Continence: Promotion and Maintenance Residential Care

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Site Applicability

Vancouver Coastal Health – Residential Care

Practice Level

- Basic Skills for all care staff
- Advanced Skills – Nurse Continence Advisor, Physiotherapist with level 1 Continence Training

Policy Statement – any VCH policies or provincial

On admission, or when there is a change in condition, all residents' urinary continence status will be assessed by completing a Voiding Record for a minimum of 3 days or longer as needed to establish an individualized toileting schedule.
An individualized Care Plan will be developed to promote continence, toileting and dignity.

Need to Know

The goals of this Clinical Practice Guideline (CPG) are:

- To maintain and improve the person's continence level to the best possible extent.
- Prevent increasing degrees of incontinence in persons who are already incontinent and may benefit from a treatment program

The development of this CPG is an opportunity to raise awareness of this care concern and to better inform and guide team members on how to maintain individuals' toileting abilities. This CPG will provide the most current information on how to assess a person's continence abilities, and to provide directions on how a care team can develop and implement an individualized care plan and evaluate the outcomes.

Urinary incontinence (UI) affects an individual's independence, functional abilities, sense of dignity and self-esteem. It is estimated that one in five Canadian women in the community have Urinary Incontinence (UI) affecting their normal activities (Canadian Continence Foundation, 2007). Incontinence occurs in 1 out of ten men (Skelly, J. et al., 2006. McMaster University. p. 2). In long-term care facilities over 50% of persons experience urinary incontinence (UI) either occasionally or on a regular basis (Morris et al. (2008). UI is not a normal part of the biological process of aging, although it frequently increases with age. UI is a contributing factor to skin breakdown, falls, urinary tract infections (UTI's) and other physical adverse conditions. It also affects self-esteem, life satisfaction and desire to socialize, thus increasing the risk for depression and anxiety. In reviewing the costs to the person and society it is stated that "a senior with incontinence living in a long-term care facility can total an average of $3,000-$10,000 per year for supplies (products, linens) and nursing care. (The Canadian Continence Foundation, 2007, p. 2)

A UK paper (2005) by the *Health Care of Older People Program* concluded there is a missed opportunity to assess, treat and reduce the number of persons experiencing incontinence as there tends to be emphasis on containment rather than cure which is expensive, from both a financial and health perspective. They note that little attention is given to privacy and dignity. Seventy-six percent (76%) of the UK care homes surveyed rationed the containment products

Definitions: (see Appendix A)

Equipment and Supplies

Basic:

- Continence Assessment and Interview Guide (Appendix B)
- Voiding Record (Appendix C)
- Continence Risk and Intervention Guide (Appendix J)
- Continence products: briefs, pads, catheters, perineal cleansers and skin protectants
- Urine collection kit
- Toilet, urinal, commode, raised toilet seat
- Mobility and transfer aids; grab bars, sit to stand lift and walker
- Bladder Scanner is recommended

Guideline

Standards of Care

1. Resident's voiding pattern will be assessed by completing a *Voiding Record* on admission for the first 3 days and up to the last day Minimum Data Set (MDS) is due (day 14) if required, and when there is a change in the voiding pattern
2. The resident will be guided by a regular, individualized toileting program with cues and positive feedback.
3. The resident is to be placed in a sitting position for elimination in a private space, preferably on the toilet in a bathroom
4. The resident is to be assisted safely with appropriate equipment and mobility aids
5. The resident will be comfortable and odour free with decreased adverse events
6. Urinary catheterization should be a last choice for determining and treating urinary retention

A. Assessment of Risk Factors

Identification of factors contributing to Urinary Incontinence (UI):

- Common changes related to aging, atrophy of pelvic floor muscles and external urinary sphincter, atrophy of detrusor muscles, alteration in diurnal pattern thus increase in nocturia, decreased transfer and mobility abilities, chronic constipation, diuretics, dehydration, multiple diagnoses, infection, hospitalization, obesity.
- Female: shorter and wider urethra, obstetrical and menopausal history
- Male: enlargement of the prostate gland

Risk factors for Transient Causes of Urinary Incontinence*:* **DISAPPEAR** Whytock, S. (2006). Transient causes of Urinary Incontinence. *Promoting Continence Care. A Bladder and Bowel Handbook for Care Providers*. Skelly, J. et al. McMaster University. p. 24

D – delirium
I – intake: amount and type of fluids (at least 1500 mlss and non caffeinated, Infection (UTI)
S – stool constipation/impaction
A – atrophic vaginitis, atrophic urethritis
P – psychological problems: depression
P – pharmaceuticals and post - operative retention
E – excess urine output related to diuretics, diabetes, heart failure
A – abnormal lab values
R – restricted mobility

B. Assessment

B.1 Client's History Related to Continence Risk Factors:

- Medical history of chronic diseases (diabetes, stroke, dementia, acquired brain injury, MS, Parkinson's, heart failure, recurrent UTI's); surgery (TURPs, hysterectomy, bladder repair) or bladder radiation, medications.
- Obstetrical and gynecological history: use of hormone therapy, number of deliveries, type of delivery; use of forceps, perineal tears, episiotomy, bladder/uterine prolapse, cesarean section
- Cognitive ability to recognize need to void, ability to postpone void, and know where to void; ability to mobilize and transfer safely
- Mood including depression and motivation
- History of a fall(s) in the past 3 months
- Timed Up and Go (TUG) score greater than 15 seconds
- History of UI: type, frequency, duration and characteristics
- Use of containment products: panty liner, pads, brief. If so, how many in 24 hours?
- Functional abilities with a focus on mobility and toileting
- Normal voiding position: sitting, standing
- Normal bowel routine, daily, q 2nd day, location, time of day
- Medication review including those that may contribute to UI or assist with continence

B.2.1 Interview screening questions for the resident

1. Are you aware of when you need to pass urine?
2. Can you delay passing urine?
3. Do you leak urine?
4. Do urinary issues interfere with your daily activities e.g. sleep, visits, outings
5. What prevents you from getting to the toilet in time e.g. difficulty with clothing, transferring, can't find the toilet?
6. What are your goals for continence care?

