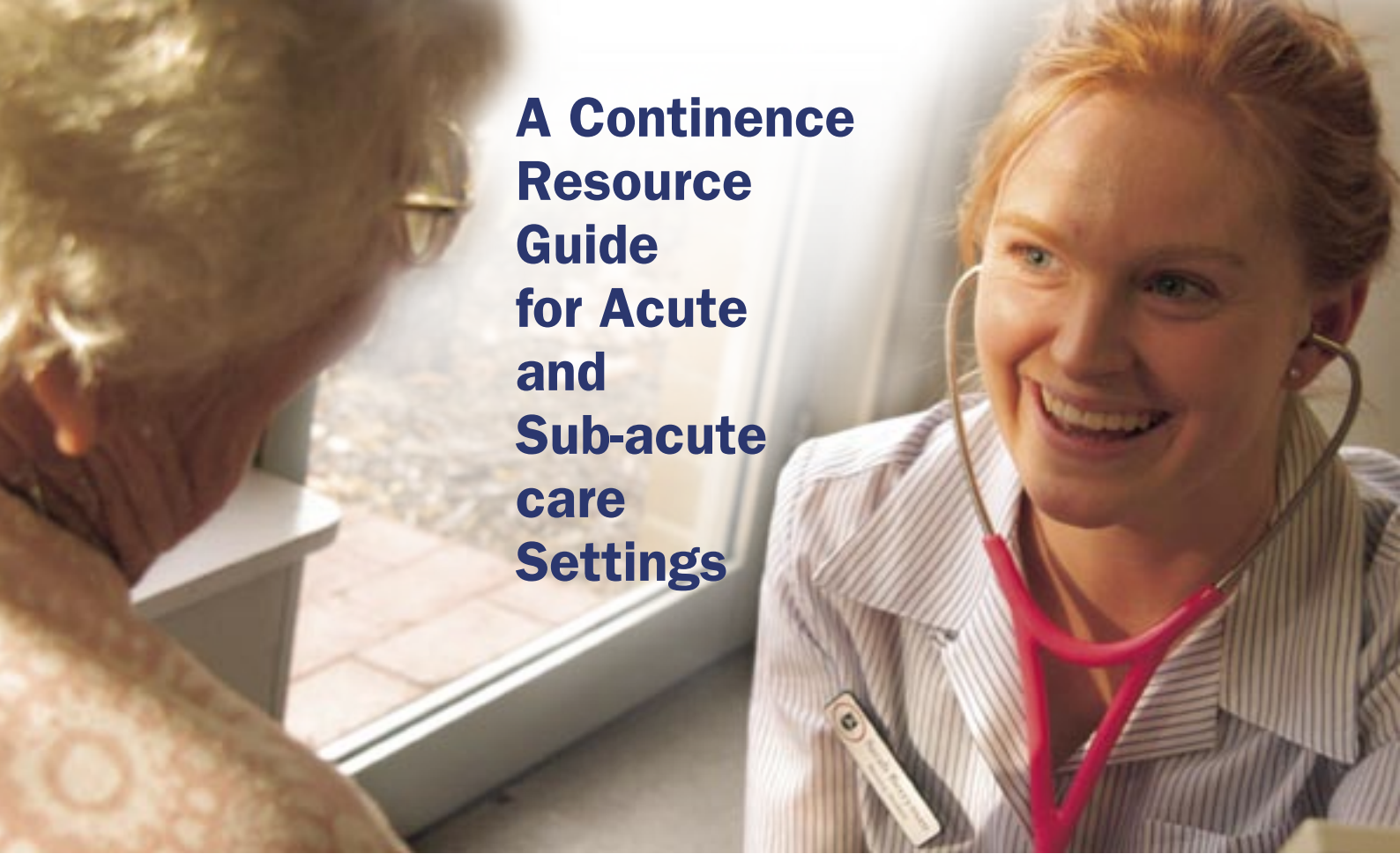

A Continence Resource Guide for Acute and Sub-acute care Settings

easternhealth

Active Ageing

DEAKIN UNIVERSITY

This project was undertaken as a collaboration of the Eastern Health Active Ageing Program & Deakin University and was funded by Eastern Health's Active Ageing Program through the Victorian Department of Human Services 'Improving Care for Older Persons' policy.

