The prevalence of urinary incontinence (UI) in the general population of adult women ranges from 25% to 45% (Abrams, Cardozo, Khoury, & Wein, 2009). The prevalence rate of UI has been estimated to be between 45% and 70% for residents in long-term care settings (DuBeau, Simon, & Morris, 2006; Lekan-Rutledge, 2004; McCliment, 2002; Newman, Gaines, & Snare, 2005; Palmer, 2008; Sparks, Boyer, Gambrel, & Lovett, 2004; Yu, Kaltreider, Hu, Igou, & Craighead, 1989). UI has been identified as a pivotal reason for admission to a skilled nursing facility (Abrams et al., 2009; Newman et al., 2005). Additionally, in terms of mortality, disability, and skilled nursing facility admission, UI has a more severe impact on frail older adults when compared to healthy elders (Abrams et al., 2009).

The findings reported in this article are from a larger study that examined the benefits of using bladder ultrasound scanners in skilled nursing facilities. Skilled nursing facilities are defined as nursing facilities certified to admit Medicare residents (OBRA-87) and provide room, board, nursing care, and therapies. With the exception of sub-acute settings, skilled nursing facilities provide the highest level of medical care for individuals outside of a hospital. A physician functions as a medical director providing coordination of medical care for residents. Clinical care is supervised 24 hours a day by registered nurses (RNs) or licensed practical nurses (LPNs). Skilled nursing facility payor sources include Medicare, Medicaid, long-term care insurance, and private pay with specific limitations for each source. Education levels of skilled nursing facility nursing staff members vary and can

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Key Words: Urinary incontinence, nursing home residents, licensed practical nurses (LPNs), certified nursing assistants (CNAs), registered nurses (RNs).
potentially impact the staff attitude and knowledge level related to UI.

A review of the evidence-based practice (EBP) literature has determined that any assessment of UI should include the availability of a bladder ultrasound scanner to determine post-void residual (PVR) urine amounts (Centers for Medicare and Medicaid Services [CMS], 2006; Lekan-Rutledge, 2004, 2006; McCliment, 2002; Newman et al., 2005; Sparks et al., 2004). In the three years prior to the study in the state where the study took place, seven out of a potential of 506 skilled nursing facilities (1.3%) purchased a bladder ultrasound scanner from a leading patent-holding U.S. manufacturer of bladder ultrasound scanners (Coombes & Millard, 1994; Tubaro, Mariani, De Nunzio, & Miano, 2010). These data are consistent with the findings that bladder ultrasound scanners are rarely found within skilled nursing facilities (Tracey, 2001; Wooldridge, 2000), possibly the result of slow integration of technology in long-term care when compared to acute and primary health care settings (Singh, 2010). Potential barriers preventing widespread adoption of bladder ultrasound scanners in skilled nursing facilities include cost (Altschuler & Diaz, 2006) and lack of clear policies and procedures regarding indications for the use of bladder ultrasound scanners as well as staff knowledge levels pertaining to UI (Ribby, 2006). Despite these obstacles, the adoption of bladder ultrasound scanners in skilled nursing facilities has the potential to improve UI assessment as well as change knowledge and attitude related to UI among skilled nursing facility staff.

The two research questions that guided this study were: a) What are the differences in UI attitude and knowledge between RNs, LPNs, and certified nursing assistants (CNAs); and b) are there changes in attitude and knowledge about UI among nursing care staff after educational inservices and the placement and utilization of a bladder ultrasound scanner in a skilled nursing facility?

Research Summary

Introduction
Prevention and treatment of urinary incontinence among nursing home residents is a challenge. Urinary incontinence is not a normal part of aging, and a basic knowledge level is important for all health care providers working in skilled nursing facilities.

Purpose
This feasibility study explored differences in attitude and knowledge related to urinary incontinence among nursing personnel who provide care for nursing home residents, and examined staff attitude and knowledge about urinary incontinence. Data were collected before and after a bladder ultrasound scanner was made available, and an educational intervention was provided.

Methods
One-hundred and seven nursing staff members from four skilled nursing facilities provided study data, which assessed attitude and knowledge about urinary incontinence. Forty-eight nursing staff members provided pre- and post-test data, which assessed attitude and knowledge about urinary incontinence. Post-test data were obtained after an educational in-service, and a bladder ultrasound scanner was made available at each study site.

