INCONTINENCE PRACTICES IN GERIATRIC REHABILITATION: NURSING ASSESSMENT AND MANAGEMENT

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AIMS OF THE STUDY

Urinary and double (urinary and fecal) incontinence are frequently encountered by nurses on rehabilitation units for older persons [1]. Rehabilitation focuses on the restoration and maintenance of function for the individual to maximize independence and return to the community. Research on continence care in geriatric rehabilitation is scant and what exists suggests limited systematic assessment and management [1], with a reliance on containment rather than proactive management [2].

Study aim: To explore nursing staffs' experience and perspectives of continence assessment and management in geriatric inpatient rehabilitation.

STUDY DESIGN

Design: An exploratory, qualitative design

Participant and setting: Staff on two geriatric rehabilitation units in a rehabilitation hospital. Purposive sampling was used to recruit staff for individual interviews.

Data collection: Written informed consent was obtained. A semi-structured interview guide with open-ended questions focused on the process of continence assessment and management. Interviews digitally recorded and transcribed verbatim.

Data analysis: Content analysis [3] involved two researchers independently coding an initial interview then developing the coding framework. A team of three researchers reviewed the coded interview and framework, then coded subsequent interviews, adding additional codes as agreed upon. Codes and categories were collapsed to themes.

RESULTS

Ten nursing team members from two units (3 Registered Nurses, 4 Licensed Practical Nurses and 3 Care Aides) participated. Eight were female, two male. Ages ranged from 27-63, years of practice 3-39, with rehabilitation experience from 2 months to 23 years.

Themes	Categories and Exemplars
Getting to know the patient. Nurses used transfer notes and information from patients to understand continence concerns. Assessment involved some standard practices and was ongoing.	**Initial Assessment** "…asking whether or not patients are able to get to the toilet or not, on their own. Whether or not they use continence products. And, you know, if they have some kind of incontinence and why." (Staff 3) **Standard Practices** "The doctor usually orders for every new patient…bladder scans daily for three days… So that's just a regular order. The standard order for everyone that's admitted" (Staff 1) **Ongoing Assessment** "So I ask if they always make it to the bathroom or not. And then if they are up often in the night and if they have frequency- so I ask a series of questions." (Staff 6)
Working together: communication Nurses worked with patients and the interprofessional team. They saw themselves as key in recording and passing information along.	**Patients** "I would talk to the patient to find out what- where they're at with it. Whether or not they realize when they are being incontinent or not, if there is a time of day when they need help" (Staff 3) **Nursing Team** "I guess the communication you could say "I just toileted that patient"…..passing it along… I know people will pass along that patient was incontinent or not incontinent." (Staff 8) **Interprofessional Team** "We have team conferences where the doctor will sit with the interprofessional team and will discuss every part from pain to bowels to peeing..." (Staff 6)
What works and what doesn't work Effective and ineffective strategies and interpersonal interactions such as coaxing to address incontinence, emphasizing practicality.	**Hands on care** "…we kind of toilet them every 2,3,4 hours when - during the day when they are awake. So that kind of actually helps a lot." (Staff 5) "…if the patient doesn't know what is going on or where they are, that can create barriers…"(Staff 10) **Interpersonal interactions** "Some people don't want to wear incontinent products…they don't want to accept that they are incontinent... you have to push them differently and explain to them this is not something to make you feel bad. This will help you" (Staff 1) **Being practical** "… and for them it's practical solutions like, you know, going regularly and everything" (Staff 3)
Rehab is a repair shop Rehabilitation as a unique setting emphasizing independence, with incontinence a potential discharge barrier. Nurses had to work around routines and jjuggle demands.	**Incontinence is important** "… it's pretty big because if someone is incontinent ….. maybe better train their bladder to be able to hold it and for them to go to the bathroom routinely, then that's better for them when they do go home " (Staff 4) **Rehab is different** "We're the repair shop. We try to prevent. We try to improve. I think that's how geriatrics- to me- that's how it works, when it comes to continence and ambulation." (Staff 1) **Falling through the cracks** "…patients fall through the cracks. if you're not there every time when they have to go, it's easy to not see it and sometimes we don't find out that it's an issue until we're in the bathroom with somebody else and we're changing the garbage and we see that's there 4 or 5 or 6 pads in there" (Staff 2)

INTERPRETATION OF RESULTS

Nursing staff used transfer information and asked patients questions about their continence status at admission and throughout hospitalization. Some limited physical assessment and bladder diary information was included. Initial assessment took up to a week and included routine physician orders for bladder scans, and bladder/bowel diaries. Patients were often asked the same questions by different team members. Assessment information was used to create and update an individualized continence care plan with nurses seeing themselves as key in gathering information, recording and passing information along to others. including at weekly interprofessional conferences. Communication gaps existed when passing information verbally.

Regular toileting was the most useful and practical strategy. Other strategies included: having the right containment products, occasional use of condom or indwelling catheters, humour, coaxing, getting patients to call for assistance, and ensuring privacy and dignity. The hospital continence service provided support. Assisting cognitively impaired patients was seen as the most challenging. Nurses sought practical approaches to assist patients to gain independence, viewing the rehabilitation mission as improving continence, mobility and skin integrity. They perceived hands on continence care as being left to nursing; patients were brought back from rehab sessions if they needed to use toilet. Nurses worked around this by trying to toilet patients. Sometimes being proactive wasn't possible as they juggled meeting continence needs with other demands on their time.

CONCLUDING MESSAGE

In contrast to earlier studies, nurses described actively trying to toilet patients, with containment a secondary strategy. In spite of some standard assessment practices in physician orders, overall assessment and management were not standardized, with some information lost. Nursing professionals need to develop systematic approaches to continence care that engage patients and the interprofessional team.

ETHICS, FUNDING AND REFERENCES

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