Project Team

- Joan Ostaszkiewicz
- Professor Bev O'Connell
- Lynne Millar
- Anthony Black
- Anne McKenna
- Amy Padgham

Photography: Courtesy of KMD Deakin University

Design and Production: Allegro Graphics Pty Ltd

Warning: This mini-CD is suitable for standard tray-loading CD-ROM drives only. Attempted use in a slot-loading CD-ROM drive will cause damage to your computer. You will need Adobe Acrobat software to access the files.

Disclaimer: This Continence Resource Guide should be used as an adjunct to sound clinical judgement and in association with institutional guidelines and protocols.

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What is the purpose of the Guide?

This evidence-based Continence Resource Guide has been developed for healthcare professionals involved in the delivery of care to older adults admitted to acute &/or sub-acute care settings. The Guide focuses on the symptoms of urinary & faecal incontinence. It does not address all bladder & bowel symptoms (i.e. nocturia, urinary urgency, urinary retention, constipation, haematuria).

How the Guide was developed

This Guide was prepared using the best available evidence at the time of development with reference to expert opinion from researchers & clinicians specialising in continence care & from research reported by an International Consultation on Incontinence (ICI) (Abrams, Cardoza, Khoury & Wein, 2005).

A detailed review of the ICI document & searches of key databases undertaken by the research team revealed a gap in evidence on the prevalence, impact, risk factors & management of incontinence & other bowel & /or bladder symptoms in adults in acute & /or sub-acute care settings. Where information was specific to continence issues in this population & setting, this was extracted & used in the guideline development process. Information was also extracted on the prevalence, impact, risk factors & assessment & management recommendations for other populations & settings (i.e. frail older adults in residential aged care settings & from studies on community-dwelling adult groups).

References

Abrams, P, Cardozo, L., Khoury, S., Wein, A. (Eds) (2005). Incontinence. Recommendations of the International Scientific Committee. 3rd International Consultation on Incontinence. Plymouth, UK: Health Publication Ltd.

Ostaszkiewicz, J., O'Connell, B., Millar, L. (2006). Essentials of continence care: stage 1. Point prevalence of incontinence in acute and subacute care facilities in Eastern Health. Deakin University. ISBN 1 74156 067 5

A Quick Guide for Clinicians

Principles of continence care

- The aims of continence care in acute & subacute care settings are to:
  - prevent incontinence & related bladder & bowel symptoms
  - identify incontinence & related bladder & bowel symptoms
  - identify possible causes/contributing factors through a focussed continence assessment
  - provide care that is based on a focussed continence assessment
  - provide optimal opportunities for patients to maintain or regain continence
- Patients are the best source of knowledge about their body. They should be involved in every stage of the care plan for the management of incontinence. In selective cases, it may be appropriate to involve family members – particularly if they are a primary carer
- Monitoring a patient's continence status is best done with the use of bladder & bowel charts
- Lower urinary tract symptoms should not be relied on for diagnosis as they may also indicate other health problems
- Urinary catheters should be avoided for the management of urinary incontinence
- Try to avoid using continence products as a substitute for providing toileting assistance

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A Quick Guide for Clinicians

Assessing bladder function

Patient history	When did the patient first notice symptoms? How often do the symptoms occur? Has the patient sought treatment? How does the patient manage their symptoms? What does the patient believe is the cause of their symptoms?
Bladder elimination signs & symptoms	Does the patient have any of the following signs or symptoms? *Frequency, Urinary urgency, Urge incontinence, Unaware incontinence, Urine loss on physical exertion, Difficulty passing urine, Incomplete bladder emptying, Straining, Hesitancy, Interrupted stream, Nocturia, Nocturnal enuresis, Constant dribble, Post void residual urine, Post void dribble, Haematuria, Dysuria, etc* What are the circumstances associated with the patient's incontinent episodes during the day & during the night?
Pattern of voiding & incontinence	How often does the patient void during the day & during the night? What are the patients's voided volumes & incontinent volumes? What are the circumstances associated with the patient's incontinent episodes during the day & also during the night?
Fluid intake	What is the patient's average 24 hour fluid intake? Is it sufficient to maintain adequate hydration? Is the patient able to assume resposibility for maintaining healthy levels of hydration?
Bowel elimination	Does the patient have coexisting problems of an altered pattern of bowel elimination? If yes, what is this problem & how has it been managed? Does the patient's dietary intake contain sufficient fibre to maintain bowel regularity?
The impact of symptoms	Does the patient's symptoms impact on their quality of life, health, discharge destination, caregiver health etc?