Results
The association between position and belief that bladder disorders are a normal part of aging was significant. The study intervention resulted in a significant positive change in attitude toward urinary incontinence.

Conclusion
Certified nursing assistants in this study appear to believe that bladder disorders are a normal part of aging, and a knowledge gap related to urinary incontinence exists. Staff education and the placement of a bladder ultrasound scanner positively impacted both variables.

Level of Evidence – VI
(Melnyk & Fineout-Overholt, 2011)
line UI knowledge level among nursing staff (Mueller, 2004), ensuring that staff are aware of the types of UI. Establishing an organizational philosophy where skilled nursing facility staff members have a common belief about UI has been found to improve the sustainability of UI programs (Mueller, 2004; Ostaszkiewicz, Roe, & Johnston, 2005; Schnelle et al., 1983). In addition, establishing UI organizational protocols that included primary prevention strategies (such as assisting residents to maintain mobility and transfer abilities) was found to reduce the incidence of UI among low-risk residents (Palmer, 2008).

Educational levels of skilled nursing facility staff members vary greatly and can potentially impact staff members’ attitudes and knowledge level related to UI. Personnel in nursing departments comprise 70% of the workforce within a skilled nursing facility (Singh, 2010). RNs are state-licensed and have completed an associate degree in nursing (ADN), diploma in nursing (Dipl), or a bachelor of science in nursing (BSN). Few RNs provide direct care in skilled nursing facilities because most are in administrative positions (Singh, 2010). Additionally, RN hours per resident day and skill mix decreased between the years 1997 and 2007 (Seblega et al., 2010).

The majority of care within a skilled nursing facility is directed by LPNs, who have graduated from state-accredited programs. LPNs working in skilled nursing facilities are responsible for providing prescribed treatments, administering medications, collecting data related to resident needs, communicating with family members, and supervising CNAs. While LPNs provide supervision, they often lack formal geriatric and management education (Cherry et al., 2007; Quinn et al., 2004). Supervisory training has been recommended for both RNs and LPNs working in skilled nursing facilities (IOM, 2001; Siegel & Young, 2010; Siegel, Young, Mitchell, & Shannon, 2008).

CNAs constitute the largest group of health care workers in skilled nursing facilities and provide up to 90% of the direct care to residents (Aylward et al., 2003; Bowers, Esmond, & Jacobson, 2000). CNAs receive 75 hours of formal training, as required by the 1987 Nursing Home Reform Act, and are responsible for the activities of daily living and personal care of skilled nursing facility residents. CNAs are primarily responsible for managing day-to-day toileting programs for residents and have been described as the first-line managers of incontinence (Bowers et al., 2000; Lawhorne, Ouslander, Parmelee, Resnick, & Calabrese, 2008). CNA activities are essential for successful incontinence programs (Lekan-Rutledge, Palmer, & Belyea, 1998). Previous research notes the lack of CNA involvement in developing UI treatment programs is a barrier to successful incontinence programs (Schnelle, Newman, & Fogarty, 1990). Research is needed to determine the effect CNA involvement has in developing and implementing UI treatment programs.

Skilled nursing facility nursing staff have varying levels of academic knowledge about caring for residents with UI. Thus, improving staff knowledge related to UI and improving the attitude about treating UI among staff rests with those who provide continuing education in skilled nursing facilities. CNAs have identified continuing education as a pivotal factor in job satisfaction and reduction in turnover (Ejaz, Noelker, Menne, & Bagaka’s, 2008). Lack of basic knowledge about incontinence among RNs and LPNs has also been noted (DuBeau, Ouslander, & Palmer, 2007; Palmer, 1995). RN and LPN responses differed significantly when asked to identify reasons for UI (Palmer, 1995). Significant UI knowledge and attitude discrepancies exist between state surveyors and skilled nursing facility staff (DuBeau et al., 2007). Achievement of commonalities in UI attitudes where staff believe UI is not a normal part of aging and achieving a basic knowledge threshold pertaining to UI are critical among skilled nursing facility staff and the skilled nursing facility industry.

This feasibility study explored differences in attitude and knowledge related to UI among RNs, LPNs, and CNAs. To the authors’ best knowledge, this is an initial attempt to compare self-reported responses between these three levels of nursing staff groups in relation to knowledge and attitude about UI. Additionally, this study examined skilled nursing facility staff knowledge and attitude about UI before and after an intervention program.

