Chronic Condition Management

Incontinence

Pressure Ulcers
Objectives

- Develop an understanding of specified MFP chronic conditions
  - Incontinence (urinary)
  - Pressure Ulcers (PUs)
- Understand the needed self-management activities related to these conditions:
  - medication management,
  - behavioral management
  - red flags
Objectives

- Discuss the negative outcomes of incontinence and pressure ulcers on patients, families, and the health care system
- Learn about the different types of equipment and products used in the management of urinary incontinence
- Understand who is at risk for developing pressure ulcers and what preventative measures can be taken.
Incontinence

Chronic Condition Management
Incontinence Facts

What is it?: Involuntary leakage of urine

Who is affected? 10 million adults have some incontinence!

Nursing Home Residents:
- > 60% incontinent
- Second leading cause of institutionalization
- 22% of continent female residents become incontinent within one year!

Community Dwelling:
- 53% of homebound older persons
- 35% older women and 22% men
- Increased risk of falls (>26%) and bone fracture (>34%)
## Incontinence: Types

<table>
<thead>
<tr>
<th>Types</th>
<th>Symptoms</th>
</tr>
</thead>
</table>
| **Functional** | Physical or psychological factors **impair the ability to get to the toilet**  
Example: An older adult unable to transfer from wheelchair to toilet |
| **Stress**   | Urine loss (usually small amounts) during **sneezing, laughing, exercise** |
| **Urge**     | Sudden strong “**urge**” to void, accompanied by a fear of leakage, and followed by urine loss |
| **Overflow** | Bladder muscles overextended and have poor tone, **overflow of retained urine.** |
| **Combinations** | “Urge” with ‘stress’ or ‘Urge’ with ‘functional’ |
Questions about incontinence should be open-ended and phrased in language easily understood by the participants
- *Tell me about any problems you are having with your bladder?*
- *"Tell me about any trouble you are having holding your urine (water)?”*

If the responses to the above questions are negative, following up with questions may be helpful:
- *"How often do you lose urine when you don't want to?"*
- "How often do you wear a pad (“depends”) or other protective device to prevent urinary accidents?“

Some people will not mention incontinence as a problem because they consider it embarrassing or just a normal part of aging.
Asking about incontinence

HISTORY: ask about ‘sudden onset’ of incontinence

✓ characteristics of the incontinence (frequency, timing, and amount of leakage)

✓ Mental status evaluation (MMSE)

✓ Functional evaluation

✓ Environmental assessment

✓ Social supports

✓ Current medical problems, and medications

These assessment activities can be used to determine the cause, severity and treatment options for a participant.
Incontinence Log Example

<table>
<thead>
<tr>
<th>Time</th>
<th>Drinks</th>
<th>Urine</th>
<th>Accidental Leaks</th>
<th>Did you feel a strong urge to go?</th>
<th>What were you doing at the time?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>How many times?</td>
<td></td>
<td>(circle one)</td>
<td>(circle one)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How Much? (circle one)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sample</td>
<td>Soda</td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7-8 p.m.</td>
<td>2 cans</td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8-9 p.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9-10 p.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10-11 p.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11-12 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12-1 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1-2 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2-3 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3-4 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4-5 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5-6 a.m.</td>
<td></td>
<td>sm med lg</td>
<td>sm med lg</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
The health care provider may conduct a **physical exam** and order **tests** to help confirm the type of incontinence

**PHYSICAL EXAM:**
- Abdominal
- Rectal
- Genital

**TESTS:**
- Urinalysis, blood test
- PVR (post void residual), pelvic ultrasound, stress test, urodynamic testing, cystogram and cystoscopy
Incontinence Treatment

Medications
- Anticholinergics, topical estrogens, imipramine
- Drug treatment should generally be prescribed in conjunction with one or more behavioral management interventions

Medical Devices
- Urethral insert
- Pessary
- Catheter

Surgery
- Sling procedure
- Bladder Neck suspension
- Artificial urinary sphincter
Treatment – Behavioral Techniques

