

FIVE ESSENTIAL INTERVENTIONS IN URINARY INCONTINENCE CARE

Incontinence is not a disease in itself, however, urinary incontinence is always the symptom of an underlying condition and as such, can often be successfully treated, improved or better managed. Implementing the five essential interventions described in this article will greatly assist healthcare workers in providing best practice for patients with urinary incontinence.

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Incontinence is not a disease in itself, however, urinary incontinence is always the symptom of an underlying condition and as such, can often be successfully treated, improved or better managed.

Urinary incontinence is defined as 'the complaint of any involuntary leakage of urine' (Abrams et al, 2002). There is always an underlying cause for incontinence and often other factors contribute to the symptoms, especially in the elderly or those with chronic disease.

Occasionally, urinary incontinence is transient. This may happen as a result of acute illness or trauma, which, once treated, will resolve itself without further intervention. Treating a bacterial infection of the urinary tract may have a similar outcome.

When incontinence is not easily resolved, a comprehensive

continence assessment is necessary and this should be undertaken by a healthcare professional who is competent to diagnose the reason for the bladder dysfunction. However, there are basic interventions or actions that can be carried out by any healthcare worker that will greatly assist this process.

THE PREVALENCE OF URINARY INCONTINENCE

Worldwide, there are over 200 million people who have significant incontinence and many more with mild bladder problems. Incontinence affects all age groups, however, prevalence increases with age.

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In the UK, urinary incontinence affects more people than those with diabetes (1.4 million) or asthma (3.4 million) (Continence Foundation, 2000), yet it receives little publicity. It is not a symptom readily discussed on television or radio because incontinence is still a taboo

subject, misunderstood and sometimes ridiculed by those who do not understand it.

Urinary incontinence affects some 24% of older people and 30–60% of people in long-term care settings (Royal College of Physicians, 1995; Hunskaar et al, 2003).

Some patient groups have a higher than average prevalence of incontinence, for example, 18% of people who survive a stroke will still be incontinent of urine on discharge from hospital (Rudd et al, 1999).

The effects of incontinence on patients are considerable and include psychological, social as well as physical aspects (these include falls and fractures in people hurrying to the toilet at night). Nocturia, having to rise during the night to pass urine, increases this risk for patients (Capezuti et al, 1999) and the risk of falls is increased by people slipping on urine and getting up because the bed is wet (Brown et al, 2000).

It is no surprise, therefore, that urinary incontinence substantially increases the risk

of admission to a nursing home (Thom et al, 1997).

HEALTHY BLADDER FUNCTION

When healthcare workers are considering urinary symptoms it is important to consider what is expected from a healthy bladder.

Healthy or 'normal' bladder function is dependent on many factors, including fluid intake and lifestyle. Individual perception is also influenced by personal expectations and experience. The healthy bladder function of adults is detailed in *Table 1*.

Healthy bladder function depends on the patient's fluid intake and the volume and type of fluid is also important. Fluid intake varies greatly between individuals, however, a healthy individual weighing 10 stones (64 kilos) should have a daily fluid intake of around three pints or two litres (Abrams and Klevmar, 1996).

BASIC INTERVENTIONS FOR URINARY SYMPTOMS

Testing the urine

Cystitis involves inflammation of the bladder, often caused by infection, and may be the reason for urinary frequency, urgency and nocturia. Urinary leakage may occur before the patient is able to reach the toilet.

If the urine is clear, test with a urine dipstick. Record the findings and report any abnormalities.

Table 1

Healthy bladder function in adults

Function	Normal	May need advice/investigation
Daytime urinary frequency	Between 4–7 voids in 24 hours. May be more with a high fluid intake	If the patient complains that he or she voids too often by day (Abrams et al, 2002)
Nocturia	Waking once at night to void may be considered normal	Waking several times at night to void urine
Maximum volume voided	Around 500–600ml. Usually this is the first void in the morning, after waking. During the day the bladder is usually emptied at lower volumes	Low maximum volume below 200ml or high maximum volume over 800ml, especially if associated with other symptoms
Urgency	Can hold on. No undue urgency unless the desire to void has been postponed several times	A sudden compelling desire to pass urine, which is difficult to defer (Abrams et al, 2002)
24-hour output	Between 1–2 litres of urine in 24 hours. A high fluid intake will mean a higher urine output	Depending on body weight, activity and any medical condition, but generally less than one litre or more than three litres
Voiding difficulty	No difficulty starting to pass urine and emptying the bladder, unless privacy is breached	Difficulty initiating voiding
Leakage	The healthy bladder should not leak between voids	Regular involuntary leakage of urine

If the patient's urine is obviously infected or bloodstained, the healthcare worker should send a clean specimen for culture and microscopy. Treating a urinary tract infection may cure the symptoms, however, recurrent urinary tract infection should be fully investigated.

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in the absence of infection, blood in the urine must be investigated following national guidelines in order to exclude serious pathology. Therefore, GP referral is indicated. A positive glucose test result indicates referral for further investigation.

Keep a bladder diary

Ask the patient to keep a bladder diary for three days, including work and leisure days if appropriate. If the patient is in a care setting, the staff must be committed to keeping an accurate record of bladder function and fluid intake over three days.

Staff or patients should be instructed to record the times of micturition and the volumes voided for each 24-hour period. In addition, the patient's fluid intake and type needs to be recorded. Any wet episodes should be recorded.

