ENHANCED HEALTH IN CARE HOMES

WORKING TOGETHER TO IMPROVE QUALITY

Bladder and Bowel Care for Nursing and Residential Homes

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Learning objectives

At the end of the training attendees will be able to answer the following questions:

- How common are bladder and bowel conditions?
- What can go wrong?
- What are the essential elements of a bladder and bowel assessment?
- How can bladder and bowel problems be treated and managed?
- How can moisture lesions be avoided and treated?
- How do we use continence pads most effectively?

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Bladder and bowel incontinence

- Write down six words that you associate with incontinence
- Be honest – whatever comes to mind first
- How do those words make you feel?
- Are they positive or negative?

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Dignity in care

- In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out.
- When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves. When dignity is absent people feel devalued, lacking control and comfort. They may lack confidence and be unable to make decisions for themselves. They may feel humiliated, embarrassed or ashamed.
- Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value.

- *"While they're wiping me down I do feel embarrassed because some of these nurses are only 20 or 30, you know, and I get very embarrassed and sometimes I break down and they say, 'What are you crying for?' and I say, 'Well, you don't realise, you don't realise, what you're doing.' You see, I feel remorse about this."*
  ~Male nursing home resident, age 88

Urinary (bladder) Incontinence – how common is it?

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- Difficult to estimate due to differences in its definition and many people won't admit to having continence problems.
- Estimates suggest that approximately 3.5 million women suffer from urinary incontinence in the UK.
- In general, urinary incontinence is two to three times as common in women as in men.
- It is estimated that 46% of women and 34% of men aged over 80 years have urinary incontinence.
- Up to 50% of people living in care home settings have urinary incontinence.

Faecal Incontinence – how common is it?

It is extremely common, affecting up to 10% of adults, but the true figure remains hidden due to the associated embarrassment and stigma felt by people with the problem.

What is your idea of 'normal' bladder function?

Make a note, or discuss with your colleagues, the answers to these questions:

- How often should we go to empty our bladder in 24 hours?
- How much urine does the average adult bladder hold?
- How often should we have a bowel movement?
- What is a normal bowel movement like?

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‘Normal’ bladder function

Question	Answer
How often should we go to empty our bladder in 24 hours?	With a fluid intake of around 2 litres, we would go to the toilet 5 – 7 times in 24 hours and no more than once during the night.
How much urine does the average adult bladder hold?	450mls when it feels full
How often should we have a bowel movement?	Between 3 times a day and three times a week
What is a normal bowel movement like?	Soft, formed – Type 4 on the Bristol Stool Scale

Where is the bladder?

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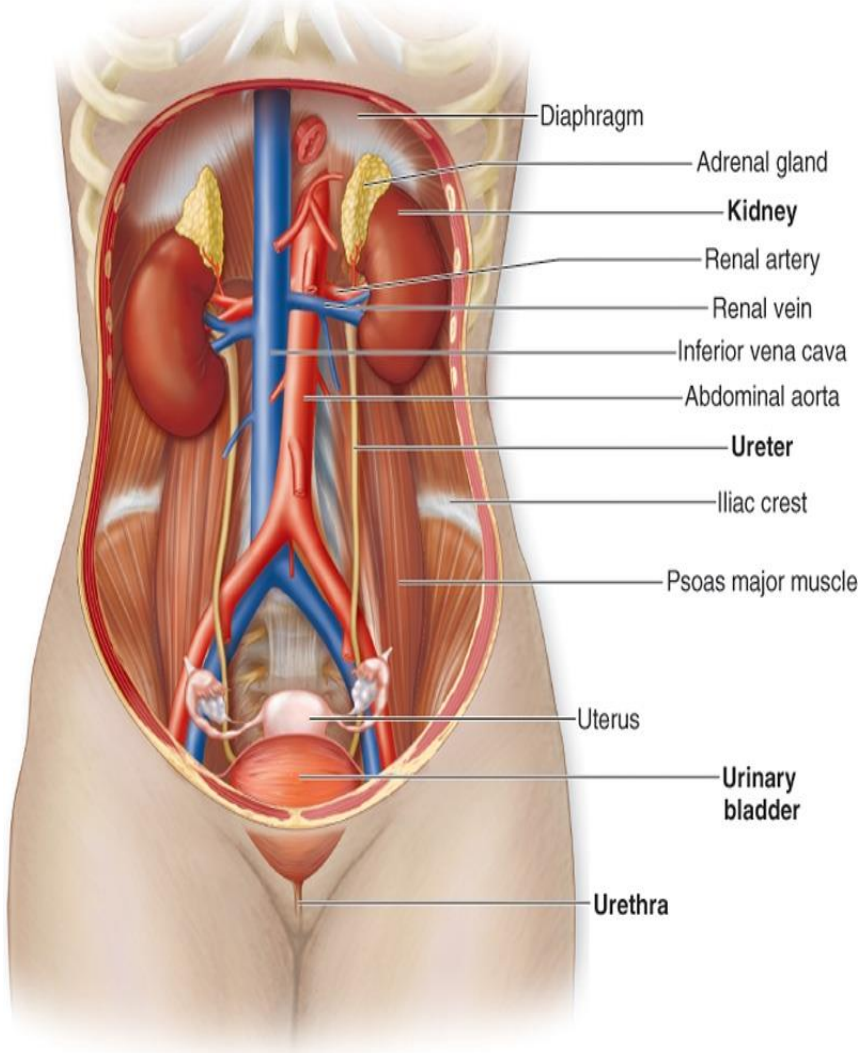

