Kessler Institute for Rehabilitation 8th Annual Stroke Conference: Part 6 of 8 Caregiver Guide to Bowel and Bladder Function After Stroke

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LIZETTE BALIN: 00:04 [music] In rehab nursing, what do we do when the patients get to Kessler? Well, our goal would be to manage fluids, prevent urinary retention, which, I said before, causes urinary tract infection, reduce risk of skin breakdown. So this is very, very important.

ANNOUNCER: 00:24 Welcome to the Eighth Annual Stroke Conference, Breaking Barriers: There's More to Getting Home than Walking. In this lecture podcast, Lizette Hocbo Balin of Kessler Institute for Rehabilitation presented Caregiver Guide to Bowel and Bladder Function After a Stroke. For more information about Ms. Hocbo Balin, read her bio in the program notes below. This conference was sponsored by Kessler Institute for Rehabilitation and was a one-day event that provided participants with an understanding of the multidisciplinary approach to rehabilitation that enables stroke survivors and their families and caregivers to rebuild their lives. Discussion will focus on communication, motivation, spatial neglect, sleep issues, bowel and bladder management, and community integration.

BALIN: 01:21 My name's Lizette Balin, and I'm a nurse manager at Kessler in West Orange. I've been a nurse manager for eleven years. And I was a night manager for five of those eleven years, so I've handled night shift and day shift. And so I've seen the patients both during the night and during the day, when they're having their bowel programs and when they're doing their bladder retraining programs. So I've seen most of it. Learning is a continuous process. So I know that as soon as I know something, I know things that I still need to learn. All right. So one of the things I want to learn is who you are. How many here are therapists: speech, PT, OT? Oh, a lot of you. Nurses and nursing students? Case managers? Okay. So hello, everyone. So the slides that I will show you and also in your handout would be a caregiver guide. So it's very simply written, simple language. And when you print it, you can actually give it to your patients or your patients' care partners or caregivers so that they will be more comfortable in handling bowel and bladder issues for their stroke patients.

BALIN: 02:42 So my goal today-- first of all, my goal is not to cough. I'm eating a cough drop right now. And so, if I do that, pardon me. I'm the one who is loud back there barking at all the speakers today. So my objectives would be to review the common problems of bowel and bladder after a stroke, understand underlying causes of bladder and bowel problems, know how a rehab nurse - I am also part of the Association of Rehab Nurses here in the Northern New Jersey chapter - how we can help with bowel and bladder management in the acute rehab setting and identify strategies for a patient's self-management of urinary and fecal incontinence, so what our patients and their care partners can do at home. I have nothing to disclose. You didn't pay to come here, so they're not paying me either [laughter]. So hopefully, this will be a topic that will be in the front line of our taking care of the patients when they go home. Because as Dr. Adler did say, one of the barriers-- they probably can transfer from wheelchair to the toilet. They can probably do all those wonderful things in therapy. But if they have

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bowel and bladder issues, particularly incontinence, that is one of the main barriers for patients not going home, right?

BALIN: 04:17

So let's start with definitions-- well, the conditions. After discharge from a stroke center-- in our case, in Kessler in West Orange, we have patients who come from Saint Barnabus Hospital, Morristown Medical Center, University Hospital. Sometimes we get from St. Joe's, and sometimes we also get from Newark Beth Israel. After discharge from their hospital, the patient comes to us for rehab, which provides an interdisciplinary team effort that focuses on helping the patients regain as much functional independence as possible. The second goal would be to prevent secondary complications and minimize the long-term disabilities of stroke. So problems with bowel and bladder are common but distressing for stroke survivors. So going to the bathroom after suffering a stroke may be complicated by the following conditions: urinary incontinence, urinary retention, which actually leads to urinary tract infection, bowel incontinence, and constipation. After a stroke, the brain may enter into a temporary acute cerebral shock phase. During this time, the urinary bladder will be in retention or what we call detrusor areflexia. Almost 25% of affected individuals develop acute urinary retention after a stroke. So it is associated with a worse functional outcome and predictive of institutionalization after. That's why it's important that we overcome the barriers of bowel and bladder.

