**URINARY INCONTINENCE CARE GUIDE**

**RESIDENT INCONTINENT**
- New or worsened?
  - YES: Assessments & Tests
  - NO: Refer care plan and continue/implement relevant interventions

**Assessments & Tests**
- Treatable/reversible cause found?
  - YES: Treat & review
  - NO: Definite indication for referral?
    - YES: Discuss referral with Interdisciplinary Team
    - NO: STILL INCONTINENT?

**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’.
- Pelvic floor muscle exercises (3 months)
- Schedule toileting
- Oestrogen cream
- Surgery

**URGE**
- Involuntary loss of urine that occurs with sudden need to urinate due to bladder spasm or contradictions.
  - 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.
- Bladder training to increase capacity (6 weeks)
- Scheduled toileting
- Pelvic floor muscle exercises
- Anticholinergic medications e.g. Oxybutin

**OVERACTIVE BLADDER SYNDROME (OABS)**
- Where no cause can be found for repeated and uncontrolled bladder contractions (e.g. not due to urine infection or enlarged prostate).
  - OABS is sometimes called an ‘irritable’ bladder or ‘Detrusor (bladder muscle) instability’.
  - Symptoms include urgency, frequency, nocturia and urge incontinence.
- Bladder re-training to increase capacity
- Anticholinergic medications e.g. Oxybutin
- Intermittent self catheterisation/permanent IDC

**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.
  - 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.
- Alpha 1 antagonists e.g. terazosin (Hytrin)
- BPH – Hytrin (or other medications)
- Neurological Diseases (MS, Parkinson’s Disease) – Anticholinergic – e.g. Oxybutynin
- Intermittent self catheterisation/permanent IDC

**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.
- Scheduled toileting
- Bed side commode/handheld urinal

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.
- 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 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