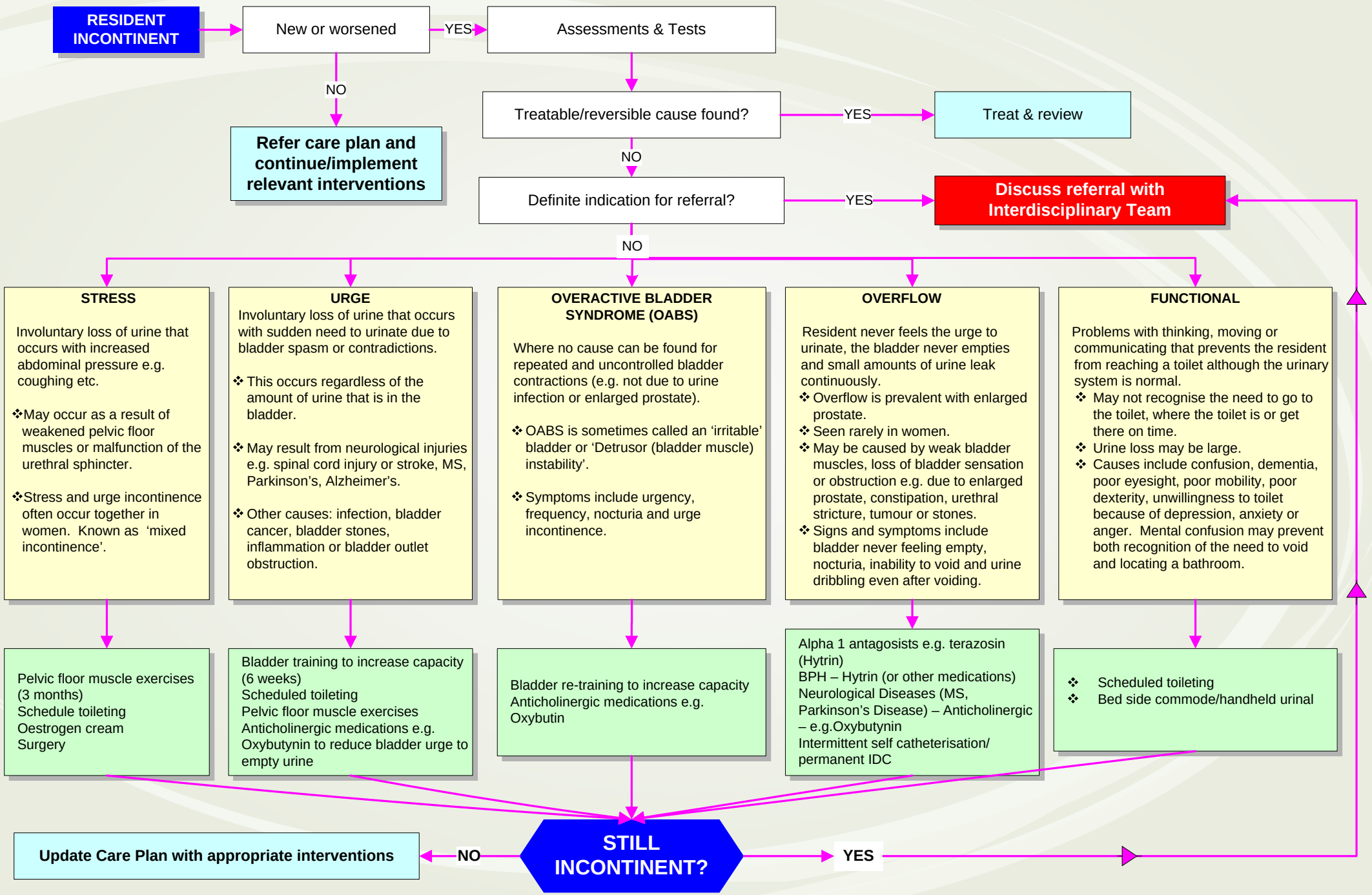
URINARY INCONTINENCE CARE GUIDE



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.
- 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 when the prostate gland enlarges (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
- Pelvic (women): external exam of labia, vagina for prolapse, atrophic vaginitis, skin changes

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

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

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 after voiding
- Persisting bladder or urethral pain
- Clinically benign pelvic masses
- Associated faecal incontinence – see p.10 Diarrhoea
- Suspected neurological disease
- Voiding difficulty
- Suspected urogenital fistulae