Basic continence assessment: what community nurses should know

Ann Yates

Problems of the bladder and/or bowel are known as continence problems, and can cause incontinence or leakage. This is a common problem and, while often associated with ageing, it is not an inevitable part of the ageing process. It is a ‘taboo’ subject and for this reason individuals are often reluctant to seek help (Bedoya-Ronga and Currie, 2014).

Within the UK, an estimated 14 million individuals are affected by urinary incontinence (NHS England, 2018), with 61% of the general population of men experiencing lower urinary tract symptoms (LUTS) and 34% of women living with urinary incontinence (NHS England, 2018). Over 6.5 million adults suffer with bowel control problems, with one in 10 affected by faecal incontinence in nursing homes (NICE, 2014; NHS England, 2018).

TYPES OF CONTINENCE PROBLEMS

Continence problems can present in many different ways, with varying symptoms, and can require different interventions. With regards to the bladder, Laver (2017) identified various common problems, including: having a full bladder (causing stress incontinence), storing urine (causing urge incontinence), voiding difficulties (causing overflow), bodily function problems (e.g. mobility, dexterity issues), or a combination of these issues. These symptoms have been summarised by Yates in Table 1 (2017a, 2018). Bowel problems can present with either storage issues, causing faecal incontinence or faecal urgency, or expulsion issues, resulting in constipation or faecal impaction (Table 2). In the majority of cases, these symptoms can be improved or cured by identifying and treating the underlying causes, based on a correct initial assessment.

ASSESSMENT

McClurg et al (2013) stated that a continence assessment should be undertaken by an experienced professional, in line with recommended minimum standards (United Kingdom Continence Society [UKCS], 2015). A face-to-face consultation is important, as observation of an individual’s behaviour, coping mechanisms, feelings and attitudes towards the problem gives the assessor valuable information for treatment options and/or management. (Yates, 2017a; NHS England, 2018). Approximately half a million adults suffer with faecal incontinence that has a negative impact on their quality of life (National Institute for Health and Care Excellence [NICE], 2014; NHS England, 2018). Nearly two-thirds of people with faecal incontinence also have urinary incontinence — ‘double incontinence’ (NICE, 2014). Faecal incontinence is closely associated with age and is prevalent in residential/nursing homes, with one in three suffering in residential homes and two in three
Table 1: Types of bladder problems (adapted from Yates 2017a; 2018)

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Symptoms</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress urinary incontinence</td>
<td>Involuntary loss of urine due to increase of abdominal pressure, usually due to physical exertion, sneezing, laughing, coughing or lifting, resulting in a small amount of leakage</td>
<td>Abnormal descent of bladder neck and urethra is usually associated with poor pelvic floor muscle support. Causes include pregnancy, childbirth, oestrogen deficiency, surgery, pelvic traumas</td>
</tr>
<tr>
<td>Overactive bladder/urge incontinence</td>
<td>Urgency, with or without incontinence, usually associated with increased frequency (more than eight times in 24 hours) and nocturia. If incontinence occurs, this is usually a medium or large loss of urine</td>
<td>Bladder contractions occurring while the bladder is filling. Causes may be associated with fluid intake, medication, medical conditions, e.g. stroke, diabetes, or they may be idiopathic</td>
</tr>
<tr>
<td>Mixed incontinence</td>
<td>Has symptoms of both stress and over-activity</td>
<td>Complaints of involuntary leakage, associated with urgency, frequency and also with exertion, sneezing, etc</td>
</tr>
<tr>
<td>Voiding difficulties/obstructive incontinence</td>
<td>Dribbling urine, feeling of bladder fullness, frequency, urgency, tendency to have urinary tract infections; hesitancy, stop/start flow. There is normally a small leakage of urine</td>
<td>Chronic urinary retention can be due to strictures, enlarged prostate, neuropathic illnesses, prolapse, or unresolved constipation</td>
</tr>
<tr>
<td>Functional incontinence</td>
<td>Amount of leakage varies from small to large according to the degree of functional disability</td>
<td>Factors that can affect functional incontinence include gender, age, cognitive function, mobility, dexterity, medical conditions, e.g. dementia, cerebrovascular accident (CVA), Parkinson’s disease, heart failure, diabetes, breathlessness, falling eyesight, poorly fitting footwear, long toenails, or environmental factors</td>
</tr>
</tbody>
</table>

Examinations (vaginal/rectal/abdominal/neurological), if required, by a competent professional
Bladder scans — if presenting with recurrent UTIs, to check for signs of incomplete emptying or underlying neuropathy
Environmental factors that may affect continence, e.g. access to toilets, room sharing, chair/bed heights, toilet height, space to accommodate equipment (e.g. walking aids/wheelchairs), floor surfaces, and unclear signage.
(adapted from Royal College of Nursing [RCN], 2007; Heath, 2009; Staskin et al, 2013; NICE, 2010; 2014; 2015; Yates, 2018)

Elements of the basic assessment will now be discussed in more detail.

