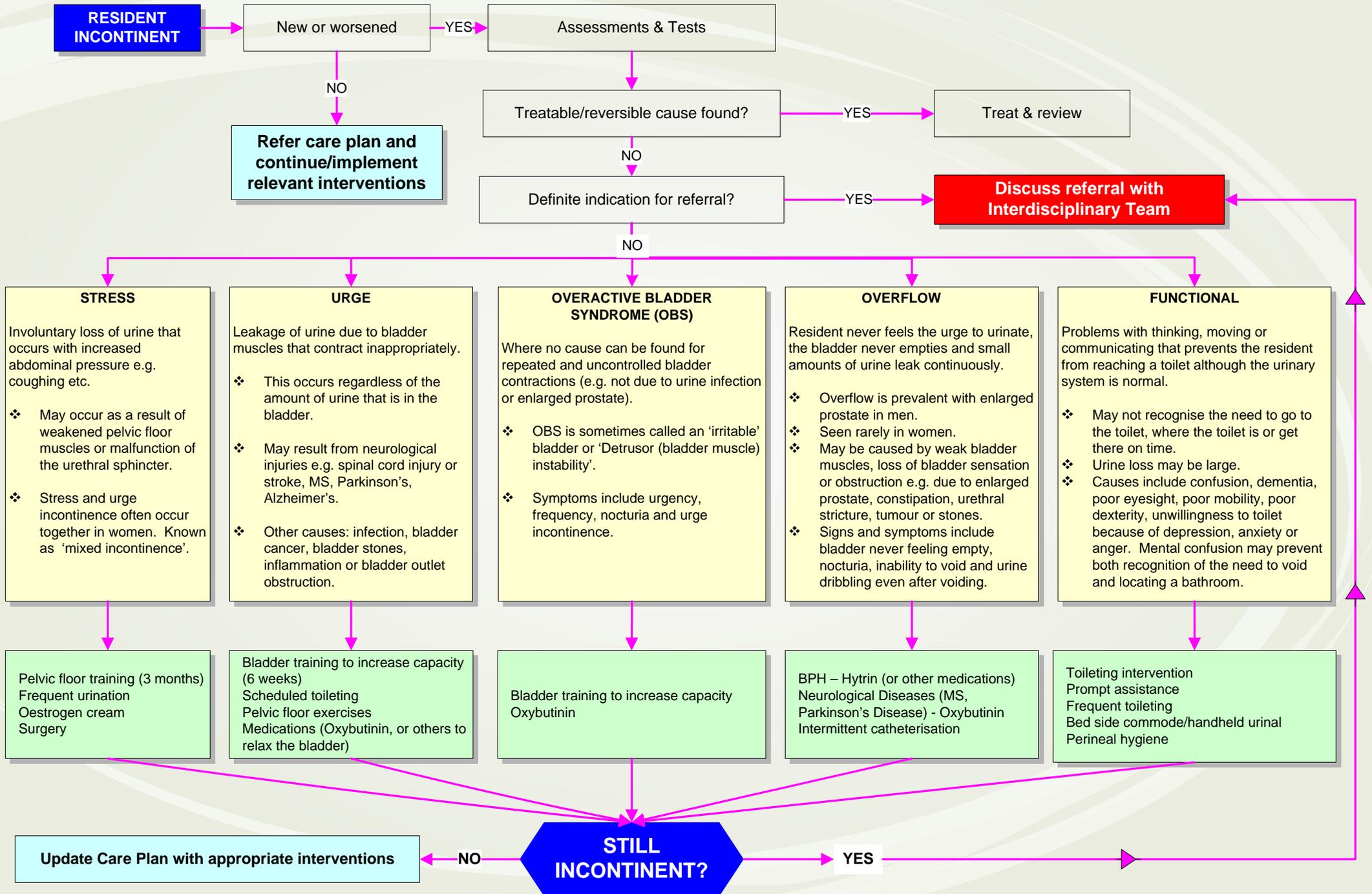


INCONTINENCE CARE GUIDE



STRESS

Involuntary loss of urine that occurs with increased abdominal pressure e.g. coughing etc.

- ❖ May occur as a result of weakened pelvic floor muscles or malfunction of the urethral sphincter.
- ❖ Stress and urge incontinence often occur together in women. Known as 'mixed incontinence'.

URGE

Leakage of urine due to bladder muscles that contract inappropriately.

- ❖ This occurs regardless of the amount of urine that is in the bladder.
- ❖ May result from neurological injuries e.g. spinal cord injury or stroke, MS, Parkinson's, Alzheimer's.
- ❖ Other causes: infection, bladder cancer, bladder stones, inflammation or bladder outlet obstruction.

OVERACTIVE BLADDER SYNDROME (OBS)

Where no cause can be found for repeated and uncontrolled bladder contractions (e.g. not due to urine infection or enlarged prostate).

- ❖ OBS is sometimes called an 'irritable' bladder or 'Detrusor (bladder muscle) instability'.
- ❖ Symptoms include urgency, frequency, nocturia and urge incontinence.

OVERFLOW

Resident never feels the urge to urinate, the bladder never empties and small amounts of urine leak continuously.

