

A Model for Excellence in Continence Care



Incontinence Affects



- 5 to 10 % in the Community
- 10 to 20 % in Acute Care
- 50 to 70 % of Complex Continuing Care



Who is affected?

1 in 4 women

1 in 10 men



Important Problem

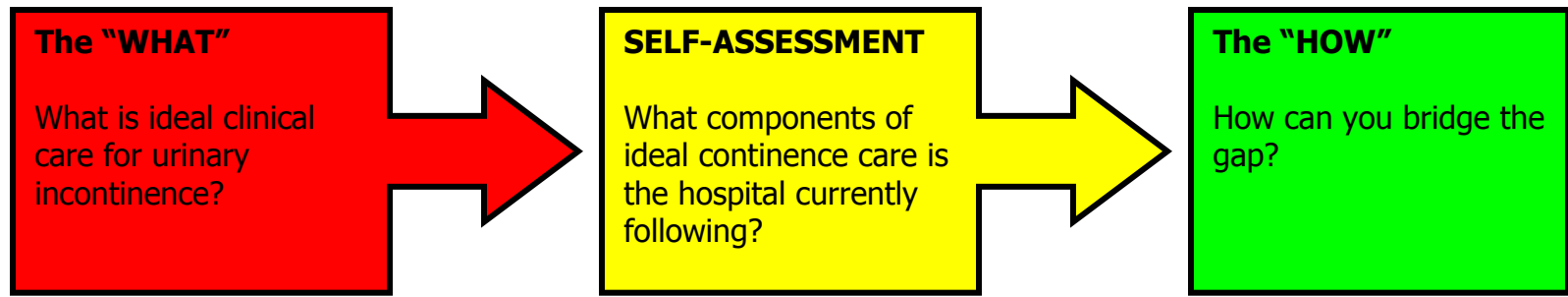
- Pervasive myth that “nothing can be done”



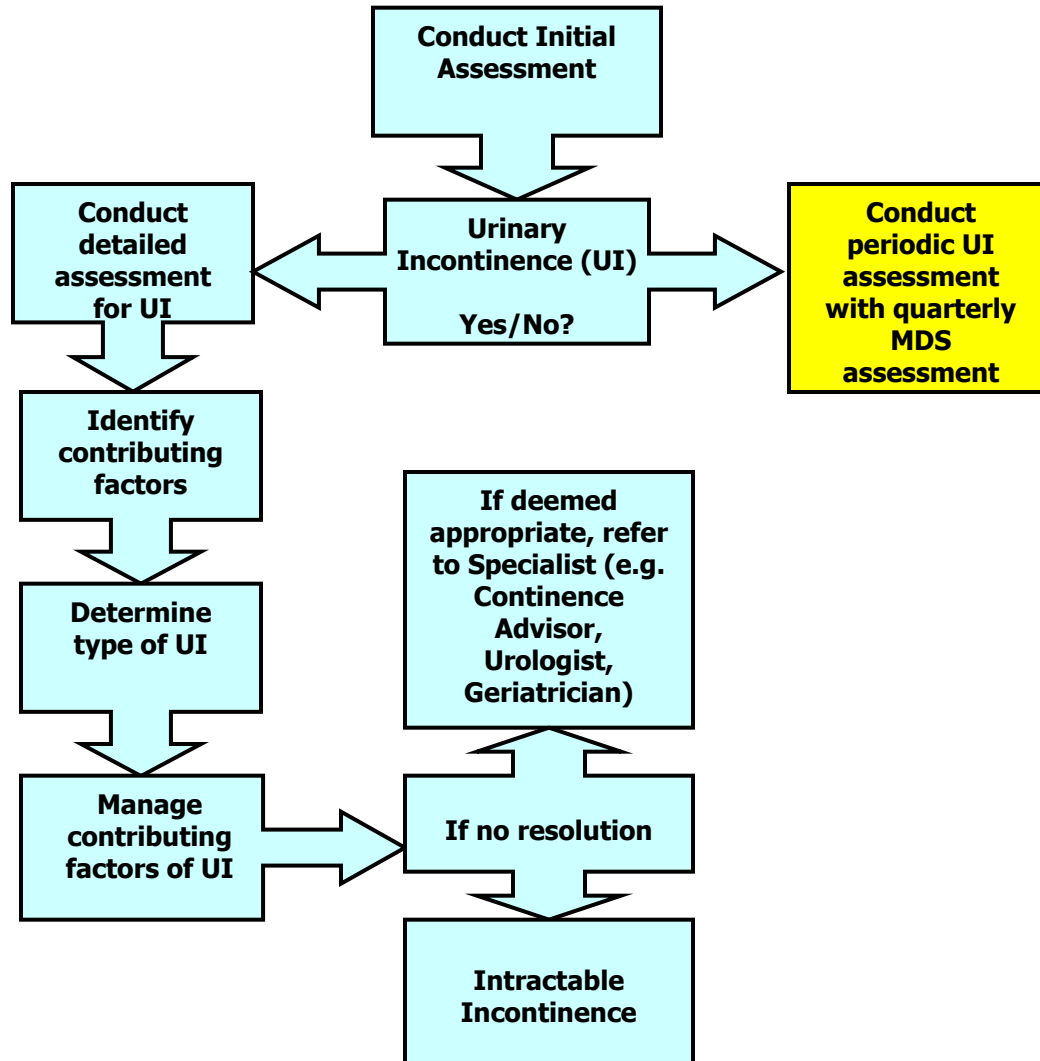
Barriers to Continence Care

- Knowledge
- Attitudes
- Resources

Clinical Model for "IC 5"



What is optimal continence care?





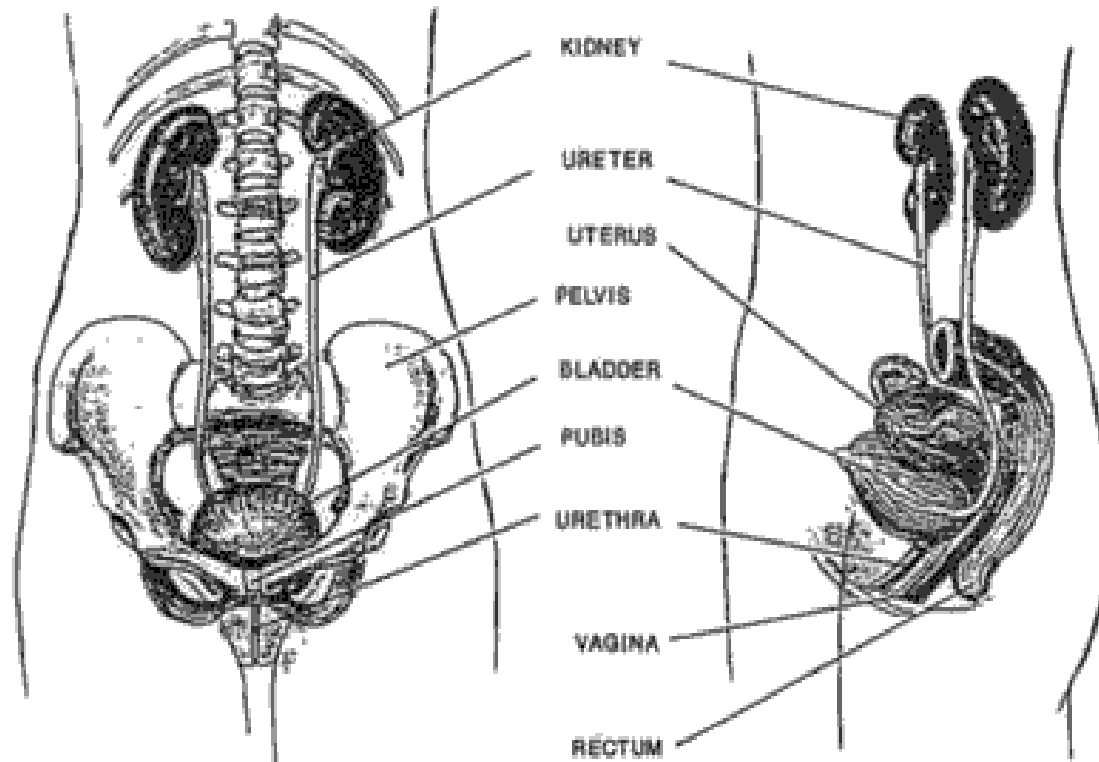
What is Incontinence?

