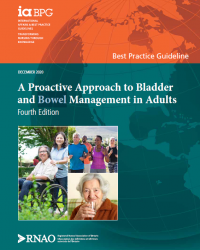
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**Gap Analysis: A Proactive Approach to Bladder and Bowel Management Fourth Edition**

**Revised 2020**

**Work Sheet**



This guideline can be downloaded for free at:

<https://rnao.ca/sites/rnao-ca/files/bpg/Bladder_and_Bowel_Management_FINAL_WEB.pdf>

RNAO Leading Change Toolkit 3rd Edition

<https://rnao.ca/leading-change-toolkit>

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**Interpretation of Evidence and Recommendation Statements**

RNAO BPGs are developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE)G and Confidence in the Evidence from Reviews of Qualitative Research (CERQual)

**What does certainty of evidence mean?**

The certainty of evidence (i.e., the level of confidence we have that an estimate of effect is true) for quantitative research is determined using GRADE methods. GRADE categorizes the overall certainty of evidence as high, moderate, low or very low (

|  |  |
| --- | --- |
| **HIGH** | We are very confident that the true effect lies close to that of the estimate of the effect. |
| **MODERATE** | We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. |
| **LOW** | Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect. |
| **VERY**  **LOW** | We have very little confidence in the effect estimate: the true effect is likely to be substantially different from it’s estimate. |

**What does confidence of evidence mean?**

The confidence in evidence for qualitative research (i.e., the extent to which the review finding is a reasonable representation of the phenomenon of interest) is determined using GRADE-CERQual methods

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| --- | --- |
| **HIGH** | It is highly likely that the finding is a reasonable representation of the phenomenon of interest. |
| **MODERATE** | It is likely that the finding is a reasonable representation of the phenomenon of interest |
| **LOW** | It is possible that the review finding is a reasonable representation of the phenomenon of interest. |
| **VERY**  **LOW** | It is not clear whether the review finding is a reasonable representation of the phenomenon of interest |

**Good practice statement:** Refers to a practice already accepted as beneficial or practical advice. The recommended practice is believed to be so beneficial, that conducting a systematic review is unreasonable. These recommendations are not based on a systematic review and do not receive a rating of the quality of evidence or strength of the recommendation.

**Recommendation:** A course of action(s) that directly answers a recommendation question. It is based on a systematic review of the literature and is made in consideration of its: (a) benefits and harms; (b) values and preferences; and (c) health equity. All recommendations are given a strength through panel consensus.

**Adopted recommendation:** This entails using an existing, trustworthy recommendation without changes to the original recommendation. The expert panel agrees with the judgments made by the original guideline developer.

**Outcomes:** A dependent variable, or the clinical and/or functional status of a patient or population, that is used to assess if an intervention is successful.

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| Date Completed: | |  | | |
|  | | | | |
| Team Members participating in the Gap Analysis: | | | | |
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Completion of this gap analysis allows for the annual comparison of your current practice to evidence-based practices as regulated by the MOHLTC per Fixing Long-Term Care Act, 2021 at <https://www.ontario.ca/laws/statute/21f39> &

[O. Reg. 246/22: GENERAL (ontario.ca)](https://www.ontario.ca/laws/regulation/r22246)