B.2.2 Continence Determined as a Focus of Care or RAP/CAP Triggered

- Complete *Continence Assessment and Interview Guide* as resident and family is able: **(**see **Appendix B)**

B.3 Observation and Assessment

- Observe behavioural indicators that the person may need to void: non verbal cues, increased agitation, restlessness, pacing, pulling on clothes
- Assess pain level when moving, sitting on toilet and when voiding and eliminating
- Assess ability to:
  - make self understood and understand others
  - locate the bathroom, see the toilet and
  - hear to respond to verbal cues
  - recognize need to void and inform others
  - hold urine until toileted with or without assistance

- Assess if person dribbles or leaks when they cough, laugh, sneeze, lift, stand up
- Observe the condition of the perineal area. Note if excoriated, dry or atrophied
- Examine the genital area for discharge or abnormalities e.g. prolapse, hypospadius
- Palpate the abdomen to detect masses, suprapubic fullness or tenderness
- If needed, determine if there is residual urine, preferably using a bladder scanner
- If no scanner is available, perform an in and out catheterization to determine urinary residual volume
- A palpable bladder may indicate there is over a 150 mL of urine
- Dull sound with percussion to the umbilicus may indicate approximately 500 mLs of urine
- Lower abdominal pain/tenderness at the umbilicus may indicate 1400–1900 mL's of urine
- If further assessment is needed determine voided volume and quality of flow

B.4 Use of Voiding Record (see Appendix C)

- On admission initiate *Voiding Record* for 3 days, continue for 14 days if needed to determine voiding pattern
- When there is a change in voiding pattern initiate the *Voiding Record* for 3 days or longer as needed
- During waking hours assist to the toilet q3 hours for the first 3 days (Standard 1)
- Analyze results of the *Voiding Record* after three days
- Establish an individualized toileting program
- Schedule to be followed until the last day when MDS is due – day 14
- The toileting program will be adjusted to maximize the individual's continence ability according to the resident's goals.
- Night time toileting is individualized with consideration of transfer ability, comfort level, skin excoriation or recognized agitation related to the need to void.

B.5 Determinants of Functional Ability to Support Toileting	B.6 Environmental Assessment
• Refer to *Mobility Screening Tool for Safe Toileting* **(**see **Appendix D)** • ADL functioning including mobility and assistance required to stand and sit • Transfer with or without aids, bed to chair and standing to sitting, on/off toilet • Ability to - remove clothing easily and in a timely manner - have feet on a firm surface; floor or transfer base - sit and the length of time able to sit comfortably. - wipe self and attend to hygiene - adjust clothing including fasteners - stand for time needed for hygiene and dressing	• Accessibility to the toilet including the distance from the main living space • Toilet height for safe sitting and transfer • Space to move in the bathroom for the resident and assistant • Privacy is provided and assured • Appropriate transfer aides, grab bars • Lighting; ease of turning on switch or sensor lights are in place • Able to see the toilet; the wall or toilet seat is a contrasting colour. Signage indicating a toilet • Call bell and toilet paper are within reach • Flushing is automatic or lever does not require the person to turn • Taps are accessible and are easy to turn on and off

B.7 Analysis

- Determine continence level: continent, usually continent, occasionally incontinent, frequently incontinent, incontinent (refer to MDS – section H1)
- Review data to identify contributing factors if person has urinary incontinence (UI)
- Identify type(s) of UI, if able (see Appendix A)
- Identify barriers to maintaining or reestablishing continence
- Determine person's individualized toileting program

C. Interventions

C.1 Common prevention and intervention measures for all types of UI

- If a catheter is present, review the purpose and remove if appropriate **(see Appendix E);** (standard 6)
- Establish a regular, individualized bowel routine
- Establish a healthy diet and promote at least 1500 ml's of fluid daily.
- Review medication profile for factors contributing to UI **(see Appendix F)**
- Establish where person will void, preferably in a sitting position on a toilet in a private bathroom. The use of bedpans is discouraged (Standard 3)
- Optimize residents' abilities to get to the bathroom safely, to get on and off the toilet, to sit comfortably, safely and attend to perineal hygiene
- Review environment to remove barriers to getting to the toilet in a timely manner e. g. clutter, tripping hazards, slippery floors

- Provide a safe environment e.g. grab bars where person stands, raised seat, feet on the floor, well fitting non slip footwear, automatic/sensored lighting, contrasting toilet seat to accommodate visuospatial perceptions, alarm call system, adapt flush handle or flush activating sensor, adapt or relocate the toilet paper dispenser, wash basin to be at convenient height with knee space underneath, faucet with single lever to control water flow or lever type (Standard 4)
- Encourage independent toileting by prompting and cueing to closest bathroom
- Provide visual cues to orient to the bathroom, e.g. picture of a toilet on the door
- Adapt clothing so it is loose and easy to unfasten or remove e.g. velcro
- Promote privacy to encourage good bladder and bowel hygiene which increases dignity (Standard 3)
- Verbal prompts to guide person through the steps of normal elimination
- Do not leave the person on the toilet for more than 10 minutes to promote comfort, safety and to decrease anxiety when on the toilet
- Encourage flow by turning on tap water
- Promote personal hygiene: may need long handled wipers or portable bidets (standard 5)
- Review use of pads and briefs to determine if they are the right product for the person and promote comfort and skin integrity; size and type, convenience for changing **(see Appendix G)**
- Promote pelvic floor/Kegel exercises, if able to follow directions **(see Appendix H)**
- If necessary due to environmental restrictions use commode with a comfortable seat
- If a UTI is suspected push fluids and treat according to person's history **(see Appendix I)**

Guidelines for interventions specific to type of UI:

C.2 Stress Urinary Incontinence (SUI)	C.5 Overflow Incontinence (OI)
• Develop specific toileting program **to go to the person before** they experience a trigger leading to an incontinent episode • Promote toileting before the bladder fullness contributes to leakage. Determine the amount of urine the bladder comfortably holds before leaking • Educate the person, if able, to contract the pelvic floor when they sense they may leak e.g. sneeze or cough • Consider hormonal creams (estrogen or progesterone) to increase the tone of the urethral muscles	• Develop regular toileting program so that the bladder does not get over full • Consider whether the person is experiencing pain related to retention or toileting • Encourage double void by standing and sitting a second time • Identify residual urine (volume of greater than > 200 ml) preferably using a bladder scanner • Treat urinary retention to empty the bladder using *Treatment of Urinary Retention (HPA Decision Support Tool)* • If urine retention is above 400 ml perform an intermittent (in & out) catheterization • for an enlarged prostate consider medications that relax the urethral sphincter and reduce resistance while producing strong detrusor contraction (CAP p. 162)
C.3 Urge Urinary Incontinence (UUI)	**C. 6 Functional Urinary Incontinence (FUI)**
• Strategies include distracting individual to decrease awareness of urge to void, cross their legs to increase pressure on the perineum, lean forward when sitting, positive self talk to lengthen time between voids and/or until the person reaches a toilet • Promote Kegel exercises, if appropriate **(see Appendix H)** along with core strengthening • Promote timed voiding before they experience a trigger leading to an incontinent episode • Ensure they drink 1500 mls of fluid	• Decrease barriers to getting to the toilet in a timely manner; go to the person according to their schedule to prevent person from unsafely rushing to the toilet • To promote self toileting use convenient or adaptive clothing
C.4 Mixed Urinary Incontinence (MUI)	**C.7 Continuing Incontinence**
• Develop specific toileting program **to go to the person before** they experience a trigger leading to an incontinent episode • Consider measures for urge and stress UI • Encourage them to drink 1500 mls of fluid • Strengthen pelvic floor muscles as appropriate • Use of medications as determined by the team	• Determine type, size and absorbency of brief/pad, when required • Determine frequency of brief /pad changes • Determine if person needs to be changed or turned during the night to maintain comfort and skin integrity while having a restful sleep • Maintain skin integrity and keep person odour free (Standard 5)

