BEST PRACTICES FOR NURSING CARE OF THE OLDER ADULT

TITLE: PROMOTING URINARY CONTINENCE
DATE: June 2007
CONTENT: 14 pages

RELEVANT TOOLS:
- Voiding Record
- Registered Nurses Association of Ontario Algorithm: “Promoting Continence Using Prompted Voiding”
- Canadian Continence Foundation “Initial Management of U.I. in women, men and frail elderly”
- Information Sheet

PURPOSE
This clinical practice guideline is designed to help nurses in acute, residential, and community settings to:

- Assist elders with urinary continence challenges to maintain dignity and quality of life and prevent complications.
- Identify elders in need of medical investigation and diagnosis.
- Ensure patients, residents and clients across the continuum of care settings attain and maintain optimal levels of urinary continence.
- Assess urinary incontinence using specific tools and records and implement interventions based on individual client needs.
- Evaluate effectiveness of individualized clinical interventions related to the promotion and maintenance of bladder health in elders across care settings.
- Raise awareness and sensitivity to psychological costs and quality of life issues associated with urinary incontinence.

Urinary incontinence (U.I) is a common condition with profoundly negative effects on quality of life, yet under-reporting and under-treatment remain common issues… Nurses are in a strategic position to reduce the incidence of incontinence by teaching bladder health strategies (i.e., fluid management, appropriate voiding intervals, constipation prevention, weight control, smoking cessation, and pelvic muscle exercises), actively assessing patients for incontinence, and initiating appropriate referrals and primary interventions.

FACTS ABOUT URINARY INCONTINENCE

- Urinary incontinence affects over one million Canadians. It is **not** an inevitable aspect of aging; however, it affects one in four Canadians over the age of 65.
- When a problem is first noted, investigation and intervention are always indicated. A team effort is required to complete a comprehensive assessment (nurse, physician, nurse continence advisor or clinical nurse specialist and care staff).
- Improvements in bladder function are possible for eight out of ten cases with appropriate interventions. Incontinence can be cured, treated, or successfully managed.
- Urinary incontinence can have a profoundly negative effect on physical health and emotional well being. Urinary incontinence:
  - Increases the elder’s risk of falls and injury.
  - Can contribute to depression, social isolation and financial burden.
  - Is a leading cause of premature facility placement because of caregiver stress and burnout.
- Elders who do **not** suffer from incontinence at the time of admission to hospital or facility must receive high priority support to maintain urinary continence during their stay in care.
- Urinary incontinence is under-reported because it is embarrassing to discuss:
  - It costs the Canadian health care system billions of dollars each year.
  - Television ads such as those portraying happy, healthy women using incontinence supplies perpetuate the myth that incontinence should be "managed" instead of assessed and treated.
  - Nurses are well positioned to provide evidenced-based education about the range of options for prevention, assessment and treatment.

DEFINITIONS

- **Incontinence**: Involuntary leakage of urine that creates a social or hygienic problem.
- **Transient incontinence**: Sudden onset incontinence usually associated with a urinary tract infection, other medical condition or reversible cause such as a new medication. Incontinence stops when the factor that precipitated it is resolved.
- **Stress incontinence**: Involuntary leakage of urine on exertion, laughing, sneezing or coughing caused by increased intra-abdominal pressure.
- **Urge incontinence**: Leakage of urine caused by an inability to delay voiding long enough to reach the toilet.
- **Functional incontinence**: Resulting from functional impairment related to a medical, cognitive, psychiatric or environmental problem as opposed to urinary system pathology.
- **Overflow incontinence**: Periodic or continuous urine leakage resulting from bladder over-distention.