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

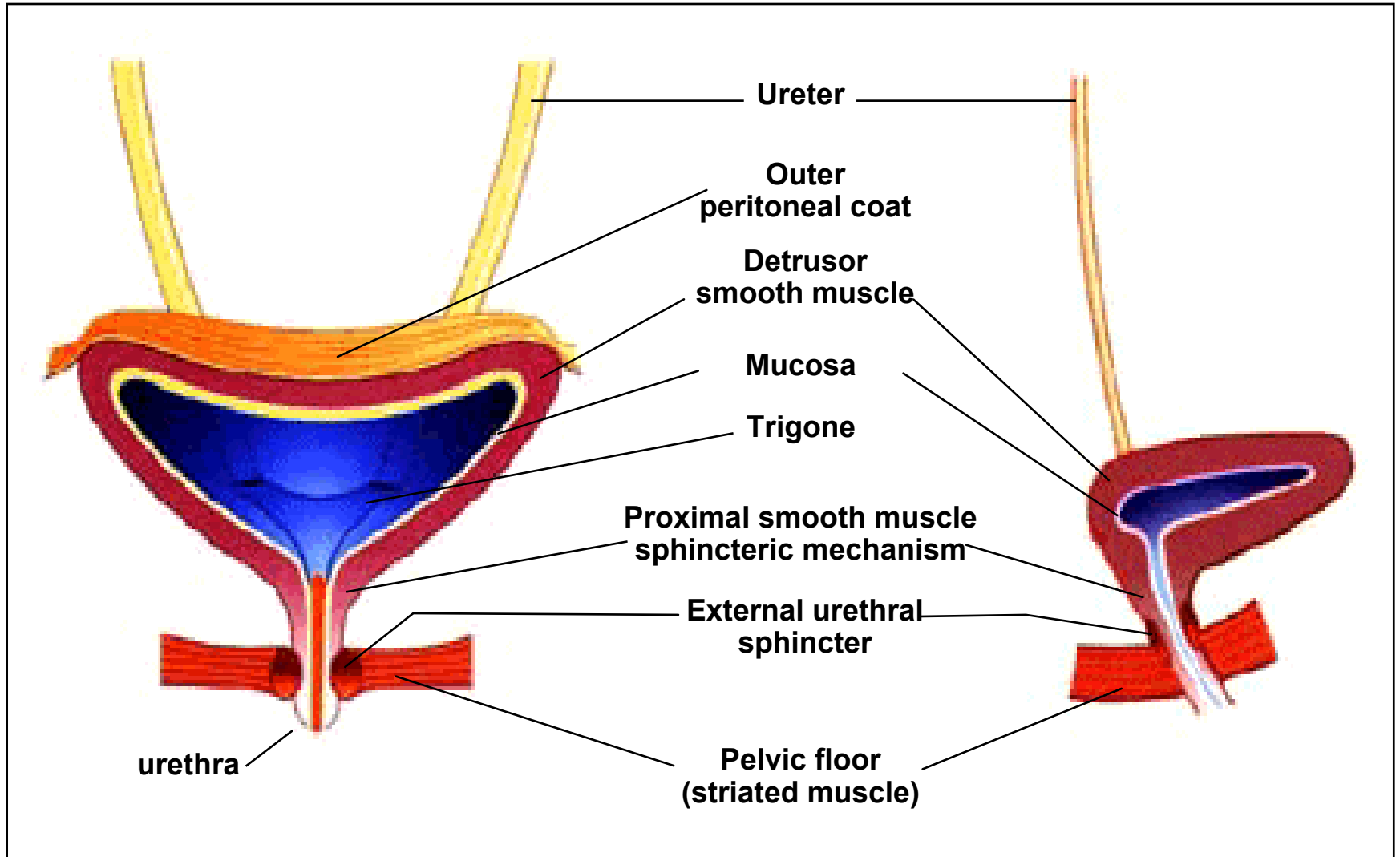
a condition where involuntary loss
of urine is a social or hygienic
problem

(ICS, 1987)