C.8 Referrals

- Refer to appropriate interdisciplinary team member for specialized assistance
- Refer to appropriate specialist Nurse Continence Advisor, Physiotherapist, Physician, Urologist, Nurse Practitioner (NP)
- Refer to local continence clinic, UBC bladder clinic

C. 9 Review of Assessment and Interventions

- Refer to *Continence Risk and Intervention Guide* **(see Appendix J)** to:
  - Identify the risks and contributing factors for UI
  - Review pertinent inter-RAI items related to UI
  - Identify key interventions that can be implemented

C.10 *Continence CPG Decision Tree* **(see Appendix K)**

- This is a one page summary of the CPG to guide decision making

Expected Client/Family Outcomes

1. Resident will participant in developing continence goals and establishing realistic expectations
2. Resident will receive assistance when requested in a timely and appropriate manner
3. Resident will be odour free
4. Resident's skin will be free of irritations and redness
5. Resident will experience comfort and receive pain management, when applicable
6. Educational material on continence care will be provided to the resident and their supports (see Appendix L)
7. Resident will experience a decreased number of falls and related injuries
8. Resident will experience less need to call out or wander to seek a toilet
9. Resident will experience decreased episodes of agitation and excessive behaviours

Evaluation

- Chart audits for Continence CPG compliance – (see Appendix M)
- Residential Care Family/Resident Surveys
- Admission and Quarterly MDS assessments and RAPS/CAPS when triggered
- Provincial Residential Care Indicators for # of wounds, falls and behaviours and pain/comfort level

Documentation

- *Voiding Record* will be initiated on day of admission and completed for at least 3 days.
- *Voiding Record* will be reviewed and if necessary will be completed for 14 days
- *Voiding Record* will be initiated when there is a change in the voiding pattern
- *Continence Assessment and Interview Guide* findings summarized in *Progress Record*
- *Continence Risk and Intervention Guide* to review contributing factors to UI as noted by Inter-RAI items and suggestions for interventions
- An individualized continence plan of care will be recorded in the Care Plan
- The summary of assessments and rationale for care will be noted in the *Progress Record*
- UTI's, risk factors and response to treatments will be recorded in the *Progress Records*
- *VCH RAI-RC Observation Tool* completed by Care Aides
- *ADL* documents to reflect current care plan

Related Documents

- McGarvey, Erin in collaboration with the BC Health Authority leads for RN Scope of Practice Implemenation. (2008). T*reatment of Urinary Ret*ention
- Bowel Health Clinical Practice Guideline (to be developed)
- FH *Identification of Agitated & Excessive Behaviours & Client-Centred Interventions* CPG
- FH *Identification of Fall Risks and Interventions for Falls and Injury Reduction* CPG
- Morris, J.N., Belleville-Taylor, P., Berg, K., Bjorkgren, M., Frijters, D., et al. (2008). *Urinary incontinence CAP guidelines,* InterRAI Clinical Assessment Protocols (CAPS), 161–165. Ottawa: Canadian Institute for Health Information.
- UBC Department of Family Medicine. (2006). *Care for Elders. Continence Module and Case Study*. Contact Dr. Martha Donnelly. marthad@interchange.ubc.ca
- VCH *Delirium* CPG (to be revised) FH *Assessment of and Interventions for Delirium* CPG

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- Continence Foundation of Australia www.contfound.org.au
- International Continence Society www.icsoffice.org
- National Association for Continence (UK) www.nafc.org
- The Continence Foundation (UK) www.continence-foundation.org.uk
- RNAO. (2005). Promoting Continence using Prompted Voiding. Nursing Best Practice Guideline. Toronto. http://www.rnao.org

Bibliography: **(see Appendix N)**

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Appendix A - Definitions

Continence: the ability to control the passage of urine. Adapted from: *Australian Health Ministers' Advisory Council (2004). Best Practice Approaches to minimize functional decline in the older person across the acute, sub-acute and residential aged care settings. Clinical Epidemiology and Health Services Evaluation Unit, Melbourne Health.*

Functional Urinary Incontinence (FUI): urinary leakage outside of the lower urinary tract associated with inability to access the toilet because of impairment of cognitive and/or physical functioning or an environmental barrier. RNAO. (2005). *Promoting Continence Using Prompted Voiding. Nursing Best Practice Guideline. Toronto.*

Mixed Urinary Incontinence (MUI): involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing. Abrams, Paul, et al. (2002). *International Continence Society*, Abrams, Paul. et al.

Nocturnal enuresis: loss of urine occurring during sleep. Abrams, Paul et al. (2002). *International Continence Society*,

Overflow incontinence (OI): periodic or continuous leaking or dribbling of urine from an over-full bladder which contributes to the bladder retaining more urine than it empties. Adapted from: *Canadian Nurse Continence Advisor Association (2006). Promoting Continence Care. A Bladder and Bowel Handbook for Care Providers. Custom Courseware.* Hamilton, ON: McMaster University.

Overactive Bladder: (OAB) involuntary contraction of the detrusor muscle leading to urgency, frequency and often nocturia. *UBC. (2006). Care for Elders Continence Module* (p.4).

Prompted Voiding: a behavioural technique using verbal and physical cues to assist the individual to use the toilet or appropriate receptacle. Prompted voiding is a first-line intervention for some types of urinary incontinence. RNAO,(2005). *Promoting Continence Using Prompted Voiding. Nursing Best Practice Guideline. Toronto.*

Stress Urinary Incontinence (SUI): leaking of urine with coughing, sneezing, straining, exercise or any type of exertion in the absence of a bladder contraction. *Canadian Continence Foundation (2007).*

Toileting: the process of encouraging the person to use some type of toilet or appropriate receptacle in which to void or defecate. Toileting is for the purpose of voiding and not just for changing briefs. RNAO, (2002). *Promoting Continence Using Prompted Voiding. Nursing Best Practice Guideline. Toronto.*

Toileting Programs: considerations include timing of meals, defecation and voiding, posture on the toilet, toileting privacy and time for toileting (adapted from *Canadian Nurse Continence Advisor Association*, (2006). *Promoting Continence Care. A Bladder and Bowel Handbook for Care Providers. Custom Courseware*. Hamilton, ON: McMaster University, p. 66.

Urinary incontinence (UI): "Involuntary leakage of urine." International Continence Society, *Anderson et al (1998).* UI is a symptom - not a disease in itself. *National (Cdn) Association of Incontinence.*

Urge Urinary Incontinence (UUI): leaking of urine associated with the sudden uncontrollable urge to empty the bladder. The urge to empty the bladder cannot be delayed and leakage occurs. *Canadian Continence Foundation (*2007).

Voiding Record: a form to document when, where and, if possible, the amount of intake and amount voided over a period of days. The purpose is to establish a baseline-voiding pattern and/or to assist in establishing a successful toileting program.