BALIN: 05:57

So let's go to definitions. Urinary incontinence is poor bladder control. Frequency is the need to go to the toilet often. Urge incontinence is a sudden, uncontrollable need to pass urine, what we call wetting accidents. Functional incontinence is difficulty getting into the toilet on time or getting clothing undone in time. So you will see these patients. Sometimes they cannot express themselves because of the stroke, so they are pounding like this on their table or wheeling themselves to the bathroom. Sometimes they have control of their bladder, but because they cannot get to the toilet in time or they don't have the dexterity of their hands to unbutton and unzip their pants or they cannot physically stand up and pull down their pants or undergarments, then they have these kinds of accidents. This is actually one of the things why we have the bladder retraining program. Nocturnal incontinence is the need to go to the toilet several times at night. This is sometimes seen in patients with other comorbidities such as diabetes sometimes, right? So when a patient has a concomitant diabetes with a stroke, sometimes they actually already have nocturnal incontinence or functional incontinence at night because of their need to go to the bathroom really frequently.

BALIN: 07:33

Urinary retention, this is more common because of the stroke, detrusor areflexia. It is a condition where a patient is not able to fully empty the bladder or when someone is holding an increasing amount of urine in the bladder. So they don't know; because of the stroke, there's this disconnect between the brain and the bladder. The bladder becomes full. The patient doesn't know that it's full, so there is urinary retention because of that. So once you have that urinary retention, you know the urine goes up to the ureters and back to the kidneys, and sometimes that causes the infection, right? So what are the symptoms of urinary tract infection? It would be a urine with bad smell, cloudiness, blood, or sediment; a patient experiences burning when

urinating; fevers and chills; cramps in the lower abdomen or side; pain in the lower back; or frequent urination or feeling like you have to go again, even if you've already gone to the bathroom or you feel like you've already emptied your bladder.

BALIN: 08:40 So before we go to bowel, so the thing is, it's really about the bladder being so full or that the bladder can't hold it. So those are the two conditions. Same thing with the bowels. Those are the two things that will affect a bladder-- I mean, a bowel. Bowel incontinence can be caused by a number of changes after a stroke. It can affect continence, including muscle weakness, change in sensation or feeling, difficulty holding on, difficulty dressing and undressing, difficulty getting to the toilet, changes in eating and drinking habits affecting your digestion. Does it sound like I'm farting? No? All right. Because of that sound-- I'm really bothered by the sound.

AUDIENCE: 09:28 I'm trying to get somebody to stop it.

BALIN: 09:30 Okay. Okay. Because I don't look like I'm passing gas all the time [laughter]. Okay. Post-stroke constipation may be caused by inactivity, lethargy, insufficient water or nutrition intake, depression, lack of exercise capabilities, cognitive impairment, reduced consciousness, and drug intake. So again, the two problems would be-- the bowel is so full because when you're at least two days in the hospital, you're somewhat debilitated. So the functions of the bowel-- the functions of the bowel are not there. So you have to reactivate that. So either there is fecal impaction there or you cannot hold it because of the stroke, right? Okay. I have a story about bowel incontinence. And I may or may not deny that this actually ever happened because it is my friend. So we are in a queue going on a-- I recently went on a trip to Israel, and there is a park there called Masada National Park. Have anyone been to Israel? Right. So the Masada is a national park where it is a plateau. So it is a mountain, and then there is a plateau, a flat-- this was the last stand of the Jewish people during the Jewish-Roman War. So we are going there for the excavations, for the old Roman palaces. But before we get to that park, we have to fall in line to get to a cable car to go up there. Now, when we were in line, my friend, who has a husband who's also a nurse, ate something bad the day before. So she didn't know it. She had to go to the bathroom the day before several times. Okay.