Assessing bladder function (continued)

Medical, surgical history	Does the patient have any current or past medical, surgical history including obstetric, gynaecological or urological conditions which may be causing or contributing to the problem?
Medication	Is the patient on medication which may potentially cause or exacerbate incontinence?
Cognition	What was the patient's cognition on admission? What is the patient's current cognitive & affective status? Does the patient's cognitive & /or affective status impair their ability to maintain continence?
Functional status	What was the patient's functional status on admission? What is the patient's current functional status? Does the patient's functional status impair their ability to maintain continence?
The environment	Can the patient get to the toilet independently? Are there any environmental barriers to the patient accessing the toilet or to voiding?
Manual dexterity	Does the patient have any fine motor deficits or pain which interferes with their ability to maintain continence?
Clinical findings	Does the patient have a UTI? Does the patient have a post-void residual urine volume? Does the patient have any abnormal findings on abdominal palpation, auscultation or percussion (i.e. distended bladder)? Does the patient have impaired skin integrity related to urinary incontinence? Does the patient have abnormalities on visual inspection of genitalia (i.e. prolapse)?

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A Quick Guide for Clinicians

General measures to manage urinary incontinence

- Develop a realistic care plan in collaboration with the patient (&/or family members/carers as appropriate)
- Implement an individualised or regular toileting program
- Encourage the patient to completely empty their bladder with each void
- Provide optimal privacy for urinary elimination
- Provide education about bladder function
- Select & offer appropriate continence products as supportive measures
- Check & change disposable pads after each episode of incontinence
- Monitor & protect patient's skin integrity (with particular attention to perineum, inner thighs & buttocks)
- Ensure the patient can access the toilet (if unable to independently access the toilet, ensure access call bell)
- Provide adequate lighting to toilet at night
- Promote an adequate oral hydration & fibre intake
- Discourage the use of known bladder irritants (i.e. coffee, alcohol, soft drinks)
- Treat underlying causes or contributing factors (i.e. constipation, medications, delirium & lack of toilet access)
- Offer the patient (&/or family members/carers as appropriate) a referral to a continence service or specialist to provide advice on continence products, behavioural therapy, medication &/or surgery

Assessing bowel function

Patient history	When did the patient first notice symptoms? How often do the symptoms occur? Has the patient sought treatment? How does the patient manage their symptoms? What does the patient believe is the cause of their symptoms?
Bowel elimination signs & symptoms	Does the patient have any of the following signs or symptoms? *Straining at stool, Hard stool, Loose stool, Faecal urgency, Faecal frequency, Faecal incontinence, Bloody stool, Mucous discharge, etc* What are the circumstances associated with the patient's incontinent episodes during the day & during the night?
Dietary & fluid intake	Does the patient's dietary intake contain sufficient fibre to maintain bowel regularity? How often does the patient void during the day & during the night? What is the patient's average 24 hour fluid intake? Is it sufficient to maintain adequate hydration & stool consistency? Is the patient able to assume responsibility for maintaining healthy levels of hydration?
Bladder elimination symptoms	Does the patient have coexisting problems of an altered pattern of bladder elimination? If yes, what is this problem & how has it been managed?
The impact of symptoms	Does the patient's symptoms impact on their quality of life, health, discharge destination, caregiver health etc?
Medical, surgical history	Does the patient have any current or past medical, surgical history including obstetric, gynaecological or urological conditions which may be causing or contributing to the problem?

A Quick Guide for Clinicians

Assessing bowel function (continued)

Medication	Is the patient on medication which may potentially cause or exacerbate incontinence?
Cognition	What was the patient's cognition on admission? What is the patient's current cognitive & affective status? Does the patient's cognitive & /or affective status impair their ability to maintain continence?
Functional status	What was the patient's functional status on admission? What is the patient's current functional status? Does the patient's functional status impair their ability to maintain continence?
The environment	Can the patient get to the toilet independently? Are there any environmental barriers to the patient accessing the toilet or to voiding?
Manual dexterity	Does the patient have any fine motor deficits or pain which interferes with their ability to maintain continence?
Clinical findings	Does the patient have any abnormal findings on abdominal palpation, auscultation or percussion? Does the patient have impaired skin integrity related to faecal incontinence?

