



# Incontinence

## Standardised care process

### Objective

Incontinence is a common condition that may decrease a person's quality of life. The objective of this SCP is to promote evidence-based practice of continence management and support to residents experiencing incontinence.

### Why support is important

While age is not a cause of incontinence for older people, the incidence of incontinence is higher in those over the age of 65 (Continence Foundation of Australia, 2022). Incontinence is an under-reported issue, in-part due to attitudes of some health professionals to older people and the associated stigma. (RNAO, 2020)

A best practice model of continence management co-designed by the National Ageing Research Institute (NARI) with aged care residents experiencing incontinence, their families and aged care staff, identified ten core principles for quality continence management in residential aged care homes. The model emphasises the need for aged care providers to deliver person-centred continence management. The model uses therapeutic communication strategies that build residents' resilience and promotes their physiological and psychological wellbeing. It also emphasises the direct relationship between a person's functional status and their continence status.

The 10 core principles include:

1. supports shared decision-making
2. is clinically informed through an assessment process
3. is informed by the best available evidence
4. promotes a resident's dignity
5. optimises a resident's functional abilities
6. is timely and responsive

7. is inclusive and respectful of a resident's cultural diversity, identity, and life experiences
8. is safe
9. is provided by an appropriately trained and skilled workforce
10. is appropriately resourced.

(Ostaszkievicz, et al. 2022)

### Definitions

**Incontinence** is defined as the inability of the body to control the evacuative functions of urination or defaecation, partial or complete loss of bladder or bowel control.

(International Continence Society, 2020)

**Urinary Incontinence (UI)** is defined as the involuntary leakage of urine caused by physiological, mechanical, and medical factors, including weak pelvic muscles, diabetes, certain medications, constipation, and bladder infection. The different sub-types of urinary incontinence include:

- **Stress incontinence** which is defined as the involuntary loss of urine due to a sudden increase in intra-abdominal pressure, via physical exertion - coughing, sneezing, laughing, rising from a seat and exercise.
- **Urgency incontinence** which is defined as the involuntary loss of urine that occurs when there is a sudden, compelling urge to urinate, and the bladder empties involuntarily.
- **Mixed incontinence** which is defined as the involuntary loss of urine associated with urgency and physical exertion.
- **Functional incontinence** which is defined as urinary leakage with no obvious neurological or structural abnormality but results from an inability to get to the toilet or, the inability to manage their own toileting.



**Faecal Incontinence (FI)** is defined as the involuntary loss of liquid or solid stools (faeces). The different sub-types of faecal incontinence include;

- **Passive** faecal incontinence, which is defined as the involuntary leakage of faeces without warning
- **Urge** faecal incontinence, which is defined as the inability to defer defaecation once the urge is perceived for long enough to reach the toilet
- **Functional** faecal incontinence, which is defined as the involuntary leakage of faeces due to limitations in mobility, manipulating clothing or toileting ability or delayed assistance with toileting.

(ICS, 2020)

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Aged Care (ACEBAC) at La Trobe University through the Department's Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2023.

Note: This SCP should be used in conjunction with the Constipation SCP (2023) as much of the content is consistent in the support of resident health and wellbeing.

## Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle, general practitioner (GP), allied health professionals such as physiotherapist, occupational therapist, exercise physiologist, residents and/or family/carers.

## Acknowledgement

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# Brief standardised care process

## Recognition and assessment

Identify residents with bladder or bowel symptoms who require support to maintain continence or manage episodes of incontinence.

- Ensure the resident understands and consents to support to maintain continence and manage incontinence.
- Discuss with the resident and family/friend (if appropriate) continence history and current issues to inform a personalised continence care plan.
- Identify the frequency and character of urinary and faecal output and episodes of incontinence.
- Obtain a clinical history.
- Undertake a physical examination of the abdomen and perineum, mobility (functionality) assessment and cognitive assessment.
- Identify other symptoms that warrant further attention/referral such as voiding difficulties or pain associated with urination or defaecation.
- Note quality of life impacts for the resident.

(RNAO, 2020)

## Interventions

Identify and document interventions that meet the resident's needs and situation.

- Identify appropriate referral for review for possible underlying causes of incontinence.
- Consider lifestyle and behaviour modifications, including changes to the environment, toileting strategies to promote optimal continence.
- Respond to the resident's continence care needs in a timely manner.
- Maintain privacy and respectful interaction during continence care interactions.

(RNAO, 2020)

## Referral

Consider referring the resident to the following:

- general practitioner, including medication review
- specialist medical practitioner including urologist, gynaecologist.
- occupational therapist
- specialist practitioner, including continence nurse practitioner/consultant/advisor
- dietitian
- pharmacist
- physiotherapist specialising in continence.

## Evaluation and reassessment

- Review and evaluate the effectiveness of the continence care plan. Seek input from the resident, interprofessional team and family as appropriate.
- Monitor diet and the functional and cognitive capacity of the resident.
- Ensure the continence management strategies continue to meet the resident's goals of care.
- Monitor for symptoms that warrant further attention/referral such as voiding difficulties or pain associated with urination or defaecation.

## Resident involvement

- The assessment and care planning process should be undertaken in collaboration with the resident, the interdisciplinary team their family as appropriate.
- Support the resident's ability to be involved in decisions about their care.
- Provide psychosocial support and education to promote dignity and active participation in continence promotion strategies.

## Staff knowledge and education

- Focus on the resident's dignity, what is important to them and in keeping with their goals of care.
- Education on continence aids and equipment.
- Education on the maintenance of skin integrity and the use of products.
- Education on the role of nutrition and hydration to promote continence.



