Urinary and Bowel incontinence and assessment

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House Rules

![Coffee cup](image1.png)

![Fire exit](image2.png)

![Bathroom](image3.png)

![Cell phone](image4.png)

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Session aims

• Definition of urinary and bowel incontinence

• Types of incontinence

• Treatment and health promotion

• Assessment tool/Management
Normal Micturition

The ability to pass urine voluntarily in a socially acceptable place at a socially acceptable time.

The term continence means that an individual has control over their bladder and bowel.
Incontinence

The unintentional passing of urine and/or faeces

“the complaint of any involuntary leakage of urine” urinary incontinence, NICE guidelines 2017
Ideal bowel movement

• Semi solid
• Soft consistency
• No urgency
• No straining
• Weight 100-150g
• 24-36hr transit time
• Glides out
• Sense of relief

Constipation is an acute or chronic condition in which bowel movements occur less often than usual or consist of hard, dry, stools that are painful or difficult to pass.
Patient & Family Quality of Life

Urinary incontinence can restrict a patient’s day-to-day functioning affecting education, social life and employment. (APPGCC, 2013)

• Embarrassment/Depression
• Social Isolation
• Loss of self esteem/body image/sexuality
• Fear – what’s wrong?
• Denial / Acceptance – ‘Comes with age’

Incontinence second to dementia in initiating a move to residential care
Bothersome Score

A score devised to find out how bothersome a patient’s symptoms are, patients rate this on their initial paperwork and then reviewed on each visit.
Risk Factors for Incontinence

- Obesity / lifestyle
- Post Pregnancy
- Medications (e.g., diuretics, aperients, painkillers)
- Decreased mobility
- Altered cognition
- Surgery
- Disease / Conditions (e.g., diabetes, prostate issues, neurological, inflammatory bowel diseases)
Professional Issues

• Need to treat the problem not simply contain it. Positive attitude towards treatment. It is important that Community Nurses are proactive not reactive (APPGCC, 2013)

‘You’re wearing a pad, just go ahead and use it’ (Wright et al, 2007) – still a common statement to hear in 2017
Types of Incontinence

- Stress (SUI)
- Overactive Bladder (OAB)
- Overflow
- Functional
- Faecal
Stress Urinary Incontinence

*Involuntary loss of urine associated with physical exertion such as coughing, sneezing or laughing*
Stress Urinary Incontinence

- 1 in 3 women over the age of 40 will experience (Nice, 2006/13, CG 171)
- Associated with the following conditions
  - Postpartum (Post child birth)
  - Postmenopausal women with a decline in estrogen
  - Organ prolapse (e.g., Cystocele)
  - Post-prostatectomy (men only)
  - Raised BMI (above 30)
Stress Urinary Incontinence: Characteristics

- Associated with loss of small amounts of urine
- Symptoms associated with physical activity, standing or change in position
- Ranges from mild to severe
Stress Urinary incontinence - Management

- Individual pelvic floor exercise programme (NICE) – most effective treatment and needs to be continued. Over 80% will improve with exercises
- Electrical stimulation / cones (aquaflex)
- Physiotherapy
- Urethral bulking agents (botox)
- Surgery – repositioning or stabilising of the bladder
Urge/ OAB Urinary Incontinence

Involuntary loss of urine associated with a strong and abrupt desire to void (urgency)
Urge / Over Active Bladder Urinary Incontinence

• Most common pattern of urinary incontinence in older adults
• Involuntary detrusor contractions causing leakage of large amounts of urine
• Frequency/urgency/rush to toilet
• Nocturia
Management - Urge / OAB

• Individual bladder retraining programme (NICE, CG 171)
• Post void rocking
• Pelvic floor exercise regime (NICE, CG 171)
• Fluid modification / reduction in bladder irritants (NICE, CG 171)
• Anticholinergic medication

https://youtu.be/srX7u69aL3E

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Overflow Urinary Incontinence

_Involuntary loss of small amounts of urine associated with an over-distended bladder_
Overflow Urinary Incontinence

• Causes: Bladder muscle weakness resulting in poor contractility, atonic bladder, bladder continues to fill and overflows with leakage
• Obstructions - enlarged prostate
• Signs and Symptoms including hesitancy, dribbling, and a feeling of “never feeling empty”
Overflow Urinary Incontinence: Management Options

• Relieve obstruction (enlarged prostate, impaction, etc.)
• Pharmacotherapy to enhance detrusor contractility (oxybutynin)
• Intermittent catheterization
• Referral for urology assessment
Functional Incontinence