Appendix B - Continence Assessment and Interview Guide

This tool is to assist with further assessment of resident identified with a continence concern. The resident or family may answer questions. Void = passing urine

Resident's Name **Male** ☐ **Female** ☐ **Onset:** **Gradual** ☐ **Sudden** ☐	**Date Assessed** _____ **Reason for assessment** _____ **Duration of UI**_____
Fluid Intake What type of fluids do you drink in 24 hours? How much fluid do you drink in 24 hours?	 Types: ☐ thickened fluids ☐ other Days ____ ml Evenings ____ ml Nights ____ ml
Bowel Care How often do you have bowel movements? Are laxatives, suppositories, enemas used?	 Days ____ Evenings ____ Nights ____ Yes ☐ Which _____
Urinary Concerns How often do you go to the toilet? How often do you have an accident? Are you able to get to the toilet when you feel the need? Describe your normal flow: Circle applicable terms Do you leak urine with physical stress? (e.g.: cough, laugh, sneeze, lifting) How much leakage do you have? Can you postpone the need to pass urine?	 Days ____ Evenings ____ Nights _____ Days ____ Evenings ____ Nights _____ Yes ____ No _____ dribble, gush, hesitancy, nocturia, dysuria, manual expression or straining Yes ☐ Yes, just after ☐ No☐ N/A ☐ Wet underwear only ☐ Wet bedding ☐ Wet outer clothing ☐ Contained ☐ Yes ☐ No ☐
Urge Loss Do you rush to the toilet when you feel the urge to void? Do you leak urine on the way to the toilet? On average; how long can you hold on after feeling the first urge to pass urine?	 Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Days ____ Evenings ____ Nights ____
Overflow Do you feel you empty your bladder when you void? Are you aware of: - the urge to pass urine? - urine being passed? - being damp or wet? Do you have trouble starting to pass urine? Do you have to strain or push to start to pass urine? Do you have dribbling after you finish passing urine?	 Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐ Yes ☐ No ☐ Occasionally ☐ N/A ☐
Products: Type used (pad, brief, make). No.in 24 hrs	Type -_____Days ☐ Evenings ☐ Nights☐

Interviewers Initials _____ History obtained from Resident ___ Family ___ Not able to respond_____

Adapted from: Canadian Nurse Continence Advisor Association. (2006) *Promoting Continence Care*. McMaster University Press.

Appendix C – Voiding Record

VOIDING RECORD

Continence Maintenance and Promotion Clinical Practice Guidline

1. What is the usual length of time between voids.?
2. Does the resident have a pattern of continence/ incontinence?
3. Is the resident able to use the toilet when offered?

Instructions for Use:	**V** - Voided on toilet
To be initiated on day of admission and completed for 3 days.	**N** - Not voided on toilet
Analyze results and document.	
Establish toileting schedule for observation period (14) days.	**R** - Refused use of toilet at this time
May need to complete for 7 days to determine pattern.	**W** - Wet brief before toileted
Mark Appropriate box	**D** - Dry before toileted

DATE	Day 1					Day 2					Day 3					Day 4					Day 5					Day 6					Day 7				
Void Diary	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**	**V**	**N**	**R**	**W**	**D**
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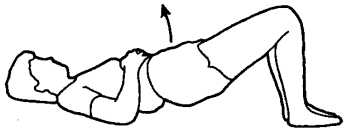
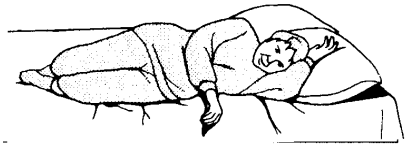
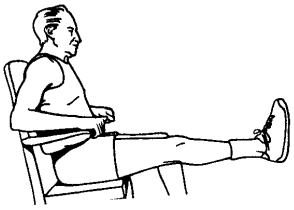
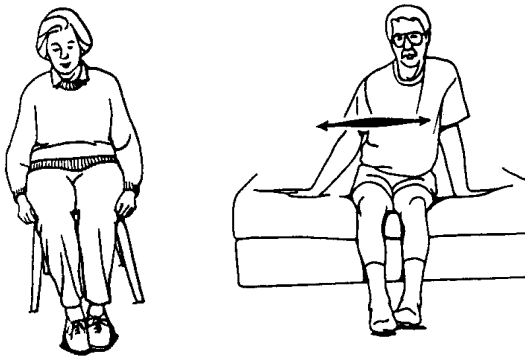
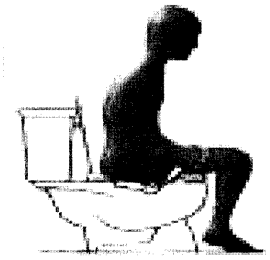
	**Cognition**	Able to follow one-step commands and instructions
	Strength	Able to lift hips off bed while lying on bed
		Able to roll from back to side without assistance
		Able to straighten each leg
	**Balance**	Able to sit upright without assistance
	**Position**	Able to sit comfortably and safely on toilet with feet flat on the floor for approximately 10 minutes

If resident does not have the above abilities, consult with your care team. To support and promote toileting, incorporate alternatives.

Appendix E – Catheter Care

Purpose:

Urinary catheterization should be a last choice for determining and treating urinary retention once all other strategies have been exhausted. Urinary catheterization provides a method for continuous, safe, and effective decompression of the bladder. The catheter is used as a conduit to drain urine from the bladder into an attached bag or container.

Goals:

- Decrease the inappropriate use of catheters for residents within Residential Care facilities.
- Encourage adequate fluid intake (1500 mls) to dilute the urine and decrease catheter encrustations
- Complete a continence assessment on all residents (see CPG) and promote "prompted voiding" to maintain normal urinary function
- Use the least invasive measures to promote bladder emptying
- Do not use indwelling catheters without medical justification: if not justified, they should be removed as soon as possible

Background:

"Indwelling catheters increase mortality and morbidity…At least 40% of all infections seen in nursing homes are in the urinary tract system and 80% are due to urinary tract catheterization and instrumentation" (Newman, 2006.p. 40).

Indications of Urinary Retention

- Discomfort, restlessness, agitation and signs of needing to void
- Inability to void even though sensation to void is present
- Frequent, small voids (<50mls)
- Continuous dribbling
- Diaphoresis
- Increased blood pressure in absence of pain or without history of hypertension
- A palpable bladder may indicate there is over a 150 mls of urine
- Dull sound with percussion to the umbilicus may indicate approximately 500 mls of urine
- Lower abdominal pain/tenderness at the umbilicus may indicate 1400 – 1900 mls

Best Practices for Catheter Care:

- Insert catheter using aseptic technique and sterile equipment
- Use sterile water to fill the balloon (10 mls for a 5 ml balloon)
- Use a closed system of urinary drainage
- Use the smallest catheter possible to minimize trauma, but a larger lumen may control leakage
- Gather a specimen from the urine sampling port on the tubing (not the bag)
- Do not irrigate the catheter
- Do not clamp the catheter
- Use a smooth (lubricath) catheter made of durable material (silicone, PVC or Teflon vs latex)
- Change the catheter only when there are clinical indications e.g. bypassing
- Indwelling catheter should be properly secured (leg or abdomen) to prevent movement and urethral traction (abdomen preferable for men)
- Empty the drainage bag regularly at least when ½ to 2/3rds full or every 3 to 6 hours so the bag does not get too heavy.

