GUIDE

NATIONAL INSTITUTE *for* MEDICAL RESPITE CARE

Clinical Guidelines for Medical Respite/ Recuperative Care

Incontinence

JULY 2021

Introduction

Incontinence affects almost half of the population of older adults in the U.S., with 1/4 of adults experiencing moderate, severe, or very severe urinary leakage (1). Adults experiencing homelessness have demonstrated similar rates of incontinence but have been found to experience these symptoms on average 10 years earlier than the general population (2). Incontinence increases social stigma and isolation and is a leading cause of falls for adults experiencing homelessness (3). Although incontinence is often perceived as a behavioral issue, there are many physiological, medical, and environmental factors leading to incontinence, many of which are occur at greater rates for people experiencing homelessness. Incontinence is a condition that can be treated and managed, and medical respite/ recuperative care presents an opportunity to address this prevalent health need.

KEY TERMS & DEFINITIONS

Incontinence is any non-intended loss of urine or stool. The loss may be large or small quality.

Incontinence Management is the ability to respond to the existence of incontinence.

There are several types of incontinence, including:

Stress Incontinence: Involuntary loss of urine, may result in leakage of small amounts during physical movement.

Urge Incontinence: Involuntary loss of urine associated with a strong desire to void. May result in leakage of large amounts of urine at unexpected times.

Mixed Incontinence: Combination of urge and stress urinary incontinence.

Overflow Incontinence: Any voluntary loss of urine associated with overdistension of the bladder.

Functional incontinence: Urinary leakage associated with inability to toilet because of impairments of cognitive or physical functioning, psychological functioning, or environmental barriers.

Clinical Considerations

CAUSES OF INCONTINENCE

Incontinence may be caused by:

- Medical conditions such as diabetes, neurological conditions, pelvic injury, or infections.
- Medication and side effects that change urinary frequency and retention.
- Physical limitations such as decreased mobility or posture.
- Mental health symptoms such as anxiety or alcohol use.
- Trauma, both recent and a history of, especially physical or sexual trauma.
- Cognitive impairment, both temporary and long-term.

Additionally, the environment of homelessness can cause or exacerbate incontinence due to:

- Lack of nutrition and fiber in a person's diet.
- Dehydration.
- Lack of consistent access to bathrooms/toilets.
- Having to hold bladder for extended periods of time.
- Not enough time to effectively void the bladder.
- Lack of access to and cost of incontinence maintenance supplies.

ASSESSMENT

In all assessment processes, it is important to implement a trauma-informed approach and ensure privacy in assessment and discussions.

Motivational Interviewing can be used to assess the person's priorities and concerns regarding incontinence and identify current barriers or supports needed.

History and Physical to identify underlying or co-occurring health issues that may cause incontinence and order initial indicated testing. H&P should also include questions regarding frequency, timing, amount, and history of incontinence.

International Consultation on Incontinence Questionnaire addresses lower urinary tract dysfunction, vaginal symptoms, and lower bowel function, and also assesses quality of life.

8-Item Overactive Bladder Questionnaire is a patient reported outcome questionnaire used specifically for overactive bladder and symptom bother.

Functional Performance-Based Assessment to identify related factors influencing incontinence management, such as habits/routines, ADL, and environmental barriers.

Recommended Strategies

PERSON-SPECIFIC STRATEGIES

- Identify medications potentially contributing to incontinence.
- Use a bladder diary to track episodes and frequency of incontinence, and potential food or activity triggers.
- Set a toileting schedule to prompt the person to use the bathroom prior to experiencing urge.
- Set routines for fluid intake, meals, and medications.
- Increase awareness of urge.
- Delay urge.
- Encourage double voiding.
- Support person in accessing needed continence supplies that are appropriately sized and fit.
- Identify potential food triggers using a bladder irritants checklist.
- Encourage hydration and consumption of high fiber foods.

ENVIRONMENTAL STRATEGIES

- Ensure bathroom facilities are easily available throughout the day.
- Ensure facilities have adequate supplies and privacy for disposing of continence products.
- Ensure access to laundry facilities and supplies to clean clothing.
- Position the person's bed or sleeping space nearby a bathroom.
- Have at least one bathroom or stall that is accessible/ADA compliant (e.g., grab bars or raised toilet seat).

REFERRALS AND INCREASED SUPPORTS

- Occupational and /or Physical Therapy to address mobility needs or adaptive strategies for toileting and dressing
- Pelvic Floor and Continence Certified Therapist (RN, OT, PT) to learn more advanced techniques and address function of pelvic muscles
- Specialist for underlying medical conditions such as a urologist or endocrinologist
- Registered dietician for diet education
- Behavioral health to address anxiety, trauma, or other symptoms that may be contributing to incontinence

DISCHARGE PLANNING

Although causes of incontinence may be resolved while the person is in medical respite care, others will need a plan to safely and effectively manage incontinence after discharge. Considerations for discharge include:

- What is the long-term plan to access incontinence supplies?
- What is the plan to support access to facilities for self-care and care of clothing?
- Is the person aware of signs and symptoms of incontinence returning or worsening?
- Who is the provider to follow-up on medical diagnoses, progress and/or exacerbation of symptoms?
- Is the person prepared to manage incontinence in the intended discharge setting (including if returning to shelter or street-homelessness)?