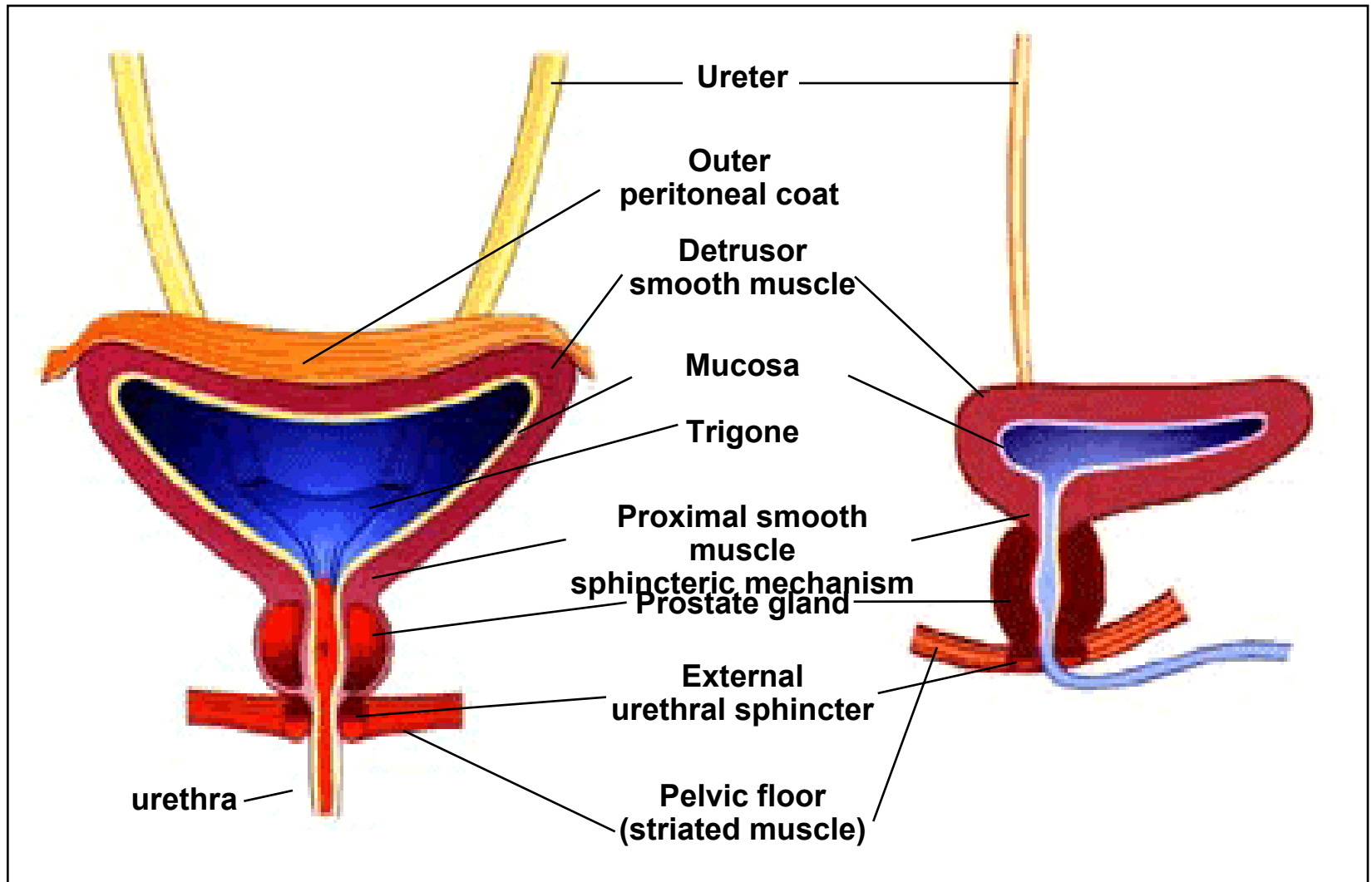
Bladder Function



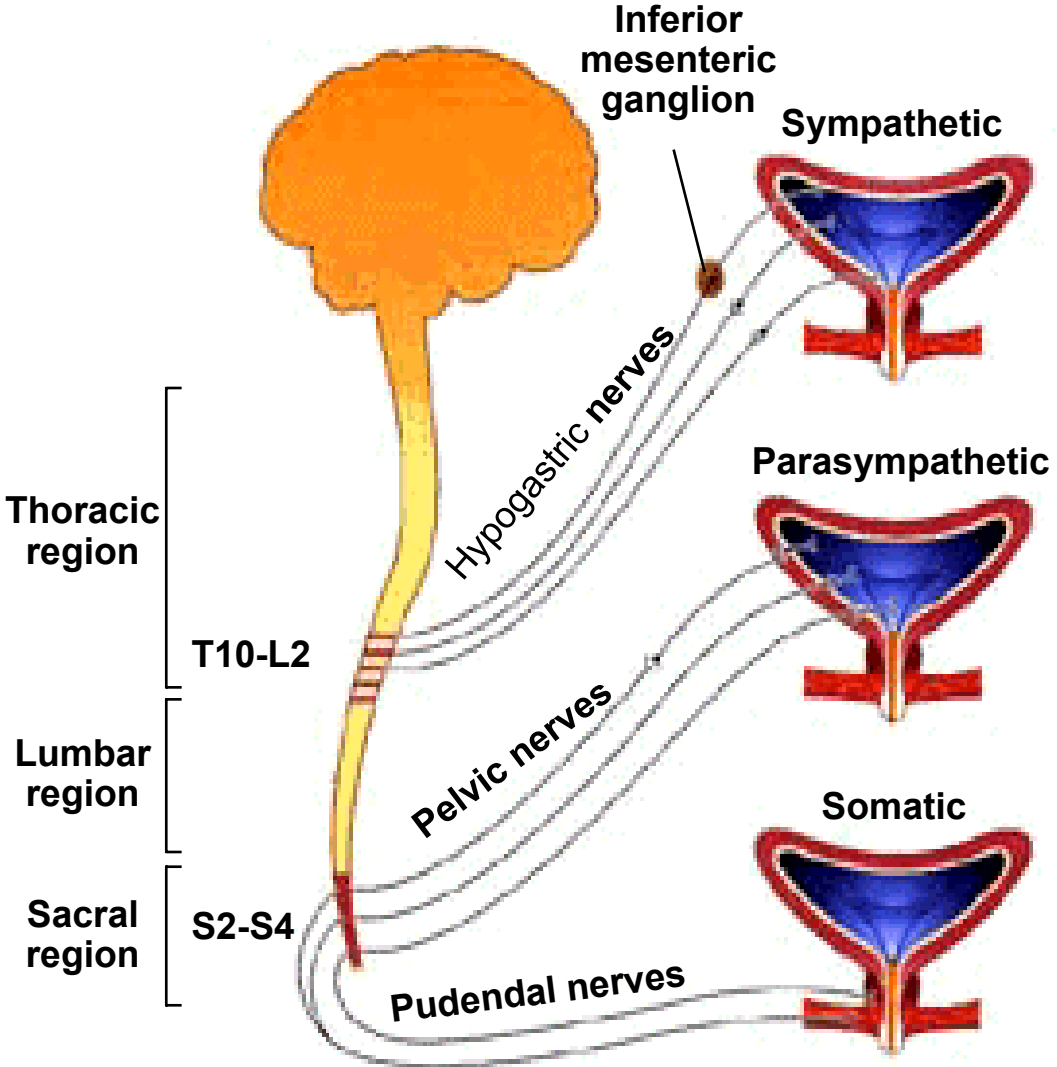
Structure of the Female Lower Urinary Tract