RISK FACTORS

- Risk factors for development of urinary incontinence in later years include:
  - Neurological conditions such as multiple sclerosis, Parkinson’s disease, dementia and C.V.A.
• Obstetrical history of vaginal deliveries, forceps delivery, episiotomy, gynecologic surgery.
• Poor prostate health or prostate surgery.
• Obesity, diabetes, smoking, caffeine intake, constipation.
• Taking medications that impact continence including, but not limited to: diuretics, anticholinergic agents, calcium channel blockers, ACE Inhibitors, narcotic analgesics, and many types of psychotropic medications (in particular, anti-psychotics, sedatives, hypnotics, anti-anxiety agents and tri-cyclic antidepressants).
• Side effects of medications with anticholinergic properties include dry mouth, constipation, urinary retention, blurred vision, increased heart rate, confusion, impaired concentration, and attention and memory impairment.

DIAGNOSTIC EVALUATION OF URINARY INCONTINENCE

❖ Questions about urinary incontinence should be part of the nursing admission or intake assessment in acute, community and residential care, because elders may be embarrassed to volunteer information about this problem.
❖ If symptoms of urinary incontinence are new, the nurse:
  • Assesses for reversible factors that cause transient incontinence such as:
    – Urinary tract infection, constipation, impaction.
    – Delirium, depression.
    – Adverse medication reaction, peripheral edema.
  • Refers the elder for investigation and diagnosis to the physician, nurse practitioner or an advanced practice nurse such as a nurse continence advisor or geriatric clinical nurse specialist.
❖ The purposes of assessment are to:
  • Identify reversible causes of incontinence.
  • Identify underlying causes that need treatment.
  • Recognize elders who require referral to a specialist.
  • Determine the type of incontinence involved (transient, functional, overflow, stress or urge).
  • Assess the elder’s options for treatment or management of the problem including surgery and pharmacological treatment.
❖ Assessment by the physician or advanced practice nurse will include a comprehensive history, evaluation of mental status and a physical examination. History includes:
  • History of medical investigations, surgeries or treatments for urinary incontinence or other urinary problems such as retention.
  • Medical conditions such as poor prostate health.
  • Gynecologic and obstetrical history including number of children, types of deliveries and age of menopause.
  • History of urinary tract infections and other medical conditions that may impact continence (i.e., vaginal prolapse, atrophic vaginitis, C.V.A., neurological diseases, diabetes, heart failure).
• Complaints of dysuria, nocturia, straining, etc., and alterations in sexual function related to urinary incontinence.

Diagnostic investigations may include:

• Blood work.
• Urinalysis, tests for specific gravity, infection, protein or blood, glucose, ketones.
• Radiographic examinations.
• Cystoscopy and urodynamic procedures used to assess function of the bladder and urethra.
• NB: In some areas, nurses can refer elders to an Occupational Therapist or Physiotherapist with advanced education as a continence advisor.

NURSING ASSESSMENT IN ACUTE, COMMUNITY AND RESIDENTIAL CARE

Nursing admission or intake assessment in acute, community or residential care reflects the nature of the incontinence (i.e. symptoms are new and acute or chronic and intractable). A comprehensive nursing assessment includes evaluation of the following physical, cognitive, functional and environmental factors:

Physical Factors

• History of in-dwelling urinary catheter.
• Presence of a urinary tract infection (U.T.I.), vaginal infection or delirium.
• Bowel habits, including problems with constipation.
• Usual voiding patterns (see attached voiding record).
• Amount and type of daily fluid intake. In particular:
  – Caffeinated drinks such as tea, coffee, cola and alcohol, because they act as diuretics and can irritate the bladder, contributing to urgency and urge-related incontinence.
  – Patterns of fluid intake during the day and evening.
  – Complications of urinary incontinence, if any (i.e., skin breakdown, insomnia).

Cognitive Factors

• Cognition (awareness of voiding, ability to understand and cooperate with treatment options, dementia).
• Mental status (depression, motivation to be continent, goals for continence).
• Effect of symptoms on mood, social participation, etc.

