Promoting Bladder and Bowel Continence with Nursing Restorative Care

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Nursing Restorative Services (NRS) for Stroke Survivors in Long Term Care Workshop
Thunder Bay, Ontario
Friday, September 30, 2011
Acknowledgements

This presentation was adapted from previous ones done for improving Continence Care Collaborative (IC3) & IC5 Projects. As well as.

Central South Regional Stroke Program. 2007. Continence and Stroke.
Goal & Objectives

Goal: Share strategies for managing bladder and bowel problems in stroke survivors.

Objectives:
- Describe normal bladder function, urinary incontinence and the effects of stroke on bladder continence
- Describe normal bowel function, bowel incontinence and the effects of stroke on bowel continence
- Discuss assessment and management of bladder and bowel incontinence
- Connect Nursing Restorative Services and Incontinence
- Apply learning to a case study
Normal Bladder Anatomy
Normal bladder function

- Most adult bladders hold 500–600 ml of urine.
- When the bladder is about half full, the urge to urinate starts.
- Urination urge can be suppressed for 1 or 2 hours until the bladder is full, in a person with normal bladder function.
- Most people urinate 3 to 6 times in the day and possibly 1-2 times during the night.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Incontinence:

- ‘A condition where involuntary loss of urine or stool is a social or hygienic problem.’
  (International Continence Society ICS, 1987)

- Affects over half of Long Term Care Residents
  (RNAO Prompted Voiding Best Practice Guideline, 2011)

- Is the most common cause of admission to Long Term Care
  (Canadian Continence Foundation, 2007)
Incontinence Myths & Truths

- Incontinence is a normal part of the aging process.
- Little can be done for incontinent residents.
- Toileting residents every 2 hours can prevent incontinence.
- Restricting fluids can reduce incontinence.
- Prompted voiding is an effective method to use with incontinent patients.
Types of Urinary Incontinence

- **Physical**:
  - Stress: cough
  - Urges: need to go **Now**
  - Overflow: leaks out

- **Functional**:
  - Need help

- **Transient**
  - Short term problem
Stress Incontinence

- Loss of urine with a sudden increase in intra-abdominal pressure (e.g. coughing, sneezing, exercise)
- Most common in women
- Can also happen to men after prostate surgery.
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 & men
- Sometimes called an overactive bladder
Overflow Incontinence

- Bladder is full at all times and leaks at any time, day or night
- Usual symptoms are a slow stream and difficulty urinating
- More common in men as a result of prostate problems
Functional Incontinence

• Associated with decreased cognitive capabilities or physical abilities (e.g. Alzheimer’s Disease, Stroke)
• Resident is unable to go to the toilet in time without help.
Transient Incontinence

A short term decline in continence usually with sudden or recent onset caused by:

- **DIAPPERS** (mnemonic)
  - Delirium, depression
  - Infection
  - Atrophic Vaginitis
  - Pharmaceuticals
  - Psychological, pain, polyuria
  - Excess fluid, environmental barriers
  - Restricted mobility
  - Stool impaction or constipation
**Stroke** can cause a loss of bowel and bladder control.

Urinary incontinence is common after stroke

• 40-60% of stroke survivors are incontinent after having their stroke.

Over time bladder continence can improve.

• Upon discharge from hospital:
  • 25% of stroke survivors are incontinent
• 1 year later:
  • 15% of stroke survivors are incontinent

Stroke and risk factors for urinary incontinence

- The more severe the stroke, the greater the likelihood of urinary incontinence
- Older age
- Female sex
- Speech difficulties
- Motor weakness
- Visual field defects
- Cognitive impairment

(Barrett 2001)
Urinary Incontinence and stroke

- Loss of the ability to identify and respond to the need to urinate.
- Loss of bladder control occurs to many stroke survivors right after a stroke but resolves within 8 weeks.
- The incontinence may come and go or be permanent.
- Continuing incontinence is associated with poor outcome in both stroke survivor & care giver.

