Assessing patients with urinary incontinence: the basics

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Urinary incontinence is a common problem in the UK, and one often seen by community nurses. While it is often associated with ageing, urinary incontinence can in fact have a number of causes and it is important that the community nurse is aware of the full range of aetiologies and presentations. Community nurses should have a good basic understanding of the causes of incontinence, be able to provide a basic first assessment, become adept at asking the right questions and be able to offer some conventional treatment and problem-solving strategies for immediate relief of symptoms. Most importantly, they should be able to identify when a patient will need referring to a specialist practitioner for more extensive assessment and investigation. This article looks at the assessment of urinary incontinence in the community, and outlines the common presentations that nurses should look out for.

Although the fact that continence issues are attracting more media attention is a step in the right direction, this does not go far enough. The media focus is often on stress incontinence, meaning that anyone with a different type of incontinence problem can feel alienated. The coverage of continence is all too often a lost opportunity to inform the public that help is available and that there are in fact different types of incontinence all with different symptoms that require a variety of management options.

This article looks at the different types of urinary incontinence and how community nurses can assess them accurately and begin to draw up an evidence-based management plan.

ASSESSING URINARY INCONTINENCE

A continence assessment is the first step in determining the particular type of incontinence a person has. Although assessment is usually performed by continence advisers and nurse specialists, this does not mean that other clinicians such as community nurses need not be involved. Continence is an issue that should be on every clinician's agenda, and the document Good Practice in Continence Services (Department of Health [DH], 2000) stated that the way to tackle such a common problem is to ensure that initial management is carried out by primary care and community teams (Winder, 2001).

A thorough initial assessment can not only reveal the type of incontinence the patient has, but also whether the problem is easily reversible and can be dealt with locally. Similarly, a good assessment can highlight more complex problems, which might mean the patient being referred onto a specialist.

Being able to perform a continence assessment — together with an understanding of the potential causes of continence problems and the ability to advise patients or refer them on — are crucial skills for community nurses (Winder, 2001; Staskin et al, 2009; Busuttil-Leaver, 2011).

DIFFERENT TYPES OF URINARY INCONTINENCE

Continence is associated with problems either filling the bladder (e.g. stress incontinence); the storage of urine in the bladder (e.g. urge incontinence); voiding (e.g. overflow); or a combination of one or more of these issues.

Asking specific questions about continence status when interviewing a patient is key, as are good interview skills, such as listening and empathy (Winder, 2001). However, there is no standardised form used by clinicians to assess continence...
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THE SCIENCE — WHAT IS URINARY INCONTINENCE?

People can experience both urinary and faecal incontinence. However, urinary incontinence is more common and up to six million people in the UK are thought to experience the unintentional passing of urine. There are several types of urinary incontinence, but the most common are:

- Stress incontinence: urine leaks when the bladder is under pressure, such as during coughing or laughing
- Urge incontinence: a sudden, intense urge to pass urine
- Mixed: a mixture of both stress and urge urinary incontinence.

Source: NHS Choices: www.nhs.uk

across the UK, and many continence specialist nurses or continence services put together their own assessment forms. This leads to a variation in documentation, none of which is validated, and which has an effect on the quality of information the clinician can collect. For example, some assessment forms are very detailed, whereas others ask the most basic questions to determine the type of incontinence, but not necessarily the cause (Winder, 2001; Getliffe and Dolman, 2007).

No matter how detailed the assessment form, a one-to-one interview with the patient is invaluable, allowing the nurse to fill in the areas that a form may miss, such as the effect on self-esteem or social life, for example.

Getliffe and Dolman (2007) stress the importance of ensuring any assessment is carried out in an environment where privacy and comfort are assured. Observing the patient’s behaviour throughout will give the assessor an invaluable insight into their attitude and feelings and possible coping mechanisms. Any initial assessment should begin with a detailed history and should include when the symptoms started, if anything triggers them, if they are getting progressively worse and how bothersome these symptoms are.

Assessment should also include the person’s diet and fluid intake as well as establishing their usual bowel habits. Other factors include:

- Noting any medication the patient is taking and if there has been any change in this recently
- Body weight
- Mobility
- Dexterity
- Cognitive awareness
- Any psychological problems
- Physical abilities
- Environmental aspects
- Previous surgery to the urinary tract, reproductive organs or genitalia
- Number of pregnancies and births
- Method of birth
- Menses history
- Family history.

It is also important to note whether or not the patient has been assessed and/or treated for the same problem elsewhere and how successful or not that treatment was, as well as if they had abandoned or stopped treatment and why (Staskin et al, 2009; Busuttil-Leaver 2011).

The assessor must always keep in mind that some patients may have more than one type of incontinence and treatment should be directed to the predominant symptom, while remaining vigilant for any impact treatment may have on the rest of the urinary system, especially the kidneys. The National Institute for Health and Care Excellence (NICE, 2015) recommended that anyone with incontinence should be asked to fill in a frequency volume chart for a minimum of three days. This will give a clearer picture of what the patient has to deal with and the impact of the symptoms on their quality of life.