General measures to manage faecal incontinence

- Develop a realistic care plan in collaboration with the patient (& /or family members/carers as appropriate)
- Offer toileting opportunities following stimulation of the gastrocolic reflex
- Encourage patients to use bowels at time of sensory urge (avoiding deferring the urge to defecate)
- Encourage the patient to completely empty their bowel each time.
- Consider measures to control odour
- Rationalise use of medications (patients with constipation with overflow should have effective bowel clearance (using a combination of laxatives & enemas & then maintenance therapy with stimulant or osmotic laxatives). (Suppositories are useful in treating rectal outlet delay & preventing recurrent rectal impaction with regular use) (Loperamide is useful in anorectal faecal incontinence in the absence of constipation)
- Provide optimal privacy for bowel elimination
- Provide education about bowel function
- Select & offer appropriate continence products as supportive measures.
- Check & change disposable pads after each episode of incontinence
- Monitor & protect patient's skin integrity (with particular attention to perineum, inner thighs & buttocks)
- Ensure the patient can access the toilet (if unable to independently access the toilet, ensure call bell access)

A Quick Guide for Clinicians

General measures to manage faecal incontinence (continued)

- Provide adequate lighting to toilet at night
- Promote an adequate oral hydration & fibre intake
- Treat any underlying causes or contributing factors (i.e. constipation, delirium, excessive use of laxatives, C. *difficile*)
- Offer the patient (&/or family members/ carers as appropriate) a referral to a continence service/specialist to provide advice on continence products, behavioural therapy, medication &/or surgery

A Quick Guide for Managers

Organisational strategies for enhancing continence care

- Identify organisational barriers to promoting continence & managing incontinence
- Target interventions to identified barriers
- Implement staff development programs to enhance staff knowledge & skills on continence care attending to issues of prevalence, impact, risk factors, screening, assessment & management of bladder & bowel symptoms
- Promote clinical leadership on continence – i.e. establish evidence-based clinical leaders to drive practice change at a local level
- Provide a framework of support for clinical leaders
- Develop structural processes for monitoring the quality of continence care (i.e. urinary tract infection rate, indwelling catheter use, episodes of urinary retention, constipation, pad usage, costs)

Research Supplement

Urinary incontinence: best available evidence in acute/sub-acute care settings

	(ICI) (Abrams et al., 2005)	Survey data (Ostaszkiewicz et al., 2006)
Prevalence of urinary incontinence	No research reported for this population	Twenty-two percent of 398 patients (n = 86) reported having experienced urinary incontinence in the preceding 24 hours The mean frequency of urinary incontinence in this period was 3.3 episodes per day
Impact of urinary incontinence	Urinary incontinence increases the risk for admission to hospital &/or residential aged care & is associated with a longer hospital length of stay	Of 61 patients who responded to this item, 14 (23%) reported it as 'extremely distressing, 17 (27%) moderately distressing, 20 (32%) slightly distressing & 10 (16%) 'not at all distressing'
Risk factors for urinary incontinence	• Congestive heart failure • Confusion • Parkinson's disease • Depression	• A pre-existing bladder problem • Mobility dependence

Faecal incontinence: best available evidence in acute/sub-acute care settings

	(ICI) (Abrams et al., 2005)	Survey data (Ostaszkiewicz et al., 2006)
Prevalence of faecal incontinence	Of 627 hospitalised patients aged 65 years of age or more (UK) - faecal incontinence occurred weekly - 14% Of 247 consecutive acutely hospitalised patients of all ages (Australia) – 22% self reported faecal incontinence The prevalence of faecal incontinence is higher in acute hospitals & nursing homes than in the community, making frail older people, the group most affected	Ten percent of 425 patients (n = 44) reported having experienced leakage from their bowel in the preceding 24 hours The mean frequency of faecal incontinence was 1.8 episodes per day
Impact of faecal incontinence	No research reported for this population	Of 31 patients who responded to this item, 7 (22%) reported it as 'extremely distressing', 12 (38%) moderately distressing', 11 (34%) as 'slightly distressing' & 2 reported 'not at all distressing'
Risk factors for faecal incontinence	No research reported for this population	Mobility dependence