Stroke and incontinence

- Damage to frontal lobe associated with urinary dysfunction after stroke

- Size of lesion, rather than its location, is more likely to predict urinary incontinence

- Unclear if incontinence is a direct (site of lesion) or indirect (eg functional impairment preventing access) consequence of stroke

- More of an effect on the lives of stroke survivors when compared to other groups of people with incontinence

Stroke and Urge Incontinence

• Stroke may cause involuntary bladder contractions.

• This causes the stroke survivor to feel a strong urge to urinate and lose control before reaching a toilet.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Stroke and urinary retention

- Stroke may interrupt nerve pathways that control bladder emptying.
- The survivor does not feel an urge to urinate.
- The bladder fills, but the person is unable to empty it.
- Then urine backs up.
- This can increase the risk of urinary tract infection and damage the kidneys.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Continence can be impaired by a stroke:

- **Vision problems**: The survivor may be unable to find the bathroom/urinal or use the toilet independently.

- **Decreased mobility**: The survivor may be unable to get to the bathroom independently or quickly enough.

- **Lack of motor coordination**: The survivor may have difficulty managing clothing, adult diapers, transfers, or the toilet.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Stroke & Functional Incontinence cont’

- Communication difficulty-aphasia affects ability to communicate need to void
- Neglect-visual or body inattention-unaware of one side of body. Risk of injury/fall.
- Impulsiveness- affects ability to wait for assistance. Risk of injury/fall

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Key Points
(adapted from Heart and Stroke Tips and Tools for Everyday Living 2010)

- Almost half of stroke survivors who have problems with incontinence had the same problems before the stroke.

- It is important to identify all the factors that affect the stroke survivor’s bladder control.

- With lifestyle changes and your support, about 80% of incontinence problems can be resolved.

- Incontinence is a strong predictor of stroke functional outcome (Meijer 2003).
Normal Bowel Anatomy

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Normal Bowel Function

A healthy bowel depends on:

- How the muscles and nerves work together
- Eating a high-fibre diet
- Drinking 6 to 8 cups of non-caffeinated fluids each day

Usually, bowel movements occur anywhere from 3 times a day to 3 times a week.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Constipation - Definition

Two or more symptoms in the past 12 months of:

- Straining*
- Hardened stools*
- Feeling of incomplete stool evacuation*
- Feeling of blockage or obstruction*
- Need for manual stool evacuation*
- Less than 3 bowel movements per week

* A person has these problems for more than one-quarter of their bowel movements.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Constipation

- Pushing too hard and too often when having a bowel movement can weaken pelvic floor muscles.
- Stool “impaction” (hard, “stuck” feces in the rectum) adds to urinary incontinence.
- “Smearing” or “staining” of stool, may be caused by constipation or possible rectocele.
How stroke can affect bowel function

- Communication deficit
- Immobility
- Poor oral intake
- Change in diet-texture and intake
- Lack of appetite
- Feeding difficulties
- Mood change

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Incontinence Management Plan

- Assess the incontinence problem
- Develop a care plan
- Implement an individualized toileting plan that addresses contributing factors
- Evaluate effectiveness of interventions
- Revise as needed
Continence Assessment - Key Elements

- Incontinence History
  - Onset
  - Duration
  - Daytime / Nighttime
  - Accidents
  - Stress Loss
  - Urge Loss
  - Aware of Loss

- Fluid Intake
- Bowels
- Medical History
- Medications
- Functional Ability
Incontinence - Assessment

- Medical Problems like Cognitive Impairment, Stroke, etc.
- Past Medical or Surgical History ie Childbirth
- Aging - Loss of pelvic muscle tone & atrophic changes
- Urinary Tract Infections
- Overweight
Incontinence – Assessment

- High Caffeine Intake
- High Alcohol Intake
- Poor Fluid Intake
- Medications
- Constipation
- Decreased Mobility
- Environmental Factors
Assessment - Cognitive Capacity

Requirements for Continence

• aware of urge to void
• able to get to the bathroom
• able to suppress the urge until resident reaches the bathroom
• able to void when resident gets to the BR
Stroke & Bowel Problems

Constipation:
• Stroke can weaken the muscles that expel the stool and cause constipation. This also happens when the bowels don’t move often enough.

