Appendix G: Continence Promotion and Management

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Presentation Overview

- Prevalence
- Impact
- Assessment
- Treatment

- Resources
- Barriers
- Continence care work at West Park
What is incontinence?

- It has been defined by the International Continence Society as:

  a condition where involuntary loss of urine is a social or hygienic problem

(ICS, 1987)
Prevalence

- 5 to 10 % in the Community
- 10 to 20 % in Acute Care
- 50 to 70 % of Complex Continuing Care
  - 1 in 4 women
  - 1 in 10 men
An Important Problem

- UI is a strong predictor of functional recovery (Brittain 2001)
- Discharge destination - institution vs. community/home (Brittain 2001; Patel et al., 2001)
- Impact on quality of life for the individual and family
- Resumption of social participation (Gallagher 1998)
  - Low self-esteem
  - Social isolation
  - Depression
Requirements of Continence

- Aware of urge to void
- Able to get to the bathroom
- Able to suppress the urge until you reach the bathroom
- Able to void when you get there
Normal Micturition Cycle

**Storage phase**
- Bladder filling
- Normal desire to void
- First sensation to void

**Emptying phase**
- Bladder filling

**Detrusor muscle**
- relaxes
- + Urethral sphincter tone
- + Pelvic floor tone

**Detrusor muscle**
- relaxed
- + Urethral sphincter contracts
- + Pelvic floor contracts

**Detrusor muscle**
- contracts
- + Urethral sphincter relaxes (voluntary control)
- + Pelvic floor relaxes
- Pelvic floor tone

**MICTURITION**

**Pelvic floor**
- contracts
- relaxes
- + Urethral sphincter tone
- + Pelvic floor tone
Types of UI

Stress

Urge (OAB)

Overflow

Functional
Stress Incontinence

- loss of urine with a sudden increase in intra-abdominal pressure (e.g. coughing, sneezing, exercise)
- most common in women
- sometimes occurs in men following prostate surgery
Structure of the Female Lower Urinary Tract

- Ureter
- Outer peritoneal coat
- Detrusor smooth muscle
- Mucosa
- Trigone
- Proximal smooth muscle sphincteric mechanism
- External urethral sphincter
- Urethra
- Pelvic floor (striated muscle)
Urogenital Changes

Bladder
- Urgency
- Frequency
- Recurrent UTI

Vagina
- Dryness
- Painful intercourse
- Recurrent infection
Pelvic Floor
Pelvic Floor Decent
Structure of the Male Lower Urinary Tract

- Ureter
- Outer peritoneal coat
- Detrusor smooth muscle
- Mucosa
- Trigone
- Proximal smooth muscle sphincteric mechanism
- Prostate gland
- External urethral sphincter
- Pelvic floor (striated muscle)

urethra
Urge Incontinence (overactive bladder)

- loss of urine with a strong unstoppable urge to urinate
- usually associated with frequent urination during the day and night
- common in women and men
- sometimes referred to as an overactive bladder
Overflow Incontinence

- bladder is full at all times and leaks at any time, day or night
- usually associated with symptoms of slow stream and difficulty urinating
- more common in men as a result of the enlargement of the prostate gland
Functional Incontinence

- patient either has decreased mental ability (e.g. Alzheimer’s disease)
- or decreased physical ability (e.g. arthritis) and is unable to make it to the bathroom in time
DISAPPEAR – Transient Causes of UI

- D  Delirium
- I  Intake of fluid
- S  Stool impaction
- A  Atrophic changes/urethritis
- P  Psychological problems
- P  Pharmaceuticals that can contribute to incontinence
- E  Excess urine output
- A  Abnormal lab values
- R  Restricted mobility

Whytock, S (Chapter 3)
Promoting Continence Care, A Bladder and Bowel Handbook for Care Providers.
Age Related Factors

- Increased
  - Detrusor Overactivity
  - Nocturnal urine output
  - BPH
  - PVR (<100 ml)
  - Bacteruria (20%)

- Decreased
  - Bladder Contractility
  - Bladder Sensation
  - Sphincter Strength (F)

- Unchanged
  - Bladder Capacity
  - Bladder Compliance
Structured Assessment

- Specialist professional structured assessment:
  - Incontinence history (premorbid urinary incontinence)
  - Fluid Intake
  - Bowel elimination history
  - Medical History
  - Medications
  - Functional Ability
- A bladder diary is helpful with identifying voiding frequency, voided volumes and frequency of incontinence
- Focused physical evaluation (pelvic exam for women / PVR bladder scan / Urine dipstick)
- Simple tests
- The assessment may take 2 to 3 sessions
Assessment resources:

- Link to Urinary Continence Assessment Tool


- Onset
- Duration
- Daytime / Nighttime
- Accidents
- Stress loss
- Urge loss
- Aware of loss
Impact of cognitive impairment on ability to be continent

