Simple steps for promoting urinary continence

NHS Direct (2004) estimates that 3–6 million people in the UK have some degree of urinary incontinence owing to partial or total loss of bladder control. Health Press (2005a) states that: ‘The idea that it affects only the elderly is completely out of date – the popularity of active sports, such as jogging, has caused more younger women to notice the problem.’

However, the occurrence of incontinence does increase with ageing, being twice as common in women than men (NHS Direct, 2004), affecting the quality of life for many older people – although many reasons for it are treatable.

Incontinence, therefore, is not an inevitable part of ageing. If it develops, contact the resident’s GP to eliminate the following underlying medical reasons:

- Is there an infection? If so, antibiotics will alleviate the problem.
- Is medication causing incontinence? Some medication, such as tranquillizers and sedatives, can affect control of the bladder muscles.
- Are drinks acting as a diuretic? Alcohol and caffeine drinks should be reduced and other fluids encouraged; for example, water and cranberry juice, not tea, coffee or cola.
- Is the client obese? Try to encourage exercise and a healthy diet.
- Does the client have weak pelvic floor muscles? If so, pelvic floor exercises will help.
- Is the resident depressed? Souhami and Moxham (1994) commented that depression could produce a ‘loss of will to be continent and loss of appreciation of what is a socially acceptable micturition state’. Medication, or simply listening, may help.

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Urinary incontinence is not necessarily part of the ageing process; there may be medical, physiological or other reasons. Julie Swann explores approaches to tackling the problem.

How continence is achieved
During the day and night, our bladders fill automatically. We often feel an urge to void but can postpone until an appropriate place to empty our bladder is found. Basic knowledge of bladder and body mechanics helps us to understand continence problems.

Sphincter and pelvic floor muscles
If the sphincter or pelvic floor muscle is weak or damaged, then incontinence can occur, particularly if excessive pressure is on the bladder. This is termed ‘stress urinary incontinence’ (SUI).

Sensors within the bladder
Sensors inform us when our bladder is full or empty. However, sometimes an urge to urinate can occur when the bladder isn’t full, or the bladder may start contracting at the wrong time. This urge urinary incontinence (UUI) is often a result of intrinsic neurological disease.

Nervous system
When nerves connecting the brain (the micturition centre) and spinal cord are damaged, a mixture of SUI and UUI occurs.

Stress urinary incontinence
The most common type of incontinence is SUI. Newman (2003) notes that 35% of continent elderly people have SUI. It can be embarrassing and distressing if a small amount of urine leaks out during physical activity, such as coughing, sneezing, vomiting, bending, lifting and even walking or laughing. This can occur during pregnancy, after childbirth and menopause or if a person is obese (weakness of pelvic floor muscles results from an increase in abdominal pressure).

The Continence Foundation (2001) describes the pelvic floor muscle as a large sling (or ‘hammock’) of muscles stretching across the floor of the pelvis, forming an ‘undercarriage’. Bo et al (1999) carried out a 6-month trial of different treatments for SUI; namely pelvic floor exercises, electrical stimulation and vaginal cones, comparing these to no treatment. Women doing pelvic floor (Kegel) exercises improved the most. Men with ‘leakage problems’ after urination find these helpful.

Pelvic floor exercises are obtainable from GPs, continence advisors, physiotherapists or the internet – for example, The Continence Foundation website (www.continence-foundation.org.uk). Exercises can be practiced individually with residents, particularly during toiletting, and some can be incorporated into a ‘movement to music’ session.

Urge urinary incontinence
Unstable or overactive bladders may feel ‘full’, causing the bladder to contract too early or empty completely before a toilet is reached. UUI can be triggered by a sudden change of position. Newman (2003) notes that causes include carcinoma, therefore any asymptomatic haematuria requires further evaluation.

Medication such as anticholinergics can relax the bladder by blocking nerve impulses, but can produce side-effects such as dry mouth, blurred vision and constipation.

Re-training the bladder (Table 1) can improve urge incontinence and frequency. By gradually stretching the bladder’s

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Swann (2005) outlines environmental management, voiding and cleansing. Route finding, cognition, mobility, clothing and recognizing a need to void, motivation, a task requiring many functions, including Continence and toileting is a complex Positive practical approaches

Overflow incontinence is rare in the bladder. The obstruction is tense and highly pressurized, causing a regular release of a small involuntary dribble of urine, which initially may occur nocturnally. The bladder cannot fill up or empty completely, leaving a residue of urine in the bladder. The obstruction can be removed by surgery.

Other forms of incontinence

- Nocturia is when people need to visit the toilet frequently during the night.
- Reflex bladder is a loss of bladder control, perhaps developed after injury or illness, such as spinal injuries and multiple sclerosis. Residents may require intermittent or continuous catheterization.
- Overflow incontinence is rare in women but common in men, because of an enlarged prostate gland pressing on the urethra. The area behind the obstruction is tense and highly pressurized, causing a regular release of a small involuntary dribble of urine, which initially may occur nocturnally. The bladder cannot fill up or empty completely, leaving a residue of urine in the bladder. The obstruction can be removed by surgery.