AUDIENCE: 11:44 Sorry.

BALIN: 11:45 That's okay. So you guys are not eating right now - right? - because my story involves-- yeah. Nope. It's not [clipping?]. Okay. So my story might gross you out just like any other caregiver might be grossed out with incontinence. So we were in line, and she had gone to the bathroom several times the night before. So we thought she was fine to go on the trip. And while we were in line, she suddenly backed to the wall. And we were just talking because it was a good trip, Israel's a beautiful country, all of that. We were so amazed that we're going to this historical place. And all of a sudden, I feel something wet on my shoe and my feet. So the husband, who's a nurse, said, "Honey, why didn't you say something?" But she couldn't because, I guess, she was in shock because she doesn't have a stroke or she doesn't have any other medical condition. Or she's probably just shocked because it happened to her and it can happen. So good

thing we were in the Dead Sea before, and we had towels and all that, and nobody knows us because we're from America. Nobody else knows us there. And we just had to clean it up. And I let them go to the bathroom, and she had to clean up.

BALIN: 13:16

But it does happen, right? I hope you won't have a story like that. But our patients with strokes experience that sometimes, right? And so I was initially shocked. I wasn't grossed out because I'm a nurse. And the husband was shocked but not grossed out because he's a nurse. But how are we going to make people who are not nurses not grossed out? Because I guess I tuned out the other people around us. It was a line like a line in Disney when you're going for rides. But how will we change the mindset of the caregivers that the important thing in that situation is what? My friend who had the episode. And the others are all just a blur. We don't care about those other people, right? Because at that time, what could your reactions be? Oh, right? I heard some of the people like, "Oh." Yeah. It is embarrassing. But we kind of have to change the mindset that sometimes this happens, right? Just like this sound is still happening even when you put that in [laughter]-- right? I'm not farting, okay [laughter]?

BALIN: 14:45

Anyway, so bowel incontinence is loss of control of the muscles when releasing stools, also happens when, I guess, you have a gastrointestinal infection, right? You cannot hold it because it needs to come out. Your body does not need that infection, so it needs to come out. So leakage from the bowels resulting in soiling one's underwear, so just remember my friend who was in the line. It may result from being unaware that you need to go to the bathroom - or because you don't want to lose your place in line, right? - weakness in the muscle that holds the bowel movement, and reluctance to ask for help. Actually, this is one of the main causes of bowel incontinence. They don't realize that they can ask for help, right? On the other [end?] of the spectrum-- so this is the other one [is control?]. This one is too much fecal matter inside the bowels, being unable to have regular bowel movements. Bowel movements do not occur as often as they used to. Is it me doing this?

BALIN: 16:35

All right. So constipation is bowel movements do not occur as often as they used to and trouble passing stools. They can also cause incontinence. When does that happen? When there is so much hard stools, we call it fecal impaction, right? And so the softer stools seeps in between, but you still have-- so sometimes this is what we call-- the patients would say, "I feel like I'm leaking." It's almost like a leak. So they would see it in their underwear. But you know that they haven't passed any solid stools, right? So that happens. It may result from reduced fluid intake - that's why you have those beautiful Saratoga Springs water, right? - diet - later on, you're going to have your vegetables and all your fiber - not moving around enough, and side effect of prescription drugs such as opioids, which most of our patients from acute care-- they are [in?] medications such as that.