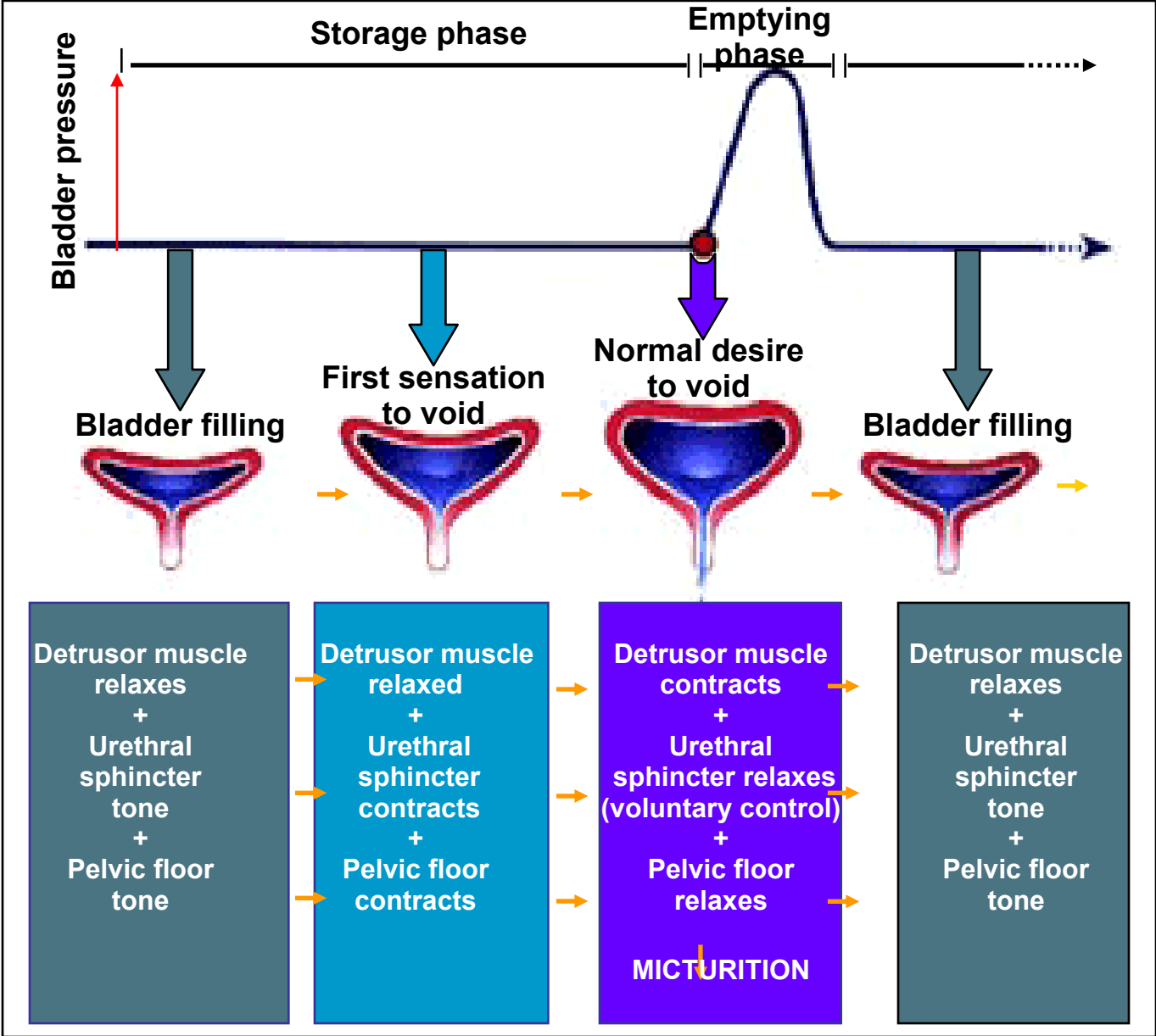
Structure of the Male Lower Urinary Tract



Innervations of the Lower Urinary Tract



Normal Micturition Cycle





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



Types of Incontinence

- stress
- urgency
- 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



Urgency Incontinence

(overactive bladder)

- loss of urine with a strong unstopppable 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

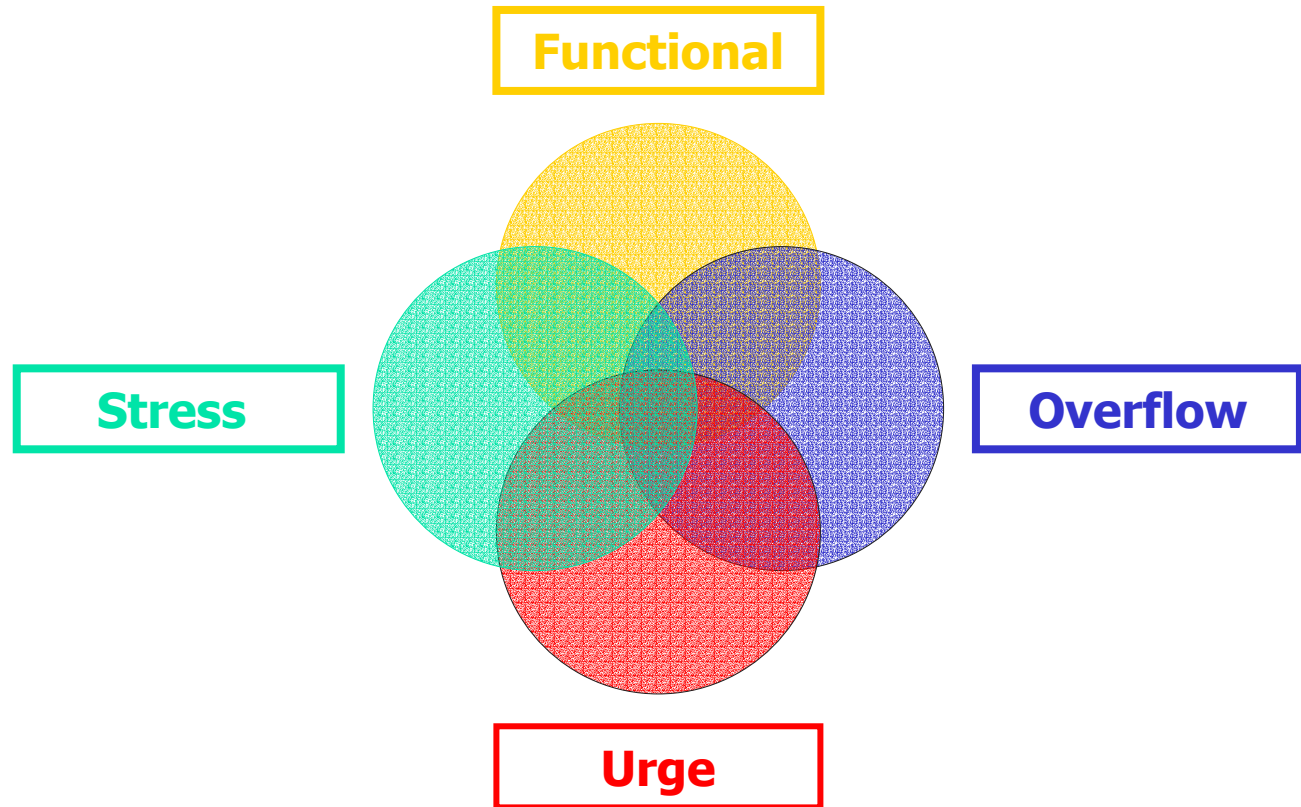
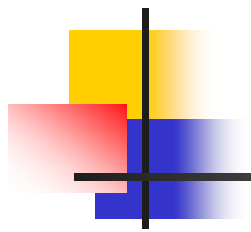
- bladder is full at all times and leaks at any time, day or night
- usually associated with symptoms of slow stream and difficulty urinating
- more common in men as a result of the prostate gland



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

Types of UI





Duration of Incontinence

- Acute
 - Recent and abrupt onset
 - Caused by reversible or transient factors
 - Sometimes know as Transient Incontinence
- Chronic intractable incontinence
 - Cognitive or physical deficits that render them unable to participate in behavioral treatment and are not candidates for surgery or medication



Assessment of Incontinence

- **Incontinence history**
- **Fluid Intake**
- **Bowels**
- **Medical History**
- **Medications**
- **Functional Ability**



Incontinence History

- Onset
- Duration
- Daytime / Nighttime
- Accidents
- Stress loss
- Urge loss
- Aware of loss



Fluid Intake

- How much?
- Restrictions
- Caffeine
- Alcohol



Bowels

- Pattern
- Constipation
- Diet
- Laxatives



Medical History

- Stroke
- Parkinson's
- Multiple Scleroses
- Diabetes
- Urinary Tract Infections
- Acquired Brain Injury
- Dementia



Medications

- Diuretics
- Anticholinergics
- Estrogen
- Sedative/hypnotics
- Antidepressants



Functional Ability

- Access to bathroom
- Ambulation
 - Needs assistance
- Wheelchair



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 Contenance

- 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



Physical Assessment

- Post Voiding Residual
- Urine Culture
- Observation of the perineum

Voiding Record



Time and amount of:

- fluid intake
- urine voided
- incontinence
- For 4 or 5 days

Voiding Record

Void: Write in the amount each time you pass urine in the toilet.