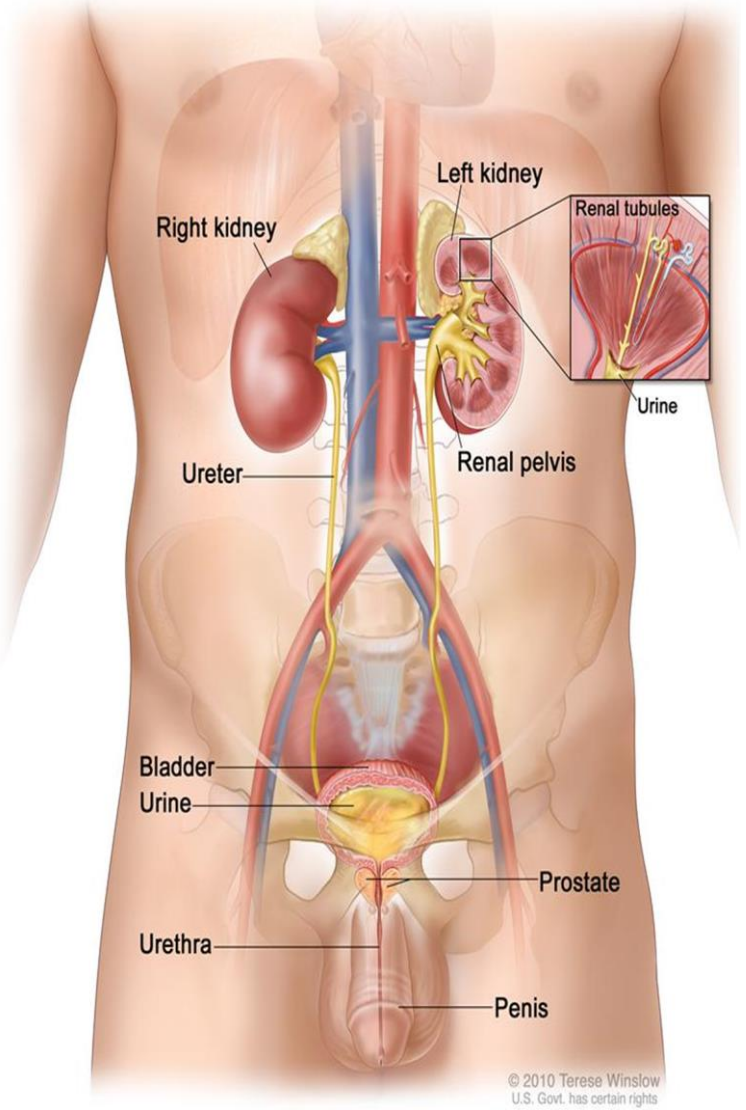

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