Healthy Skin Interview

For this issue's Healthy Skin interview, Deb Tenge spoke with Pamela Quirk, APRN, BC, gerontological clinical nurse specialist at the Soldiers' Home in Holyoke, Massachusetts. Established in 1952, the Soldiers' Home provides both long term and outpatient care services to eligible veterans who reside in the state of Massachusetts.

Success Stories with Incontinence Care

Interview by Deb Tenge
RNC, MS, CWOCN

Soldiers' Home facility

In 1999, the Soldiers' Home created a bowel and bladder team to investigate and develop an evidence-based bowel and bladder policy and procedure. At the time, Soldiers' Home's incontinence budget was out of control. Incontinence products were not being used consistently on residents, which led to skin problems, leakage, odor and ultimately complaints from the residents and their families.

That was then, this is now. Under Soldiers' Home's revamped incontinence program, residents now experience less leakage, fewer skin problems and a reduction in urinary tract infections–and the facility can also boast about cost savings.

While Soldiers' Home, being a veterans facility, is not required to follow CMS guidelines, Pamela Quirk says they elect to do so. The issues they face regarding incontinence are the same issues seen in other long term care facilities. Why not see if the changes they made at their facility could benefit yours?

Q – Deb Tenge: Can you provide some background information about the facility?
A – Pamela Quirk: We are accredited by the Joint Commission on Accreditation of Healthcare Organizations and are inspected annually by the Veterans Administration. Although we are not inspected by state surveyors, we do follow CMS guidelines. Services are provided to veterans who are in need of long term care and outpatient services including optometry, ophthalmology, orthopedics, dental, ENT, minor surgery, podiatry, urology, hematology, nephrology and cardiology.

Q – DT: What is your total licensed census and what are the current incontinence issues for your population?
A – PQ: The current census is 275 LTC beds. Included in this census are an eight-bed acute unit and 18 comfort care beds. The facility has a larger male population, with only 16 females in residence. As far as incontinence is concerned, there are more overflow incontinence issues, due to our predominately male population. We also encounter more benign prostatic hypertrophy and prostate cancer compared to other long term care facilities.

Several members of the bowel and bladder team; Lori Manning, Michelle Beaudry, Jim Sadlowski and Judy Pickford.

Problem

- Incontinence budget out of control
- Inconsistent product usage on residents
- Complaints from residents and families
- Leakage and odors
- Skin problems related to incontinence

Solution

- Education of staff
- Assessment and proper sizing
- List of residents, product used, size used
- Spreadsheet calculates par levels for each unit so delivery is correct
- Monthly quality improvement checks encourage staff compliance

Results:

- Cost savings
- Dramatic reduction in leakage
- Decreased incidence of skin problems– from 4.4 percent in 2003 to 2 percent in 2006
- Fewer UTIs
- Improved staff compliance

Q – DT: When did you start your incontinence team, and why was it started?

A – PQ: The bowel and bladder team officially began in response to the facility change from a more institutional organization to units we call veteran care centers. There are four veteran care centers, each managed by a veteran care coordinator. Each coordinator is a team leader for one of our focus groups targeted at one of four areas: skin, pain, falls, and bowel and bladder. I was assigned to bowel and bladder, beginning a new enthusiasm for incontinence care.

Q – DT: What were the initial issues you wanted to target? Who was on your team?

A – PQ: Initially, the goal was to investigate and develop an evidence-based bowel and bladder policy and procedure. My group had representation from each unit with licensed staff, CNAs, a social worker and a dietitian. We included all work shifts. In the beginning, it was difficult to get consistent representation from each of the shifts and units. This continues to be an issue, especially on the 3-11 shift, where there is a higher rate of staff turnover.

In 2005, we added the infection control nurse to comply with F-Tag 315 changes with the goal of decreasing UTIs. We also added the buyer, central supply clerk and storeroom clerk to address distribution issues. Staff members were chosen based on their interest in bowel and bladder health and also their leadership abilities and experience here at the facility.

Judy Pickford makes sure that the right-sized product is used on the right resident by checking the list.

Q – DT: What problems were you looking to solve?
A – PQ: There was a variety of issues. We had complaints from veterans and their families about wet clothes and odors. The residents were not always wearing a consistent product because by the weekend all the larges were gone and the staff had to substitute something different. The perception at the time was that a bigger brief would hold more and control leakage better. Also, on the bed we often had blue underpads stacked with reusable underpads in several layers–all on top of a pressure reduction mattress, so the effectiveness of the therapy was diminished. We had skin issues due to incontinence that we felt could be avoided. Also, the staff's efforts to manage incontinence leakage often resulted in "brief stuffing" (placing additional products within the brief).

Cathy Bergeron, Kathy Monahan, Pamela Quirk and Helga Simpson discuss incontinence issues at a recent meeting

Q – DT: How did you get started?
A – PQ: We took advantage of clinical support from our incontinence vendor in the form of a nurse specializing in incontinence. The incontinence nurse began doing education and rounds on all shifts to assist with development of our policy and procedures. She in-serviced proper measurement and product sizing so that the residents were fitted with the right size garment. The nurse also checked for proper brief application and use of appropriate products. This hands-on help got us off to a great start.

