

## GERONTIC NURSING CARE MANAGEMENT EXCELLENT SERVICE ON NY. S WITH URINARY INCONTINENCE IN UPTD SOCIAL SERVICES ELDERLY BINJAI PROVINCIAL SOCIAL SERVICE ORTH SUMATRA IN 2025

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### ABSTRACT

The Decree of the Minister of National Development Planning Number Kep.136/M.PPN/HK/12/2021 is a strategic step in supporting the achievement of the Sustainable Development Goals (SDGs), particularly Goal 3 (health and well-being) and Goal 17 (partnerships to achieve the goals). One relevant area is geriatric nursing, particularly in the management of non-communicable diseases such as urinary incontinence in the elderly. This study aims to evaluate service-excellent geriatric nursing care management in the case of Mrs. S, an elderly resident of the UPTD for Elderly Social Services in Binjai, North Sumatra, who experienced urinary incontinence. The assessment method was carried out through interviews, observation, and documentation of nursing care. The results showed that Mrs. S had experienced urinary incontinence for the past two years, accompanied by sleep disturbances and decreased bladder control. The main interventions provided were health education and Kegel exercises twice daily. These exercises have been proven effective in improving urinary control and the physical and emotional comfort of the elderly. The intervention was implemented collaboratively between nurses, families, and institutions. This study emphasizes the importance of a multidisciplinary approach, psychological support, and integrated care that refers to the SDGs principles to improve the quality of life of the elderly in social institutions.

**Keywords:** *geriatric nursing, urinary incontinence, Kegel exercises, elderly, excellent service*

### Introduction

The achievement of the Sustainable Development Goals (SDGs), especially the 3rd goal on health and welfare, requires strategic steps in the management of non-communicable diseases in the elderly (Kemenkes, 2024). One of the main challenges in gerontic nursing is urinary incontinence, a condition of loss of bladder control experienced by about 200 million people worldwide (Miller, 2019). In North

Sumatra, the prevalence of this condition reached 9.81%, and at the Binjai Elderly Social Service UPTD, it was found that 65 out of 198 elderly people experienced similar problems. Urinary incontinence that is not treated with excellent service can have a negative impact on the physical, mental, and social aspects of the elderly (Simanjuntak, Sitanggang, 2020). In the case of Mrs. S (79 years old), this condition has lasted for two years and causes sleep pattern

disturbances and decreased motivation for self-care.

Achieving the Sustainable Development Goals (SDGs) target in 2030, especially in the pillars of health and well-being (Goal 3), requires an inclusive transformation of the health service system for vulnerable groups, including the elderly (elderly). As life expectancy increases, the complexity of degenerative health problems is becoming a significant challenge for health workers (Kementerian PPN/Bappenas, 2020). One of the problems that is often overlooked but has a big impact on the quality of life of the elderly is urinary incontinence. This condition is defined as the inability to consciously hold back urine, which is estimated to affect around 200 million individuals worldwide (WHO, 2017).

Health profile data shows that the prevalence of urinary incontinence in the North Sumatra region reaches 9.81%. Specifically, at the Binjai Elderly Social Service UPTD, it was recorded that 65 out of 198 elderly people (32.8%) had urinary elimination disorders. This phenomenon is not only a physical problem, but also triggers psychosocial complications such as social isolation, depression, decreased confidence, and chronic sleep pattern disorders (Dinkes Provsu, 2021).

The type of interview used in data collection was a guided interview, conducted based on a specific format for geriatric nursing case studies. This technique aims to ensure that all information obtained aligns with the focus of the study. Furthermore, observations were conducted systematically through direct observation of behavior and recording of matters related to the problem being studied. The physical examination was conducted using four main techniques: inspection (visual observation), palpation (touching), percussion (tapping), and auscultation (listening with a stethoscope).

These four techniques were used to identify physical signs related to the client's health condition, thereby supporting the objective determination of nursing diagnoses.

In the context of services in social institutions, the application of conventional nursing care management is often not enough to meet the expectations of the comfort of the elderly. Therefore, a Service Excellent approach is needed that focuses on empathy, precision of interventions, and responsiveness to patient needs (WHO, 2015). Mrs. S (79 years old), one of the residents at UPTD Binjai, has reported incontinence for the past two years. This condition causes physical fatigue due to frequent waking up at night and decreased motivation to self-care.

One of the non-pharmacological interventions that has been shown to be effective in the management of elimination is Kegel exercises. This exercise aims to strengthen the pelvic floor muscles so as to increase the functional capacity of the bladder (Sari, N. M., Ratnawati, 2020). The integration of systematic nursing care management with excellent service standards is expected to provide significant results in reducing the frequency of incontinence in Mrs. S, as well as improving her quality of life in old age. Based on this urgency, this case study was conducted to evaluate the effectiveness of gerontic nursing care management in Mrs. S in 2025.