- Regular meatal cleansing theoretically reduces colonization of bacilli in this area but recent studies have not shown reduction in infections, so more study is needed

Indwelling Catheterization Long Term (more than 30 days)

- Used to maintain urine output in residents who have undergone surgery e.g. bladder or prostate, require strict monitoring of output or those who have an obstruction to urine flow leading to retention.
- Used for those who cannot empty their bladder related to a neurological deficit when the nerves do not consistently relay the correct message to and from the bladder and the brain. This can be related to diabetes, acute infections, stroke and injuries to the spinal cord
- Elderly are at an increased risk of urinary retention and urinary tract infection due to decreased bladder and kidney function, decreased metabolism of drugs that may affect the urge to void, and bladder damage leading to a decreased perception of bladder distention. (2007, BC Provincial Health Professions *Treatment of Urinary Retention)*.
- Use least invasive measures such as portable bladder ultrasound (bladder scanner) to diagnose urinary retention and assess Post Void Retention (PVR) whenever possible.

Intermittent Catheterization

- Maybe applicable for bladder management for those with neurological deficits
- May be necessary to assess urinary retention

References:

McGarvey, Erin in collaboration with the BC Health Authority leads for RN Scope of Practice Implemenation. (2008). T*reatment of Urinary Ret*ention. http://vhnet/programs_services/pp_nursing/health_professions_act/_docs

Newman, D. (2006). Urinary incontinence, catheters, and urinary tract infections: an overview of CMS Tag F 315. *Ostomy/Wound Management*. 52(12), 34-44.

Nicoll, L. (2001). The chronic indwelling catheter and urinary infection in long-term-care facility residents. *Infection Control and Hospital Epidemiology,* May, 316-321.

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Sense, V., Hendricks, M,. Morrison, M., & Harris, J. (2006). Clinical Practice Guidelines. Care of the patient with an indwelling catheter. *Urological Nursing,* 26 (1), 80-81.

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Appendix F – Medications that Improve or Hinder Continence

Consider whether resident's chronic disease including Dementia, are stable

PHARMACEUTICALS THAT CAN CONTRIBUTE TO INCONTINENCE.

Sandra Whytock for the BC Acute Care Geriatric Nurse Network

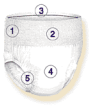
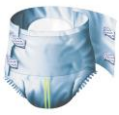
CLASS	EXAMPLES	EFFECT ON BLADDER CONTROL
Diuretic	furosemide, hydrocholorothiazide caffeine (coffee, tea), alcohol	Polyuria, frequency, urgency
Anticholinergic	oxybutynin (Ditropan), flavoxate (Urispas), dimenhydrinate (Gravol)	Relaxes the bladder. Can cause constipation (impaction). Results in retention with overflow
Antidepressant	amitriptyline, doxepin, imipramine, nortriptyline, trazodone	Anticholinergic effect, sedation (decreased sensitivity to bladder cues)
Antipsychotic	haloperidol, chlorpromazine, thioridazine, loxapine, risperidone, etc.	Anticholinergic effect, sedation (decreased sensitivity to cues), rigidity, reduced mobility
Sedatives	lorazepam, oxazepam, diazepam	Decreased sensitivity to bladder cues, muscle relaxation, confusion
Narcotic analgesic	morphine, codeine, etc.	Urinary retention (especially if administered with another anticholinergic medication), fecal impaction, sedation, confusion
Alpha-adrenergic blocker	prazosin (Minipress), doxazosin (Cardura), terazosin (Hytrin), tamulosin (Flomax)	Relaxes the urethral sphincter (can contribute to stress incontinence)
Alpha-adrenergic agonist	ephedrine, sudafed (contains pseudoephedrine)	Increased urethral closing pressure/resistance (can result in retention, especially if there is pre-existing obstruction)
Muscle relaxants	baclofen (Lioresal), dantrolene (Dantrium), cyclobenzaprine (Flexeril)	Smooth muscle relaxation (can cause retention)
Calcium channel blockers	verapamil (Isoptin), nifedipine (Adalat), felodipine (Plendil), diltiazem (Cardizem)	Can reduce smooth muscle contractility in the bladder. Can cause retention especially if given with an anticholinergic

MEDICATIONS USED TO IMPROVE BLADDER CONTROL

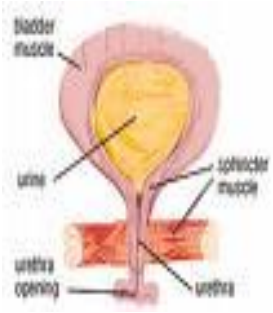
	MEDICATION	EFFECT	NOTE
Stress and/or Urge Incontinence	Estrogen cream for post-menopausal women - or vaginal jelly (Trimo-San or Replens)	Restores atrophic epithelium; increases outlet resistance	Use tiny amount of estrogen cream applied externally. No estrogen if history of reproductive cancer
	pseudoephedrine	Increases tone of muscles around the urethra	May contribute to increased heart rate and blood pressure
Urge incontinence	oxybutynin (Ditropan) flavoxate (Urispas) tolterodine (Detrol)	Decreases involuntary bladder contraction	Anticholinergic - dry mouth, constipation, confusion, etc.
	imipramine (Tofranil)	Imipramine also may tighten sphincter	
Overflow incontinence	terazosin (Hytrin) doxazosin (Cardura) tamsulosin (Flomax)	Relaxes urethral sphincter; reduces urethral resistance	Side effects: rapid heart rate, drop in blood pressure, headache, fatigue
	bethanocol (Urecholine)	Produces strong detrusor contraction	Can cause urethral constriction
	estrogen cream (see above)	Increases bladder muscle tone	
Nocturia	DDAVP (Desmopressin)	Increases water reabsorption in renal tubule	Combine with fluid restriction at night Not for on-going use, for once in a while
Frequent UTI	Cranberry juice (pure, mixed with other juice, or cranberry cocktail), or cranberry tablets or capsules	Coats bacteria to prevent adherence to bladder wall	Recommended dose varies: Juice: 500-750 mL per day Capsules or tablets: 300-400 mg twice per day

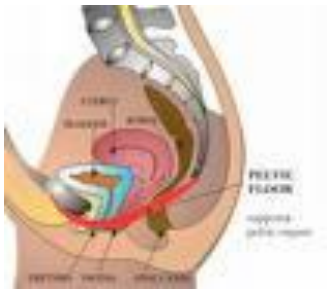
Appendix G – Containment Products

The following descriptions may be used to determine the right product for your resident. This will result in quality resident care and comfort, as well as cost effective use of containment products.
To consider: fit, cost, absorbency, gender of user, activity level of user, ability of user to apply/remove brief or brief, and ease of cleaning or disposing of brief.