| **RNAO Best Practice Guideline Recommendations for Urinary Incontinence** | Met | Partially Met | Unmet | Notes  (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners) |
| --- | --- | --- | --- | --- |
| **GOOD PRACTICE STATEMENT:**  **Prior to developing a plan of care or carrying out interventions, health providers conduct a focused initial continence assessment in collaboration with the person experiencing urinary incontinence ( does not require GRADE application)** | | | | |
| **Sections for components and detail of assessments 1-5 pages 36-40**  **Components of Assessment**  1. Obtain a clinical history to accurately determine:   * Identification of the type of urinary incontinence:  1. stress incontinence: involuntary loss of urine that occurs due to sudden increase in abdominal pressure due to coughing, sneezing, laughing, lifting, exercise 2. urgency incontinence: sudden compelling urge to urinate and the bladder contracts and empties in an involuntary fashion 3. mixed incontinence: involuntary loss of urine associated with urgency and physical exertion 4. functional incontinence: normal urine control but have trouble getting to bathroom in time due to mobility issues also referred to as disability incontinence  * determine possible underlying causes or contributing factors to guide the plan of care and support appropriate interventions   **Details of Assessment :**  Obtaining a general health history can include the following:   * Identifying factors, including co-morbidities, to determine the underlying causes of urinary incontinence. See Appendix I for a list page 133 * Conduct a medication review of prescription, OTC and supplements. See Appendix J page 135 for a list of meds that may contribute to UI in collaboration with pharmacist or prescriber. * Assess the functional and cognitive status of person living with UI   Obtaining a clinical history can include:   * Type of amount of daily fluid intake, including caffeine and alcohol * Type, onset and duration of symptoms * Daily use of incontinence products * A perineal skin assessment to determine the impact of urinary incontinence and the impact of the social, psychological, and sexual aspects of QoL * Identification of barriers to successful toileting * Assessment of any red and/or yellow flags associated with urinary incontinence. * Red flags are high alert clinical indicators that require reporting to the appropriate team member of continence specialist. Examples include pain on urination, blood in urine or person describing feelings or pressure in the vagina * Yellow flag alerts are concerning clinical indicators that require ongoing assessment (i.e. monitoring) and reporting to the appropriate member of the IP team or continence specialist. Examples of yellow flags include but not limited to, urinary incontinence potentially causing delirium, infection, medications, reduced mobility or stool impaction |  |  |  |  |
| **2. Components of Assessment :**  Obtain a voiding record to evaluate the frequency of incontinence and voided volume  **Details of Assessment :**   * A three day voiding record should be used to collect details on: * Frequency, amount and severity of incontinence; and * Use of incontinence products * Record all voiding events for 3 consecutive days beginning when the person starts the day on day one and ending when the person starts on day four * Prior to initiating toileting strategies, identify the person’s pattern of incontinence using a 3 day voiding diary * Sample voiding record, see Appendix K page 137 |  |  |  |  |
| **3.Components of Assessment:**  Assess urinary urgency using validated questionnaires  **Details of Assessment :**   * For validated questionnaires and scales to assess urinary urgency, see Appendix L page138 \*(these are not open access resources) * For those persons who are able, an options is to have them complete a validated questionnaire on symptoms and effects of incontinence on QoL |  |  |  |  |
| **4. Components of Assessment:**  Use dipstick urinalysis as a screening tool to further assess, glycosuria, hematuria, proteinuria and pyuria in accordance with policies and procedures of local setting  Caution: A dipstick should not be used to diagnose a urinary tract infection (UTI)  **Details of Assessment:**   * A dipstick urinalysis should not be used to diagnose a UTI; however, it can be a tool to determine if further assessment is needed, especially if a new onset of urinary incontinence is suspected. * A dipstick urinalysis should only be used in accordance with the policies and procedures of the local setting |  |  |  |  |
| **Components of Assessment**  5. Measure post-void residual (PVR) volume within a few minutes of voiding, either by calculating bladder volume using a portable ultrasound scanner or by in and out catheterization (unless otherwise directed)  **Details of Assessment**   * Measure of PVR is indicated to know how well the bladder if emptying (e.g., a PVR of less than 50 – 100 ml is normal with a voided volume of 100 ml or more). * Direct care providers report a measure of voided volume prior to the measurement of PVR volume * Measurement of PVR volume should be based on an order from a physician or NP. |  |  |  |  |