Diarrhea:
• Diarrhea is marked by frequent, watery stools.
• Causes can range from viral infections (flu) to serious medical problems (ex Crohn’s disease).
• Fecal incontinence is often mistaken for diarrhea.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
RAI MDS SECTION H: CONTINENCE IN LAST 14 DAYS

H1a BOWEL CONTINENCE
Control of bowel movement, with appliance or bowel continence programs, if used

H1b BLADDER CONTINENCE
Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used

H2 BOWEL ELIMINATION PATTERN (Check all that apply in LAST 14 DAYS.)

a. Bowel elimination pattern regular—at least 1 movement every 3 days
b. Constipation
c. Diarrhea
d. Fecal impaction
e. NONE OF ABOVE
RAI MDS SECTION H: DEFER
CONTINENCE IN LAST 14 DAYS (Cont.)

H₃ APPLIANCES AND PROGRAMS
(Check all that apply in LAST 1₄ DAYS.)
a. Any scheduled toileting plan  
b. Bladder retraining program  
c. External (condom) catheter  
d. Indwelling catheter  
e. Intermittent catheter  
f. Did not use toilet, commode, urinal  
g. Pads or briefs used  
h. Enemas, irrigation  
i. Ostomy present  
j. NONE OF ABOVE

H₄ CHANGE IN URINARY CONTINENCE
Resident’s urinary continence has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).
0. No change 1. Improved 2. Deteriorated

## Individualized Assessment Tool

### RAI-MDS Complementary Assessment

- An assessment for use with residents who trigger the Continence Resident Assessment Protocol (RAP) or where a more detailed continence history is required.

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<table>
<thead>
<tr>
<th>RAI-MDS Complementary Assessment</th>
<th>Resident Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BLADDER</strong></td>
<td></td>
</tr>
<tr>
<td>Urinary Incontinence (UI)</td>
<td></td>
</tr>
<tr>
<td><strong>Frequency and timing</strong></td>
<td></td>
</tr>
<tr>
<td>No day time incontinence</td>
<td>Poor vision</td>
</tr>
<tr>
<td>Less than daily</td>
<td>Altered mental status</td>
</tr>
<tr>
<td>1-2 times a day</td>
<td>Pain poorly managed</td>
</tr>
<tr>
<td>Night time only</td>
<td>Can’t manage clothing</td>
</tr>
<tr>
<td>Both day and night</td>
<td>Can’t manage clothing</td>
</tr>
<tr>
<td><strong>Urinary Incontinence-Vol</strong></td>
<td>Bowel</td>
</tr>
<tr>
<td>Small volume leaks, drips, spurt</td>
<td>Normal pattern for BMI – usual time of day</td>
</tr>
<tr>
<td>Continuous bladder leakage</td>
<td>Triggers for BM – coffee fibre</td>
</tr>
<tr>
<td>Unable to determine</td>
<td>Constipation</td>
</tr>
<tr>
<td><strong>Frequency and timing</strong></td>
<td></td>
</tr>
<tr>
<td>Sudden</td>
<td>Dribble</td>
</tr>
<tr>
<td>Gradual</td>
<td>Blood, mucous, other discharge</td>
</tr>
<tr>
<td>Duration</td>
<td>Hemorrhoids</td>
</tr>
<tr>
<td>&lt; six months</td>
<td>Urinary tract or renal tract problems</td>
</tr>
<tr>
<td>6 mo – 1 year</td>
<td>Laxative, suppository, enema use</td>
</tr>
<tr>
<td>&gt; 1 year</td>
<td>Fecal incontinence</td>
</tr>
<tr>
<td>Unknown</td>
<td>Other factors to cause loss of bowel control</td>
</tr>
<tr>
<td>Symptoms over the past 6 months</td>
<td>Awareness of urge to defecate</td>
</tr>
<tr>
<td>Worsening</td>
<td>Physical Exam Abdominal – soft distension</td>
</tr>
<tr>
<td>Stable</td>
<td>Bowel sounds – 4 quadrants</td>
</tr>
<tr>
<td>Improving</td>
<td>Adequate fluid intake (&gt; 1500 ml/day)</td>
</tr>
<tr>
<td>Fluctuating</td>
<td>Nutritional intake (&gt; 35% at 3 meals)</td>
</tr>
<tr>
<td>Unknown</td>
<td>ASSESSMENT</td>
</tr>
<tr>
<td>Stress Incontinence</td>
<td></td>
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<tr>
<td>Urge Incontinence</td>
<td></td>
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<tr>
<td>Strong incontinence</td>
<td></td>
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<tr>
<td>UI moderate, large volume (goal)</td>
<td></td>
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<tr>
<td>Function Incontinence</td>
<td></td>
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<tr>
<td>Limited mobility</td>
<td></td>
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<tr>
<td>Requires assistance with toilet</td>
<td></td>
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<tr>
<td>Requires aids (mechanical lift, raised toilet)</td>
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<tr>
<td>Aware of urge to void</td>
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<tr>
<td>Unable to get to the toilet on time</td>
<td></td>
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<tr>
<td>Can’t hold urinal or sit on toilet</td>
<td></td>
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<tr>
<td>Can’t reach: use call bell</td>
<td></td>
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<tr>
<td>Restraints or gen-chair</td>
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Developed by Nadia Thacker St. Joseph’s Care Group Thunder Bay, 2017 based on work done at the Pears Veterans Institute