# Full standardised care process

## Recognition

Effective bladder and bowel habits are an important part of overall health and wellbeing, inclusive of physical and psychosocial health. The aim of assessment in this setting is to promote person-centred continence management that helps the person feel safe, respected, and dignified. Use therapeutic communication strategies that build residents' resilience and their physiological and psychological wellbeing.

Incontinence should be suspected if the resident complains of urine leakage or faecal soiling, or staff observe that:

- the resident has episodes of urine leakage or faecal soiling
- the resident either requests or experiences frequency of urination during the day or night
- the resident has urine or faecal leakage before getting to the toilet
- the resident is unable to recognise the need to empty their bladder or bowel
- the resident is regularly constipated and has some faecal overflow.

(RNAO, 2020; Bliss et al. 2017; ICS, 2020; Musa et al. 2019; CFA, 2022)

## Resident involvement

- Promote self-esteem and provide support to maintain dignity.
- Involve resident in treatment/management decisions and options.
- Educate resident and family in relation to the importance of diet and exercise.
- Focus on supporting functional ability and independence as appropriate.

## Assessment

A bladder and bowel assessment should be completed on admission and whenever incontinence is suspected. Consider referral to specialist continence practitioner for further assessment and support if incontinence is suspected or reported by the person, their family or staff. A bladder and bowel assessment should:

- include a Quality of Life (QoL) assessment using a validated instrument

- include a voiding history (3-day bladder chart) to identify the frequency and nature of urinary incontinence and the volumes voided. Measure post void residual urine (if able, using bladder scanner)
- include a urinalysis to look for the presence of:
  - glycosuria (glucose in urine)
  - haematuria (blood in urine)
  - proteinuria (protein in urine)
  - pyuria (pus in urine)
  - nitrates
- check for the presence of pain with urination
- check for pain or bleeding with bowel actions
- check for faecal incontinence related to delirium, infection, diarrhoea, and medication
- collect a history of faecal incontinence or reports of feelings/sense of incomplete bowel movements
- collect information about the resident's usual bowel patterns and habits, and their views in relation to these habits
- assess current bowel function using a seven-day bowel 'diary' or charting to includes the following information:
  - usual time, frequency
  - character of stool (amount, colour, consistency, and presence of mucus) – the Bristol Stool Chart is recommended
  - ability to sense urge to defecate
  - symptoms of bloating or pain on, or between, bowel movements.
- review functional ability, particularly the resident's ability to access and use the toilet (for example, can the resident get to the toilet, adjust their clothing, sit on the toilet at its normal height?)
- assess the level and frequency of physical activity
- ascertain dietary history (for example, preferred foods, fibre intake)
- identify fluid intake including type of fluids preferred, usual daily intake and the timing of consumption
- audit the environment for:
  - ease of access and signage to the toilets
  - privacy level (for example, a shared bathroom)
  - ability of resident to alert staff (if required) for assistance
  - access to continence aids.

(RNAO, 2020; ICS 2020; Goodman et al. 2015; CFA, 2022)



## Interventions

The primary aim of any intervention is the promotion of continence and a decrease in episodes of urinary and faecal incontinence through:

- identification and reduction of risk factors associated with incontinence
- promotion of regular bladder and bowel habits
- increase in gentle physical exercise as appropriate
- modification of diet, including fibre intake and fluid intake. If fibre intake is generally low an increase of fibre rich foods such as wholegrain cereals and vegetables may be appropriate. Note increasing fibre is not recommended for residents with low mobility and reduced hydration.
- use of continence aids as appropriate based on the assessment and preference. Decisions around appropriate aids may require trialling a number of aids to determine the most appropriate for the individual.
- toileting strategies, based on the persons functional and cognitive ability including:
  - assistance to undertake the toileting process
  - prompted toileting using verbal and physical cues
  - use of aids to improve toileting posture (for example, Squatty Potty®) particularly for difficult defaecation
- monitoring fluid intake to ensure adequate hydration (refer to Dehydration SCP)
- controlling weight
- environmental modifications – access, signage, lighting, privacy
- monitoring voiding patterns through accurate recording using validated tools
- monitoring bowel habits and stool consistency (Bristol Stool chart)
- medication review
- referral to appropriate specialist depending on assessment findings.

(RNAO, 2020; ICS 2020; CFA 2022; Hodgkinson et al. 2008)

## Referral

- General practitioner for full assessment and referral
- Pharmacist for a medication review
- Specialist practitioner, including continence nurse practitioner/consultant/advisor
- Dietitian
- Occupational therapist
- Physiotherapist specialising in continence
- Specialist (for example, urologist, uro-gynaecologist, gastroenterologist)

(RNAO 2020)

## Evaluation and reassessment

- Review and evaluate the effectiveness of the continence care plan. Seek input from the resident, interprofessional team and family as appropriate.
- Monitor episodes of urinary and faecal incontinence, using appropriate assessment tools (available in your facility).
- Monitor for episodes of infection and pain.
- Monitor diet and the functional and cognitive capacity of the resident.
- Ensure the continence management strategies continue to meet the resident's goals of care.
- Regularly review medication.
- Monitor and assess skin for incontinence associated dermatitis (IAD).

(RNAO, 2020; CFA, 2022; DoH, Victoria, 2021)

## Staff knowledge and education

- Focus on what is important for the resident and in keeping with their goals of care, including preservation of dignity.
- Education on continence aids and equipment.
- Education on the maintenance of skin integrity and the use of products.
- Education on the role of nutrition and hydration to promote continence.

(RNAO, 2020; Hodgkinson et al. 2008)



## Evidence base

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**Important note:** This standardised care process (SCP) is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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