Medications

• History of all prescription medications, over-the-counter drugs and herbal remedies.
• Medications that significantly impact continence including diuretics, anticholinergics, psychotropics (in particular amitriptyline), opioids, medications that cause constipation.
• If a diuretic is ordered, type and timing of administration.
Functional Factors

- Degree to which patient, client or resident is currently continent (i.e., during the day, length of continent periods).
- Functional abilities required for toileting self care (i.e., getting on and off the toilet, undoing zippers and buttons, ability to use urinary incontinence products and ability to clean self:
  - Mobility and balance.
  - Transfer ability.
  - Eyesight.
  - Flexibility, arm strength and manual dexterity.

Environmental Factors

- Obstacles impeding continence such as:
  - Lack of privacy.
  - Inadequate proximity of nearest bathroom.
  - Use of restraints or safety devices.
  - Lengthy response time for help to bathroom.

Nursing Interventions

- Treatment and management plans for urinary incontinence are determined on an individual basis. Interventions are individually selected in relation to the type of incontinence, duration of symptoms, and abilities of the client. For example, consider:
  - Is the elder aware of the need to void?
  - Can he or she communicate that need?
  - Is the elder able to fully empty the bladder when assisted to the toilet?
  - Is he or she functionally able to successfully use the toilet or commode?
- In many cases, nursing interventions can support elders to establish and maintain a higher level of continence than previously experienced through:
  - Exercises to strengthen pelvic muscles (Kegel exercises).
  - Cognitive therapy programs.
  - Bladder training protocols.
  - Behavioral support programs.
  - Scheduled voiding regimes.
  - Prompted toileting protocols.
  - N.B.: An in-dwelling catheter may be determined to be an appropriate aspect of end of life care depending on the elder’s medical condition, pain level, skin integrity, etc.

- Acute care nurses assist senior patients to establish and maintain optimum levels of continence by:
  - Assisting seniors undergoing diagnostic investigation and surgical interventions for urinary incontinence.
• Providing education, support and advocacy.
• Educating the elder and/or family about pharmacological treatment (i.e. medications that act on sphincter tone, detrusor activity).
• Teaching treatment strategies such as Kegel exercises.
• Ensuring that the elder’s level of continence does not deteriorate during hospitalization for another reason.
• Facilitating the elder’s use of the toilet (i.e., removing environmental barriers to the bathroom or commode and responding quickly when help is requested).
• Preventing complications of incontinence such as skin breakdown.
• Providing education and participating in discharge planning.

Where recommended, nurses with current knowledge can provide education to elders about “Kegel” exercises. These exercises strengthen pelvic floor muscles and may be helpful in controlling bladder urges. Nurses who wish to learn the correct technique should approach an expert in this field.

For the elder with a history of chronic, long-term incontinence who lives in the community or a residential facility, the nurse plans interventions designed to facilitate the optimum level of continence and maintain safety and dignity:

• Soon after admission or intake, initiate a three-day voiding pattern (see attached sample record).
• Analyze data to determine if scheduled assistance to the bathroom and/or prompts to void would support continence. Implement the appropriate regime.
• Complete the care plan and/or ADL card for facility staff or for a community caregiver:
  - Assist the elder to the bathroom,
  - Maintain dignity and safety.
  - Develop strategies for helping the elder to maintain an optimal level of continence.
  - Ensure correct use of incontinence products (type, size, correct application) in accordance with the manufacturer’s instructions for selection of product, size and use.
  - Prevent skin breakdown.
  - Develop an individualized plan for continence care during the night (checking, waking, letting sleep).
• After trialing a prompted voiding regime for several weeks, initiate the three-day voiding record again to evaluate progress.

Elders who are more likely to benefit from a prompted voiding regime are those who:

• Recognize the need to void.
• Can ambulate independently.
• Are able to void successfully when assisted to the toilet.
• Have the ability to understand the process.