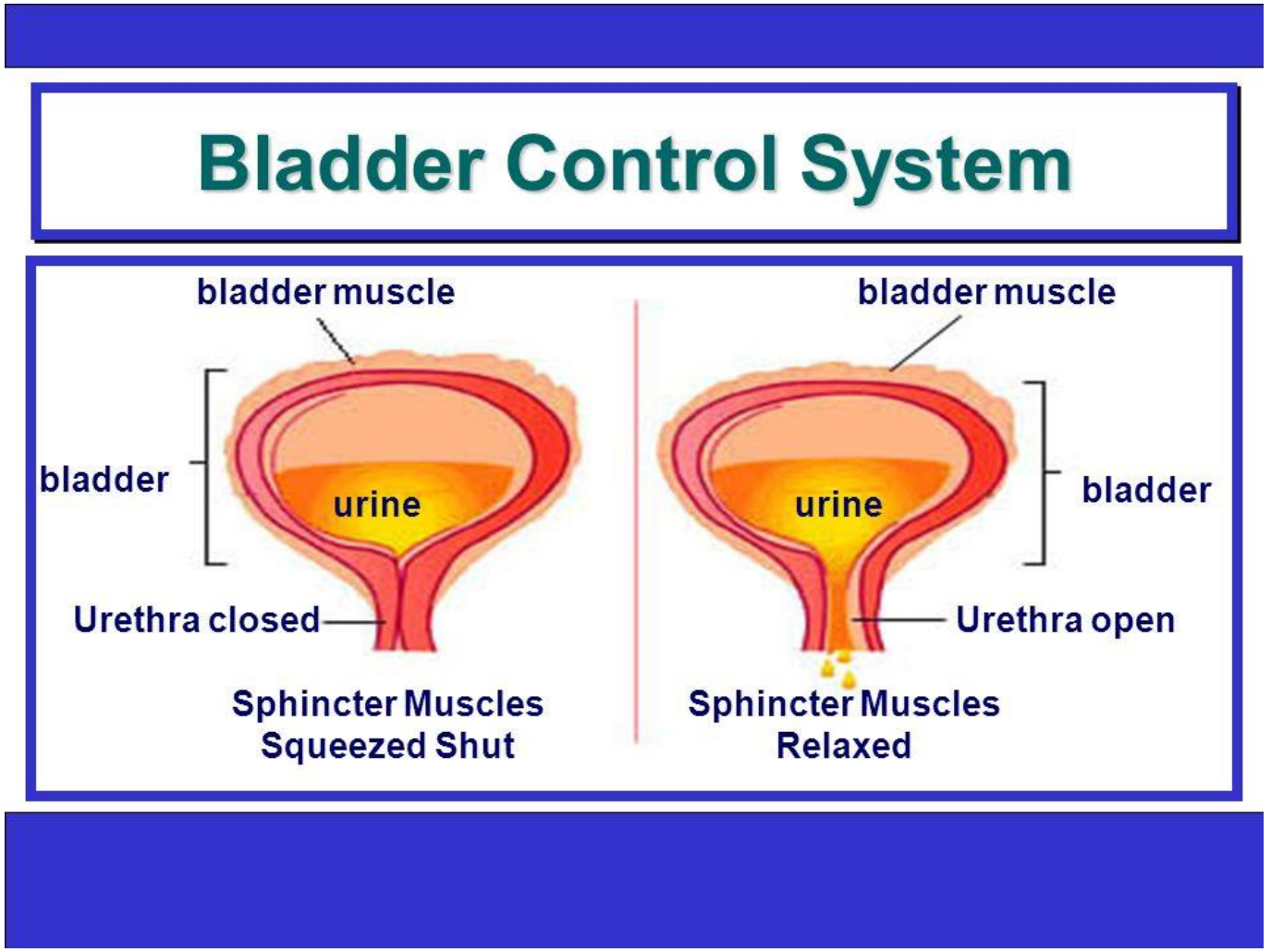
How does the bladder work?