Involuntary loss of urine or bowels caused by factors such as environmental or functional factors or cognitive or mental disorders
Functional Incontinence: Characteristics

• All types of incontinence can be exacerbated by functional incontinence and complicate the management options available for the incontinent patient
• Associated with cognitive impairment or poor mobility and environmental issues
Functional Urinary Incontinence: Management Options

- Environmental changes – equipment
- Carer’s visits
- Visual aids
- Observation of body language
- External collection devices
- Occupational Therapy
- Physiotherapy
Bowel Incontinence

- Loose stools
- Weak anal tone
- Multi medications – over use of laxatives
- Ignoring the ‘call to stool’
- Constipation

https://youtu.be/YbYWhdLO43Q
Diseases affecting bowel function

- Inflammatory bowel disease
  Crohn’s disease, Ulcerative colitis, Diverticulitis
- Irritable bowel Syndrome (IBS)
- Constipation
Crohn’s disease

There is no cure

• Long-term condition causes inflammation of the lining of the digestive system.
• Symptoms: diarrhoea, abdominal pain, fatigue, weight loss, blood and mucus
  ➢ Medications to treat symptoms: steroids, immunosuppressant's, anti-inflammatories,
  ➢ Control active disease/treat bacterial growth
  ➢ low residue/exclusion diet
  ➢ low-fibre with low-residue diet (milk/dairy products)

Surgery/external symptom management – avoided if possible
Ulcerative Colitis

• Long-term condition, where the colon and rectum become inflamed
• Symptoms: recurring diarrhoea, with blood/mucus/pus, abdominal pain, fatigue, Loss of appetite, weight loss, needing to empty bowels frequently

- Medication to treat symptoms: amino salicylates, Corticosteroids, immunosuppressant's
- A well-balanced diet that's high in protein, complex carbohydrates, whole grains, and good fats.
- External symptom management – surgery is a last option
Diverticular disease

50% population over 60 years of age are affected

- Lifelong deficiency of fibre in diet
- ‘pockets’ occur in the mucosa
- Small stools
- Irritation, ulceration and haemorrhage common

- High-fibre diet may help prevent diverticular disease, and should improve symptoms.
- Diet should be balanced and include at least five portions of fruit and vegetables a day, plus whole grains
- Good fluid intake
- Bowel care
Irritable Bowel Syndrome

- Diagnosed via exclusion of all other organic conditions
- Symptoms: abdominal pain/cramps, change in your bowel habits – such as diarrhoea, constipation, or sometimes both, bloating/swelling of your stomach, excessive wind, urgent need to go to the toilet, feeling of fully emptying bowels, passing mucus from the bottom

Possible causes:

- Stress
- Hyperventilation
- Food intolerance

Treatment

- Individualised approach
- Counselling
- Diet and fluid advice
Haemorrhoids

• Anal canal ‘cushions’
• Causes
  – Constipation
  – Pregnancy/child birth
  – Occupational
  – Genetics
• Classification 1 – 4 grades
Skin/Anal tags

- Chronic straining
- Childbirth
- Constipation
- Not significant
- Can be removed
- Do swell and can lead to haemorrhoids
- Perianal Crohn’s
Rectal prolapse

- Common in elderly ladies
- Cause – not 100% known
- Constipation/straining
- Not life threatening but can strangulate
- Surgery
Constipation

- Bowel habit altered
- Infrequent, hard pellet like stools
- Incomplete emptying
- Diarrhoea – overflow
- Abdominal pain
- Flatulence/bloating
- Nausea/vomiting
- Urinary dysfunction
- Poor appetite/bad breath/malaise

NICE- treating chronic constipation and managing short duration constipation (October 15)

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Bowel medications

4 types of laxatives
- Bulking agents (fybogel)
- Stool softeners (docusate)
- Osmotic agents (movicol, lactulose)
- Stimulants (senna, bisacodyl)
Bulking agents

- Good for BSC type 1
- Increase the weight and water absorbency of the stool
- Increase production and peristalsis
- Taken with at least 1 glass of water
- Must have at least 1 fibre rich food per meal
- Drink 1.5 – 2 litres fluid daily
- Can cause bloating / flatulence
- Avoid in intestinal obstruction or faecal impaction
Stool softeners

- Oral and or as enemas Lower the surface tension of the faeces and allows water to penetrate and soften
- Take 24 – 48 hours to work
- Good for patients with haemorrhoids
Osmotic agents

- Retain fluid in the bowel by Osmosis
- Must be taken for 3 days regularly before effect is seen
- Not for rapid relief of constipation
- Can cause bloating, cramping and flatulence
Assessment forms

