases as an individual gets older, it is not a regular part of aging.

In younger residents, incontinence is often the result of a single factor. In older residents, incontinence commonly involves more than one cause. Often, **scheduled toileting, prompted voiding,** or **habit training** methods can be used to manage the causes and reduce incontinence episodes.

Residents who experience **urinary or bowel incontinence** are not at fault. Incontinence is not a sign of laziness or carelessness. Afflicted residents suffer from a health problem that, like other disorders, is caused by certain ailments and can be managed with the use of specific treatments. A complete understanding of the condition will allow CNAs to provide the highest level of care to incontinent residents.

Have a good day of training, and stay tuned for next month's issue of **CNA Training Advisor,** which will cover interacting with difficult families.

PROGRAM PREP

Program time

Approximately 30 minutes

Learning objectives

Participants in this activity will learn how to:

- Provide incontinent residents with the highest possible level of care
- Identify the common causes of urinary and bowel incontinence
- Recognize the types of urinary incontinence

Preparation

- Review the material on pp. 2–4
- Duplicate the **CNA Professor** insert for participants
- Gather equipment for participants (e.g., an attendance sheet, pencils, etc.)

Method

1. Place a copy of **CNA Professor** and a pencil at each participant's seat
2. Conduct the questionnaire as a pretest or, if participants' reading skills are limited, as an oral posttest
3. Present the program material
4. Review the questionnaire

Share your techniques for care

CNAs can learn a lot about caring for incontinent residents by sharing their experiences. Encourage your CNAs to describe the care techniques they've found to be most effective. You may need to remind CNAs that the goal of the exercise is to help others and improve care, not to share stories that may compromise residents' dignity.

Tips and tools for CNA training

Looking for more information about CNA training? Sign up to receive the **LTC Nursing Assistant Trainer,** a free biweekly e-newsletter that addresses all of your training needs. The **LTC Nursing Assistant Trainer** provides training tips on nursing measures, best practices, and other crucial aspects of job training for CNAs. This free e-newsletter gives you valuable information and tools to help you conduct efficient, innovative training for every CNA in your facility.

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INCONTINENCE

Residents who cannot control when or where they urinate suffer from urinary incontinence (UI). There are ways to improve this condition, but it is important to know what the cause is so residents can receive proper care and treatment. Potential causes of UI include the following:

- Urinary tract infections
- Confusion and forgetfulness
- Muscle weakness
- Vaginal problems (women)
- Prostate problems (men)
- Medication reactions
- Problems with clothing
- Trouble getting to the bathroom
- Constipation

A resident who wets the bed, leaks urine on the way to the bathroom, or has to use protective pads or padded briefs is suffering from UI. If you notice a resident, a bed, or a room that has urine stains or a urine odor, then you know the resident needs help with this condition. You probably don't know which kind of UI the resident has, but you can often determine this by watching him or her closely and keeping track of the resident's urinating habits in a bladder record.

Residents may experience more than one type of UI at a time. The following list includes some of the more common UI types:

- **Functional incontinence** refers to loss of urine in residents whose urinary tract function is sufficiently intact. These residents are unable to maintain continence because of external factors (e.g., inability to utilize the toilet facilities in time).
- **Overflow incontinence** is associated with leakage of small amounts of urine when the bladder reaches its maximum capacity and becomes distended.
- **Stress incontinence** is associated with impaired urethral closure (malfunction of the urethral sphincter), which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is increased by events such as sneezing, coughing, laughing, lifting, standing from a sitting position, or climbing stairs.
- **Transient incontinence** refers to temporary episodes of UI that are reversible once the cause of the episodes is identified.
- **Urge incontinence** (overactive bladder) is associated with detrusor muscle overactivity (excessive contraction of the smooth muscle in the wall of the urinary bladder resulting in a sudden, strong urge to expel moderate to large amounts of urine before the bladder is full).
- **Mixed incontinence** is the combination of stress incontinence and urge incontinence.

Caring for residents with urinary incontinence

CNAs' first responsibility is to report UI to their supervisor, the facility nurse, or the resident's doctor. Observations about the resident (e.g., the bladder record) will help the doctor or nurse determine the cause and UI type. A care plan can then be developed that will include at least one of the following UI treatments:

- Behavioral treatments
- Medicine
- Surgery

Behavioral treatments help residents control their urine and use the toilet at the right time. They work well for residents who have problems getting to the bathroom or are not able to tell you when they need to urinate. There are three types of behavioral treatments for UI with which a CNA can assist:

1. **Scheduled toileting.** Use scheduled toileting for residents who can't get out of bed or reach the bathroom alone. Assist the resident to the bathroom every two to four hours on a regular schedule. A nurse should individualize each scheduled toileting program to best suit the resident's needs.