Past medical history, symptoms and medication
It is imperative that healthcare professionals undertaking the assessment understand how health conditions affect continence issues and identify any relevant medical, surgical, neurological, obstetric and mental health history (NICE, 2015; Yates, 2018). This could include conditions such as diabetes, stroke, hysterectomy, prostatectomy, haemorrhoidectomy, spinal injuries, multiple sclerosis, dementia, learning disabilities, depression, gastrointestinal problems, or surgery that limits mobility. With regards to obstetric history, it is crucial to know the number of births, type of delivery (and any interventions), weight of baby and length of labour. Allergies and BMI should also be noted. Social and environmental factors (as listed above) should be identified and addressed early on in the assessment process.

Symptoms should be recorded as they present. There are many validated quality of life/symptom profiles available for each type of continence problem, but currently none validated for both bladder and bowel in one questionnaire. NICE (2013) recommends a variety of questionnaires for female urinary incontinence problems, e.g. Bristol Female Lower Urinary Tract Symptoms questionnaire (UK Continence Care Society, 2015). For men, the International Prostate Symptom Score (I-PSS) poses seven questions, of which six relate to urinary continence symptoms and one relates to quality of life. The International Consultation Incontinence Questionnaire (ICIQ), which also comes in a shortened version (ICIQ – short form), covers both female and male urinary issues. For bowels, there is the St Mark’s incontinence score or the ICIQ-B bowel questionnaire. Most of these tools are accessible and free (UK Continence Care Society, 2015; NHS England, 2018).

Most medication has some effect on bladder or bowel function, so it is important to assess the use of prescribed and over-the-counter medication, herbal remedies or recreational drug use. Common drugs that can affect continence include diuretics, antidepressants, antibiotics, laxatives, antimuscarinics, alpha blockers, sedatives and analgesia (Thirugnanasothy, 2010; Yates, 2017a).
Bladder/bowel charts, diet and fluid intake

A relevant chart of bladder or bowel function, or both (according to continence issue presentation), is an essential part of the assessment process. It is recommended by NICE (2013) that the bladder chart or diary is completed over three days, split into 24-hour periods, with individuals recording voiding patterns and episodes of leakage ranging from damp to soaking. There are several different charts available, from simple versions recording output and leakage, to others recording fluid intake and voiding urgency (NICE, 2013; UK Continence Society, 2015; Yates, 2018).

Bowel diaries, which are usually completed for a minimum of a week, allow the individual to record bowel frequency, stool consistency, amounts passed, any leakage or soiling, urgency, any pain on defaecating, and medication use, e.g. laxatives or stool firmers, such as loperamide (sold over the counter by McNeil Pharmaceutical as Imodium A-D).

These charts can only be used if the individual is capable of independent or assisted completion. If the patient is unconscious or cognitively impaired, an observational chart may be more appropriate.

It is important that the amount and type of fluid consumed is recorded, as this can affect continence. Average fluid intake over a 24-hour period should be approximately 1.5 litres (Fonda and Abrams, 2006; Chartier-Kastler, 2011; Yates, 2016). However, individual consumption may vary according to age, state of health, activity and weather. Low fluid intake can contribute to constipation, while excessive intake may increase continence problems and voiding activity (Gilbert, 2006). Caffeine (found in coffee, tea, drinking chocolate, cola, and other carbonated drinks) may have a stimulant effect on the bladder and bowel and can exacerbate bladder frequency, urgency and nocturnal voiding activity, as it is a mild diuretic and can increase the amount of urine produced. This is also true of alcohol.

Other fluids, such as fruit juices and herbal teas, can also have an impact on bladder or bowel continence (www.nhs.uk/live-well/eat-well/water-drinks-nutrition/).