Based on data obtained from the Binjai City Senior Citizens' Social Services Unit (UPTD), under the auspices of the Social Services Department, 198 seniors were receiving care at the facility. Of these, 65 were diagnosed with urinary incontinence. In this case study, only one resident of Wisma Dahlia was included in the research sample, as the individual met the established inclusion criteria.

Data analysis was conducted during the data collection process, beginning during the fieldwork and continuing until all data were collected. This was accomplished by presenting facts and then explaining them in a discussion of the findings.

### Result

Currently Mrs. S is 79 years old and has lived in a nursing home for 10 years. In the theoretical study, it was explained that the lower urogenital system experienced anatomical and physiological changes, such as the patient experiencing leakage of a certain amount of urine when coughing, getting up, and sitting; there was a very short interval between the perceived need to urinate, leakage or normal intervals, amount, and flow; there was no sensation of urination, dribbling, or frequent urination. (Rosmega Pakpahan, 2022)

In this case, the data showed that Mrs. S experienced sensory and cognitive urinary elimination disorders. The results of the mental disorder examination, namely the SPMSQ (Short Portable Mental Status Questionnaire) and MMSE (Mini Mental State Exam), were found. In theory, there are several different disease diagnoses that can be related to urinary incontinence. The nursing diagnoses found in the case theory four are: Functional urinary incontinence related to decreased bladder tone, Sleep pattern disturbance related to lack of sleep control, Skin/tissue integrity disorder related to skin integrity care, Self-care deficit related to motivation and interest (Siregar, 2022) Meanwhile, based on case data obtained through interviews, physical examinations, and direct observation, the formulation of the problem identified in Mrs. S, is different from the diagnosis found in the case, there are four nursing diagnoses because some diagnoses in the theory do not have data found in the case to support the establishment of the diagnosis in the case. The following nursing

diagnoses were found in the case, namely: Impaired urinary elimination related to decreased bladder capacity, Self-care deficit related to decreased motivation/interest, Sleep pattern disturbance related to lack of sleep control. At the stage of implementing nursing actions, the author made them according to the plan that had been prepared in the intervention section. Interventions were carried out on Mrs. S for 3 days, in the implementation carried out to address the client's problems. The main action that can be done on the three diagnoses is doing Kegel exercises where the aim is to strengthen or tighten the pelvic floor muscles. At this stage, the evaluation was made by the author based on the objectives and outcome criteria contained in the intervention stage and from the results of each action carried out in the implementation of nursing which was carried out for 3 days by evaluating each nursing diagnosis. In the first nursing diagnosis, the evaluation on the last day was that the client had made a Kegel exercise schedule, the client had begun to be able to control urination, the patient had begun to apply Kegel exercises in her activities, Mrs. S had begun to be able to go to the toilet before wanting to urinate. In the second nursing diagnosis, the evaluation on the last day obtained by the author was Mrs. S was able to carry out self-care, Mrs. S would change clothes if they were wet with urine, Mrs. S had felt comfortable. In the third nursing diagnosis, the evaluation on the last day was Mrs. S had been able to regulate her sleep patterns while resting, the patient no longer looked lethargic, Mrs. S had been able to reduce drinking before bed.

### Research Method

This study used a case study design to evaluate the effectiveness of gerontic nursing care management in elderly patients with urinary incontinence problems. The main focus of this

study is the integration of systematic care management with service excellent standards. The elderly who are in the Binjai Elderly Social Service UPTD, North Sumatra Provincial Social Service. Data collection is carried out comprehensively through interviews, observations, and physical examinations. The nursing intervention was carried out for 3 days with a focus on the Service Excellent approach (empathy, accuracy, and responsiveness). The main intervention provided is Kegel Exercises which aim to strengthen the pelvic floor muscle.

### Result

Mrs. S is experiencing impaired urinary elimination related to decreased bladder capacity, characterized by a urinary frequency of more than ten times per day, difficulty holding urine until reaching the toilet, wet pants during assessment, and restlessness. After 24 hours of nursing care, there was improvement in urinary elimination with increased urination sensation, decreased urinary urgency, bladder distension, incomplete urination, dribbling, and bedwetting. Interventions included observing age-appropriate urinary patterns, supporting consistent toilet use, scheduled urinary training (including Kegel exercises), and educating the patient to urinate regularly. Mrs. S experienced a self-care deficit related to decreased motivation, characterized by frequent involuntary bedwetting, especially at night, reluctance to change wet clothes, and the presence of urine odor in clothes and the room. The patient still wore adult diapers. After 24 hours of nursing care, Mrs. S showed increased interest and ability in performing self-care, including maintaining personal hygiene and going to the toilet independently. Interventions included observing self-care habits, providing a regular schedule, and educating the patient about the importance of maintaining hygiene. Mrs. S also experienced sleep pattern disturbances related to lack of sleep control, characterized by frequent nighttime

awakenings, restless sleep, and complaints of fatigue.