Drink: Write in the amount each time you have a drink.

Wet event: * each time you are wet.

Time	Void	Drink	Wet Event	Time	Void	Drink	Wet Event
6:00 am				6:00 pm			
6:30 am				6:30 pm			
7:00 am				7:00 pm			
7:30 am				7:30 pm			
8:00 am				8:00 pm			
8:30 am				8:30 pm			
9:00 am				9:00 pm			
9:30 am				9:30 pm			
10:00 am				10:00 pm			
10:30 am				10:30 pm			
11:00 am				11:00 pm			
11:30 am				11:30 pm			
12:00 noon				12:00 night			
12:30 pm				12:30 am			
1:00 pm				1:00 am			
1:30 pm				1:30 am			
2:00 pm				2:00 am			
2:30 pm				2:30 am			
3:00 pm				3:00 am			
3:30 pm				3:30 am			
4:00 pm				4:00 am			
4:30 pm				4:30 am			
5:00 pm				5:00 am			
5:30 pm				5:30 am			



Urine Tests

- looking for:
 - infection
 - blood
 - diabetes
 - kidney disease

- use a combination of urine dipstick, microscopy and culture



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**

Contributing Factor – Urinary Tract Infections

- burning feeling or pain when voiding
- having to void frequently and urgently
- the bacteria irritates the bladder and makes it contract more often
- vaginitis is itching, redness +soreness in and around the vagina. discharge from the vagina can lead to UTI.



Contributing Factor - Poor Fluid Intake



**If you drink less
you pee less and
you wet less.**

- **In fact the opposite is true**
- **The less you drink the more concentrated your urine becomes and the more irritating.**
- **You pee just as often only smaller amounts.**

Contributing Factor - Caffeine



- acts as a “diuretic”
- bladder muscles become irritated (which causes the bladder to contract more often), making you want to void more
- for every cup of caffeinated drink, you need 2 cups of non-caffeinated fluid to replace the fluid lost

Contributing Factor - Alcohol



- can depress the central nervous system by reducing the feeling of the need to void
- makes you need to void by producing more urine
- it can also “trip you up” when trying to go to the toilet
- bothers the bladder so that it contracts more often

Contributing Factor - Constipation



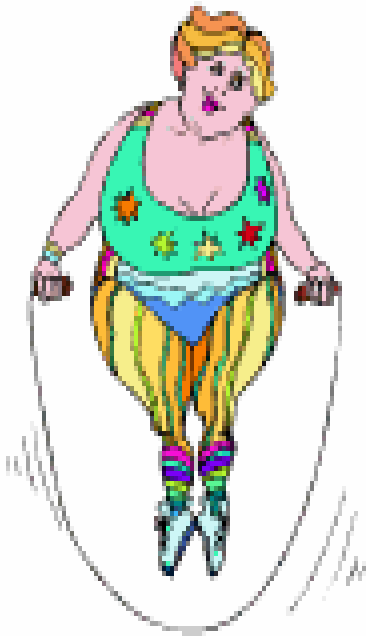
- pushing too hard and too often when having a bowel movement can weaken pelvic floor muscles
- stool “impaction” (hard, “stuck” feces in the rectum) adds to urinary incontinence
- “smearing” or “staining” of stool seen on underwear, may be caused by constipation or possible rectocele

Contributing Factor - Medications



- certain medications can make the bladder too active or not active enough
- learn about herbal preparations that can badly effect the bladder
- there are prescription medications that can lessen urge incontinence

Contributing Factor - Overweight



- too much weight on the abdomen constantly pushes down on the bladder causing stress on the bladder and pelvic floor muscles
- poor abdominal muscle strength from excess weight adds excess weight on the pelvic floor muscles

Contributing Factor **Limited Mobility**



- any problems that lessen your power to get a toilet in time can cause functional incontinence
- problems or diseases of the nervous system can lead to or result in incontinence (Multiple Sclerosis, Parkinson's Disease, dementia, delirium, and stroke)



Contributing Factor - Environmental

- Restraints
 - physical
 - Sedation / analgesics
- Clothing
- Access to bathroom
- Distance to the bathroom