Type of Product	Reasons to Choose Product
Pull – Up Underwear 	**May be used when person is:** Ambulatory and is self-toileting Requires minimal assistance in the day Breathable stretch panels provide comfortable fit, containment and promotes normal toileting Tear away sides for easy removal
Flex-I-Fit 	**May be used when person:** Is toileted & assisted to change while standing Weight bears with 1 or 2 person assist The long belt-like straps attach around the waist with velcro and the brief attaches in front with velcro for easy removal and refastening. Determine amount of absorbency needed
Two Piece **(Pad and Pant)**  	**May be used when person:** • Wishes a natural looking undergarment • Maintains normal elimination by lowering briefs and sitting on toilet • Pad is chosen for amount of absorbency needed • Pant is chosen for size • Pant is washed in facility machines (50 washes
One Piece (Brief 	**May be used when person:** • Requires containment • Has chronic diarrhea • Has difficulty turning • Measure hips or waist (whichever is larger). • Type for amount of absorbency needed
Night Super 	**May be used when person:** • Prefers uninterrupted night time sleep and remains comfortable without changing • Is on extended outings • Is considered to have large volumes of urine due to medical condition or medications
Reusable briefs  	**May be used when person:** • Leads an active life style • Prefers cloth, reusable fabric • Able to clean garment properly • Outside plastic pant should be breathable to prevent heat and moisture build up

Appendix H – Kegel Exercises





To begin:

- Find a quiet space to practice
- It is best to be sitting
- Try to squeeze the muscles that prevent you from passing rectal gas

Steps to perform Kegel Exercises

- Squeeze your pelvic muscles
- Hold and count slowly… 1 and 2 and 3 and
- Relax for ….1 and 2 and 3.
- The muscles are to be relaxed for the same amount as you contract the muscle
- These can be done lying, standing but sitting is preferred
- 10 exercises are called a set
- Perform 1 set 5 times a day
- As comfort with the exercises increases count to 5 then relax for 5
- Occassionally perform a shorter set to assist with shorter muscle fibres; squeeze for 1 second, relax for 1 second
- It takes about 3 to 6 months to begin to feel results

Reference:

Skelly, J., Carr, M. Cassel, B., Robbs, L., and Whytock, S. (2006). *Promoting Continence Care. A Bladder and Bowel Handbook for Care Providers*. Custom Courseware Press. Hamilton: McMaster University

Appendix I – Assessment and Management of Urinary Tract Infection

Principles:

1. Urinary tract infection (UTI) includes only symptomatic UTI's
2. All symptoms must be new or acutely worse – change in the resident's status
3. Non-infectious causes of signs and symptoms should be considered before making a diagnosis of an infection
4. Identification of infection should not be based on a single piece of evidence. Elderly persons with non-specific symptoms should have a full clinical assessment.
5. Laboratory tests are used to confirm clinical evidence and guide treatment.
   - Note: It is not recommended to maintain surveillance of asymptomatic bacteriuria as most residents baseline would show a positive urine culture with an absence of signs and symptoms of a UTI

Symptomatic UTI – One of the following criteria must be met:

1. Resident does not have a catheter and has at least 3 of the following signs
   - Change in mental status or functional ability
   - Fever > 38^{o}C or chills
   - Change in character of urine
   - New or increased burning pain or new frequency or urgency
   - New flank or suprapubic pain or tenderness
2. Resident has an indwelling catheter and has at least 2 of the following signs:
   - Change in mental status or functioning ability
   - Fever > 38^{o}C or chills
   - Change in character of urine
   - New or increased burning pain or frequency or urgency
   - New flank or suprapubic pain or tenderness

Use of dipstick as a screening tool for UTI's:

It has been shown that the urine dipstick for leukocytes and nitrates is an unreliable tool for evaluating the presence of an UTI. The test is inaccurate, provides too many false positives, leads to overuse and misuse of antibiotics that can lead to the development of resistant microorganisms. If both nitrates and leukocytes are negative, it may suggest that there is no UTI. *"Positive dipstick tests for LE (leukocytes) and/or nitrate are not specific indicators of UTI, and are not suitable for screening of LTC inpatients for UTI because of high false-negative rates of the LE and nitrate." (Arinson et al, 2008)*

Treatment

- If a urinary tract infection is suspected, obtain a urine specimen for culture and sensitivity (MSU (mid stream urine), in and out catheterization, catheter specimen from newly inserted catheter)
- Promote comfort and treat symptoms quickly

Measures to prevent UTI

Avoid Catheterizations/Remove catheters

Toileting	Bowel health
Hygiene	Treat bladder dysfunction
Hydration	Nutrition
Improve quality of tissues eg estrogen cream	

Arinzon, Z., Peisakh, A., Shuval, I., Shabat, S., & Berner, Y.N. (2008). Detection of urinary tract infection (UTI) in A long-term care setting: is the multireagent strip an adequate diagnostic tool? *Archives of Gerontology and Geriatrics.* Feb. Retrieved 23/05/2008. www.ncbi.nlm.nih.gov/pubmed.

Deville, W.L.J.M., Yzermans, J.C., vanDuijn, N.P., Bezemer, P.D., van der Windt, D. & Bouter, L.M. (2004). The urine dipstick test useful to rule out infection. A meta-analysis of the accuracy. BioMedCentral (BMC) Urology 4:4 http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=434513

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North East Valley Division of General Practice. (2006). Residents of Aged Care Homes and Urine Testing Protocol. www.nevdgp.org.au.