A simple procedure that can be performed at this stage is to test the urine for infection using a dipstick. Urinary infections may trigger incontinence, so symptoms may be reversed or improved if treated.

Another useful test is the pad test, which can give a clearer picture of how much urine leaks from the patient’s incontinence pads over the course of 24 hours. Patients are asked to store all the pads they use over a 24-hour period in a plastic bag or similar to ensure they do not dry out. The total weight of the wet pads, less the weight of the pads when dry, will then indicate the amount of urine lost over 24 hours.

Taken together with the frequency volume chart where pad changes are noted and the amount of urine voided is measured and recorded, this will provide the assessor with an accurate picture of how frequently urine is voided, when urine loss happens and the volume lost (Getliffe and Dolman, 2007). These basic steps will go a long way to help identify the types of incontinence causing the symptoms and, if indicated, will allow conservative treatment to be initiated, or alternatively generate a referral to a specialist for more extensive investigations (NICE, 2015).

SPECIFIC ASSESSMENTS

Stress urinary incontinence

Stress urinary incontinence is the most common type of incontinence in women, although men may also experience it, especially following prostate surgery (Dorey, 2007). Stress urinary incontinence is defined as the involuntary leakage of urine on effort or exertion (Abrams et al, 2002).

The pelvic floor muscles surround the external sphincter muscles, which control how the urethra is opened and closed. They form a sling across the pelvis, thus supporting the pelvic organs (Vodusek, 2004). There is also a ring of muscles at the bladder neck — the internal sphincter. These muscles are closed when the bladder
fils so that the closure pressure in the urethra is higher than that in the bladder as it fills with urine. If the pelvic floor muscles are weak or there is damage to the sphincter muscles they will not close efficiently. Once there is an increase of pressure in the bladder, for example when coughing or sneezing, the pressure in the bladder becomes higher than the closure pressure in the urethra and urine leaks out.

There are several causes of stress incontinence including pregnancy, damage during childbirth, obesity, chronic cough, surgery, menopause, nerve damage, medication or connective tissue disorders (Leaver, 2011). Some problems may cause temporary stress incontinence, for example a urinary tract infection. This is not true stress incontinence as there is no problem with the pelvic floor or the sphincters, but it can be no less distressing even if transient. Some women only leak on exercising or when engaging in sexual activity, either during or after sexual intercourse.

A physical examination of the perineal area will also show if there is an underlying problem causing the symptoms, such as a vaginal or rectal prolapse (NICE, 2015; Hagen et al, 2016). Sometimes asking the patient to cough while examining the perineal area will demonstrate the leak, a technique called direct visualisation.

Checking the strength of a patient’s pelvic floor may also be useful. The easiest way to do this is for the community nurse to insert a lubricated gloved finger into the woman’s vagina while asking her to squeeze the pelvic floor muscles. The weaker the squeeze pressure felt, the weaker the pelvic floor. This technique is also used as a way to help women identify where their pelvic floor muscles are and ensure that the right muscles are being squeezed when performing pelvic floor exercises (National Association for Continence [NAFC], 2016).

In male patients, squeezing the pelvic floor correctly will result in the base of the penis retracting into the body and a lifting of the testicles (Dorey, 2007).

**Urge incontinence**

Urge incontinence is defined as the complaint of involuntary leakage accompanied by or immediately preceded by urgency. This may result in minor leaks in between full micturition or complete emptying of the bladder.

Urgency can develop due to an overactive bladder, where the bladder muscle — the detrusor — contracts either spontaneously or on provocation, creating an urge to pass urine (Getliffe and Dolman, 2007). Not everyone with urgency is necessarily incontinent, however; urgency can result in a urine leak if the individual is unable to access a toilet quickly enough, for example. Some patients are not able to control the urge at all and leak the full contents of their bladder as soon as the detrusor muscle contracts.

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basics, however, the assessor needs to establish if the patient feels an urge to pass urine before voiding or leaking. This should trigger more specific questions, such as for how long the person can hold their urine before having to respond to the urge to empty the bladder; and whether any particular events trigger the urge, for example cold weather, the sound of running water or coughing.

Other possible triggers may be related to the type and amount of fluids the person drinks, such as their caffeine or carbonated drink intake, while food and drinks also known to trigger urge incontinence include spicy foods, chocolate, citrus juices, artificial sweeteners and coffee (NAFC, 2016).

It is also important to establish whether the patient has had a recent change in their medication that may have triggered the symptoms or made them worse, or if they are taking a new medication, e.g. diuretics or sleeping tablets. Smoking and alcohol intake has also been found to cause urgency.