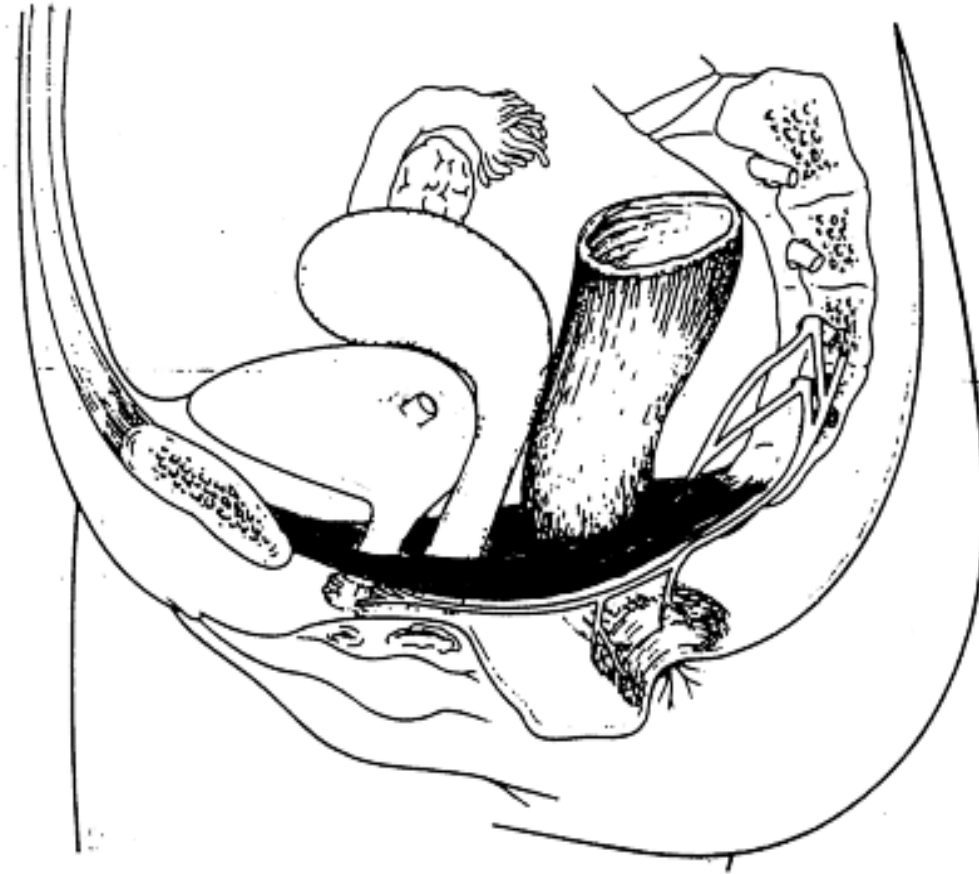


Contributing Factor - Childbirth

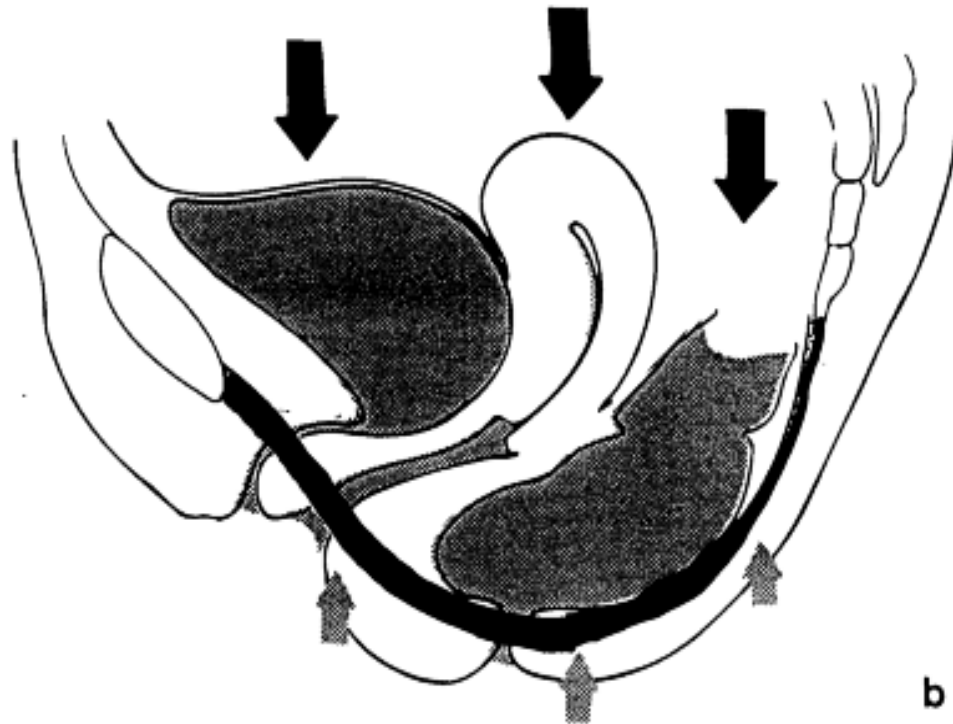


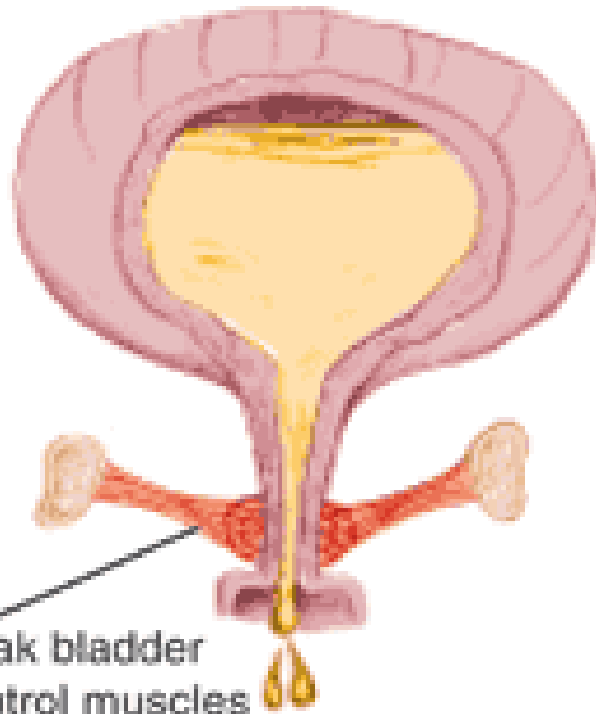
- vaginal childbirth can cause damage to the pelvic floor muscles by weakening the strength and tone of the muscles holding up the bladder, uterus and rectum
- the more births, the greater the risk for urinary incontinence
- vaginal births with an “episiotomy” or a tear increases the chance of incontinence

Pelvic Floor

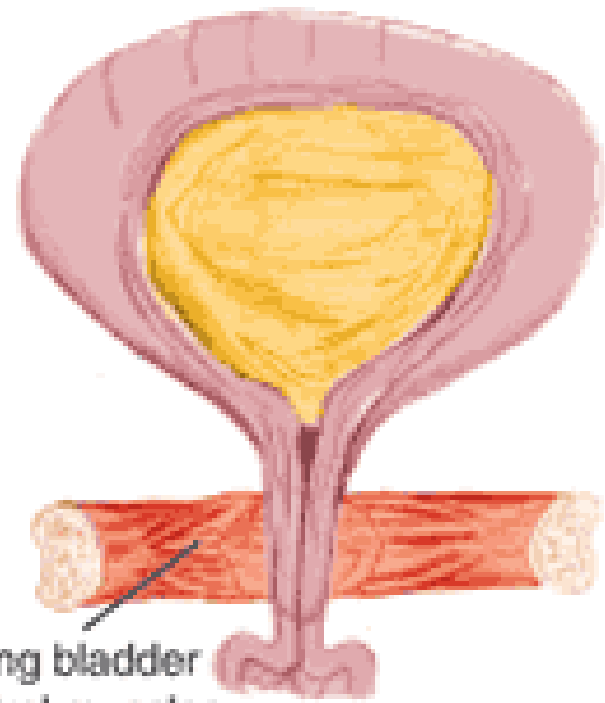


Pelvic Floor Decent



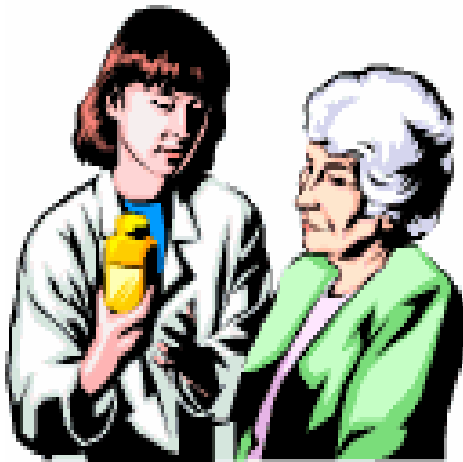


weak bladder control muscles



strong bladder control muscles

Contributing Factor - Loss of Estrogen



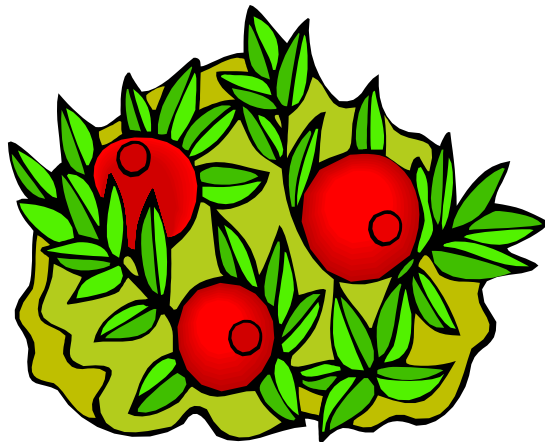
- cause the "tissues" around the bladder to lose their tone. This makes it hard to hold onto your urine.
- causes loss of tightness of the "sphincter muscle"
- leads to "urethritis", "vaginitis", "cystocele", and "uterine prolapse" which all can cause urinary incontinence