Appendix J – Continence Risk and Intervention Guide

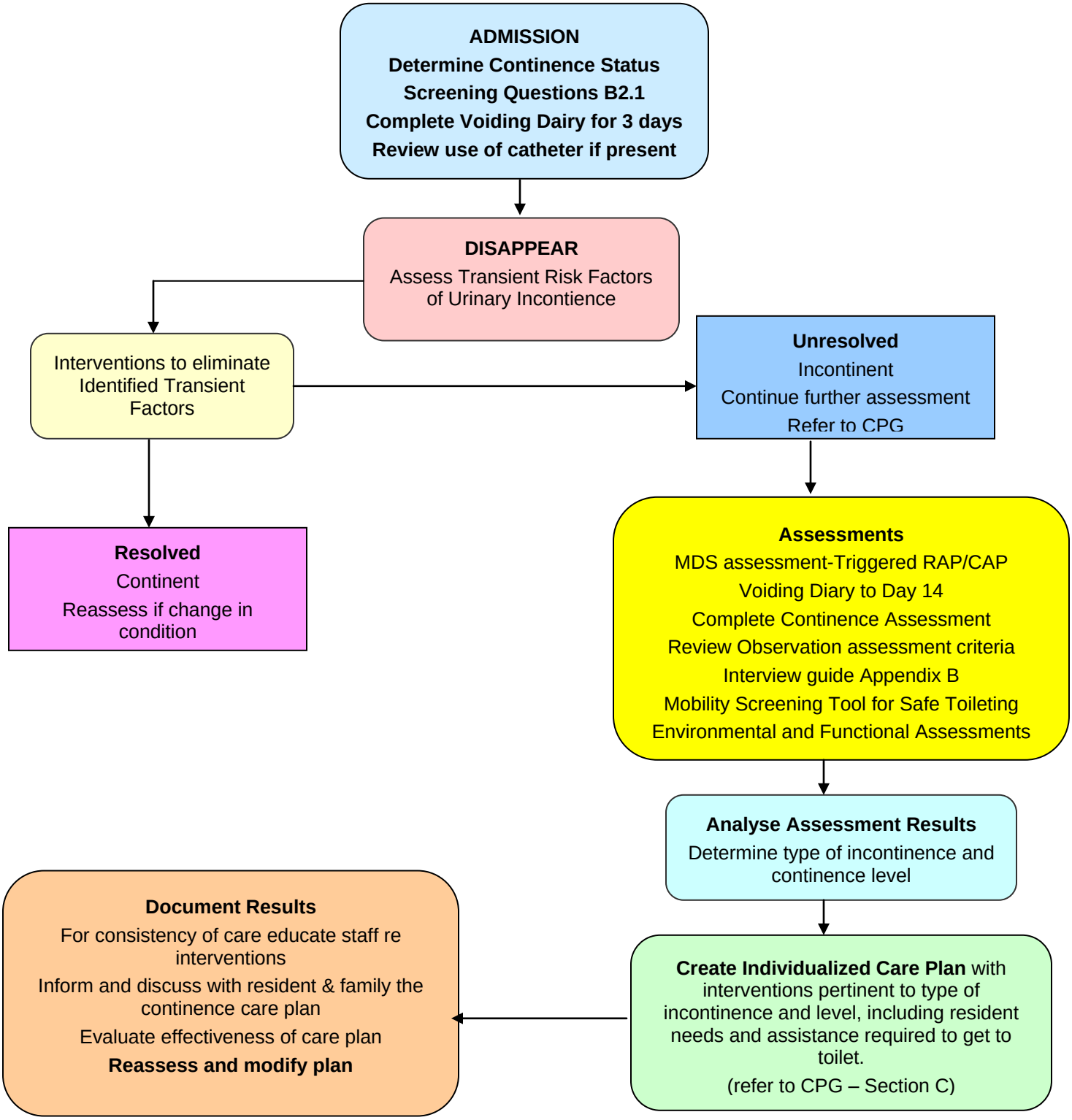
If YES to any of the below questions, implement interventions

FACTORS	Assessment - to identify risks & causative factors		Resident-Centered Interventions
D - Delirium	History of Delirium. Recent hospitalization	☐ No ☐ Yes	☐ Delirium Preventative Measures ☐ Refer to Delirium CPG
	Recent change in cognitive status, memory or recall	☐ No ☐ Yes	
	Fluctuating episodes of disordered thinking/awareness	☐ No ☐ Yes	
	A change in making self understood & understanding others	☐ No ☐ Yes	
I – Intake	Did not consume most fluids in last 3 days	☐ No ☐ Yes	☐ To have > 1500 cc's of fluid daily ☐ Around the clock fluids ☐ Avoid citrus juices, carbonated & caffeine beverages. Treat infections
	Left 25% or more of food uneaten at most meals	☐ No ☐ Yes	
	Drinks citric juices, caffeine, carbonated beverages	☐ No ☐ Yes	
	Infections, recurrent UTI's	☐ No ☐ Yes	
S – Stool	Constipated or fecal incontinence; diarrhea, fecal impaction	☐ No ☐ Yes	☐ Develop individualized bowel plan ☐ Sit in private area (< than 10 min) ☐ Fluids, diet for bowels q 1 to 2 days ☐ Review medications
	History of bowel meds; laxative, enemas	☐ No ☐ Yes	
	Difficulty passing stool q 2 days with/without meds	☐ No ☐ Yes	
A – Atrophy	Vaginitis, urethritis, noted by urgency and dysuria, yeast infections	☐ No ☐ Yes	☐ Review brief/pad: size and type ☐ Protect skin e.g. barrier cream
	Discharge, itchiness, dry labia, burning on urination	☐ No ☐ Yes	
P – Psychological	Depressed, lack of motivation	☐ No ☐ Yes	☐ Regular activities chosen by person ☐ Review *Voiding Record* ☐ Assist person to the toilet before they have a need to void
	Change in last 90 days	☐ No ☐ Yes	
	Resists care and toileting	☐ No ☐ Yes	
	Seeks help toileting; makes noises or wanders	☐ No ☐ Yes	
P – Pharmaceutics	A recent change in medications	☐ No ☐ Yes	☐ Team to review medication profile ☐ Type, dosage, form, ease of swallowing ☐ Consult with pharmacist/physician
	Is on meds that assist with continence or contributes to UI	☐ No ☐ Yes	
E – Excess urine output	On diuretic, voids large volumes	☐ No ☐ Yes	☐ Review *Voiding Record, Fluid Intake* ☐ Adapt toileting routine
A – Abnormal lab values	There have been abnormal lab values in the last 90 days	☐ No ☐ Yes	☐ Review and discuss with team ☐ Consult with physician
R – Restricted mobility	Needs assistance to move in bed, transfer, get on & off toilet	☐ No ☐ Yes	☐ Refer to OT/PT as appropriate ☐ Pain management ☐ Ensure appropriate mobility devices, follow care plan to assist to toilet
	Needs assistance to move w/c, and to walk	☐ No ☐ Yes	
	Needs assistance with ADL's, to dress, and to wipe after BR	☐ No ☐ Yes	