Methods

Project Overview

A mid-western public university collaborated with the nursing staff of four skilled nursing facilities to assess the benefits of bladder ultrasound scanners in skilled nursing facilities. The study funded and provided for the purchase and placement of bladder ultrasound scanners in each skilled nursing facility. Additionally, the researchers developed and provided an EBP educational program for staff aimed at improving the management and treatment of UI. A multi-disciplinary team, the Bladder Research Team, composed of faculty and staff from the fields of gerontology, nursing, health services, occupational therapy, and diagnostic medical sonography, conducted the 14-month project. The four skilled nursing facilities participating were located in a mid-size city and its surrounding community. Skilled nursing facilities varied by size – one considered small, two considered medium, and one considered large. Facility bed sizes ranged from 63 to 212, with a mean bed size of 116. Each skilled nursing facility accepted Medicare, Medicaid, and private pay residents. The study was reviewed and approved by the university’s Institutional Review
Board.

Data were collected on multiple levels to determine changes before and after participating in the project. Initial meetings occurred at each skilled nursing facility. Members of the Bladder Research Team met with the skilled nursing facility administrator and members of nursing administration to review the project. The skilled nursing facility administrator acknowledged participation by signing a memorandum of understanding.

The two research questions explored in this study were a) what are the differences in UI attitude and knowledge between RNs, LPNs, and CNAs; and b) are there changes in attitude and knowledge about UI among nursing staff after educational in-services and the placement and utilization of a bladder ultrasound scanner in a skilled nursing facility? These researchers gained valuable information on two fronts: a) baseline information on attitudes about UI and knowledge levels of UI among nursing staff members working in skilled nursing facilities, and b) the impact of educational interventions and of bladder ultrasound scanner placement on UI attitude and UI knowledge. This article offers a unique contribution to the field since it compares differences in attitude and knowledge related to UI among three levels of nursing staff in skilled nursing facilities: RNs, LPNs, and CNAs.

Study Design

A quasi-experimental, within-subject, longitudinal design (two time points) was used to assess within group differences. The Staff Satisfaction and Incontinence Knowledge Survey was administered to skilled nursing facility staff prior to attending the first staff in-service entitled Bladder Ultrasound Basics. Identical surveys were distributed 12 weeks after the first staff in-service and placement of the bladder ultrasound scanner in the skilled nursing facility. In addition to the longitudinal data collected, cross-sectional data were gathered at the first data collection time period and offered valuable insights on differences between staff attitude and knowledge related to UI.

Survey Design

The Staff Satisfaction and Incontinence Knowledge Survey was designed to capture staff attitude toward and knowledge about UI. The tool was designed by the research team to capture a range of UI knowledge and attitude across a variety of responders. Knowledge questions were based on current literature pertaining to UI, as well as from a clinical nurse specialist in gerontology. Basic demographic data were self-disclosed to allow researchers to describe the study population and compare knowledge and attitude across positions.

Staff members provided written consent to participate in the study and received a study code, which provided anonymity to their responses. Codes were used for survey identification and data review. The master employee name and code list was maintained by a researcher and kept at the university in a locked private office. Data were reported in aggregate form only. No individual employee data were shared.

Study Interventions

The Staff Satisfaction and Incontinence Knowledge Survey was completed before the study intervention as a pre-test and at the conclusion of the study period as a post-test. The study intervention consisted of the placement of the bladder ultrasound scanner and multiple educational interventions. The first educational intervention was the Bladder Scanner Basics staff in-service. The Bladder Ultrasound Scanner Basics in-service covered EBP education related to UI, the mechanics of using the bladder ultrasound scanner, demonstration of the scanner, and hands-on practice time for staff. The Bladder Research Team members worked with skilled nursing facility staff to assure that competencies were met for the initial assessment. A total of nine Bladder Ultrasound Scanner Basics in-services were held among each of the four skilled nursing facilities over a two-week period. For staff unable to attend the Bladder Ultrasound Scanner Basics in-service, a 17-minute university-designed and produced DVD reviewing the primary topics of the initial in-service was provided. The DVD was also designed for newly hired staff members and as a refresher in-service tool for current staff. The bladder ultrasound scanner was placed in each skilled nursing facility two weeks after the initial Bladder Ultrasound Scanner Basics in-service. Twelve weeks after the placement of the bladder scanner in the skilled nursing facility, the Bladder Research Team provided the skilled nursing facility staff at the four care settings a voluntary interactive educational refresher in-service. In this refresher in-service, skilled nursing facility staff members played Bladder Jeopardy®, including the topics UI regulations; UI knowledge; signs, symptoms, and types of bladder dysfunction; the use of bladder ultrasound scanner technology; and treatments for UI. Two refresher in-services were held at each study site.