| **Components of Assessment**  6. Report findings  **Details of Assessment:**   * A comprehensive assessment of UI is to be conducted by a continence specialist * Based on individual needs of the person, findings can be reported to a member of the IP team: * NP, Physician * Dieticians * Continence specialists including: Gynecologists, urologists, Nurse continence advisors, ET and wound care specialists, Pelvic PTs * The reporting process may be individualized based on the needs and wishes of the person and their supports |  |  |  |  |
| **1.1 Health care providers offer individualized toileting strategies in persons living with UI including:**  **Strength of recommendation: Strong**  **Strength of evidence of effects: Low**  **Low Confidence of Evidence: N/A** | | | | |
| **All strategies may not be appropriate or realistic.**   * Consider individualized toileting strategies based on a person’s age, physical limitations and cognitive status.   **Prompted Voiding** *refers to using verbal or physical cues to prompt a person to attend to their wet/dry status and then encouraging them to use the toilet through positive reinforcement.*   * For residents 65 yrs and older, including persons with cognitive impairment. * Intervention period 6 months * Residents prompted to void every 2 to 2.5 hours, from 0700 hrs to 1900 hrs, seven days a week * Best predictor of success to prompted voiding is the success during a trial of PV. Responsive to PV relates to recognizing need to void, higher number of self initiating requests to toilet, ability to void successfully when given assistance to toileting, able to ambulate unassisted, more cognitively intact, higher completion of assigned prompted voiding sessions by HCP   **Bladder Training** *involves lifestyle modifications (eliminating bladder irritants from diet, managing fluid intake, weight control, bowel regulation and smoking cessation) and the use of relaxation and distraction techniques for the control of urinary frequency and urgency.*   * Evidence reflecting mostly women between ages 22-65 years * Training includes urge suppression techniques, self-monitoring (voiding diaries), lifestyle modifications (i.e., eliminating bladder irritants from diet, managing fluid intake, weight control, bowel regulation, and smoking cessation) and timed voiding * Evidence reflecting men and women 40 yrs and older living with idiopathic overactive bladder * A 30 minute bladder training program that consisted of: education on normal daytime frequency and amount, normal physiology of urination, holding urine until a certain goal is met * Train the bladder by: refraining from going to bathroom after feeling an urge to void, ceasing action and thought temporarily in order to stop thinking about voiding; and performing pelvic floor exercises 5-6 times a day * Feedback and problem shooting with a specialized nurse practitioner. * Do not routinely use continence containment products (including briefs or pads) for older adults to reduce risk of adverse outcomes such as diminished self-esteem, perceived QoL, dermatitis, pressure wounds, and UTIs. * Assessment conducted to determine the risk of such outcomes before initiating or continuing the use of such products |  |  |  |  |
| * 1. **Health providers encourage persons living with UI to engage in low-intensity physical activity, as tolerated**   **Strength of recommendation: Strong**  **Strength of evidence of effects: Low**  **Low Confidence of Evidence: N/A** | | | | |
| Low-intensity physical activity refers to light, non-strenuous and repetitive bodily movement. It should be individualized and appropriate to the person’s age, physical ability, and associated health status.  Research suggested that low-intensity physical activity may decrease episodes of UI and physical limitations (improves the degree of physical and functional activities such as walking and climbing)  Research suggested that low-intensity exercise included:   * Yoga for 6 weeks * Stretching followed by stationary cycling * Treadmill exercises * Resistance training for 52 weeks |  |  |  |  |
| **Adopted Recommendation: Health providers offer women who live with stress or mixed urinary incontinence a trial of supervised PFMT for at least 3 months as first-line management. A comprehensive assessment should be conducted to determine the applicability of PFMT for these women.**  **Strength of recommendation: Strong**  **Strength of evidence of effects: Very Low to Low**  **Low Confidence of Evidence: N/A** | | | | |