2. **Prompted voiding.** Use prompted voiding for residents who know they have a full bladder but do not ask to go to the bathroom. Check these residents often for wetness, ask them whether they want to use the toilet, and then help them to the toilet. Compliment these residents for being dry and then say you will come back to take them to the bathroom again.
3. **Habit training.** Use habit training for residents who tend to urinate at about the same time every day. Watch the resident to determine what times he or she urinates and keep a bladder record. Take the resident to the bathroom at those times every day and compliment him or her for being dry and using the toilet.

Keep the following in mind for any behavioral treatment:

- Be patient. These things take time.
- Treat the resident as an adult.
- Answer call bells as soon as possible.
- Do not rush the resident.
- Give the resident plenty of time to empty his or her bladder.
- Give privacy by closing the door, even if you must stay in the bathroom.
- Never yell or become angry with the resident if he or she is wet. Say, "You can try again next time."
- Respect the resident's dignity and confidentiality at all times.

There are many other ways to help residents with UI. Pelvic exercises, also known as Kegel exercises, make muscles around the bladder stronger and help with UI.

To perform Kegel exercises, a person tightens his or her pelvic muscles, which start and stop the flow of urine. Residents can squeeze the muscles tightly for a few seconds and then release them, up to 10 times in one sitting, four times every day. Then whenever the resident feels that urine might leak, he or she tightens those muscles and prevents urine from leaking. Kegel exercises should not be done during urination.

Residents who can't get out of bed or to the bathroom for some reason may need to use a bedpan, urinal, or bedside commode. If needed, these articles should be kept by the bed. Also, if a resident uses a wheelchair, walker, or cane to get to the bathroom, keep that item near the bed as well. Make sure the bathroom is clear and well-lit.

Encourage residents to wear clothes that are easy to remove and that have simple fasteners. If a resident needs to wear special pads or clothing to help keep his or her skin dry, you should change these often. Use soft pads and clothing, keep them wrinkle-free, and use protective skin creams if allowed. Remember that wet skin can develop sores and rashes.

Some residents need to use a urinary catheter, which is a tube inserted into the bladder by a doctor or nurse that drains urine into a

Constipation and fecal impaction

According to the *RAI User's Manual* for the MDS 3.0, a resident suffers from constipation if he or she has two or fewer bowel movements during the seven-day look-back period, or if for most bowel movements (regardless of frequency) the stool is hard and difficult for the resident to pass. Constipation is also described by a sense of bloating or intestinal fullness, a decrease in the amount of stool, the need to strain to have a bowel movement, or the need to use laxatives, suppositories, or enemas to maintain regular bowel movements.

The most common causes of constipation include:

- Inadequate fiber or fluid intake
- Inactivity or a sedentary lifestyle
- Change in routine
- Abnormal growths or diseases
- Damaged or injured muscles, sometimes caused by repeatedly ignoring the urge to go
- Medication side effects and laxative abuse

Dietary management for bowel incontinence and constipation

The average American consumes 10–15 grams of fiber per day. The amount of fiber recommended for good bowel function is 25–30 grams of fiber per day, plus 60–80 ounces of fluid. Most people can successfully treat their bowel irregularities by adding high-fiber foods to their diet along with increasing their fluid intake to desired levels. Fruits and beans are good sources—they contain higher amounts of dietary fiber than white breads and rice. Increase dietary fiber slowly to give the bowel time to adjust.

Bear in mind that certain foods cause some people to experience constipation or diarrhea. Dairy products such as milk and cheese, wheat products such as bread, and foods containing chocolate are some of the more common problem foods. A physician should evaluate any resident who seems to have particular food sensitivities.

Fecal impaction

According to the *RAI User's Manual* for the MDS 3.0, a fecal impaction is a large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, which is often a sign of a fecal impaction.

bag. Sometimes men use an external catheter that fits over the penis. Catheters can cause infections, and if external catheters are too tight, they can be harmful. Be sure to check catheters often. They are not recommended for most incontinence problems.