Continence care and products
Assessment

• Trust specific assessment form
• This is not a tick box exercise and shouldn’t be hurried
• Key sections:
  – Medical / Surgical History to include UTIs
  – Urinalysis  men>1    women>2
  – Medications – awareness of effects on continence
  – Urinary & Bowel Continence History
    • 3 day fluid intake and output chart
    • 7 day bowel diary and food diary/Bristol stool
Assessment Cont’d

• Miscellaneous Risk factors - triggers (caffeine intake, alcohol, fibre, exercise)
• Toileting pattern and any products used
• Carer provision
• Physical abilities: mobility and dexterity

Red Flags

• ONCE COMPLETED – you should have an individual holistic assessment to enable correct provision of continence needs
• PADS ARE ALWAYS THE LAST OPTION
Beambridge Funnel

- Designed for use in and out of bed
- Easy to hold and comfortable
- Can be paired with drainage bags and leg bags connected to the devise
- Can be used as a director when urinating into the toilet for patients with reduced mobility
Washable products

- Products for ladies – full briefs (white) and mini briefs (black and white) both hold up to 250mls, mini briefs have two different absorbency's
- Briefs are measured at the hip
- Products for gentleman – boxer shorts (black) and y front (white) hold up to 250mls
- Male products measures at the waist
- Ensure code is written on order
- Need to purchase first to ensure that they fit and then to get 6 on the delivery service for the year. They would not get any other products on the service
Urinary Sheath

Variety of sizes:
1. Standard length: centrally positioned adhesive, Suitable for an average length
2. Pop on: a shorter sheath with maximum adhesive for short or retracted penis
3. Wide band: a standard length sheath with greater adhesive area to maximise security for those who are active and have struggled with other products

Great Bear sheaths on PPL

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Body Stocking

Ideal for patient’s with dementia who remove products when soiled

Get two per year on the service – can purchase more

To wear with the abri-fix pants underneath

Chest and waist size – take the biggest measurement

Tend to come quite small in size
Bed Squares

X2 types for the bed
One has fabric to fold under the bed and hold this in place
The other is a square which is not held in place
X2 on Abena delivery this is for the year only and needs to be emphasised they would need to purchase other products.
Disposable ones are only available from the shop now (Abri-soft – 30 for £8.40)
## Products

**REMEMBER – TRIAL FIRST**

<table>
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<th>Price per annum (1 pad per day)</th>
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<td>400ml</td>
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<td>Abrisan 9</td>
<td>800ml</td>
<td>.18p</td>
<td>£65.70</td>
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<td>faecal</td>
<td>.06p</td>
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<td>Abrifix (3 x alt deliver)</td>
<td>Pant (S-5XL)</td>
<td>.36-.61p</td>
<td>£2.16-£3.66</td>
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</table>
Currently re-assessments only – email team for new user form which goes directly to Abena

ABENA online

- Can check clients delivery date
- Can check products currently on
- When last assessment completed and by whom
- Not postal – no risk of losing paperwork
- Staff aware of progress of assessment ie, rejected/accepted/pending
Other useful information

- Buffer stock
- Requesting samples – email to abena samples@abena.co.uk end encrypt
- Shop letter
- Link nurses
In Conclusion

• An understanding of the ‘normal’ is needed before you can assess the ‘abnormal’
• Assessment is paramount and key to effective management of incontinence issues
• When planning care – consider the ‘clues’ within the assessment to aid management
• Approach professionally and with a positive attitude:
  – Non stereotypical
  – Confident
  – Interested
  – Promote Privacy and Dignity
Any questions?

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Relevant documents

- Good Practice in Continence Services (DOH, 2000)
- NSF Older People (DOH, 2001)
- NICE guidelines (2006/2013, CG 40, CG 171)
- NICE guidelines urinary incontinence in women (2017)
- Essence of Care (DOH, 2010)
- National Audit of Continence Care (DOH, 2010)
- Integrated Continence Services (APPG, 2011)
- Cost Effective Commissioning for Continence Care (APPG, 2011)
- Minimum Standards for Continence Care in the UK (APPG, 2014)

– www.appgcontinence.org.uk
– www.bladderandbowelfoundation.org
That’s it....

• Thanks for your participation and attention
• Please contact us if you would like further information or leaflets

http://cwptintranet.covwarkpt.nhs.uk/business-units/operations/CHWS/ContinenceService/Pages/default.aspx

https://www.covwarkpt.nhs.uk/continence-health-professionals

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Thanks