Research Supplement

Urinary Incontinence: prevalence, impact & risk factors

Prevalence

- Frail older adults in residential aged care settings: 55%
- Community-dwelling young adult women: 20-30%
- Community-dwelling middle aged women: 30-40%
- Community-dwelling elderly women: 30-50%
- Post prostatectomy (males): 2-57%

Impact

- Longer hospital length of stay
- Embarrassment, social isolation
- Increased costs (i.e. diagnostic & treatment costs such as routine care, use of pads, etc)
- Skin irritation, urinary tract infections, falls, fractures, additional nursing home & hospital admissions
- Reduced quality of life for caregivers, increased burden of care, caregiver physical fatigue & need for information about resources

Common risk factors

Women

- Vaginal delivery
- Pregnancy
- Genital prolapse

Men

- Bladder outlet obstruction

Lifestyle factors

- Obesity
- Smoking

Medical/surgical factors

- Diabetes
- Stroke
- Parkinson's disease
- Urinary tract infections
- Medications (i.e. diuretics, benzodiazepines)
- Previous gynaecological or urological surgery (i.e. hysterectomy, prostatectomy)

Frail older adults (usually multifactorial)

- Impaired cognition (i.e. dementia, delirium, depression)
- Environmental barriers
- Sensory impairment (i.e. impaired vision)
- Impaired mobility
- Use of physical restraint

Research Supplement

Urinary Incontinence: assessment & management

General assessment recommendations

- A basic screening & assessment should be conducted to identify potentially treatable conditions that can cause or contribute to urinary incontinence. This includes:
  - A careful history
  - An assessment of cognitive function, mobility & environmental factors
  - A physical examination
  - A urinalysis
  - An estimation of post-void residual urine
- The patient's voiding pattern should be monitored to establish the frequency & severity of incontinence

General management recommendations

- Management should be informed by the individual's preferences for care, goals of care, determination of costs & benefits.
- Promote hydration to increase voided volume
- Encourage reduced caffeine intake
- Actively manage constipation
- Promote toileting assistance where appropriate
- Individualise continence care
- Support family caregivers
- Limit continence products, indwelling urinary catheters & condom catheters to carefully selected individuals
- Provide advice and referral information for follow-up on discharge from hospital

Research Supplement

Urinary Incontinence: assessment & management (continued)

- **Drug treatment**
  - Drug treatment should be considered after investigation and following a trial of behavioural forms of management
  - Patients should be monitored for possible side effects of prescribed drugs
    - Older adults are more susceptible to the side effects of drugs
- **Surgery**
  - Surgery should be considered after investigation and following a trial of behavioural forms of management
- **Referral & specialist intervention**
  - Some patients should be referred for urodynamic investigation and/or further specialist investigation

Research Supplement

Urinary Incontinence:

patients who require specialised assessment & management

Women

Some women have complicated urinary incontinence & require specialised assessment & management.
They include women with:

- pain
- haematuria
- recurrent infections
- suspected or proven voiding problems
- significant pelvic organ prolapse
- persistent incontinence
- recurrent incontinence after previous pelvic surgery or pelvic irradiation

Men

Some men have complicated urinary incontinence & require specialised assessment & management.
They include men with:

- haematuria
- pain
- recurrent infection
- poor bladder emptying

Research Supplement

Urinary Incontinence:

Using an indwelling urinary catheter for urinary incontinence

Indwelling catheters should be avoided for the management for urinary incontinence

Indications for use

- When patients or caregivers are fully informed of the risks & choose this as a form of management

- For patients with urinary retention that cannot be corrected surgically or medically; or cannot be managed with intermittent catheterisation. Consider intermittent catheterisation for chronic urinary retention in patients who can be taught to self catheterise or who have a caregiver who can perform the technique or in frail elderly undergoing bladder retraining after an episode of acute urinary retention
- When patients have skin wounds or pressures sores that are contaminated by incontinent urine
- For the care of terminally ill or severely impaired patients for whom bed & clothing changes are uncomfortable or disruptive

Research Supplement

Faecal Incontinence: prevalence, impact & risk factors

Prevalence

- Frail older adults in residential aged care settings: 54%
- Community-dwelling adults: 2-5% & increasing with age

Impact

- Admission to residential aged care
- Reduced participation in social activities
- Anxiety
- Depression

Common risk factors

Frail older adults (usually multifactorial)