The best predictor of response to prompted voiding is the individual’s success during a trial of prompted voiding.
EVALUATION

The success of a continence promotion philosophy can be measured by:

- Expressed patient, client or resident satisfaction.
- Expressed satisfaction from family members.
- Absence of skin breakdown related to incontinence.
- Maintenance of dry skin and bedding overnight.
- An environment free from the odor of urine.
- Evidence of commitment by staff to individualized continence interventions (e.g., prompted voiding schedules, voiding records) that reflect an awareness of and respect for each elder’s bladder health.
- Open and respectful discussion about continence by staff, patients, clients and residents as an important aspect of health, wellbeing and quality of life.
- Ongoing opportunities for continued learning in the area of continence promotion.

Nurses interested in becoming a Nurse Continence Advisor (NCA) may wish to explore the McMaster University “NCA” Distance Education Certificate Program:

- Established 1997
- Uses a self-directed, problem-oriented approach to developing evidence-based practice in continence care
- A one-year program combining academic study with preceptored and independent clinical practice
- Recognized for two full credits for nurses in post-diploma programs
- Intakes in January and June

For more information, please visit www.fhs.mcmaster.ca/nursing/nca/.
# Overview of Nursing Interventions to Support Urinary Continence

<table>
<thead>
<tr>
<th>Support</th>
<th>Nursing Intervention</th>
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<tr>
<td>Nursing/Medical</td>
<td>• Ensure that the problem of urinary incontinence has been reported to the family physician and investigated.</td>
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<td>• Assess current impact of urinary incontinence on socialization, mood and safety.</td>
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<td>• Teach Kegel exercises if recommended (see attached instructions).</td>
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<td>• Implement scheduled voiding routines if appropriate.</td>
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<td>• Implement prompted voiding protocol if appropriate.</td>
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<td>• Support optimal management of diabetes.</td>
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<td>• Help to prevent constipation (see the NH Prevention of Constipation Clinical Practice Guideline).</td>
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<td>• Review medications that cause or worsen incontinence; collaborate with the physician.</td>
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<td>• Prevent complications of urinary incontinence such as skin breakdown.</td>
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<td>• Provide emotional and psychological support and encourage cognitive strategies such as positive self-talk.</td>
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<td>Healthy Choices</td>
<td>• Encourage the elder to restrict caffeinated drinks, alcohol, and bladder irritating foods (citrus, acidic, etc).</td>
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<td>• Support intake of 1,500 to 2,000 ml. of fluids per day unless medically contraindicated.</td>
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<td>• Encourage limitation of fluid intake during evening hours.</td>
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<td>• Support to maintain a healthy weight.</td>
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<td>• Suggest smoking cessation if a chronic cough exacerbates incontinence.</td>
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<td>Functional</td>
<td>• Assess type of clothing being worn to ensure it does not impede easy access to voiding.</td>
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<td>• Ensure that the correct incontinence product has been chosen and is being properly used.</td>
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<td>• Provide assistance to the toilet in accordance with the elder’s usual pattern of voiding.</td>
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<td>• Provide assistance to correctly use incontinence products such as pull-ups, briefs and liners.</td>
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<td>Environmental</td>
<td>• Ensure that the elder has privacy to use the toilet and that staff respond in a timely manner when help to the bathroom is requested.</td>
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<td>• Eliminate environmental barriers to the bathroom (remove clutter and mats, improve lighting, install grab bars, etc.).</td>
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VOIDING RECORD

Date: _________________________________
Void: The amount voided
Drink: The amount of fluids
Bowel Movement: BM—“x” each time

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Appendix B: Promoting Continence Using Prompted Voiding Algorithm

Promoting Continence Using Prompted Voiding

Assessment
- History of incontinence
- Cognitive awareness of voiding
- Motivation to be continent
- Fluid intake
- Frequency of bowel movement
- Medical/Surgical history
- Medications
- Functional ability
- Environmental barriers
- Presence of infection

Prompted Voiding Protocol
- Three-day voiding record

Decision to proceed to prompted voiding protocol

Address constipation/fecal impaction

Minimize caffeinated and alcoholic beverages (ensure adequate fluid intake)

Initiate individualized prompted voiding schedule

Protocol in place for minimum of 3 weeks and maximum of 8 weeks

Evaluate using 3-day voiding record
N.B. Need permission for use.
BIBLIOGRAPHY


University of Iowa College of Nursing, Gerontological Nursing Interventions Research Centre, Research Translation and Dissemination Core. *Prompted voiding for persons with urinary incontinence: Evidence-based protocol*. To order the protocol, E-mail to research-dissemination-core@uiowa.edu.