The patient also admitted to frequently drinking water before bed. After 24 hours of nursing care, Mrs. S's sleep quality improved, with fewer complaints of difficulty falling asleep and nighttime awakenings. Interventions included observing sleep patterns, modifying the sleep environment, and educating her about the importance of getting enough sleep and avoiding drinks before bed. Implementation was carried out in accordance with the planned interventions. The following is the implementation according to the 4 diagnoses obtained by the researcher for diagnoses.

During the nursing care process, observations were made on Mrs. S is urinary habits by recording the frequency of urination according to her age. The patient was supported to use the toilet consistently by being encouraged to go to the toilet before bedwetting. In addition, scheduled urination training was provided through Kegel exercises to help strengthen the pelvic floor muscles. The patient was also educated about the importance of regular urination to prevent incontinence and maintain personal hygiene. After the intervention, the patient began to show improvement in urinary control and was more aware of urination times. Dx2 During nursing care, Mrs. S's urinary frequency was recorded to determine her urinary habits according to her age. The patient was encouraged to go to the toilet regularly, especially before feeling the urge to urinate, to prevent bedwetting. In addition, the nurse trained the patient to urinate according to a schedule and provided Kegel exercises to help strengthen the bladder muscles. The patient was also educated about the importance of regular urination to maintain bladder function and reduce the risk of incontinence.

After the intervention, the patient began to be able to manage her urination schedule and demonstrated a willingness to maintain personal hygiene. Dx3 During nursing care, Mrs. S. was introduced to her self-care habits. Observations indicated that Mrs. S still lacked independence in self-care, such as changing clothes or maintaining personal hygiene. Therefore, the nurse helped schedule a morning self-care routine to help the patient become accustomed to it and maintain a sense of direction. Furthermore, the patient was educated on how to consistently perform self-care according to her abilities. After assistance, Mrs. S began to demonstrate a willingness to perform self-care independently. During the nursing process, Mrs. S's activity and sleep patterns were observed, including factors that disrupted her sleep. It was discovered that the patient frequently woke up at night, one of the reasons being her habit of drinking large amounts of water before bed.

The nurse observed the cause and advised Mrs. S to reduce her fluid intake before bedtime. To improve sleep comfort, the room environment was modified to be calm and comfortable. The patient was also educated on avoiding foods or drinks that could disrupt sleep. After the intervention, Mrs. S showed improved sleep quality and complaints of insomnia began to decrease. Here, the researcher only drew conclusions from the evaluation results from the final day, namely the third day.

Dx1 S: The patient stated that she was starting to be able to control a full bladder in a timely manner. The patient stated that she had noticed a change in her urination pattern, from 10 times a day to 6 times a day. The patient stated that she had created a Kegel exercise schedule and was implementing Kegel exercises.

O: The patient was starting to be able to control urination and was able to implement

the exercise schedule. The patient no longer appeared anxious.

A: The urinary elimination disorder problem was partially resolved.

P: The intervention recommended by the field nurse was a short, clear, and easy-to-understand narrative. Dx2 S: The patient reports being able to perform self-care by changing clothes if they become wet from urine. The patient reports being interested in performing self-care.

O: The patient has been able to overcome difficulties in controlling urine.

A: The problem of changing clothes if they become wet from urine and controlling urine has been resolved. The problem of interest in self-care has been resolved.

P: The intervention is discontinued.

Dx3: S: The patient reports being able to regulate sleep patterns while resting. The patient reports being able to reduce drinking when going to bed at night.

O: The patient no longer appears lethargic. The patient no longer appears restless.

A: The problem of disturbed sleep patterns, and the patient is able to limit drinking large amounts of water before bed, has been resolved.

P: The intervention is discontinued.

