Pulling the plug on containment

The practice of containing incontinence must be replaced with proactive interventions to prevent and actively manage it, writes Geraldine McCarthy, Alice Coffey, Brendan McCormack, Jayne Wright and Brenda Lehane.

The well known adage that prevention is better than cure is entirely applicable in the case of incontinence where the costs, both in terms of the impact on quality of life and finance, are heavily weighted in favour of prevention.

Research from a recent Irish study, conducted in rehabilitation units for older people, one in the Republic of Ireland and one in Northern Ireland, indicated that current management of incontinence consists predominantly of continence containment, rather than proactive management. The use of absorbent products and timed voiding, without proper assessment of, or collaboration with the patient, was evident in 97% of cases. Consequently, very few cases re-established continence.

There are many forms of urinary incontinence (UI) but the most common is stress incontinence, where raised intra-abdominal pressure causes involuntary loss of urine. Faecal incontinence (FI) can be either passive or urgent and its causes are more diverse. Incontinence is a symptom and the identification of the underlying cause is paramount.

Incidence

The reported incidence of urinary incontinence varies depending on the population in question. For example, in the UK a 9% incidence of UI was found in the adult population. However, a similar Irish study found the figure to be much higher, at 33%. What is known is that UI affects more women than men and that the prevalence of incontinence increases with age.1

The exact prevalence of FI is difficult to determine due to the under-reporting of its symptoms, the lack of a standard scoring scale and variations in populations. It is estimated to affect approximately 3% of the population over 65 years.

Whatever the exact incidence or population affected, incontinence has devastating consequences on the individual and also burdens the carers of those who require personal care. However, 52% of Irish people believed urinary incontinence to be a natural part of the ageing process.2 This misconception obscures the fact that incontinence is reversible for the majority of patients.

Treatment

There are three options in the management of incontinence: conservative, pharmacological and surgical management. A detailed assessment that encompasses history (including voiding history), physical examination, urinary investigations, and an analysis of the patient’s environment, social support networks, manual dexterity and mental status are necessary to devise a plan of care suitable to individual need.3

The general rule of incontinence management is to start with the least invasive method that has the fewest side effects and move towards the more intrusive methods.
Conservative management is predominantly the role of the nurse/midwife. It involves educating and supporting the person to make behavioural adjustments and lifestyle changes (in diet, weight reduction, smoking), as well as teaching exercise techniques, such as pelvic floor muscle exercises (PFM). However, older adults may achieve better results from bladder retraining exercises, due to the physical attributes necessary for PFM performance.

In cognitively impaired individuals prompted voiding or timed voiding can be effective in reducing or eliminating incontinence.

Education is paramount in conservative management, as it provides individuals with vital information and skills that can greatly reduce the incidence and severity of incontinence. A major component of the successful management of incontinence is promoting client integrity and motivation. Allowing clients to share their feelings on the impact of their incontinence is vital. Nurses and midwives should expect continence rather than incontinence and articulate that incontinence can be reversed. The use of absorbent products should be restricted. Failing this, pharmacotherapy can be added in an attempt to control involuntary leakage.

While there are many medications that can be used in the management of incontinence, their effectiveness is uncertain.

For a minority of cases, surgical interventions can be warranted to restore continence.

Incontinence negatively affects the individual’s physical, emotional, psychological, sexual and social health. Urinary incontinence has been found to be a leading determinant in the decision to enter long-term care for an older adult due to inability to cope at home. Thus, continence promotion and restoration are vital roles of the nurse/midwife to ensure clients and their families can live as independently as possible and with a high quality of life.

Findings

The study was conducted to identify the prevalence and management of urinary and faecal incontinence in two rehabilitation units. The results showed that 60% of patients suffered from UI, 3% from FI and 37% from both UI and FI. In many cases there was no documentation of a diagnosis of incontinence. Only 9% of patients in site two had a record of their incontinence in continence charts and just 2% of patients from the same site were referred to nursing or medical specialists.

Treatment for incontinence consisted mainly of treatment for constipation and urinary tract infections. Incontinence management consisted predominantly of containment using body worn pads (50%) and timed voiding (57%).

In most cases of faecal incontinence there was no documented diagnosis or cause of the incontinence identified. Management included the use of laxatives to treat constipation, dietary changes and antibiotics. The outcome was not surprising then – that 86% of patients remained incontinent following ‘treatment’.

Furthermore, 30% of patients had a urethral catheter in situ, of which 75% had no record of the date of insertion. Of the written records found, 75% were recorded in the patient’s medical notes. These findings highlight the lack of an holistic approach, which addresses lifestyle, behaviour, diet, environment and social factors that contribute to incontinence.

The study also exposes the minimal use of bladder retraining and medication management, which are cited in the literature as effective. Involvement of patients in their incontinence management is paramount. However, it was absent in more than 90% of cases.

Some 66% of participants were unsure whether they were satisfied with the management of their incontinence. Overall, the assessment and management practices for incontinence were inadequate with little rationale for treatment decisions documented, demonstrating a reactive rather than a proactive and restorative approach. However, the study did discover some positive findings; toileting facilities in both sites were deemed conducive to continence promotion and management, and policy guidelines for incontinence management were available to staff, but only in one site.

The study recommended a review of current practices in relation to continence care and urges the introduction of evidence-based practices. A large number of patients in these units were found to suffer from incontinence. A ‘containment’ approach to incontinence was identified, attributable to the little evidence of continence assessment, documentation or continence promotion in these settings.

The planning of care with patients or their carers, was absent from documentation in almost all cases and incontinence persisted for the majority of patients. Thus, a review of current continence management is essential to improve practices in continence care.

This study calls for implementation of evidence-based, individualised care that collaborates with patients and their carers, in the formation of a personalised continence care plan.

References