**WEB SITES OF INTEREST**

The Canadian Continence Foundation: [www.continence-fdn.ca/content/htm](http://www.continence-fdn.ca/content/htm)

Canadian Nurse Continence Advisor Association: [www.cnca.ca](http://www.cnca.ca)

Continence Worldwide: [www.continenceworldwide.org](http://www.continenceworldwide.org)

Registered Nurses’ Association of Ontario Best Practice Guidelines Program: [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices)
INFORMATION SHEET
URINARY CONTINENCE

Don’t suffer in silence. Help is available!

- Millions of Canadians, young and older, men and women, suffer from urinary incontinence (the involuntary leakage of urine). It affects quality of life, can lead to a variety of health problems and causes financial burden.
- Incontinence is **not** part of the normal aging process—it is a sign of an underlying problem. The best time to seek help is when problems are new. Incontinence can be caused by problems that are reversible, such as a urinary tract infection or a new medication.
- Don’t be embarrassed to ask your doctor or nurse what help is available. Incontinence is a medical problem that can often be cured, treated or managed more effectively.

Treatment options

- Your health care professional will determine the cause of the problem using a variety of diagnostic tests.
- He or she will want to know about your medical conditions, past surgeries and any medications you take. Information about how your voiding patterns will also be useful (the number of times you pass water and how much, in a 24 hour period).
- Treatment of incontinence depends on the cause of the problem. Options may include medications, surgery, “Kegel” exercises done by women to strengthen pelvic muscles, and a variety of self-care strategies.

What can I do to improve my situation?

- Many people find that cutting back on alcohol and caffeinated drinks such as coffee, tea and cola helps, but continue to drink adequate amounts of water each day, because restricting fluid intake does not prevent incontinence—in fact, it may make it worse.
- Cutting back on fluids during the evening hours may reduce the need to void during the night.
- Ask your physician or nurse about all medications you are taking (prescription and over-the-counter) because some drugs contribute to urinary incontinence.
- Lifestyle changes such as avoiding constipation, quitting smoking and losing weight can make a big difference.
- Stay as physically active as possible. Make every effort to effectively manage medical conditions such as diabetes.
- Women can ask the physician or nurse if practicing Kegel exercises would help.
- Make your environment free from safety hazards that slow access to the bathroom (i.e., clutter and mats on the floor, poor lighting). Install grab-bars in the bathroom if they are needed.
- For more information, check the Web site of the Canadian Continence Foundation: www.continence-fdn.ca/content/htm.

Created by Harrigan Consulting

*Talk to your nurse or doctor if you have questions!*
Continence Precautions

A large number of falls happen because a patient attempts to toilet themselves unsafely especially at night. There are many patients on medications that affect urine and bowel output. The following need to be addressed when assessing for continence precautions.

- assess the risks and benefits of prescribed medications affecting urinary output
- brief system chosen for resident is still appropriate?
- elimination patterns: Is the resident attempting to toilet themselves unsafely at certain periods of the day where a toileting regime would be of benefit and could be delegated daily as a caregiver’s responsibility?
- toileting regimes are needed for the type of patient that attempts to toilet self unsafely. Is there an appropriate regime set up for this patient? There may need to be a toileting pattern record set up in order to capture an appropriate toileting regime.
- if the toileting regime is not effective and patient continues to unsafely ambulate potentially due to output needs then consider a Bed/Chair alarm. This information can be found in this section under the guideline for Bed Position/Rails/Alarms
- consider history of urinary tract infections (UTI’s) and the signs and symptoms displayed by the patient. Ensure that this is reflected in the patients’ care plan
- consider fluid consumption and its’ effects on the resident. Do we need to restrict fluids or types of fluids after a certain time to decrease the need to toilet. Keep in mind that the effects of dehydration, also affects mobility such as weakness, dizziness, confusion.
Falls and Continence