- **Physical Therapy**
  - Pelvic floor muscle strengthening
- **Bladder training**
- **Scheduled toilet trips (every 2-4 hours)**
- **Lifestyle changes**
  - ✓ Lose weight
  - ✓ Increase physical activity
  - ✓ Diet changes (reduce alcohol, caffeine, acidic foods)
Managing Incontinence

Pads, protective garments, skin products, DME
Red Flags

- **Urinary Tract Infection** is most common cause of **bacterial sepsis** in older adults
  - Sepsis affects 3 in 1000 people and severe sepsis contributes to more than 200,000 deaths per year

- Yeast infection

- Check for dehydration

- Skin irritation – redness, peeling

- Pressure ulcers
Question 55: Does the participant need help with toileting?

- Indicator 283: Participant has mobility problems (balancing, transferring) when using the toilet
- Strategy 28: Arrange for grab bars around toilet and toilet riser and monitor deliver/installation
- Strategy 1: Arrange for a commode, monitor delivery and provide instructions for proper use.

Question 59: Does the participant have other risks associated with activities of Daily Living not addressed above?

- Indicator 16: Participant needs medical equipment to function safely at home.
- Strategy 51: Arrange for the deliver of medical supplies, durable medical equipment or other medical devices
**Incontinence:**
MFP Risk Questions and Mitigation Strategies

**Question 65:** Does the participant have an important, serious health issue not addressed through previous questions?

- Indicator 311: participant has undiagnosed signs or symptoms
- Strategy 62: Arrange, verify and monitor appointment(s) with healthcare provider for new onset or worsening symptoms.

**Are there other risk questions that you, the TCs, have used?**
Incontinence Resources

- The National Association For Continence (NAFC) publishes a resource guide of **continence products and services**, which includes a listing of the manufacturers and distributors of specific products. To get a copy of this resource guide, call 1-800-BLADDER or go to the website [www.nafc.org](http://www.nafc.org)


- National Association For Continence
  Charleston, South Carolina
  1-843-377-0900
  [www.nafc.org](http://www.nafc.org)

- Simon Foundation for Continence
  Chicago, Illinois
  1-800-237-4666
  [www.simonfoundation.org](http://www.simonfoundation.org)
Pressure Ulcers (PU)

Chronic Condition Management

Note: This section of the presentation contains some graphic images
A pressure ulcer (PU) is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction”

(NPUAP, 2007)
The classification system:
(increasing degrees of skin and tissue damage)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Nonblanchable erythema</td>
</tr>
<tr>
<td>II</td>
<td>Partial-thickness skin loss</td>
</tr>
<tr>
<td>III</td>
<td>Full-thickness skin loss</td>
</tr>
<tr>
<td>IV</td>
<td>Full-thickness tissue loss</td>
</tr>
</tbody>
</table>

(qualitative descriptors)

Suspected Deep Tissue Injury – Depth unknown
Unstageable – Depth unknown
BAD NEWS!

About 2.5 million people develop pressure ulcers (PUs) in the U.S. each year.

33% of ICU patients who develop full thickness pressure ulcers die within 30 days of PU onset, and about 73% die within one year.

GOOD NEWS!

Following established practice guidelines and quality improvement initiatives, indicate that it is possible to reduce the incidence of PU by 50%!

Prevention is key!
Contributing factors/Risk factors

Does your MFP participant have any risk factors?

Intrinsic contributing factors include:

- Malnutrition
- Dehydration
- Impaired mobility
- Chronic conditions
- Impaired sensation (paralysis)
- Decreased LOC
  - Infection
  - Advance age
  - Steroid use
- Pressure ulcer present OR history of PU

External contributing factors include:

- Pressure
- Friction
- Moisture
- Incontinence
  - Shear
The Braden Scale is a screening tool that was developed by Barbara Braden and Nancy Bergstrom in 1987.