When healthcare workers are recording fluid intake, they should ensure that the staff member who is removing cups or glasses from the patient's bedside records how much

has been drunk as sometimes patients only drink a small amount from a full cup.

The following information can be collated from the bladder diary:

- ▶▶ Daytime frequency (the number of voids during the day)
- ▶▶ Nocturia (the number of voids when woken from sleep by the desire to pass urine)
- ▶▶ 24-hour frequency (the total number of voids in 24 hours)
- ▶▶ Maximum volume voided (the highest volume passed in one void)
- ▶▶ Total voided in 24 hours
- ▶▶ Volume of fluid intake and type of fluid
- ▶▶ Number of incontinent episodes.

This information gives a baseline against which improvement can be measured.

Advise on fluid intake

A low fluid intake may increase the risk of urinary tract infection in susceptible individuals and concentrated urine can also result in feelings of discomfort and a desire to empty the bladder frequently.

Fluid intake includes not only drinks, but also foods with a high water content, such as soup and ice cream and for the purposes of determining a healthy fluid intake these should be taken into account. Fluid intake will also vary depending on how active the person is, but as previously stated, a healthy individual weighing 10 stones (64 kilos) should have a daily fluid intake of around three

pints or two litres (Abrams and Klevmar, 1996).

In some patients, increasing fluid intake may not be advisable, therefore, existing medical conditions such as heart disease must be taken into account before advising a patient to increase fluid intake.

If an otherwise healthy individual weighing 10 stones (64 kilos) has a regular fluid intake in excess of three litres

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and complains of bladder symptoms, this should be discussed and the patient advised accordingly.

Some fluids appear to irritate the bladder in some patients, for example, caffeine is a well-known diuretic – the kidneys produce urine at a higher rate following the ingestion of caffeine in food or drink.

Drinks that are high in caffeine include coffee, tea and some carbonated drinks such as colas. Other items that contain caffeine include chocolate as well as some medicines.

Observe and report

A physical examination should be carried out by a competent healthcare professional (a nurse, doctor or physiotherapist), with

the informed consent of the patient (in line with local and national policy guidelines).

However, those carrying out day-to-day personal care are in a position to observe for abnormalities such as abdominal swellings, skin lesions and prolapse.

Visual assessment of the abdomen and genitalia may reveal abnormalities such as:

- ▶▶ Previous surgery scars
- ▶▶ Hernia (rupture)
- ▶▶ Significantly enlarged bladder or pelvic mass
- ▶▶ Prolapsed rectal mucosa
- ▶▶ Haemorrhoids
- ▶▶ Skin excoriation
- ▶▶ Discharge
- ▶▶ Third degree uterine prolapse (in the female patient)
- ▶▶ Hydrocele (in the male patient)
- ▶▶ Epispadias or hypospadias (a congenital abnormality in which the urethra opens on the upper or underside of the penis).

Any abnormalities observed by healthcare staff should be reported immediately.

Maintain bowel function and prevent constipation

Constipation involves infrequent or difficult bowel movements. A loaded rectum will cause pressure on the urethra, which in turn results in voiding difficulties and urinary incontinence.

This direct pressure may cause bypassing of urine in catheterised patients and chronic and prolonged straining

to open the bowels can weaken the pelvic floor muscles.

A rectum loaded with soft faeces can cause similar problems and may result in faecal smearing.

Regular bowel function with effective emptying of the lower bowel is therefore essential in promoting urinary continence.

CONCLUSION

Straightforward interventions and advice from healthcare workers can improve and even cure a patient's incontinence symptoms. Healthcare workers are in an ideal position to help patients through the following simple yet essential interventions and advice:

- ▶▶ Test the urine and ensure treatment for any abnormalities
- ▶▶ Complete a bladder diary for at least three days
- ▶▶ Advise on fluid intake. Modify high or low fluid intake (National Institute for Health and Clinical Excellence [NICE], 2006)
- ▶▶ Observe and report any physical abnormalities
- ▶▶ Monitor bowel function. Prevent constipation and promote regular bowel emptying. **CE**

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Key Points

- ▶▶ Incontinence is not a disease in itself, however, urinary incontinence is always the symptom of an underlying condition and as such, can often be successfully treated, improved or better managed.
- ▶▶ Urinary incontinence is defined as 'the complaint of any involuntary leakage of urine'.
- ▶▶ There is always an underlying cause for incontinence and often other factors contribute to the symptoms, especially in the elderly or those with chronic disease.
- ▶▶ Occasionally, urinary incontinence is transient. This may happen as a result of acute illness or trauma, which, once treated, will resolve itself without further intervention.
- ▶▶ When incontinence is not easily resolved, a comprehensive continence assessment is necessary and this should be undertaken by a healthcare professional competent to diagnose the reason for the bladder dysfunction.
- ▶▶ The effects of incontinence are many and include psychological, social as well as physical effects (these include falls and fractures in people hurrying to the toilet at night).
- ▶▶ However, there are basic interventions or actions that can be carried out by any healthcare worker that will greatly assist a patient to gain continence.
- ▶▶ Healthy or 'normal' bladder function is dependent on many factors, including fluid intake and lifestyle. Individual perception is also influenced by personal expectations and experience.