In addition to the formal in-service educational interventions described, additional educational interventions were developed and implemented during the study period in response to feedback received from the skilled nursing facilities. These included a) cue cards created for and posted in each skilled nursing facility to prompt the nursing staff to use the bladder ultrasound scanner, b) an incentive program to increase bladder scanner utilization among staff, c) handouts and posters to increase basic UI knowledge in skilled nursing facility staff, d) personal consults by members of the Bladder Research Team, and e) update reports on bladder ultrasound scanner utilization to each skilled nursing facility.

Participants

A convenience sample of
nursing personnel at the four skilled nursing facilities provided study data. The administration of each skilled nursing facility identified nursing staff to be educated to use the bladder ultrasound scanners. Participants provided written informed consent by signing a consent form prior to the start of the study. Participant data were coded to maintain response anonymity. This population consisted of 180 staff members and constituted the potential study population. Of these, 107 (59%) completed the pre-test. Individual samples for each question varied based on question completion rates. CNAs encompassed 30.8% \( (n = 33) \) of respondents, 54.2% \( (n = 58) \) of respondents were LPNs, and 15.0% \( (n = 16) \) were RNs. Results are reported by the positions of CNAs, LPNs, and RNs. Positions are indicative of education, training, and licensure necessary for each job category. Four percent \( (n = 4) \) of the respondent group described themselves as male; the remaining 89% \( (n = 95) \) were female, with 7% \( (n = 8) \) not responding to the item. At post-test, responses were received from 48 participants; missing responses resulted in a data set with a sample size of 43. Of the 48 post-test respondents, 29.2% \( (n = 14) \) were CNAs, 54.2% \( (n = 26) \) were LPNs, and 16.6% \( (n = 8) \) were RNs. Table 1 displays the study population.

### Results

#### Attitudes and Knowledge Regarding UI at Pre-Test By Position

Data were obtained from 107 participants. Responses were initially analyzed together and then separated by position, which provided a means to compare differences in frequency of responses. A Fisher’s Exact Test was performed to examine the significance of the association of correct responses among CNAs, LPNs, and RNs. When providing a true/false answer to the statement, “Bladder disorders are a normal part of aging,” the percentage of correct responses differed significantly by position. Eighteen percent \( (n = 6) \) of CNAs responded correctly, while 50% \( (n = 28) \) of LPNs responded correctly \( (p < 0.003) \). The rate of correct responses also differed significantly by position when comparing CNAs \( (18\%, n = 6) \) and RNs \( (62.5\%, n = 10) \) \( (p = 0.003) \). The rate of correct responses did not differ significantly \( (p = 0.410) \) by position when comparing LPNs \( (50\%, n = 28) \) and RNs \( (62.5\%, n = 10) \).

Likewise, when asked to respond to the true/false statement (“Performing a bladder...
scan is an invasive procedure”), the percentage of correct responses differed by position. The rate of correct responses differed significantly \( p = 0.015 \) by position when comparing correct responses among CNAs \( (67.7\%, \ n = 21) \) and LPNs \( (90.9\%; \ n = 50) \).

The rate of correct responses differed significantly \( p = 0.046 \) when comparing CNAs and RNs \( (CNAs = 67.7\%, \ n = 21; \ RNs = 93.8\%, \ n = 15) \). The rate of correct responses did not differ significantly \( p = 0.591 \) by position \( (LPNs = 90.9\%, \ n = 50; \ RNs = 93.8\%, \ n = 15) \).

When asked to respond with true or false to the statement, “Decreasing daily fluid intake can prevent episodes of urinary incontinence,” the percentage of correct answers differed by position. The rate of correct responses differed significantly by position, from \( 67.7\% \) \( (n = 22) \) among CNAs and \( 94.5\% \) \( (n = 52) \) among LPNs \( p = 0.002 \). The rate of correct responses differed significantly by position, from \( 67.7\% \) \( (n = 22) \) among CNAs compared with \( 100\% \) \( (n = 16) \) among RNs \( p = 0.009 \). The rate of correct responses did not differ significantly by position, with LPNs reporting \( 94.5\% \) \( (n = 52) \) and RNs achieving \( 100\% \) \( (n = 16) \) \( p = 0.459 \). The percentage of correct responses did not differ by position when responding to the following true/false statements: “Urinary incontinence is seen in at least 50% of nursing home residents,” and “The BladderScan® is only used when initially assessing a newly admitted resident.” These results are represented in Table 2.