BALIN: 17:48

So what do we do? In rehab nursing, what do we do when the patients get to Kessler? So our goal would be to manage fluids, prevent urinary retention, which I said before causes urinary tract infection, reduce risk of skin breakdown. So this is very, very important. Why don't you want your-- why do you want your patients clean and dry at all times? Because you don't want any stool or urine, the chemicals that are in

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	these materials, you don't want them on the skin. So think about babies, right? I always think about babies sometimes when I take care of my patients. So when do you want to change their diaper? As soon as they're--?
AUDIENCE: 18:43	Soiled.
BALIN: 18:43	Soiled. Right. So same thing with our patients. I just treat them as taller kids, right? Although I don't tell them that because [inaudible]-- but in my mind. There's no shame in it, right? Because babies can't hold it; sometimes the patients can't hold them too, right? So same thing, what do we do with babies? I try to put them under the sink, right, and wash them off, wash everything out, like hold them and then put them under the faucet. So same thing with adults, right? We try to make them as clean and dry as possible, right? Because especially if a patient who had a stroke is elderly, their skin is not as taut as our skin because we're young. All of us here are young, right? So we still have our good collagen and all of that. So with a skin breakdown-- just by a small injury, like even IV placement or shearing with transfer, a skin can break down. How much more if that skin gets soiled with urine and stool, right?
BALIN: 19:57	And the most important thing for the patient is what? To gain control of their bodily function, not to be treated like a child, right? Because they want some sort of control, some sort of control especially of their bodily function. So what we do in rehab nursing, we do assessments: their continence history prior to stroke; their recent history; any kind of comorbidities that may cause UTI - I would say diabetes is the most common, right? - awareness of the need to void; ability to perform toileting and get to the bathroom, again, before the injury and after; hygiene needs; assistance and privacy issues. What do you need? What do you use? Do you just use toilet paper? Do you just use wipes? I really prefer just water, just lots of water. Catheter, any need for catheterization. So there are different types of catheters. We have intermittent catheter for urinary retention. For incontinence, we have condom catheters for males, right? Fluid intake, any medication that might affect increase in producing urine, for example, diuretics, right?
BALIN: 21:28	So here are the things to do when a patient has urinary retention following stroke. Timed voiding program. So have you heard about that, how you do the bladder retraining? So timed voiding is-- think about us. We are here, sitting here for about, like what, almost two hours now. After my session, you probably want to go to the bathroom, right? Or if you're not drinking this water, at least maybe two times for the past six hours. So think about a patient who has impaired bladder because of the stroke. So they may need to go every two to three hours. So that's what we do with bladder retraining. In Kessler, we try to bring the patient to the bathroom after meals or before therapy and then every two to three hours after that. I actually advise my nurses to set a time on their phone. Or if the patient has no cognitive deficits, set a timer on their phone to make sure that they need to go to the-- they have to go to the bathroom, whether or not there is an urge to void. Adequate hydration, making sure that you have enough fluids. So drink up all your spring water over there. Drink them all up.