Appendix J	**If YES to any of the below questions, implement interventions**	
HISTORY		
Predisposing Factors	Female, over 70, similar family history ☐ No ☐ Yes	☐ Conduct Continence Assessment/Interview
Gynecology	2 + births, difficult delivery, C section, episiotomy, menopause ☐ No ☐ Yes	☐ Encourage exercises & Kegels
Surgeries	Had a hysterectomy, bladder repair, TUPR ☐ No ☐ Yes	☐ Provide smoking cessation info
Lifestyle	History of smoking, physical occupation ☐ No ☐ Yes	☐ Record weight and refer to dietitian
Weight	Is obese, recent weight gain or weight loss ☐ No ☐ Yes	☐ Provide nutritional info
History of Disease	Chronic diseases:	☐ Ensure consistent control of disease
	Diabetes, CVA, MS, Parkinson's, heart failure, lung disease ☐ No ☐ Yes	☐ Assess and manage pain
	Recurrent UTI's, repetitive health complaints ☐ No ☐ Yes	☐ Maintain skin integrity
	Pain, skin condition, hemorrhoids ☐ No ☐ Yes	☐ Assess person's perception of health
Infections	Has had a Urinary Tract Infection in last 30 days ☐ No ☐ Yes	☐ Increase water intake, supplements
	Recent Infections: respiratory, skin, eye ☐ No ☐ Yes	☐ Assess retention - bladder scanner
Cognitive Abilities	Change in last 90 days ☐ No ☐ Yes	☐ Review *Voiding Record*, establish toileting routine
	MMSE score is above 15 or CPS above 3? ☐ No ☐ Yes	☐ Respond to non-verbal cues re: BR
	Not able to recognize need to void, where to void ☐ No ☐ Yes	
Psychosocial	Reduced social interaction ☐ No ☐ Yes	☐ Cue person to BR re: schedule
	Socially inappropriate behaviour ☐ No ☐ Yes	☐ Promote sleep and comfort
	Do continence issues effect their q day life; sleeping, activities ☐ No ☐ Yes	☐ Encourage exercises and activities
Functional	Are there barriers to toileting, e.g. space in B/R, clothing ☐ No ☐ Yes	☐ Assess & adapt environment
	height of toilet, lighting, cluttered pathway ☐ No ☐ Yes	☐ Adapt clothing
		☐ Use mobility assists
Appliances & programs	Requires a scheduled toileting plan ☐ No ☐ Yes	☐ Assess & remove catheter if possible
	Has an Ostomy? Catheter? Dialysis? ☐ No ☐ Yes	☐ Assess feelings towards appliances
	Uses a containment product? Brief - pad: type, size ☐ No ☐ Yes	☐ Right brief/pad: size & absorbency
Safety	Does not ask for assistance when required ☐ No ☐ Yes	☐ Follow toileting schedule, assist person to toilet
	Takes unnecessary safety risks ☐ No ☐ Yes	before feels need to void
	If YES to any of the above questions, implement interventions	

Appendix K – Continence CPG Decision Tree

Identification of Incontinence Risk Assessment and Interventions



Appendix L – Resident Education Pamphlet

Common Preventative Measures

- Drink at least 1500 mls of fluids per day
- Fluids that contain caffeine, carbonated or citrus juices are not recommended as they may irritate the bladder
- Encourage toileting in the bathroom

- Provide a safe environment: grab bars, automatic lights in BR, automatic flusher, contrasting colours e.g. toilet seat and wall, handy toilet paper and water taps
- Promote privacy

- Feet flat on the floor or safe surface
- Adaptive clothing, Velcro
- Provide visual and verbal prompts
- Promote pelvic floor/Kegel exercises
- Provide the right protective product (pad or brief) for the person, as necessary. Consider the style and size

Where to Seek Help

- **Your Professional Health Care Provider**
- **Seek a bladder/continence clinic in your community**
- **Websites that may be useful:**

- Canadian Continence Foundation (2007) www.continence-fdn.ca
- Canadian Nurse Continence Advisors www.cnca.ca
- International Continence Society www.icsoffice.org
- National Organization for Continence (UK) www.nafc.org
- RNAO (2005). Promoting continence using prompted voiding. Nursing Best Practice Guideline. Toronto. http://www.rnao.org

Continence: Promotion and Maintenance

Urinary Incontinence (UI):
involuntary leakage of urine

It affects a person's sense of dignity, self-esteem and sense of independence.

It is estimated 1 in 5 women (20%) have UI and 1 in 10 men have UI.

Over 50% of those in living in residential care facilities have UI.

It is a medical condition and not the result of getting older.

The goal of care is to take the person to the toilet regularly to encourage and support the normal voiding pattern. For those living in care facilities this may require the use of mobility and transfer aids and coordination of the health care team.

Activities to Promote Continence

Some measures that may reduce urinary incontinence include:

Improve Fluid Intake:

Recommend at least 1500 mls per day (6 – 8 glasses of fluid per day)

Maintain a Healthy Diet:

Follow Canada's Food Guide including 5 fruits and vegetables per day

Maintain a Regular Bowel Pattern:

It is healthy to pass a stool every 1-2 days.

Be Active and Mobile

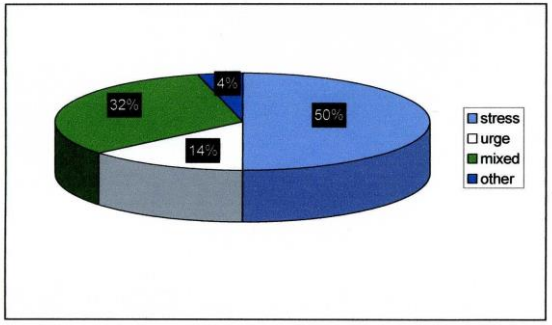
Regular activities including walking as able

Strengthen Pelvic Floor Muscles:

Exercise to improve pelvic and core muscle strength e. g. Kegel exercises

Types of Incontinence

Comparative Prevalence of different types of Incontinence[5]:



Urge: leaking of urine associated with the uncontrollable urge to empty the bladder

Stress: the leaking of urine with coughing, exercise or any type of exertion in the absence of bladder contraction

Mixed (MI): involuntary leakage associated with urgency and also exertion, sneezing or coughing

Overflow (OI): periodic or continuous leaking from an over-full bladder which contributes to the bladder retaining more urine than it empties

Functional (FUI): urine leakage because not able to access the toilet due to impairment of cognitive and/or physical functioning or an environmental barrier

Screening Questions

- Are you aware of the urge to void?
- Can you postpone voiding?
- Do you consider urinary issues to interfere with your daily activities? E.g. sleep, visits.
- Are there environmental barriers to getting to the toilet?
- What are your goals for continence care?
- What types of fluids do you drink?

- Do you drink at least 6 glasses of fluids throughout the day and night?
- Are your bowels regular? How often?
- What do you use to promote regular bowels?
- Do you use any briefs or pads to contain urine leakage?

Appendix M – Chart Audit for Continence CPG

Agency:	**Nursing Unit:**												
Signature of Evaluator:	**Reporting Period:**												
Number of charts: 10/unit	**Key: Met = M, Not met = N, Not Applicable = N/A**												
Health Record #											**% M**	**% N**	**% N/A**
Progress Record													
Resident participated in developing continence goals													
Summary of transfer, mobility, required equipment and aids to assist person to a sitting position to void													
Summary of ability to get person to the B/R, sit & have privacy													
Summary of the voiding pattern was noted (Review the last 3 months)													
Changes in voiding pattern noted													
Ease of toileting: no discomfort noted													
Healthy skin: no perineal redness, irritation													
Voiding Record:													
Resident toileted q 3 hrs when awake, for the first 3 days following admission													
Record completed for 14 days observation, per protocol													
Record was initiated when change in voiding pattern or new incontinence noted													
Care Plan & ***ADL Sheet***													
Individualized toileting routine noted: place, time, special features													
Resident Education Pamphlet													
Educational material was provided to the resident and supports													
Outcomes													
Resident was odour free													
Reduced number of falls and agitation													
Total													

Total Compliance = **Total Number Met ( ) X 100 =** _____

Total Number Met + Not Met ( )

Appendix N – Bibliography

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