| PFMT is an exercise program aimed at improving specific deficiencies in pelvic floor muscle structure or function. It is based on the ability to contract the pelvic floor muscle.  In practice, it has been applied to both men and women, and for men after prostate surgery   * Comprehensive assessment would be conducted by a health provider who has the appropriate knowledge and skills pertaining to in performing PFMT such as Nurse Continence Advisor (NCA) or Pelvic health PT (find a health care professional at <https://pelvichealthsolutions.ca/>) * Non invasive conservative measures should be considered prior to medication or surgery * PFMT program should comprise of at least 8 contractions, performed 3 times per day * Do not use perineometry or pelvic floor electromyography as biofeedback, as a routine part of PFMT. * Continue exercise program if PFMT is beneficial     CAUTION: *PFMT may not be appropriate for frail older women or those living with cognitive impairments. It should be facilitated and supervised by a health provider with the appropriate knowledge and skills such as an NCA or pelvic health PT* |  |  |  |  |
| **3.1 Health-service organizations implement an interprofessional approach to providing care for persons living with UI**  **Strength of recommendation: Conditional**  **Strength of evidence of effects: Low**  **Confidence of Evidence: N/A** | | | | |
| IP approach refers to a coordinated approach to continence care by a team of health providers- including reporting and/or referring to a continence specialist based on individual needs   * IP may include nurses, Nurse Continence Advisors, nurses specialized in wound, ostomy and continence (NSWOC), physicians(general, urologists, urogynecologists, colorectal surgeons), PSWs, PTs, OTs, dieticians, pharmacists * IP approach to care includes: triage and referral, categorization of person reports, consultation and consideration by relevant specialists, and discussion of complex problems in weekly IP meetings |  |  |  |  |
| **RNAO Best Practice Guideline Recommendations for**  **Fecal Incontinence and/or Constipation** | Met | Partially Met | Unmet | Notes  (Examples of what to include: is this a priority to our home, information on current practice, possible overlap with other programs or partners) |
| **GOOD PRACTICE STATEMENT:**  Prior to developing a plan of care or carrying out interventions, health providers conduct a focused initial assessment in collaboration with the person experiencing fecal incontinence and/or constipation. ( does not require GRADE application) | | | | |
| Definition of Constipation: The difficult or infrequent passage of stools (less than 3 bowel movements per week). Constipation may be acute or chronic (lasting more than 3 months) and it may be in response to a variety of physiological, mechanical, and medically related factors, including medication use. However, the most common type of is functional constipation for which there is no underlying cause.  Assessment of Fecal Incontinence and Constipation:   * Understand types of fecal incontinence  1. Passive fecal incontinence – involuntary leakage of feces without warning, small amount of seepage between buttocks, frequently related to internal anal sphincter dysfunction 2. Urge fecal incontinence – inability to defer defecation once the urge is perceived for long enough to reach a toilet. 3. Functional fecal incontinence – involuntary leakage of feces “due to limitation in mobility, manipulating clothing, or toileting ability or delayed assistance with toileting  * Obtain baseline history of daily bowel pattern: type and quantity of stool, frequency and timing and any straining * Timing of fecal incontinence: post defecation or during the night to evaluate if fecal incontinence is associated with BM * Assess stool using a Bristol Stool chart * Dietary history 7 day history of daily fluid and fibre intake to rule out possible underlying causes * Medication review to evaluate effect on fecal incontinence (laxatives, anti-anginal and anti –hypertensive meds may reduce sphincter tone, magnesium antacids cause diarrhea) * Medication review of medications that can cause constipation pg 146 * Medical conditions  1. Age related (frailty) 2. Previous surgeries (anal fissures, fistula, pelvic radiation, organ prolapse) 3. Impaired mobility 4. Functional impairment (impaired cognition) 5. Environmental (inaccessible toilets, lack of timely toileting assistance, use of restraints) 6. Dementia 7. Neurological disease (Stroke, MS, SCI) 8. Chronic medical conditions (congenital anorectal anomalies, constipation with fecal impaction, DM, hemorrhoids, IBD, rectal prolapse) 9. OB history (low birth weight, posterior delivery, use of forceps, fourth degree tear)  * Perform digital rectal examination of determine fecal impaction * Perianal skin assessment * Assess impact on QoL: social, psychological, sexual * Assessment of red flags which are high alert clinical indicators such as pain, bleeding with BM etc and require reporting to the appropriate IP team member of Continence specialist * Assessment of yellow flags relating to fecal incontinence which are concerning clinical indicators caused by delirium, infection, medication SE, diarrhea, stool impaction, or inadequate toileting access that require ongoing assessment or monitoring and reporting to IP team member or Continence specialist. Or, clinical indicators relating to constipation caused by inadequate intake of fluids/fibre, reduced mobility, or medication side effects   Report findings:   * Comprehensive assessment is conducted by continence specialist which includes performing a digital rectal examination to determine anal sphincter tone, anal fissure, rectocele, and presence of hemorrhoids * Report finding to member of IP team who may refer to continence specialist: physician, NP, PT and dieticians * Continence specialists include: gynecologists, urologists, colorectal surgeons, NCs, NSWOCs, OTs, Pelvic floor PTs |  |  |  |  |