This tool has been used worldwide to assist health professionals to identify persons at risk of developing pressure ulcers.

Identify those at risk for developing PUs, so we can prevent PUs!
<table>
<thead>
<tr>
<th>SENSORY PERCEPTION</th>
<th>MOISTURE</th>
<th>ACTIVITY</th>
<th>MOBILITY</th>
<th>NUTRITION</th>
<th>FRICTION &amp; SHEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ability to respond meaningfully to pressure-related discomfort</td>
<td>degree to which skin is exposed to moisture</td>
<td>degree of physical activity</td>
<td>ability to change and control body position</td>
<td>usual food intake pattern</td>
<td>degree of friction and shear</td>
</tr>
<tr>
<td>Unresponsive (does not moan, whimper, or groan) to painful stimuli, due to diminished level of consciousness or sedation ** OR ** limited ability to feel pain over most of body</td>
<td>Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned</td>
<td>Confined to bed</td>
<td>Does not make even slight changes in body or extremity position without assistance</td>
<td>Never eats a complete meal. Rarely eats more than 1/2 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement ** OR ** is NPO and/or maintained on clear liquids or IV's for more than 5 days.</td>
<td>Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or ataxia leads to almost constant friction</td>
</tr>
<tr>
<td>Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness ** OR ** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.</td>
<td>Skin is often, but not always moist. Linen must be changed at least once a shift.</td>
<td>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.</td>
<td>Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.</td>
<td>Rarely eats a complete meal. Generally eats only about 1/2 of any food offered. Protein Intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. ** OR ** receives less than optimum amount of liquid diet or tube feeding.</td>
<td>Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.</td>
</tr>
<tr>
<td>Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. ** OR ** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</td>
<td>Skin is occasionally moist, requiring an extra linen change approximately once a day.</td>
<td>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair</td>
<td>Makes frequent though slight changes in body or extremity position independently.</td>
<td>Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered ** OR ** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.</td>
<td>Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.</td>
</tr>
<tr>
<td>Responds to verbal commands. Has no sensory deficit which would limit ability to feel or volition pain or discomfort.</td>
<td>Skin is usually dry. Linen only requires changing at routine intervals.</td>
<td>Walks outside room at least twice a day and inside room at least once every two hours during waking hours.</td>
<td>Makes major and frequent changes in position without assistance.</td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.</td>
<td>Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.</td>
</tr>
</tbody>
</table>

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Risks related to PU in MFP

- Chronic Conditions
- Impaired Mobility, paralysis
- Pressure, friction, shear
- Inactivity
- Inadequate Nutrition & Hydration
- Advanced Age
- History of PU
- Incontinence
RISK: Chronic Conditions

- 42% of MFP participants have 5 or more chronic conditions

Manage comorbid conditions

Keep provider appointments!

- TC to Arrange transportation for participant
- TC to arrange for someone to accompany participant to office visits
- Reconcile medications with participant/family/caregivers following appointments
Risk: Impaired Mobility –

*Proper size/fit wheelchair to avoid pressure points!*

(Bariatric size for persons > 250 #)

Wheelchair cushions:
PU Management & Prevention: Pressure

Risk: Pressure
Managing pressure is necessary—it is recommended to:

- Off-load heels - use pillows or positioning boot
  (Purchase “heel protectors” or purchase extra pillows)
- Use pillow between legs for side lying
- Do not position directly on hip bone
- Do not use doughnut-type devices
PU Management & Prevention: Friction and Shear

Risk: Friction & Shearing
Reducing friction & shear is necessary—it is recommended to:

✓ Purchase bed trapeze
✓ Hospital bed:
  • Keep head of bed elevated 30 if tolerated
  • Elevate foot of bed slightly, if condition permits
✓ Purchase pillows or wedge to support hip for side-lying
✓ Order lifts and transfer devices---
✓ PT if needed
Risk: Inactivity
To reduce inactivity it is recommended to:

- Reposition **every two hours in bed**
- Reposition **every hour when in chair**
- Arrange for PT “evaluation and treatment”
Risk: Inadequate nutrition & hydration

- Encourage protein, calorie-dense foods and fluids, unless contraindicated

- Monitor intake, weight and skin turgor

- Assess and address dental problems and swallowing problems

- **Arrange for assistance** with meals if needed

- **Arrange Dietary consult**
PU Management & Prevention: Advanced Age

Risk: Advance Age
PU Management & Prevention: History of Pressure Ulcers

Risk: History of PU

Recurrence rates for pressure ulcers remain extremely high, ranging from 23% to 40%!