Positive practical approaches

Continence and toileting is a complex task requiring many functions, including recognizing a need to void, motivation, route finding, cognition, mobility, clothing management, voiding and cleansing. Swann (2005) outlines environmental obstacles that may need addressing. Other positive steps can be taken to reduce incontinence among residents. Consider the following:

- Recognizing a resident’s need to visit the toilet. The Alzheimer’s Association (2005) website describes common signs to watch out for, including restlessness, anxiety, agitation, pacing, unusual sounds, facial expressions, sudden behavioural changes, pulling at clothes, dropping pants and suddenly stopping eating. These signs are particularly important to notice if residents are unable to communicate their needs effectively.
- Inappropriate urination: Look for reasons and adopt an ABC of behaviour (antecedent, behaviour and consequence). If toilet facilities are difficult to use or locate, residents may void in inappropriate places. Residents may prefer to use a urinal; indeed, this is easier for male residents to use that standing or transferring onto a toilet.
- Maintaining a routine: Establish a routine of regularly toileting even after an episode of incontinence, ensuring that the bladder is never over-full (there is a difference between increasing bladder capacity and letting residents sit and hold on until the effort of rising, transferring or walking puts pressure on the bladder and causes voiding).
- Assisting with toileting: Ensure that residents have suitable mobility equipment to enable them to manoeuvre safely. Provide help in a reassuring manner to preserve dignity and modesty. If transferring space is limited, then consider using a wheeled commode chair or a hoist. Give verbal cues and guide appropriately. Provide environmental clues – look for the blue door – is an easier verbal clue than ‘the toilet is five doors down the corridor’.
- Ability to cleanse self: Put essential items within reach, particularly if residents have limited dexterity and range of movements. Several manufacturers produce toilets that wash the user with warm water and gently dry with warm air, eliminating the need for assistance to cleanse. For example, Total Hygiene Ltd (Cheshire) produce the Clos-o-Mat automatic WC/shower toilet. It is advisable to check that products have Regulatory Approval (approved by the Water Regulations Advisory Scheme).

Special clothing

Impaired dexterity causes problems with fastenings and managing clothing. Altering the style of clothing will help; for example, stockings or ‘hold-ups’ are easier than tights, and elasticized waistbands and Velcro fastenings are easier than zips and buttons.

The Disabled Living Foundation’s (2003) factsheet on Clothing for Continence and Incontinence provides guidelines and clothing suggestions for the management of catheters and urinals, including the use of drop-front, open-crotch and French knickers.

Incontinence garments and appliances

For infrequent light incontinence, when a small amount is voided, panty liners or sanitary pads may suffice. Alternatively, discreet and comfortable absorbent underpants that can be washed and reused with an effective absorbency of 100 ml, such as ‘Kylie Lady’ (Hybrand Ltd, Berkshire), are suitable for light urinary incontinence.

Continence pads

Body-worn pads (Figure 1) and urine collecting devices are also available. Continence pads of varying absorbency, including ones specifically designed for men, are produced by many different companies. For example:

- Hybrand Ltd manufactures the ‘Kanga’ and ‘Kylie’ brands of pads
It is important to note that pads can cause skin rashes and the skin must be washed thoroughly. The Alzheimer’s Association (2005) website provides brief details of skin care under the section of incontinence and toileting. NHS Direct (www.nhsdirect.nhs.uk) provides details of the nearest continence service and advises on eligibility for free supplies.

**Conclusion**

There are many incontinence garments and pads on the market, which are helpful in managing urinary incontinence. However, it is important for care staff to look for reasons for incontinence, as environmental and behavioural factors may be the cause. It is often possible to facilitate continence by practical measures, including checking that mobility equipment is appropriate and ensuring that residents’ bladders are never over-full and that they can locate and get to the toilet easily.

Pelvic floor exercises are effective and can be incorporated into an activities programme. In a care home setting, it is essential to adopt a positive approach to toileting that treats people with dignity and respect. A tactful, sensitive approach is needed to preserve residents’ self-esteem.

**Further information**

- **The Continence Foundation:**
  307 Hatton Square
  16 Baldwins Gardens
  London EC1N 7RJ
  Tel: 020 7831 9831
  continence-help@tial.pipex.com

- **Incontact (Action on Incontinence):**
  United House
  North Road
  London N7 9DP
  Tel: 0870 7703246
  www.incontact.org

**Health Press Ltd (2005a) Urinary incontinence.**
www.embarrassingproblems.com/urinary.clinmpress (accessed 07/05)


**KEY POINTS**

- Refer the resident for medical advice, as incontinence may be treatable.
- Environmental and behavioural factors can cause incontinence.
- Check that residents can manage the process of toileting.
- Talk to the residents about continence issues – several alternative solutions may be possible.
- Develop a toilet routine for individual residents.