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BALIN: 22:52	Monitor intake and output. This is what the nursing assistants in Kessler do and assist the nurses with because-- who here have nurse's assistants in their facilities? Who usually brings them to the bathroom? Usually, the nursing assistants. If the nursing assistants are not available, then my nurses will help take care of this. But they would be the ones to determine how much they voided, also how much they ate or drank during their meals. Measure post-void residual. So after going to the bathroom, we are assuming that the bladder is emptied, but then we cannot assume because of the tendency of the bladder to have retention. So what we do is, after voiding, we ask them to go back to bed, and we just measure using a bladder scan if there are any urine left. And if it's greater than 300 cc, the doctor has a standing order of intermittent catheterization. Hopefully, they don't have that. Keep drinking. All right. Provide time, privacy, and adaptive equipment for hygiene, so whatever they need to maybe wipe their perineal area after voiding. We work with occupational therapists for this. And then provide safe environment. How do we determine if a patient is safe? Usually, if they are not falling, they are safe, right? Because there's no really determinant for safety for me. As a nurse, as long as they are not falling or they don't have a tendency to fall, they are safe.
BALIN: 24:46	We just piloted at Kessler, West Orange, on my unit-- I have a 57-bed unit. About 20% of that is stroke. We are piloting a bathroom tag program. What does that mean? Usually, when you bring a patient to the bathroom, do you leave them alone, or do you have to supervise them?
AUDIENCE: 25:11	Supervise them.
BALIN: 25:12	We usually have to supervise them if they're stroke because they are high risk initially. But how would you know? Because I know that there is not one nurse for one patient or one nursing assistant for one patient. Is that correct?
AUDIENCE: 25:25	Mm-hmm.
BALIN: 25:26	So if some other patient is calling and I'm a nursing assistant or I'm a nurse, how will I know if I can leave the patient in the bathroom? Sometimes if the patient is cognizant, high-level stroke - they don't have that much deficit - they would say, "I'm okay. I can pull." And you've seen it done before, right? You've seen it done several times. And you probably have done [it?] and stepped back, and maybe you're at the door, and you've done it before. Then you can leave them in the bathroom and take care of the other patient who is calling, because everybody's calling us, right? Everybody's calling the nurse when they're on the unit. But how will you determine if it's okay? So we started this bathroom tag program where it's a red, yellow, green. Red is stop. You cannot leave this patient alone. So even if the patient cannot verbalize that they are-- you know, "Leave me. Okay. Leave me." They're just [inaudible] for you to leave the room. You would say, "Unfortunately, based on what the therapist and our assessment is, you're a red. We cannot leave you." So at least the patient knows that he or she is a red. We cannot leave you. Yellow is maybe you have the foot at the door, eyes on the patient, leave them for a distance, but have your eyes on the patient. That's yellow. And then green is you can leave the patient in

the bathroom, probably a high-level stroke patient that you have observed multiple times. The patient can be left alone. Patient can pull the call bell when they need us. So that is what we do to provide a safe environment, okay?

BALIN: 27:17

For bowel, what do we do? Again, assess for the continence history prior to stroke. How many times did the patient use to move their bowels per week? Is it every day? Is it three times a week? Is it every morning like my husband? I can hear it. I can smell it sometimes [laughter], right? Don't go to the bathroom between 7:00 to 7:30. And if I have to work early, I have to go before 7:00 because we only have one full bath. So sometimes it could be that, every day, right? So you have to assess continence history prior to the stroke. Awareness of the need to defecate. Assess for bowel sounds. So I like seeing nurses with the stethoscopes because it's not a doctor's stethoscope only, right? The nurses have to have their stethoscope to assess for bowel sounds: increased/decreased bowel sounds, no bowel sounds. That would be dangerous, right? Abdominal tenderness or distention, normal kind of distention, not like your six-month perpetual pregnancy right here. Ooh, that's not a good joke. Yeah. I can only joke about myself. All right. Ability to get to the bathroom and ability to remove clothing, like I said earlier. And then hygiene needs, again, being able to reach at the back and cleaning yourself. Privacy and positioning. Of course, the best position to move your bowels is not in the bed, right? I would prefer not in the bedpan, if possible. I would like the patient to be on the toilet if there's a raised toilet seat, grab bar, and all of that, because if you-- that's why they have those Squatty Potties, right? Because if you have that position where a patient can lean forward a little bit, that would aid in the passing of your stools, right?

BALIN: 29:31

So what do we do, again, at Kessler? We establish a bowel program. So like I said before, usually the bowel program at Kessler happens at night. So when I was a night manager-- and I know some people here worked nights before. You would know this because it starts with giving a suppository after a meal, right? And sometimes you may or may not perform digital simulation. But when you gave a patient a suppository, you will see the evidence or result of effective suppository or other stool softeners. It would be on the bed, on the bedsheets, sometimes on the floor. And sometimes if the patient is able to walk to the bathroom, you would see some evidence on the wall. Who is here at night-- I mean, who are the people who work at night in the hospital? Nurses, right? Who else are with us? Security. Nurses aides. Yes. Security. And that's it sometimes. So would be the housekeeping who would clean those walls, those floors, and those sheets? The nurses. Yes. So just making sure that you are aware that that's what you're going into. Hopefully, the patient does not have to do this at home-- but establishing a bowel program so that they don't have to do this at home. That's why they are in acute rehab setting so that they can do this. Increased fluid intake, again, fiber and water will aid in the formation of good, solid stools, right? Monitor intake and output. Monitor bowel sounds. Position the patient upright. I already told you about this.