- ability to follow and understand prompts or cues
- ability to interact with others
- ability to complete self care tasks
- social awareness
Interpretation

- recognition
- recall

Impact on continence

- identifying the urge to void
- remembering how to respond
- locating the toilet
Interaction

- comprehension
- expression

Impact on Continence

- understanding reminders
- asking for assistance
Self Care

- voluntary and purposeful movement
- spatial orientation

Impact on Continence

- removing clothing
- sitting on the toilet
Social

- attention deficits
- conversation

**Impact on continence**

- remembering how to respond
- motivation to be continent
Voiding Record

Time and amount of:

– fluid intake
– urine voided
– incontinence
– For 4 or 5 days
Cystoscopy

- performed by a physician when the condition cannot be completely diagnosed by simpler, less invasive tests

Urodynamics

- used to assess the function of the bladder and urethra
- used to determine the problem in more complicated situations
- often done in conjunction with a cystoscopy
Contributing Factors

- Urinary Tract Infections
- Fluid Intake
- Caffeine / Alcohol Intake
- Constipation
- Medications
- Weight
- Mobility
- Environmental Factors
- Cognitive Impairment
- Childbirth
- Pelvic muscle tone
- Atrophic Changes

It is important to determine the contributing factors, this will lead logically to intervention planning.
So what do you do with all this information you have gathered?

The assessment follows a logical path to help you to think about the patient’s problem of UI
Conservative Management

- Client focused
- Using education
- Behavior modification
- Problem solving strategies
Most cases of UI can be effectively managed with conservative approaches.
Conservative Treatment Options

- Toileting
- Pessaries
- Kegel Exercises
- ISC
- Behavior modification
- Urge Suppression

- Functional
- Stress
- Overflow

Urge
Preventing Urinary Tract Infections

- drink extra fluids like water
- There is some evidence to show that use of cranberry juice or capsules can prevent UTI’s in women
  – Cochrane Reviews
Personal Care

- Wash and wipe from the front to the back
- Wash with warm water and pat or blow dry
- No soap
- Use a product that doesn’t affect vaginal pH
tablet, patch, ring or cream

works by improving the tissues of the vagina and urethra in post-menopausal women

risks concerns
  - breast cancer
  - uterine cancer
Increase Water Intake

- Increase intake of healthy fluids, especially water
- Try adding a slice of lemon or a sprig of mint to the water
- Offering fluid frequently or readily accessible
Reduce - Caffeine

- slowly cut down on the amount of caffeine to 1-2 cups a day (1 cup = 250ml)
- slowly switch to decaffeinated beverages (eg. decaffeinated tea, decaffeinated coffee, caffeine-free beverages)
- read labels closely (eg. green tea is caffeinated)
Managing Constipation

- Provide opportunities for exercise everyday
- Offer plenty of “healthy” fluid (warm water may stimulate the bowel)
- Introduce gradually, foods high in fibre such as bran, oatmeal, whole wheat, green leafy vegetables
- Avoid using laxatives on a regular basis
Limited Mobility

- Ensure a toilet is close by (a bedside commode or bedpan)
- Offer regular timed trips to the washroom
- Keep walking aide near (cane, crutches, or walker)
- Provide clothing that can be easily removed
Developing Best Practice Guidelines
Prompted Voiding

- It has been shown to decrease the number of incontinent episodes per day and increase the number of continent voids (A level evidence)

- It can be used with persons who have physical or mental impairments or little ability to determine how best to meet their needs

- The identification of individual voiding patterns (individualized toileting) rather than routine toileting (e.g. q2h) can promote the highest level of success with toileting
3-Day Voiding Record

- 3-day voiding record recommended
- Identify patterns of voiding
- Use to monitor interventions
- Motivates staff & residents
Prompted Voiding

It aims to improve bladder control for people with or without dementia using verbal prompts and positive reinforcement.
There are three primary behaviours that the caregiver uses each time PV is initiated

- Monitoring
- Prompting
- Praising
Provide visual cues in the environment to promote desired toileting behaviour
Using the right product
Resources

- Clinical Practice Guidelines for Urinary Continence Management of Stroke Survivors in Acute and Rehabilitation Settings, The Ottawa Hospital, 2008

  
  http://www.rn ao.org/Page.asp?PageID=924&ContentID=1274

- Hospital Report Research Collaborative, IC5 Improving Continence Care in Complex Continuing Care
  - Facilitation using Quality Improvement Methodology
  
  http://www.hospitalreport.ca/projects/QI_projects/IC5.html

- Incontinence: A Canadian Perspective
  A comprehensive look at incontinence in Canada
  A 37 page burden of illness paper commissioned by TCCF in 2007

  http://www.canadiancontinence.ca/health-profs/health-profs.html
Comments?

Feedback?