Conservative Management

- client focused
- using education
- behavior modification
- problem solving strategies

Preventing Urinary Tract Infections



- drink extra fluids like water
- cranberry juice attacks the most common germ, E-coli that often causes a UTI.
- cranberry capsules can be another choice to cranberry juice.

Personal Care

- Wash and wipe from the front to the back
- Wash with warm water and pat or blow dry



Increase Water Intake



- Try to drink more water in a day.
- If you don't like the taste of water try adding a slice of lemon or a sprig of mint to the water
- Try carrying a water bottle that you can sip on all day long.

Reduce - Caffeine



- slowly cut down on the amount of caffeine you drink until you reach 1-2 cups a day (1cup=250ml)
- slowly switch to decaffeinated beverages (eg. decaffeinated tea, decaffeinated coffee, caffeine-free beverages)

Managing Constipation



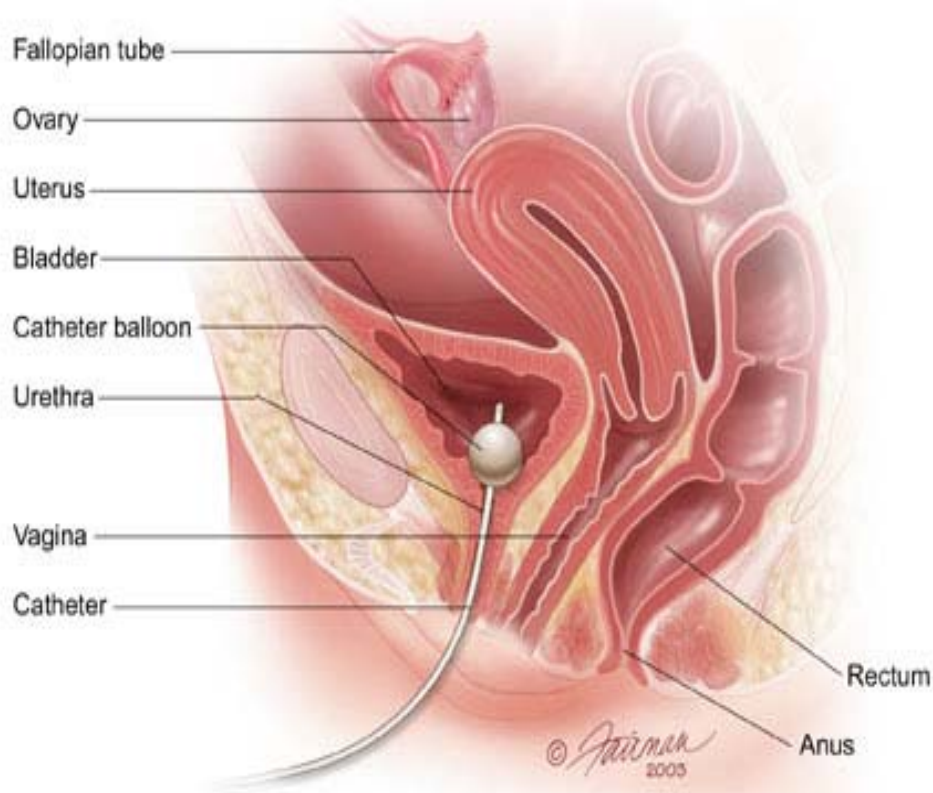
- exercise everyday
- drink plenty of “good” fluid. warm water may stimulate the bowel.
- eat foods high in fibre such as bran, oatmeal, whole wheat, green leafy vegetables
- avoid using laxatives on a regular basis

Limited Mobility



- have a toilet that you can get to close by (a bedside commode or bedpan.)
- make regularly timed trips to the washroom
- keep walking aide near you. (cane, crutches, or walker.)
- wear clothing that can be easily removed

Catheterization



- **Intermittent**
- **Indwelling**
- **Suprapubic**



Catheterization

- Smaller sizes are better 12-14 French
- Balloons 5 – 10 ccs
- Ensure proper drainage
 - Connecting tubing for leg bags
- If leaking occurs – increasing the size of the catheter or the balloon is not the answer
- Clamping catheters no longer considered good practice

Using the right product





RNAO Best Practice Guidelines

- Promoting continence by using prompted voiding and reducing constipation in the older adult population



Best Practice Guidelines

- improve consistency and quality of patient care



Prompted Voiding

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



Prompted Voiding

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



Prompted Voiding

- The identification of individual voiding patterns (individualised toileting) rather than routine toileting (e.g. q2H) can promote the highest level of success with toileting.



Management Strategy

- Initiate individualised prompted voiding schedule based on client's toileting needs as determined by the voiding record.



Prompted Voiding Intervention

There are three primary behaviours that the caregiver uses each time PV is initiated

- Monitoring
- Prompting
- Praising



Constipation

- 30 -50% of the elderly in the community use laxatives on a regular basis and this increases with institutionalization.
- The increased abdominal pressure associated with constipation contributes to bladder instability and can result in incontinence.



Factors Contributing to Constipation

- low fluid intake
- low dietary fibre intake
- prolonged use of laxatives
- ignoring urge to defecate
- sedentary lifestyle
- polypharmacy



Reducing Constipation

Interventions

- ⌚ **Fluid intake should be between 1500 -2000 mls per day. (evidence = B)**



Reducing Constipation

Interventions

Fluid intake should be between 1500 -2000 mls per day. (evidence = B)

Strategies

- **container of fluid at the bedside**
- **ensure fluids at meals are consumed**
- **eliminate caffeine and alcohol**



Reducing Constipation

- **Interventions**

Dietary fiber intake should be 25 to 30 grams per day. This can be gradually increased as fluids increase (Evidence =B).



Reducing Constipation

- **Interventions**

Dietary fiber intake should be 25 to 30 grams per day. This can be gradually increased as fluids increase (Evidence =B).

Regular consistent toileting each day (Evidence =B).



Reducing Constipation

■ **Interventions**

Dietary fiber intake should be 25 to 30 grams per day. This can be gradually increased as fluids increase (Evidence =B).

Regular consistent toileting each day (Evidence =B).

Physical activity (Evidence =B).