BALIN: 31:31

So what are our tips? Doctor may suggest different types of treatment, but going to the bathroom at regular times help train both the bowel and the bladder, right? Seek assistance as soon as the urge to urinate is felt. It's important to get to the bathroom

on time. Drink plenty of fluids during the day and limit them in the evening. Limit caffeine and alcohol at night. And ask the physical therapist for help in strengthening pelvic floor muscles, such as Kegel exercises. So anybody knows how to do Kegel exercises?

AUDIENCE: 32:09 Yeah [laughter].

BALIN: 32:10 So okay, very good. So you can do it right now. Come on [laughter]. All right. Tips for patient education, for urinary retention. Ask if medication is indicated. Ask your doctor if you need medications like Ditropan, Levsin, and all of that. Inform the doctor of other medications that may be causing urinary retention. Use catheter as needed, but hopefully when they go home, they don't have to use a catheter. Try waterproof underpants, liners, or disposable adult diapers. For bowel, again, like bladder, schedule a predictable pattern. Sitting position. Be active during the day. That's why it's good-- my transition from nights to days was excellent because I know what they are during the night. And then during the day, I know that they have to go to therapy so that at night they can just sleep. That's the best patient, right, when they're just sleeping at night. And then we can do all our maintenance documentation at night as nurses. But sometimes it doesn't happen, right? So sometimes a patient comes in. They are awake at night. And so during the day, they are poor arousal, especially stroke patients. So they need some medication to be aroused so that-- but this would all aid in getting a much more regular pattern.

BALIN: 33:33 So if a patient used to be an early riser, we set them up for therapy at 9 o'clock. If the patient is a late riser, we set them up for therapy 10:30 or maybe even afternoon sessions. Because it's important that they are active during the day, not just for sleep-wake cycle, but also for their bladder evacuation. Eat healthy food to reduce constipation and improve bowel control. Okay. Products that can help. So we work with occupation therapists for different products, like raised toilet seats, commode chairs, portable urinal bottles, and water resistant bedsheets, just like you have a baby or a dog. Sometimes you do that with pets as well, right? Whenever you repeatedly practice something, it activates nerve plasticity and rewires the brain. So that's why we have to do this repeatedly. We start it in acute rehab, and rehab doesn't stop when you are discharged, right? Keep extra garments in all bathrooms because, like I said, they might be rushing to go there. They might not have all the buttons and zippers, and they just wear their sweatpants and just bring them down. But still, sometimes, they get soiled-- so if they have extra garments in the bathroom. It's not in the handout, but what helped me clean faster would be the bidet. Have you heard the bidet?

AUDIENCE: 35:05 Yeah.

BALIN: 35:06 So you can actually now purchase it in Home Depot or Lowe's, all of that. You can actually install it. It's a good way to make sure that you clean everything, because if you are dealing with patients who have not reached their backside in a long, long time, they wouldn't even do it after a stroke. So there is aids in all of these for cleaning. Make sure that they know all of these things before leaving the hospital.

	Know the professionals who can help. So one of the barriers for discharge? Urinary and bladder incontinence-- but if we can have them gain control of managing their incontinence. Number two, if the caregivers change their mindset about incontinence, then there is a possibility for them to go home. So if you have any questions, I will be here at the panel at the end of the lectures following me. Dr. Chen is following me. So that's all. Thank you very much, and have a great day. [applause]
ANNOUNCER: 36:18	[music] For more information about Kessler Foundation, go to KesslerFoundation.org. Follow us on Facebook, Twitter, and Instagram. Listen to us on Apple Podcasts, Spotify, SoundCloud, or wherever you get your podcasts.