[http://ltctoolkit.rnaho.ca/resources/continence#Assessment-Tools](http://ltctoolkit.rnaho.ca/resources/continence#Assessment-Tools)
Assessment Tool

Monthly Bowel Record:
• This record describes bowel movements, laxative use and effectiveness.

http://ltctoolkit.rnao.ca/resources/continence#Assessment-Tools
Continence & Restorative Care

- In Ontario, Continence Retraining is not captured or documented Nursing Restorative Care (P3).
- A Resident on- Any scheduled toileting plan (H3a) or a Bladder Retraining Program (H3b), may contribute to the RUG's score.
Continence Program Criteria

- Resident must have been assessed by RN to ensure that they have restorative potential

AND

- Resident has difficulty locating the toilet OR
- Resident has difficulty in transferring and/or walking to the toilet OR
- Resident may have symptoms of incontinence, ie. Stress, urge, frequency, etc.
Toileting Programs

- Resident’s care plan must show that the resident’s toileting program was:
  - organized,
  - planned,
  - Documented,
  - monitored and
  - evaluated.

- Toileting programs are for residents whose continence can be improved or maintained by their toileting plan.

Minnesota Dept. of Health. 2004. Nursing Rehabilitation/Restorative Care and MN Case Mix
Incontinence Management Strategies

• The Best Incontinence Intervention for your resident depends on:
  • the resident’s history and
  • the type of incontinence,
  • etc.

Scheduled Toileting Plan (H3a) using Prompted Voiding

- Assess resident’s bowel/bladder pattern with a voiding record to determine the most appropriate times to toilet the resident.
- Set a measurable, resident-centered goal:
  - Resident will be 100% bladder continent during days and evenings.
Scheduled Toileting Plan (H3a) using Prompted Voiding

- Clearly describe toileting plan so all staff can toilet the resident.
- Document the resident’s incontinence daily.
- Monitor the effects of toileting program and make adjustments to the plan as necessary.
- Reevaluate the resident at least quarterly.
Assessment Tool

Voiding Record:

- A 3-day, hourly fluid intake and urine output record.
- Useful for determining when a resident voids in relation to intake for a prompted voiding intervention.

http://ltctoolkit.rn ao.ca/resources/continence#Assessment-Tools
Prompted Voiding