- Check nursing home records for history of pressure ulcers
- Check claims data for history of PUs
Risk: Incontinence

Manage Incontinence

- Timely cleansing
- Apply barrier ointment to intact skin
- If skin is red or denuded use a paste
- Use appropriate incontinence disposables
- Apply fecal incontinence pouch if needed
The best intervention is **Prevention**:

- Identifying those at risk
- Manage chronic illnesses
- Minimize pressure, friction, shear
- Purchase assistive DME
- Promote increased activity
- Adequate nutrition and hydration
- Managing incontinence
- Participant/caregiver education
PUs Assessment, Diagnosis & Treatment

ASSESSMENT

- Pressure Ulcer Staging
- Class
- Size Measurement
- Undermining/Tunneling
- Base Tissues
- Exudate
- Edge/Perimeter
- Pain
- Infection

STAGES I-IV & UNSTAGEABLE
PUs Assessment, Diagnosis & Treatment

- Ankle-Brachial index – comparison of perfusion pressures
- Pulse volume recording - perfusion volume
- Doppler waveforms – single vessel flow
- Duplex imaging – ultrasound imaging for venous disease (also test for DVT)
- Transcutaneous oxygen pressure (TcPO2)
Protect Wound and Periwound Skin
- Use barrier products to protect from adhesives and moisture
- Change dressings at appropriate intervals to avoid pooling of exudates

Debridement: Removal of Nonviable Tissue
Removes growth medium, controls/prevents infection, defines extent of the wound and stimulates the healing process

Wound Dressing: The cause of the wound directly affects dressing choice. Other factors: size, base, exudates, etc.

Wound Care Products: Antimicrobial products, barrier products, aglignates, collagen, composite products, compression wraps, foams, gauze, hydrocolloids, hydrofiber, hydrogels, NaCl impregnated dressings, petrolatum impregnated dressings, transparent films.

Negative pressure wound therapy: V.A.C. system

Surgical repair: various types of reconstruction
Pain: A critical aspect of local wound assessment both from the perspective of the participant and as a clinical indicator of infection

- Include location, type/cause, rating (use validated scale), participant description and nonverbal signs

Wong-Baker FACES Pain Rating Scale

Infection – Signs and Symptoms:

- Redness, warmth and induration of adjacent tissues
- Pain or tenderness
- Dysmorphic and/or friable granulation
- Unusual odor
- Purulent exudates
- Systemic signs (fever, chills, sweats)
Pressure Ulcer:
MFP Risk Questions and Mitigation Strategies

- **Risk #43:** Does the participant require special infection precautions?
  - **Indicator 292:** Participant has ‘infected’ wounds
  - **Strategy 25:** Arrange for and monitor education on wound management and bandage changing
  - **Strategy 21:** Arrange for an monitor education on diagnoses/conditions
  - **Strategy 30:** Arrange for and monitor home care nursing.
  - **Strategy 62:** Arrange for and monitor appointment(s) with healthcare provider for new onset or worsening symptoms
Are there other risk questions that you, the TCs, have used?
Agency for Healthcare Research and Quality (AHRQ) has established evidence based clinical practice guidelines for PU prevention.

The National Pressure Ulcer Advisory Panel (NPUAP) (an independent not-for-profit professional organization dedicated to the prevention and management of pressure ulcers) has established guidelines.  [http://www.npuap.org/](http://www.npuap.org/)