Certain medications have proven to be beneficial for treating UI. Some relax the bladder so it can fill without experiencing the contractions that cause voiding. Other medications assist the sphincter muscle and urethra to work better to control the flow of urine.

Hormones may be useful in situations in which incontinence is due to the drying of the urethral tissue. This type of tissue drying frequently occurs during menopause.

Some medications have side effects that may limit their use by people with other health problems. CNAs should be alert to these possible side effects and tell a nurse if they notice any of them.

If noninvasive types of treatment are not found to be appropriate after a thorough assessment, a physician may recommend surgery. The type of surgery performed depends on the cause of the incontinence. For example, in women, surgery may alter the position of the bladder. In men, surgery may remove part of the prostate gland.

Although there is no dietary treatment for UI, some foods and drinks can irritate the bladder, such as sugar, chocolate, citrus fruits (e.g., oranges, grapefruits, lemons, and limes), alcohol, grape juice, and caffeinated drinks (e.g., coffee, tea, and cola). Residents with UI can try eliminating these foods and beverages from their diets and see whether their condition improves.

Caring for residents with bowel incontinence

Residents who cannot control when and where they pass gas or stool suffer from bowel incontinence (BI). There are things that can be done to improve this condition, but it is important to know what the cause is.

Some of the most common causes of bowel incontinence include:

- Incorrect diet or fluid intake
- Confusion and forgetfulness
- Muscle injury or weakness of the anal muscles
- Nerve injury
- Medication reactions or laxative abuse
- Trouble getting to the bathroom
- Constipation or fecal impaction
- Diarrhea

As is the case with UI, CNAs should report episodes of BI to their supervisor, the facility nurse, or the resident's doctor. Treatments for BI include:

- Medicine
- Surgery
- Dietary management
- Bowel management and retraining
- Biofeedback

Two of the aforementioned treatments—dietary management and bowel retraining—involve care that CNAs can provide. Both of these treatments are also used to help residents suffering from constipation. For information about dietary management, see the sidebar on p. 3.

Bowel retraining is executed by designating a specific time each day for a bowel movement. Maintain a record of the resident's bowel habits, just as you would a bladder record. If a pattern develops, you can use that pattern to set up a habit regimen that will reinforce a scheduled time each day for the resident to have a bowel movement. Help the resident stick with this schedule, even when he or she does not feel the need to go. Over time, the body will develop a habit that conforms to the scheduled routine.

The Kegel exercises used to prevent UI can be slightly modified to strengthen the anal muscles that control the outflow of stool. To perform these exercises, the person tightens the muscles around the rectum. He or she squeezes the muscles tightly for a few seconds and then releases them, up to 10 times in one sitting, four times every day. ■

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CNA PROFESSOR From HCPro

INCONTINENCE

Mark the correct response.

Name: Date:

1. Which of the following is not a potential cause of urinary incontinence (UI) for a female resident?
   a. Urinary tract infection
   b. Prostate problems
   c. Medication reactions
   d. Problems with clothing

2. Residents may experience more than one type of UI at a time.
   a. True
   b. False

3. _____ incontinence is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and becomes distended.
   a. Functional
   b. Overflow
   c. Stress
   d. Transient

4. Mixed incontinence is the combination of functional incontinence and urge incontinence.
   a. True
   b. False

5. Prompted voiding, which is a type of UI behavioral treatment, should be used with residents who know they have a full bladder but do not ask to use the bathroom.
   a. True
   b. False

6. _____ works best with residents who tend to urinate at about the same time every day.
   a. Medication
   b. Scheduled toileting
   c. Prompted voiding
   d. Habit training

7. Which of the following foods and drinks has been found to irritate the bladder?
   a. Walnuts
   b. Milk
   c. Lemons
   d. Apple juice

8. Which of the following is not a common cause of bowel incontinence (BI)?
   a. Muscle injury or weakness of the anal muscles
   b. Medication reactions or laxative abuse
   c. Constipation or fecal impaction
   d. Anxiety or depression

9. A _____ is a large mass of dry, hard stool that can develop in the rectum due to chronic constipation.
   a. high bowel
   b. fecal blockage
   c. fecal impaction
   d. low bowel

10. Of the five main treatments for BI, two involve care that CNAs can provide. One of those treatments is _____.
   a. medicine
   b. surgery
   c. dietary management
   d. biofeedback