- Urinary incontinence
- Increased dependency
- Impaired mobility
- Use of restraints
- Visual impairment
- Watery stool/diarrhoea
- Constipation
- Stroke
- Dementia
- Male gender
- Depression
- Increased body mass index

Community-dwelling women

- Irritable bowel syndrome
- Diabetes
- Abdominal hysterectomy
- Forceps delivery
- Pudendal nerve or sphincter muscle damage

Research Supplement

Faecal Incontinence: assessment & management

General assessment recommendations

- All frail older people with faecal incontinence should have structured multidisciplinary assessment & treatment of their bowel problem
- The impact of faecal incontinence on patient & carer quality of life, usual activities & attitude should be qualitatively assessed

General management recommendations

- Patient & carer education should be undertaken to promote self-efficacy & other coping mechanisms & where appropriate, self management
- Advice on skin care, odour control & continence aids are important
- Patients with constipation with overflow should have effective bowel clearance (using a combination of laxatives & enemas & then maintenance therapy with stimulant or osmotic laxatives). Loperamide is useful in anorectal faecal incontinence in the absence of constipation. Suppositories are useful in treating rectal outlet delay & preventing recurrent rectal impaction with regular use
- Digital rectal examinations may be required to assess the effectiveness of a bowel clearance programme
- Causes of loose stool should be identified & treated. In patients with loose stools due to C. *difficile*, infection, preventative measures against recurrent infection should be taken

Resource Supplement

Educational resources

This Continence Resource Guide for acute & sub-acute care settings includes a CD-ROM containing seven PowerPoint Presentations. Each PowerPoint presentation addresses a discrete topic relevant to the promotion of incontinence in hospitalised older adults. They have been developed for use by health professionals involved in the delivery of care to older adults admitted to acute & /or sub-acute care settings.

PowerPoint presentation topics:

1. Urinary incontinence & related bladder symptoms: prevalence, risk factors & impact
2. Assessing urinary incontinence & related bladder symptoms
3. Managing urinary incontinence & related bladder symptoms
4. Faecal incontinence & related bowel symptoms: prevalence, risk factors & impact
5. Assessing faecal incontinence & related bowel symptoms
6. Managing faecal incontinence & related bowel symptoms
7. Managing incontinence with continence products/devices

Resource Supplement

ID LABEL

Bladder Chart

Day ___/___/___ Please complete details for each time the patient passes urine (day & night)

Time	Voided volume		Comments (associated circumstances & effects of incontinence) (i.e. occurred on way to toilet, unaware incontinence, very distressed)
	Continent volume	*Incontinent volume (i.e. damp, wet, saturated pad)*	

Resource Supplement

Bladder Chart (continued)

Day ___/___/___ Please complete details for each time the patient passes urine (day & night)

Time	Voided volume		Comments (associated circumstances & effects of incontinence) (i.e. occurred on way to toilet, unaware incontinence, very distressed)
	Continent volume	*Incontinent volume (i.e. damp, wet, saturated pad)*	

Resource Supplement

ID LABEL

Bowel Chart

Please complete details each time the patient has a bowel action

Day	Time of bowel action	Leakage? *Yes/No*	Circumstances *(if incontinent)*	Stool Type *(refer to scale)*

Resource Supplement

Bowel Chart (continued)

The Bristol Stool Form Scale *(Use this as a guide to the stool type)*

Type 1
Separate hard lumps like nuts (hard to pass)

Type 2
Sausage-shaped but lumpy

Type 3
Like a sausage but with cracks on its surface

Type 4
Like a sausage or snake, smooth and soft

Type 5
Soft blobs with clear-cut edges (passed quickly)

Type 6
Fluffy pieces with ragged edges, a mushy stool

Type 7
Watery, no solid pieces ENTIRELY LIQUID

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Clive Ward Centre, 16 Arnold Street,
Box Hill Victoria 3128 Australia
PO Box 94, Box Hill 3128
Tel: (03) 9895 3259 Fax: (03) 9895 3176
Email: info@easternhealth.org.au
Website: www.easternhealth.org.au

Authorised by Eastern Health EH0108 ACR003

DEAKIN UNIVERSITY

School of Nursing
Burwood Campus
221 Burwood Highway
Burwood Victoria 3125 Australia
www.**deakin**.edu.au