## Attitudes and Knowledge Regarding UI at Pre-Test And Post-Test

Forty-eight staff members from the four skilled nursing facilities of the 107 participants \( (44.9\%) \) provided post-test data, which were obtained at the conclusion of the study. Pre- and post-respondent groups were compared for differences in frequency of responses. Only paired surveys were compared to assure respondents were exposed to the study interventions. When analyzing true/false statement responses among groups, researchers found that when answering “Bladder disorders are a normal part of aging,” McNemar’s statistic suggests there is a statistically significant difference in the proportions of correct/incorrect answers before and after the interventions \( p < 0.001 \). The percentage of correct responses increased from \( 50\% \) \( (n = 23) \) in the pre-test to \( 91.2\% \) \( (n = 42) \) in the post-test. The proportions of correct answers did not differ between pre- and post-test surveys when responding to the following true/false statements: “Performing a bladder scan is an invasive procedure,” “Urinary incontinence is seen in at least 50% of nursing home residents,” “The BladderScan® is only used when initially assessing a newly admitted resident,” and “Decreasing daily fluid intake can prevent episodes of urinary incontinence.” These results are presented in Table 3.

## Discussion

Despite the variances that exist in formal educational preparation for nursing positions in skilled nursing facilities, a unified organizational philosophy, defined as a common belief among all staff members that UI is not a normal part of aging, must be pervasive for the success of a UI program. Once staff members believe that UI is not a normal part of aging, they are more likely to be diligent in carrying out a plan of care related to UI. Additionally, basic knowledge about types of UI and treatment for UI is necessary for all skilled nursing facility staff who provide direct care and emotional support for residents. Education surrounding UI should extend beyond nursing to include other departments, such as physical therapy, occupational therapy, social work, activities, and environmental services.

With respect to attitude about UI, there appears to be an association between position and belief that bladder disorders are a normal part of aging; CNAs overwhelmingly believe this is true \( (82\%) \). Fewer LPNs \( (50\%) \) and RNs \( (38\%) \) responded that UI is a normal part of aging. There was no association between RNs and LPNs and the belief that bladder disorders are a normal part of aging. Yet, \( 50\% \) of LPNs and \( 37.5\% \) of RNs answered “true” to...
the statement “Bladder disorders are a normal part of aging.” Additional research is necessary to determine if these data are consistent in a larger sample. Congruency in the belief that UI is not a normal part of aging is crucial in the development of an organizational approach to UI in skilled nursing facilities. Additionally, an organizational approach to UI has the potential to change attitude across all staff, beyond nursing to departments who see the impact of UI, such as therapy, social work, activities, and environmental services. The knowledge level of CNAs was also much lower than that of LPNs and RNs at pre-test when asked to answer true or false to the following statements: “Performing a bladder scan is an invasive procedure,” and “Decreasing daily fluid intake can prevent episodes of urinary incontinence.” This information indicates the need for continuing education tailored to CNAs in select areas related to UI in the skilled nursing facility environment.

These data, which demonstrate that staff believe bladder disorders are a normal part of aging in skilled nursing facility residents, could explain, to some degree, the lack of UI management care planning and treatment. If skilled nursing facility staff members believe that bladder disorders are a normal part of aging, they may be less likely to vigorously pursue a non-pharmacological UI treatment program, such as scheduled voiding or bladder retraining. Recognition that bladder disorders are not a normal part of aging, along with an appreciation for the negative impact on the resident’s quality of life, should aid in increased value of and use of these management and treatment programs in the resident care plan.

The study intervention (placement of scanner and education sessions) resulted in a significantly positive change in attitude toward UI. These findings can potentially affect a staff member’s belief in playing a role in improving UI among skilled nursing facility residents. Raising self-efficacy levels among staff is an important component in UI treatment in skilled nursing facilities, just as improving self-efficacy of those with UI is important (Abrams et al., 2009). Skilled nursing facility staff who believe that UI can be treated and improved are more likely to embrace a UI treatment program.