Individuals who suffer from constipation are advised to eat high fibre foods, while those with faecal incontinence are advised to avoid such foods, caffeine and artificial sweeteners (NHS Choices, 2018; www.nhs.uk/conditions/bowel-incontinence/treatment/). Other conditions, such as lactose, wheat or barley intolerance, should also be ruled out before any treatment.

Investigations

Staskin et al (2013) identified that a dipstick urinalysis is not a diagnostic but a screening test when undertaken for a continence assessment. It can rule out numerous abnormalities, e.g. haematuria (blood in the urine), glucose, and protein. It is also a good indicator of an individual’s hydration state. However, the diagnosis of UTIs should be based on the patient’s symptoms and not on dipstick urine testing (Public Health England [PHE], 2019a; 2019b).

Post void residual urine (PVRU) can be tested via an in/out urethral catheter or bladder scan, both of which require a skilled professional for implementation and interpretation. Individuals who suffer from neurological problems (e.g. stroke, diabetes, spinal injuries) or obstruction of the urethra (due to enlarged prostate or prolapse) are at greater risk of not emptying their bladders completely. There is no clear consensus regarding the constitution of a normal or abnormal post void residual (PVR) volume with regards to retention. Volumes of 100–150ml are usually considered significant, but this will depend on total bladder capacity.

Staskin et al (2013) and NICE (2013) advise that abdominal, neurological and pelvic floor examinations are part of continence assessment. For a basic assessment, professionals will not always have the required skills and competence to undertake internal examinations; however, a visual inspection of the perineum can highlight a multitude of conditions. For example, healthcare professionals can see if there is skin damage or excoriation from urinary/faecal leakage. Prolapse, or urinary leakage or dribbling, may also be apparent, especially when the patient coughs. Visual examination of the rectal area may identify external haemorrhoids or anal fissure, which may be indicators of constipation, straining to defaecate or a degree of faecal leakage. An internal

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Symptoms</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faecal leakage</td>
<td>Involuntary loss of faeces usually due to physical exertion, sneezing, laughing, coughing or lifting</td>
<td>Anal sphincter or pelvic floor damage. Anal sphincter damage can be due to degeneration, childbirth (especially first baby, instrumental deliveries, weight over 4kgs, midline episiotomy, more than 3–4 births, abnormal presentation). Gut motility is affected by infection, inflammation, radiation, emotions such as anxiety, stool consistency and diet, which can all result in frequent, loose stools</td>
</tr>
<tr>
<td>Faecal urgency</td>
<td>Frequency of defaecation (usually more than three times daily) with severe urgency and usually loose stools</td>
<td>Anal sphincter or pelvic floor damage. Gut motility/stool consistency. Local pathology — prolapse, piles, fistula, anal tear</td>
</tr>
<tr>
<td>Constipation</td>
<td>Hard faeces, infrequent passing of stool (less than once every three days)</td>
<td>Immobility, poor diet, elderly, neuropathic conditions, medication, poor toilet facilities</td>
</tr>
<tr>
<td>Faecal impaction</td>
<td>Hard faeces causing impaction (with liquid faeces overflow)</td>
<td>Constipation, immobility, poor diet, elderly, neuropathic conditions, medication, poor toilet facilities</td>
</tr>
</tbody>
</table>
examination may be appropriate to identify constipation or fullness of the rectum, but only by those competent in the skill.

CONCLUSION

Continence is not a life-threatening condition, but can significantly affect the quality of life of patients and their families. NHS England (2018) states that ‘incontinence produces marked loss of self-esteem, depression, loss of independence, and can affect relationships and employment prospects’. It also states, ‘it is an important component in a person’s health and wellbeing at any stage of life’. Healthcare professionals should promote wellbeing, so it is their responsibility to provide accurate assessments of patients identified with continence issues. This article outlines the basics required to undertake a good assessment — an important prerequisite of creating better outcomes for the individual.

REFERENCES


KEY POINTS

- Continence issues are a common problem in the UK and are often seen by healthcare workers.

- Healthcare workers should have an understanding of the different types of bladder and bowel issues that can present.

- Healthcare workers should have the knowledge to undertake all the components of a basic continence assessment, which include taking full history, use of relevant charts, assessing post void residual urine and visual examination.

- Healthcare workers should be able to identify simple things that they can instigate to improve continence status, i.e. fluid and dietary advice, and environmental changes.

- Continence is not a life-threatening condition, but can significantly affect quality of life for patients and their families.