The team made the decision to move to a more absorbent brief, which resulted in a cost savings for the facility. By using one brief that was more absorbent, the staff stopped using extra products inside briefs and reduced the use of blue underpads. Complaints have declined significantly. Both residents and families are happier with the better-performing product. This product also saves money for the facility because it has refastenable tapes. These tapes allow staff to check the resident and continue to use the same brief if it is not soiled. Waste is reduced because tapes no longer rip the plastic.

Q – DT: What other improvements were you able to make?
A – PQ: Our vendor's incontinence nurse identified distribution problems. Each unit had deliveries once a week–a certain number of cases in each size. The storeroom was jammed on delivery day, but staff was often scrambling by the weekend. We might only have small sizes left because the larger sizes were used earlier in the week. No wonder there was leakage! This problem was alleviated when we developed a spreadsheet that set product par levels for the residents on each unit. The unit coordinator updates it regularly with sizing information and saves it on a network drive that can be accessed by the buyer and central supply personnel. Now the correct numbers of each size of briefs are delivered twice a week to the unit. This has been a huge improvement!

Q – DT: Which issues took longer to solve?
A – PQ: Even after education and training, our staff often used the wrong product, which drove up costs. This could have been related to our distribution system – the "who wears what item" information was not readily available to the CNAs. We have since placed individual product identification lists on supply carts and in the bathrooms, along with a size matrix and a troubleshooting guide. To truly exact change, we have found that a monthly review is critical. During these brief performance improvement rounds, we check to make sure that the lists are current and located in the cart and bathrooms. We also select five residents at random to audit whether they are in the proper product and proper size.

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Q – DT: What types of outcomes have you seen?
A – PQ: We have witnessed cost containment by using the appropriate product. We've also seen less skin breakdown. Certainly resident and family complaints have gone down. Each care center now has a bladder scanner, which helps to identify urinary retention. Veterans are administered cranberry tablets for UTI prevention. We continue to look for a downward trend in the number of UTIs. Presently, numbers are not increasing.

Q – DT: How often does your bowel and bladder team meet and what are your current targeted issues?
A – PQ: Staff compliance is an ongoing issue. We need to provide constant reinforcement. Performing monthly performance improvement checks has really helped. The team also receives budget versus spending information from the business office so if incontinence costs have increased, we can track down and solve the problem. Currently, the team is meeting monthly in order to gain control of product compliance with the main issue being the misuse of the overnight (high-capacity) brief.

Q – DT: What are some of your concerns regarding the use of your high-capacity brief?
A – PQ: The overnight brief is extremely absorbent and can hold very large voids, which is fantastic. But our staff was misusing this brief, using them on all veterans instead of targeting those who really needed them. Subsequently, costs went up. It became a compliance issue on all shifts. It might be partially due to poor performance on the part of a few staff members who did not want to change veterans when incontinent. The team has implemented a tool titled Guidelines for Use of Overnight/High Capacity Brief (see Forms & Tools page 90). It integrates the following components: the veteran's diagnosis (e.g., diabetes, CHF, tube feedings) and medication regimen (e.g., diuretics, behavioral issues, wandering during sleep). We identify those who qualify for use of the overnight brief. Then we include justification within the care plan with rationale, including prevention of sleep deprivation, maintenance of skin integrity and preservation of veteran dignity. Currently, performance improvement data has shown marked improvement, with 100 percent compliance in the last two months.

Q – DT: Not all facilities have access to bladder scanners. How do you use them?
A – PQ: We use our bladder scanner as part of the resident's admission assessment to test for overflow incontinence by measuring the post-void residual (PVR). We are lucky to have a urology clinic within the outpatient portion of the facility. The urologists frequently request our staff to check for PVR. We also can use the bladder scan if a veteran has not voided in eight hours. If the reading is greater than 250ml, a straight catheter is used to relieve retention. To meet the needs of our population, administration supported the purchase of bladder scanners for all four care centers.

Q – DT: What areas do you see your committee working on in the future?
A – PQ: Toileting residents is still an area that can always be improved, particularly since our building design doesn't include as many bathrooms as we'd like. It's interesting to think about how times have changed. Years ago our primarily male population could hang plastic urinals on their wheelchairs no matter where they went. This resulted in more self-toileting, but the filled urinals were everywhere! Currently, our staff focus is to know a resident's individual voiding pattern so that even if he is off the floor, we can track him down whether to help him with the bathroom or to check and change him.

The future for us holds even more resident-centered care as we embrace culture change and train our staff using the LEAP* program, which is resident driven. The bowel and bladder team will continue to meet regularly and tackle problems as they come up.

*LEAP is a program designed by Mather LifeWays to educate, empower and retain staff by using a resident-centered approach.

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