If the person is not able to effectively manage ongoing incontinence, and it does not resolve while in medical respite, questions to consider include:

- Is the person agreeable to a higher level of care?
- Can the incontinence/cause of incontinence be addressed with more intensive support and rehabilitation?
- What setting or level of care is appropriate based on severity and ongoing needs?

Advanced Training & Advocacy

Additional resources and training to address incontinence include:

- Provider education and training on medication management for incontinence.
- Certification and training in pelvic floor exercises and rehabilitation.
- Certification and training in biofeedback and electrical stimulation modalities (e-stim).

Advocacy efforts to improve quality of life for individuals with incontinence include:

- Access to bathrooms/toilets and incontinence supplies as regularly available resources for people experiencing homelessness throughout the community.
- Trauma-informed education on incontinence for staff and providers of shelters and housing programs.

References

1. Gorina, Y., Schappert, S., Bercovitz, A. et al. (2014). Prevalence of incontinence among older Americans. U.S. Department of Health and Human Services: Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/series/sr_03/sr03_036.pdf
2. Brown, R. T., Hemati, K., Riley, E. D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric conditions in a population-based sample of older homeless adults. The Gerontologist, 57(4), 757-766. https://www.doi.org/10.1093/geront/gnw011
3. Abbs, E., Brown, R., Guzman, D., Kaplan, L., & Kushel, M. (2020). Risk factors for falls in older adults experiencing homelessness: Results from the HOPE HOME cohort study. Journal of General Internal Medicine, 35(6), 1813-1820. https://doi.org/10.1007/s11606-020-05637-0

Case Examples

CASE EXAMPLE 1

Background: Darryl is a 50-year-old who identifies as male. He was referred to a shelter-based medical respite program after hospitalization for multiple recurrent episodes of hyperglycemia and diabetes stabilization. He has an additional diagnosis of depression, which is managed through medication and ongoing therapy. Darryl is also diagnosed with neuropathy resulting from diabetes.

While at the medical respite setting, another resident reported to staff that Darryl had been using empty soda bottles as urinals and storing them under his bed. Darryl was approached by staff using trauma informed principles, and confirmed this was true. He reported since hospitalization, he had experienced intense urge and increased frequency to urinate, especially overnight, and had trouble getting to the bathroom on time. To avoid incontinence, he had been using the soda bottles as a personal urinal.

Assessment: The onsite medical provider completed a physical and incontinence screening with Darryl to identify potential causes. Darryl did not have any fevers or pain with urination, indicating it was not likely an infection. It was found that Darryl had multiple medications that increased urinary frequency as a side effect. He also noted the neuropathy made it difficult to unbutton and pull down his pants, especially when feeling rushed. The screening also indicated Darryl experienced increased anxiety due to the incontinence.

Intervention: Darryl's providers adjusted his medications to minimize the impact of side effects while monitoring his diabetes and glycemia. Darryl was also encouraged to address his anxiety with his behavioral health provider, who was able to identify calming strategies including deep breathing. The staff supported Darry in developing a self-management plan, which included using the bathroom pre-emptively at routine times, taking a deep breath when feeling an onset of urge, and wearing sweatpants while his symptoms were addressed.

Outcome: With a combined approach of medication adjustment and self-management strategies, Darryl experienced significantly fewer episodes of incontinence. He also reported feeling more capable of managing symptoms, less anxiety, and more comfortable transitioning back into the main shelter floor.

CASE EXAMPLE 2

Background: Quinn is a 28-year-old who identifies as non-binary. They were referred to the medical respite program following hospitalization for a bladder infection that progressed to a kidney infection, and dehydration. Due to feeling unsafe staying within a shelter, Quinn had been sleeping in a tent. Quinn identified feeling unsafe in using most available publicly accessible restrooms, resulting in holding their bladder for long periods of time, and minimized drinking beverages to avoid having to use the restroom. Quinn was agreeable to a referral to the medical respite program in which they would have a private sleeping space and bathroom, to complete their antibiotic treatment and recuperate from dehydration.

Assessment: During the medical intake process, Quinn expressed concerns about the recurrence of their bladder infection and UTI once leaving the respite program. Quinn also screened positive for a history of trauma, and identified they had not been successful in accessing inclusive mental health services. Quinn noted they would like to use incontinence supplies while the infection was resolving, but felt uncomfortable buying them in public.

I**ntervention:** The RN assisted Quinn in ordering incontinence supplies through their pharmacy, where they could pick up supplies more privately. Quinn was educated on the impact of dehydration and bladder health, and implemented a fluid intake and bladder voiding schedule. The community health worker assisted Quinn in identifying restrooms in the community they felt safe using, including a drop-in center for gender diverse individuals. Quinn completed an intake appointment at community clinic inclusive for all gender identities where they could access primary and behavioral health care, and was appreciative of the CHW escort to the intake appointments.

Outcome: Quinn was able to complete their treatment and resolve the infection. Quinn also established a routine to relieve their bladder every 3 hours, and remained consistent with fluid intake. Quinn remained engaged with the clinic, with an intention to prevent further infections and address mental health needs.