Further research is necessary and should include extending this study to a larger sample size, skilled nursing facilities located in different areas of the U.S., and different demographic populations among skilled nursing facility residents. Additional research is needed to determine if knowledge gained will impact resident care outcomes related to UI.

**Limitations**

Participants in the study sample had varying levels of years of experience in their jobs, which was not accounted for in this study. Study participation did not provide a control group; thus, randomization of study participants could not occur. All appropriate nursing staff personnel were able to participate in the pre-test, intervention, and post-test. However, data analysis was performed only on paired surveys, and these data were used to determine the impact of the intervention. Nursing personnel attrition occurred in each skilled nursing facility, which caused alterations in study participation. The study site was limited to one geographical area. The small sample size, particularly in select group measures, could potentially lead to Type II error. Because of the small sample size and the use of a convenience sample, the generalizability of certain items remains in question.

The Hawthorne effect may have produced a threat to the data in that the mere act of administering the pre-test results is a sensitization that may cause an attitude change on the post-test. It is also important to note that novelty effects resulting from the use of new technology by the staff members may have influenced post-test results. These results may be reflective of the staff’s eagerness or indifference with regard to incorporating the bladder ultrasound scanner into the daily routine.

In addition to the limitations mentioned above, specific limitations surround the bladder ultrasound scanner. Although bladder ultrasound scanner results have shown to be just as accurate as invasive catheterization methods for measurement of PVR volumes (Coombes & Millard, 1994), the accuracy of the results is operator dependent. If staff perceived the PVR volumes as inaccurate, they may have experienced decreased confidence in helping a resident with his or her UI problems. Decreased staff confidence may have occurred due to lack of a staff member who acted as a bladder ultrasound champion to encourage repeated use of the scanner and to monitor potentially inaccurate results.

**Implications for Management And Practice**

Findings from this feasibility study identify distinct implications for management and practice. These include improving knowledge of UI among all skilled nursing facility nursing staff and integrating a bladder ultrasound scanner into practice.

A knowledge gap about UI was noted at pre-test among each classification of nursing staff personnel. It is the contention of the researchers that treatment of UI in skilled nursing facilities would improve if all skilled nursing facility nursing staff who provide direct care and emotional support to residents had an increased knowledge of incontinence that includes types of UI and EBP UI treatment programs. This increased knowledge can potentially improve communication between direct care staff and charge nurses involved in resident assessment of UI. The model (see Figure 1) depicts how an increase in knowledge of UI among frontline skilled nursing
facility staff will ultimately lead to improved skilled nursing facility quality.

EBP research identifies the need to utilize bladder retraining programs and scheduled voiding program for management and treatment of incontinence (Dowling-Castronovo & Bradway, 2007; DuBeau, 2005; DuBeau et al., 2006; Newman, 2007; Shamliyan, Kane, Wyman, & Wilt, 2008; Watson, Brink, Zimmer & Mayer, 2003; Wyman et al., 2004). A bladder ultrasound scanner may be utilized in a bladder retraining program to notify the resident when the bladder is distended and voiding is required. The scanner may also be useful when initiating a scheduled voiding program. If a resident is unable to void, urinary volume may be scanned and measured to determine the need for urinary catheterization. However, adding another regimen to an already hectic schedule of existing duties can be discouraging for skilled nursing facility staff.

Finally, the basic understanding that UI is not a normal part of aging must be integrated throughout the skilled nursing facility if any UI program is to be successful. Basic knowledge about UI is necessary for all skilled nursing facility staff providing direct care and emotional support for residents, including nursing, therapy, social work, activities, environmental services, and administration departments.

Conclusion

Increased knowledge related to UI, the use of the bladder ultrasound scanner for treatment intervention, and the development of an organizational philosophy about UI are three crucial determinants for improving UI in skilled nursing facilities. Data from this study suggest there is a knowledge gap and attitudinal misconception related to UI in skilled nursing facilities. Educating skilled nursing facility staff who provide emotional support and care to residents is the first step in the development of an organizational philosophy on UI in skilled nursing facilities. Further research will determine if educational interventions and the placement of a bladder ultrasound scanner will reduce the episodes of UI and improve quality of life for skilled nursing facility residents.

References


Note: This figure represents a path to increasing nursing home quality through increased knowledge of urinary incontinence among direct care staff.

Figure 1.
Increased Nursing Home Quality Through Knowledge of Urinary Incontinence