Successful implementation

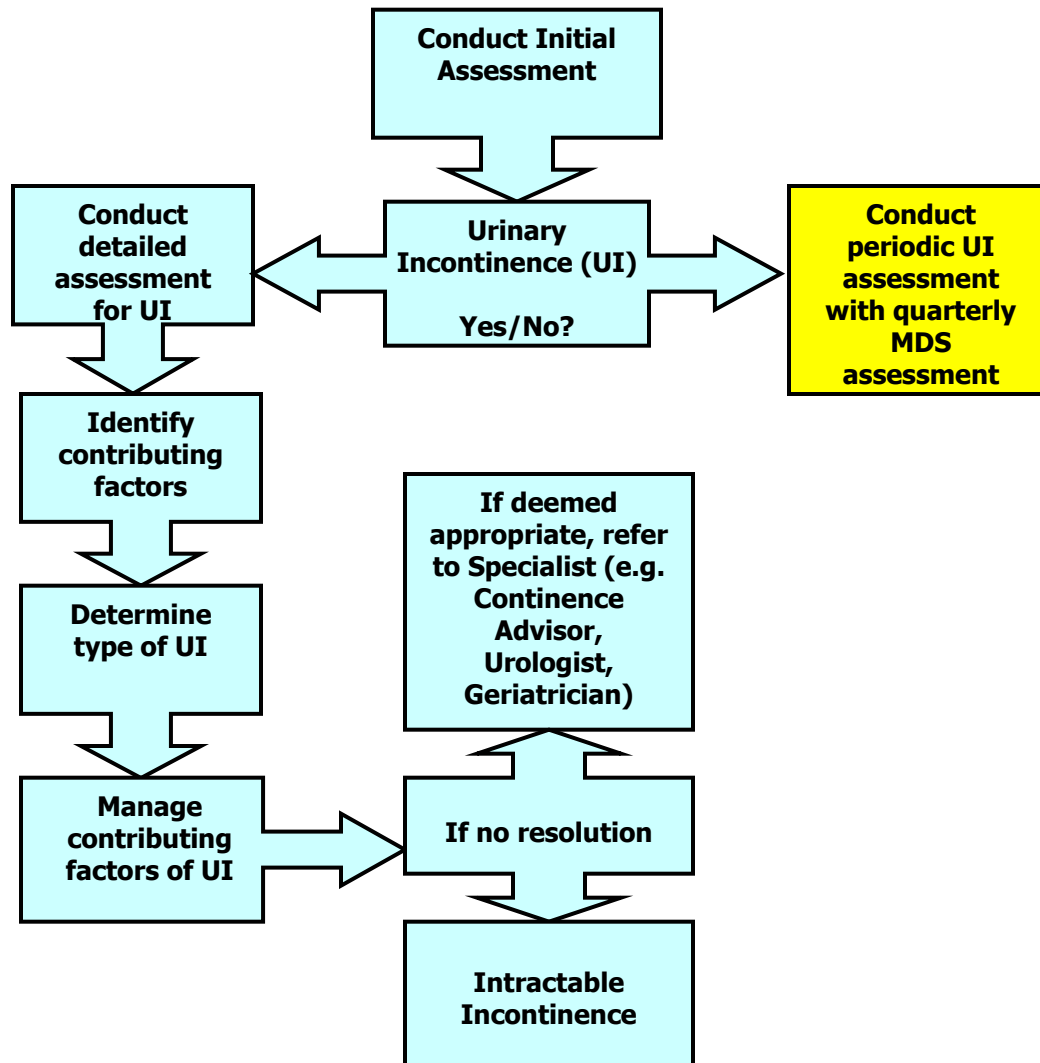
- management support
- education and training
- support and active involvement of key clinical staff
- plan for gradual implementation such that only one or two clients at the most are on the protocol at one time



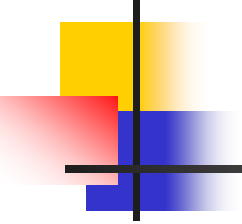
Successful implementation

- collection of baseline information about patients, resources and existing knowledge
- interpretation of this data and identification of problems
- development of implementation strategy
- monitoring of the program

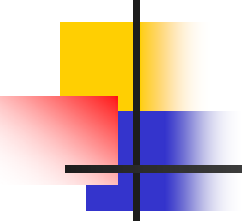
What is optimal continence care?



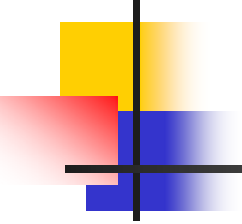
Case Study – Urinary Incontinence

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- Mrs. Georgina Jones, age 83, experienced a sudden onset of incontinence following her stroke.
 - She voids every hour during the day and usually experiences a loss of urine on her way to the bathroom.

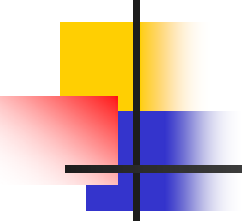
Case Study – Urinary Incontinence

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- At night, she gets up to void at least twice and is incontinent on her way to the bathroom. She loses urine when she coughs and sneezing.
 - She is aware of the urge to void and is unable to postpone the urge for any length of time.

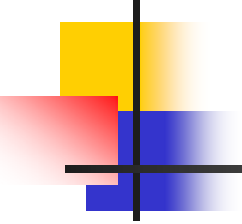
Case Study – Urinary Incontinence

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- Mrs. Jones drinks tea with all her meals and restricts her intake between meals.
 - She has several experienced urinary tract infections in the past few months and also has problems with osteoarthritis
 - She takes a diuretic each day.

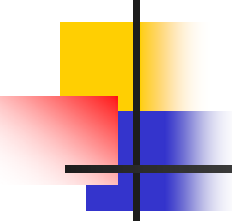
Case Study – Urinary Incontinence

- 
- Mrs. Jones shares a room with 3 other women.
 - There is only one bathroom
 - Mrs. Jones' stroke has reduced her ability to walk without the assistance of a wheeled walker.
 - She is able to get to the toilet but does not get much warning and her walker will not fit easily into the bathroom.

Case Study – Urinary Incontinence

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- As part of the assessment, Mrs. Jones voided 125 mls and a post-voiding residual of 5 cc was determined by ultrasound. A mid stream urine test was positive for WBC's (white blood cells) using the urinalysis strip test, so a sample was sent to the lab for culture and sensitivity.

Case Study – Urinary Incontinence

- 
-
- What factors may be contributing to Mrs. Jones's incontinence?
 - How would you classify Mrs. Jones's incontinence?

Case Study – Urinary Incontinence



Contributing Factors

- Caffeine
- Arthritis
- CVA
- Diuretic
- Mobility
- Environmental barriers

Type of incontinence

- Urge
- Stress
- Functional

Case Study – Urinary Incontinence



Contributing Factors

- Caffeine
- Arthritis
- CVA
- Diuretic
- Mobility
- Environmental barriers

Type of incontinence

- Urge
- Stress
- Functional

Treatment Options

- Reduce caffeine
- Increase fluid intake
- Treat UTI
- Have diuretic reassessed
- Physio/OT assessment