- ❖ Overflow is prevalent with enlarged prostate in men.
- ❖ Seen rarely in women.
- ❖ May be caused by weak bladder muscles, loss of bladder sensation or obstruction e.g. due to enlarged prostate, constipation, urethral stricture, tumour or stones.
- ❖ Signs and symptoms include bladder never feeling empty, nocturia, inability to void and urine dribbling even after voiding.

FUNCTIONAL

Problems with thinking, moving or communicating that prevents the resident from reaching a toilet although the urinary system is normal.

- ❖ May not recognise the need to go to the toilet, where the toilet is or get there on time.
- ❖ Urine loss may be large.
- ❖ Causes include confusion, dementia, poor eyesight, poor mobility, poor dexterity, unwillingness to toilet because of depression, anxiety or anger. Mental confusion may prevent both recognition of the need to void and locating a bathroom.

STRESS

Pelvic floor training (3 months)
Frequent urination
Oestrogen cream
Surgery

URGE

Bladder training to increase capacity (6 weeks)
Scheduled toileting
Pelvic floor exercises
Medications (Oxybutinin, or others to relax the bladder)

OBS

Bladder training to increase capacity
Oxybutinin

OVERFLOW

BPH – Hytrin (or other medications)
Neurological Diseases (MS, Parkinson's Disease) - Oxybutinin
Intermittent catheterisation

FUNCTIONAL

Toileting intervention
Prompt assistance
Frequent toileting
Bed side commode/handheld urinal
Perineal hygiene

Update Care Plan with appropriate interventions

STILL INCONTINENT?

YES

NO

CHANGES WITH AGE

- ❖ The maximum amount of urine that the bladder can hold tends to decline.
- ❖ The ability to postpone urination after feeling the need to may decrease.
- ❖ The amount of residual urine increases with aging.
- ❖ In women the urethra shortens and its lining becomes thinner as the level of oestrogen declines during menopause, decreasing the ability of the urinary sphincter to close tightly.
- ❖ In men the rate of of urine flow out of the bladder and through the urethra slows, especially when the prostate gland enlarges, which is common as men age.

REVIEW HISTORY OF URINARY INCONTINENCE

- ❖ Medical diagnoses
- ❖ Medications
- ❖ Characteristics of voiding – frequency, timing, volume
- ❖ Previous treatment for urinary incontinence and outcome
- ❖ Importance to resident
- ❖ Resident / family expectations
- ❖ Bowel habits
- ❖ Use of restraint
- ❖ Use of continence products

GENERAL ASSESSMENT

- ❖ Mental status / motivation
- ❖ Mobility
- ❖ Environment

TARGETED PHYSICAL EXAMINATION

- ❖ Lower extremity oedema
 - ❖ Neurological
 - ❖ Abdominal
 - ❖ Rectal (including prostate for men)
 - ❖ Pelvic (women): external exam of labia, vagina for prolapse, atrophic vaginitis, skin changes
- Internal Pelvic Exam:** may not be tolerated or appropriate for severely confused residents

TESTS

- ❖ Urinalysis, urine culture and sensitivity if symptomatic
- ❖ Post void residual urine
- ❖ Stress cough test
- ❖ Supplemental blood work where indicated

GENERAL CONSIDERATIONS

- ❖ Avoid caffeine (can irritate the bladder)
- ❖ Maintain fluid intake (concentrated urine can irritate the bladder)
- ❖ Time administration of diuretics so the resident can be close to the toilet
- ❖ Alcohol may make symptoms worse

POTENTIALLY REVERSIBLE CONDITIONS

- ❖ Impaired ability or willingness to reach a toilet
- ❖ Delirium
- ❖ Illness, injury, or restraint that interferes with mobility
- ❖ Depression
- ❖ Irritation or inflammation in or around lower urinary tract
- ❖ Urinary tract infection
- ❖ Atrophic vaginitis or urethritis
- ❖ Stool impaction
- ❖ Increased fluid intake
- ❖ Metabolic (hyperglycaemia, hypocalcaemia)
- ❖ Volume overload
- ❖ Venous insufficiency with oedema
- ❖ Congestive heart failure
- ❖ Drug side effects: rapid acting diuretics, anticholinergics, narcotics, calcium channel blockers, alpha-adrenergic agonists, psychotropic drugs

INDICATIONS FOR REFERRAL

Always refer for:

- ❖ Microscopic haematuria
- ❖ Visible haematuria
- ❖ Recurrent or persisting Urinary Tract Infection associated with haematuria
- ❖ Suspected pelvic mass arising from the urinary tract
- ❖ Symptomatic prolapse visible at or below the vaginal introitus
- ❖ Palpable bladder on bimanual or physical examination after voiding

Consider referral for:

- ❖ Persisting bladder or urethral pain
- ❖ Clinically benign pelvic masses
- ❖ Associated faecal incontinence
- ❖ Suspected neurological disease
- ❖ Voiding difficulty
- ❖ Suspected urogenital fistulae
- ❖ Previous continence surgery
- ❖ Previous pelvic cancer surgery
- ❖ Previous pelvic radiation therapy