### Discussion

Mrs. S, a 79-year-old Muslim woman. During the case study process, Mrs. S provided direct information. She is married and graduated from the Religious Teacher Education School (SPGA). Currently, Mrs. S is experiencing urinary incontinence, which is the uncontrolled flow of urine that causes discomfort in carrying out daily activities. In terms of family support, her younger brother, M. Fadli, is a family member who can be contacted if Mrs. S needs help or additional information to support the treatment process. Main complaint: Mrs. S complained of constant urination and was unable to hold it, which

resulted in bedwetting incidents. Mrs. S stated that she had a habit of consuming a lot of fluids before bed, especially at night. This condition causes sleep disturbances, characterized by difficulty falling asleep, frequent waking up during both nighttime and daytime sleep, and feeling dissatisfied and not getting enough rest. Mrs. S also complained of changes in sleep patterns. In addition, Mrs. S stated that she felt reluctant to change clothes that were wet from urine. Observation results showed that Mrs. S's pants were wet, and the room where Mrs. S was smelled of urine. Chronology of Complaints Since about two years ago, Mrs. S began experiencing urinary incontinence characterized by the inability to control urine output, especially when experiencing emotional stress or doing physical activity. This condition is exacerbated by the aging factor which causes a decrease in pelvic floor muscle strength and decreased bladder function (Sipahutar, W. S. B., 2025). These complaints cause discomfort for Mrs. S, so she tends to limit her involvement in social activities. To reduce the symptoms felt, Mrs. S tried to overcome it by reducing fluid intake at night before bed. Reason for Entering the Home, Mrs. S independently decided to live in a social home for the elderly with the consideration of obtaining more optimal care and an environment that suits her needs. The decision was also taken because Mrs. S did not want to be a burden on her family members. Date of Admission to the Home, Mrs. S began becoming a resident of the social home for the elderly since February 18, 2015. Past medical history, Mrs. S has no allergies to food and drugs. Mrs. S is recorded as having a complete immunization history.

The main complaint currently felt is the inability to control urine. In addition, Mrs. S was hospitalized in 2015 with a diagnosis of gastritis. The client has a

history of using antacid drugs that are consumed according to medical recommendations when the complaint recurs. Family health history, Mrs. S stated that she has a very close relationship with her younger sibling, who has always provided emotional support and attention. Currently, Mrs. S is experiencing psychological disorders in the form of a strong desire to be picked up and returned home, which causes anxiety and often makes her mentally burdened. To overcome this feeling of discomfort, Mrs. S chooses to perform worship and provide inner peace and spiritual strength in dealing with various problems, including her current health condition (Manurung & Sigalingging, 2020). Regarding the client's perception of her illness, Mrs. S expressed a desire to be picked up and returned home. After receiving guidance while at the institution, Ny. S hopes to always be given health and be in good condition. Mrs. S said that after living in the institution, she felt difficulty in dealing with various things. She also expressed feeling healthier, happier, and having the opportunity to do more charity. Mrs. S is a devout and diligent woman in carrying out religious activities at the orphanage such as prayer and tarawih. Mrs. S believes in death. Daily habits: Nutrition, Mrs. S eats 3 times a day with a good appetite. The types of food consumed are generally rice, side dishes, vegetables. Mrs. S does not like spicy food because she has gastritis, Mrs. S's habit is to wash her hands first and pray before eating. Mrs. S's weight is 40 kg and her height is 150 cm. Elimination, Mrs. S urinates ten times a day at irregular times, yellow in color.

Complaints when wanting to urinate are not being able to control or hold back when wanting to urinate. Defecation, Mrs. S defecates once a day in the morning, with a yellow color and a distinctive odor. Solid consistency, no complaints when

defecating. Personal hygiene Mrs. S maintains good hygiene and bathes twice a day using soap. Mrs. S brushes her teeth three times a day, namely in the morning, afternoon, and evening. Mrs. S washes her hair three times a week using shampoo. Mrs. S also shows attention to personal hygiene by regularly cutting her nails twice a month. Resting, Mrs. S sleeps five hours every night and has a habit of taking a one-hour nap. Mrs. S has difficulty sleeping at night because of frequent urination. Activities and exercise, Mrs. S regularly participates in gymnastics at the orphanage twice a week on Tuesdays and Fridays. In her free time, Mrs. S really enjoys doing sports, although it does not interfere with other activities such as dressing, bathing and grooming. Habits, Mrs. S does not have any habits and does not consume alcohol. Mrs. S has also used antacid drugs to overcome her gastritis complaints. Mrs. S's habits are usually frequent trips to the bathroom to urinate. Mrs. S is in good general condition with stable vital signs (BP 100/70 mmHg, RR 22 beats/minute, HR 98 beats/minute). Physical examination reveals a relatively normal appearance: clean hair, symmetrical eyes, although the conjunctivae appear anemic.

Her nose, ears, mouth, neck, chest, breasts, respiratory, cardiovascular, and musculoskeletal systems are within normal limits. She complains of difficulty swallowing and urinary incontinence. Bowel sounds are normal (10 breaths/minute). Neurologically, Mrs. S demonstrates good cognitive function and memory, is able to answer questions appropriately, and maintains eye contact during interactions. Her mental status indicates good orientation to time, person, and place, and is emotionally stable and responsive.

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