Bladder overactivity may also be an indication that there is an underlying neurological condition (NICE, 2012), such as stroke or Parkinson’s disease. Alternatively, the bladder may be irritated locally making it more sensitive. Having a tumour, urinary stone, prostatic enlargement or an acute urinary tract infection may also result in urge incontinence.

Many patients may develop an idiopathic overactive bladder where no actual cause of the very real symptoms can be detected (Getliffe and Dolman, 2007), while some patients will describe both stress and urge symptoms. This is known as mixed urinary incontinence.

It is usual to treat the symptoms of urgency first in these cases for the following reasons:

- Firstly, reducing the urge means there is less chance of urine being ‘pushed’ back up into the kidneys via the ureters. This is known as ureteric reflux and can result in infection and scarring of the kidneys and compromise kidney function.
- Secondly, reducing or eliminating the urgency will result in a reduction in bladder pressure, which may result in the stress symptoms resolving without any or minimal intervention. (Abrams et al, 2013; Wein and Smith, 2014).

Overflow incontinence

Overflow incontinence is linked to incomplete emptying of the bladder. Anything which obstructs the flow of urine can cause incomplete emptying of the bladder, which leads to the bladder stretching to accommodate the increasing amount of urine it has to hold.

The most common cause is an enlarged prostate in men, though urethral strictures also cause the same symptoms as will anything that presses onto the urethra such as a prolapse, tumour or impacted rectum.

The same symptoms can also occur if the patient’s bladder muscles do not contract properly (detrusor hypoactivity), so that their bladder emptying is incomplete and the bladder consequently expands. This may be the result of nerve damage to the peripheral nerves of the bladder and damage to the lower spinal cord.

Key questions to ask in any assessment of a patient’s overflow incontinence centre around the following areas:
- What the patient’s normal flow of urine is like
- If they pass urine frequently during the night (nocturia) and how often
- If there is any hesitancy at micturition
- If they have had any urinary tract infections
- If they ‘dribble’ urine after passing urine (post micturition dribble)
- If there are urgency symptoms with or without urine leaks (many men with overflow incontinence may also develop urgency) (NICE, 2010).

Physical examination may reveal a distended lower abdomen due to an enlarged bladder. If the community nurse has access to a bladder ultrasound machine, then a pre- and post-micturition ultrasound will confirm incomplete emptying by measuring the residual urine (Getliffe and Dolman, 2007).

Functional incontinence

At times, incontinence may not be linked to any physiological problem of the urinary tract but may occur because of outside factors, which can cause or exacerbate a continence problem.

Again, a detailed assessment of factors such as lifestyle or environment changes and mobility or dexterity problems as outlined above can identify the problem. For example, the patient may have urgency but still be able to ‘hold on’ without leaking if able to access a toilet quickly enough. However, if the patient develops mobility problems, or has a change in environment which results in a lack of facilities in the vicinity (e.g. the toilet being upstairs), this will mean that the delay in accessing a toilet can result in a leak. Similarly, being unable to undo clothing in time to go to the toilet because of poor dexterity is another example.

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- Is there any one patient episode that stands out as exceptional practice in challenging circumstances?
- How has this contribution affected patient care?
- How has this contributed to tissue viability nursing overall?
- Is there any evidence to support the entry (national guidelines, literature, etc).
As part of any continence assessment, it is vital to check the patient’s past and current medications (e.g., diuretics and sleeping tablets), as well as any recent changes as this can have a significant impact on continence.

polypharmacy, constipation, changes to diet or fluid intake, severe cough, endocrine disorders and urinary tract infections are all examples of factors that may result in functional incontinence (Getliffe and Dolman, 2007; Wilkinson, 2009).

ASSESSING URINARY INCONTINENCE IN THE COMMUNITY

Ideally, any continence assessment should automatically form part of the physical assessment of community patients whether or not they volunteer the fact that they have continence problems. Waiting until the patient approaches the topic themselves usually means that symptoms have escalated and are causing real problems.

The longer the problem is not identified and therefore untreated, the more likely it is that conventional treatment will not be as effective and the damage greater. The consequences may not only effect the function of the bladder, but also the kidneys, with far-reaching complications.

Having a trigger question about bladder function in any assessment will encourage the patient to divulge any problems, perhaps for the first time, which can then be followed up with a structured assessment.

Community nurses should ensure that they have a good basic understanding of the causes of incontinence, be able to provide a basic first assessment, become adept at asking the right questions and be able to offer some conventional treatment and problem-solving strategies for immediate relief of symptoms. Most importantly, they should be able to identify when a patient will need referring to a specialist practitioner for more extensive assessment and investigation.

REFERENCES


KEY POINTS

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- While it is often associated with ageing, urinary incontinence can in fact have a number of causes and it is important that the community nurse is aware of the full range of aetiologies and presentations.

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- Most importantly, community nurses should be able to identify when a patient will need referring to a specialist practitioner for more extensive assessment and investigation.

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