| **4.1 Health providers encourage persons living with constipation to engage in low-intensity physical activity for 30 – 60 minutes (as tolerated) at least three times a week to help manage constipation**  **Strength of recommendation: Strong**  **Strength of evidence of effects: Low**  **Confidence of Evidence: N/A** | | | | |
| Low intensity physical activity refers to light, non strenuous repetitive body movement such as:   * walking, low-impact aerobic exercise, * light resistance training and * Engaging in leisure-level sports.   Low-intensity exercise alone is not enough. Behaviours need to be encouraged such as:   * adequate dietary fibre, * a low calorie diet (for obesity), * adequate fluid intake and appropriate * appropriate squat positions for defecation |  |  |  |  |
| **5.1 Health providers counsel persons on adequate fibre intake to prevent and manage constipation.**  **Strength of recommendation: Conditional**  **Strength of evidence of effects: Low**  **Confidence of Evidence: N/A** | | | | |
| Adequate fibre intake may decrease laxative use.  Caution: *psyllium fibre is not recommended for those with opioid-induced constipation as it can lead to bowel obstruction*   * encourage adequate fluid intake along with fibre intake * refer to dietician for incorporating fibre into a diet * along with fibre supplements, fibre rich foods and plant based fibre for optimal microbiota diversity can be recommended |  |  |  |  |
| **5.2 Health providers counsel persons living with constipation on adequate fluid intake to help manage constipation.**  **Strength of recommendation: Strong**  **Strength of evidence of effects: Very Low**  **Confidence of Evidence: N/A** | | | | |
| Aside from fluid intake, health providers counsel persons living with constipation on:   * adequate fluid intake (1500 – 2000 ml) but would need to be tailored individually for adults living with kidney failure or heart disease or other relevant health conditions * dietary fibre consumption * balanced diet * exercise * optimal positions to defecate * indications of appropriate laxative use   Refer to registered dietician for incorporating fluid into diets to prevent constipation if further support required |  |  |  |  |
| **5.3 Health providers promote the option of using psyllium fibre supplements for persons living with fecal incontinence in the community**  **Strength of recommendation: Conditional**  **Strength of evidence of effects: Moderate**  **Confidence of Evidence: N/A** | | | | |
| Psyllium fibre supplements may improve stool consistency, QoL and reduce episodes of fecal incontinence in the community.  **It is not recommended for the long term care setting**  Caution: *Psyllium fibre may cause potential harms such as constipation or fecal impaction if used in persons who are not mobile and do not have adequate hydration. Therefore, it is not indicated for persons who are bed bound or older adults living in long term care settings.*  Adequate psyllium fibre intake page 70. |  |  |  |  |
| **6.1 Health service organizations implement an interprofessional approach to providing care for persons living with fecal incontinence and/or constipation.**  **Strength of recommendation: Conditional**  **Strength of evidence of effects: Low**  **Confidence of Evidence: Low** | | | | |
| * IP team approach tailored to individual care needs. * Primary care settings use evidence based management and have resources for referral to continence specialists and/or continence care services such as continence clinic * Use of clinical pathways with referrals and consults to a continence team for fecal incontinence * Clinical pathway includes anorectal surgeons, pelvic physiotherapists, anorectal NP, bowel function nurse continence team, and researcher   Quality Improvement:   * Constipation audits * IP team to develop an algorithm to prevent, detect and treat constipation * IP team of nurses, nurse manager, dieticians, PT and doctors |  |  |  |  |
| **7.1 Health service organizations implement a bowel protocol to manage constipation, which can be individualized**  **Strength of recommendation: Strong**  **Strength of evidence of effects: Very Low**  **Confidence of Evidence: N/A** | | | | |
| Components of a bowel protocol   * Individualized for person’s needs, preferences and health history * Promotion of fibre and fluid intake * Health teaching regarding exercise/mobility * Medication review, followed by physical assessments * Medication for relief * If still no bowel movement, the protocols suggested contacting the physician   Developing a bowel protocol   * Include a IP working group (physician, pharmacist, nurse, researcher, dietician, management, nurses, PTs) |  |  |  |  |