Janice Brown  BN, NCA, GNC©
Clinical Nurse Specialist

“Can you hold please?”
Falls and Urinary Incontinence

- Dribbling / leaking as you get up or walk / run to BR – slip on floor
- Get up quickly as need is urgent BP drops = fall
- Confusion – delirium/ dementia not sure where BR is
- Functional (slow moving may leak on way to BR
- Rushing to BR and not able to maintain balance
- Getting up in a dark room one can trip or fall over clutter
- Unfamiliar surroundings
- Wait too long for assistance

Barriers to Continence Care

- Knowledge
- Attitudes
- Resources
Assessment

- Continence History
- Medical history
- Fluid intake
- Bowels
- Medications
- Functional ability

**Sensitive questioning:**
Those who work in the field of continence have discovered through experience some useful ways to ask about pre-admission continence status in non-threatening ways: (questions for resident or caregiver)
Assessment- Ask the Questions

- Any problems controlling your bladder?
- Caught short on the way to BR?
- How long can you hold?
- How often day? Night?
- Leak when laugh, cough, sneeze?
- Pain? Odour?
- Hx of UTI?
- What bothers you the most?

Further Assessment

- **Voiding record**
  - key is 3-4 days for true picture
  - indicated pattern
  - indicates bladder capacity
Types of Incontinence

- Transient Incontinence
- Persistent Incontinence
  - Find out Bladder and Bowel history

Transient Causes
DISAPPEAR

- Delirium (sudden change in behavior)
- Intake (amount, type, timing)
- Stool impaction (know bowel pattern)
- Atrophic Vaginitis
- Pharmaceuticals (Gravol, Loxapine, Opiods HS sedation)
- Psychological (depression)
- Excess fluids (pedal edema, IV)
- Abnormal labs (UTI, pneumonia, elevated blood sugar)
- Restraints/restricted mobility
Continence?

“My bladder is more active than I am.”

Persistent Causes

- **Stress** – physical stress causes UI
- **Urge** - urgency and frequency with or without incontinence
- **Mixed** stress and urge
- **Functional** – unable to get to BR on time
- **Overflow** - caused by urinary retention
  (If suspected do PVR)
Putting the Pieces Together

- Ensure adequate fluids
  - Ask family to assist in hydration strategies
  - Fluid choices not just tea and coffee (cranberry/blueberry juice)

- Reminders
- All staff aware to encourage fluid intake
- Timing of fluid intake

Putting the Pieces together

- Knowing voiding and bowel pattern (bladder capacity - avoid bedpans)

- Prompted voiding (monitoring, prompting praising)

- Look for behaviours that may precipitate need to void
Putting the Pieces Together

- Facilitate toileting (clothing – lifts)
- Encourage kegals if able to follow directions
- Avoid unnecessary indwelling catheterization and take out indwelling catheters as soon as possible.

Create an Environment that Promotes Continence

- Avoid clutter
- Adequate lighting
- May need “drop mat” on floor
- Clothing that is easily taken down
Create an Environment that Promotes Continence

- Walking aids nearby
- Call bell in place
- Asking if resident has to use toilet prior to your leaving the room
- Let resident know when you will return

Incontinence Products

- Proper incontinence product
  - If leakage light use lighter pads
  - Encourage independence with pull-ups
  - Ensure adequate product for nighttime
  - Watch for skin breakdown
Returning Dignity

- Be knowledgeable
- Educate
- Advocate
- Make continence care a primary health care issue that is part of your every day professional practice
- You can make an incredible difference in quality of life of your residents!