• Approach Resident when he/she would normally void.
  • Monitor - Ask the resident if he/she needs to use the toilet.
  • Prompt - Remind the resident to use the toilet and try not to void between prompted voiding sessions.
  • Praise - Give positive feedback to resident to reinforce dryness and appropriate toileting
• Carefully record and monitor resident’s response

RNAO. 2011. Promoting Continence Using Prompted Voiding
Bladder Retraining

Bladder retraining gradually increases the time between going to the bathroom. This helps the survivor to:

- Correct the habit of frequent voiding
- Increase bladder capacity
- Suppress the feeling of urgency
- The plan may include pelvic floor exercises which involve tightening and relaxing the muscles of the pelvic floor

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Bladder Retraining

The protocol also includes a schedule for urinating such as this:

- Periodically increase the interval between voids by 15 minutes (or less if needed)
- Continue increasing the intervals until the time between voids is 3 to 4 hours

What you can do to help:

- Remind and encourage the survivor to practice pelvic floor exercises, as needed

Adapted from *Heart & Stroke Tips and Tools for Everyday Living* 2010
Incontinence Strategies

- Encourage the stroke survivor to sit leaning forward during urination, with the feet flat on the floor or on a stool.
- If the stroke survivor uses a urinal, keep it where it can be easily seen and reached - try placing one urinal on each side of the bed.
- Bedpan: Make sure the head of the bed is raised as upright as possible to allow the survivor to sit as normally as possible when using a bedpan.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Constipation Strategies

• Gravity and increased abdominal pressure promote more complete bladder and bowel emptying than using a bedpan.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
More Incontinence Strategies

- Encourage independence and self-care:
  - Suggest Adaptable clothing
  - Communicate – Work out ways so your resident can tell you what he or she needs
  - Use Adaptive devices – commode, grab bars, urinals, bed pans, call bells
  - Give Privacy

Adapted from Central South Regional Stroke Program. 2007. Continence and Stroke.
Other Incontinence Strategies

- Use Dementia Care strategies, Responsive Behaviour strategies, PIECES
- Use Environmental prompts. ie. signs
- Delay incontinent product use until after everything else has been tried.

Adapted from Central South Regional Stroke Program. 2007. Continence and Stroke.
Hygiene & Incontinence Strategies

Give good hygiene & skin care:

- Wipe from *front to back* after voiding
- Change underwear daily or more often if soiled
- Always provide thorough peri-care after urinary or fecal incontinence.
- Wear gloves for peri-care, remove the gloves, wash your hands, and wash the hands of the stroke survivor

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Hygiene & Incontinence Strategies

- Do not use deodorant sprays, powder, or perfumes on perineal skin.

Continence products

- Use the right sized continence products. Do not double up liners and products or use over-sized products.
- Watch for leaking, tightness, skin irritation, or rash.
- Report redness, irritation, or skin breakdown to registered staff.

Adapted from Heart & Stroke Tips and Tools for Everyday Living 2010
Key Incontinence Strategies


- Ensure Adequate fluid intake – 1500ml/day (MOHLTC standard)

Adapted from Central South Regional Stroke Program. 2007. *Continence and Stroke.*
Case Study – Mabel

- Mabel is a 77 year old woman, recently widowed, with no family support locally.
• She was admitted to your long term care home 1 month ago.

• She had a left hemisphere stroke 3 months ago.

• Prior to her stroke she was living independently in her own home with some support from CCAC.
Mabel has mild expressive aphasia (difficulty getting her words out).

She also has weakness in her right arm, hand and leg.

Mabel is able to walk short distances with a walker but mainly uses a wheelchair throughout the day. She is able to transfer to a chair with help from one person.

She requires assistance with eating and dressing.
- She has occasional urinary incontinence.
- In the past week Mabel has started to cry for no apparent reason.
- She appears to be having memory difficulties.
- Mabel has occasional outbursts of shouting at staff and other residents.
Case Study-Activity

- What is Mabel’s goal related to continence?

- Identify at least 2 reasons why she is occasionally incontinent

- What can you do to help Mabel achieve her goal
Activity
Resources


Resources


