The challenges of continence promotion on the Stroke Unit

Helen Mann, Stroke CNS

6th October 2010
Session content

- Prevalence
- Patients’ and carers’ experience
- Aetiology
- Attitudes
- Guidelines
- Management
Incontinence services condemned by Drs

Millions in UK face "life sentence of suffering"

- RCP audit >18,000 England, Wales & N.Ireland
- Diagnosis & treatment often non-existent or poor
- Services often fail to meet NICE standards
- Inadequate training
- Continence management given low priority.
Prevalence of urinary incontinence

- Affects 1 in 5 over 65 (DH)
- Estimates after stroke vary according to methodology and definitions
  - Patel et al (2001) immediately - 40% 3/12 - 19%, 1yr - 15%, 2yrs - 10%
- Many studies include premorbid UI (17%)
- Containable urinary symptoms will cause post stroke incontinence
How does it feel to be incontinent?

• The feeling of absolute horror as the urine flows..
• The feeling of despair as you try in vain to stop it..
• The hope that no-one will notice..
• The shame as you strip off your soiled clothes..
• The worry that you will smell before you have a shower..
The patients’ and carers’ experience

• ‘Most people I meet can manage their continence issues, so would not be classed as incontinent, nonetheless there has often been a change in their toileting habits or needs that makes life difficult.

• For example, some people with mobility problems have trouble getting out in and of or into bed. So if they need the toilet at night – and many do – they need help to get there. This disturbs their carer’s sleep as well as their own...
Aetiology

• Subsequent to any stroke except for occipital lobe
• Frontal lobe supplied by MCA, ACA → urgency, frequency, nocturia - aware but ↓ control
• Pons – co-ordinates muscle activity for voiding
• detrusor muscle hyperreflexia - No time to get to toilet
Aetiology of incontinence

• **Neurogenic** – frontal lobe, micturition pathway in pons

• **Physiological** - Urinary Tract Infection, high blood sugar levels ➔ polyuria, constipation, enlarged prostate

• Impaired **mobility**

• Impaired **cognitive function**
‘Competence, attitude & behaviour of health professionals’  (Ayres & Wells 2007)

- Medications (constipation), diuretics
- Lack of knowledge, lack of understanding
- Low priority
- Failure to implement appropriate strategies
- Environment (signposting, equipment)
Containment v. proactivity

- Continence care in older people - RCP audits revealed protocols re pad provision & delivery
- Lack of knowledge
- Negative attitudes
- Low attendance at continence courses
- UI viewed as ‘untreatable’
- Time management to facilitate continence promotion
Guidelines

• HC4L competencies:
• Knowledge of cause
• Effect on patients’ mood
• Privacy and dignity
• Practical management, bladder retraining
• Don’t specify need for assessment

• Cochrane Review (2007) – paucity of evidence re management
RCP (2008) Nursing guidelines

• Assessment and management protocols in place
• 2/52 post stroke – re-assessment for other causes of incontinence
• Documented management plan
• Start with simpler treatments; bladder retraining, pelvic floor exercises, equipment
• Management plan for discharge
Management - Assessment

- Physical examination: identify reversible conditions
- Identify pre-morbid incontinence
- Voiding difficulties (hesitancy, straining, poor stream)
- Frequency, urgency, nocturia
- Constipation
- Eating and Drinking habits
- Medication
- Mobility
- Cognitive issues
MDT approach to facilitating continence

- Doctors – physical examination
- SALT, OT, PT – communication and cognitive issues, sitting balance, transfers, exercise tolerance
- Dietitian – fluids, fibre
- Nurses - inclusion of all of above in assessment and regular reviews
- Patients and family
Management

- Regular review (MDTM)
- Management of constipation / UTI
- Bladder Scanning
- Intermittent catheterisation rather than indwelling catheter
- Bladder training
- Depression / incontinence link
- Pads & pants design
- Vernagel
- Appropriate medication
7 day Bladder Record Chart

- Please put a check (✓) in Blue column each time urine is passed.
- Place a check (✓) in Red column each time you are wet.
- Add "D" for damp or "W" for Wet beside the check (✓)
Equipment

• Enough hoists, commodes
• Tilt in space commode
• Male and female urinals
• Curtains that close properly
• Adequate space in toilet
Female Urinals

- Bourdalon, or female urinal, English, c. 1805
Local plan for improved continence promotion

• Awareness raising
• Questionnaire re knowledge, management, equipment, emotional effects
• Audit and educational programme
• Assessment and documentation
• Re-audit
Summary

• Knowledgeable staff
• Appropriate skills
• Commitment and empathy
• Adequate equipment
• High priority when organising workload
References

- www.continence-foundation.org.uk
- www.promocon.co.uk
- Miles, B (1984) ‘Incontinence following stroke’
Continence Key Competencies

• Describe how stroke can affect continence
• Identify and highlight continence problems that occur with appropriate staff members
• Demonstrate the promotion and support of patients privacy and dignity in relation to incontinence (e.g. providing the patient with means of accessing help)
• Briefly describe the effect of incontinence on: moving and handling, pressure care, positioning, skin integrity, ADL’s
• Explain the principles of bladder re-training and toileting programmes
Continence Key Competencies

• Explain the principles of bladder re-training and toileting programmes
• Demonstrate how you would action the principles of bladder re-training and toileting programmes
• Describe knowledge of the psychological, social and emotional impact of continence
• Describe knowledge of other factors that may contribute to difficulties with continence (age, medical condition, beliefs and preferences, diet, mobility etc.)
• Demonstrate the encouragement of individuals to use recommended continence equipment, techniques and clothing