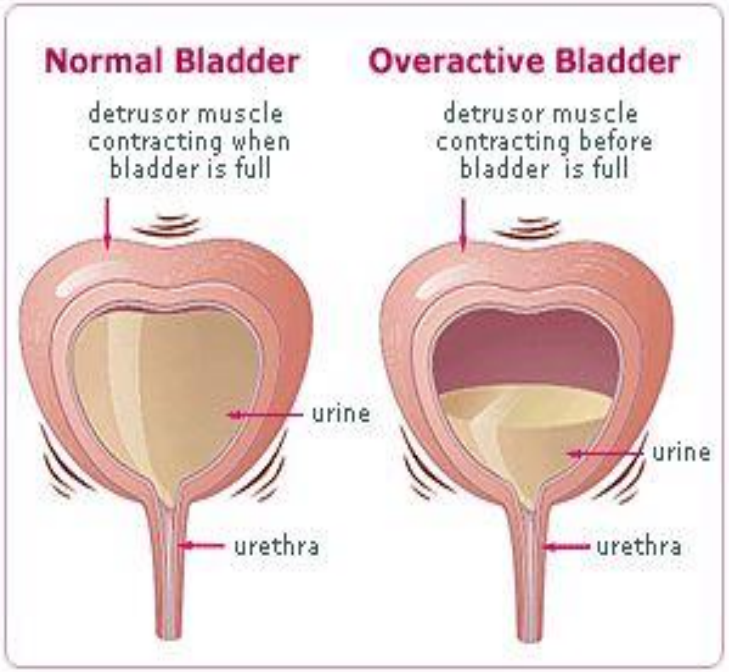
What can go wrong?

- Functional incontinence: the patient is unable to reach the toilet in time for reasons such as poor mobility, unfamiliar surroundings or confusion – there are no problems with bladder function.

- Stress incontinence: involuntary leakage of urine on effort or exertion, or on sneezing or coughing. Stress incontinence may be associated with genitourinary prolapse and is more common in women than men.

Urge incontinence

- Involuntary urine leakage with a strong urge to pass urine but an inability to hold.
- Instability (hyper-reflexia) in the bladder muscle leading to involuntary bladder contraction.
- Can occur for no known cause or because of infection, bladder stones, or in people with neurological problems such as stroke, Parkinson's Disease, multiple sclerosis, or spinal cord injury.



Overactive bladder (OAB)

- Urgency that occurs with or without urge incontinence.
- People usually have frequency and get up at night a lot (nocturia).
- It may be called 'OAB wet' or 'OAB dry', depending on whether or not the urgency is associated with incontinence.
- It can be caused by infection, inflammation of the bladder, enlarged prostate, small bladder, neurological conditions, going to the toilet ‘just in case’.

Overflow incontinence

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- The bladder cannot empty and so incontinence develops as it overflows
- Can be due to an obstruction preventing urine from leaving the bladder
- It is often due to prostate disease in men
- People with neurological problems can develop this as the bladder cannot contract to empty anymore
- It can lead to kidney damage due to back pressure (reflux) so early assessment and intervention is required.
- True incontinence: may be due to a fistulous tract between the vagina and the ureter, or bladder, or urethra. There is continuous leakage of urine.

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Careful observation and questioning is needed to identify whether your resident is reliant on any of the following strategies to maintain or control their continence problem:

- Going to the toilet frequently
- Reducing fluid intake
- Adapting food intake
- Sitting near to the toilet
- Staying in room
- Avoiding social activities
- Wearing pads “just in case”
- Staying in nightclothes / not wearing underwear
- Uses disposable/re-usable continence products

Any of these strategies can indicate a hidden continence problem

How does the problem make people feel?

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- Anxious?
- Upset?
- Depressed?
- Do they appear unconcerned?
- Are they keen to get the problem ‘sorted out’?

Actively seek residents views

- Discuss their willingness to participate in a care plan
- Consult relatives / advocate where appropriate
- Assess resident’s cognitive ability to participate in the process and adapt the plan to also meet these needs

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Local Assessment Documents

- The District Nurses carry out continence assessments in Residential Homes

- The Registered Nurse in a Home should carry out the continence assessment for a resident in a nursing bed.

Whilst it is important that a Registered Nurse does the assessment, carers and health care support workers can assist by filling out bladder and bowel diaries accurately.

- The paperwork required to complete an assessment can be found in the virtual training resource file
- To order a continence product from East Lancashire Bladder and Bowel Service the following documents should be completed:
  - Bladder assessment form*
  - Bowel assessment form*
  - Bladder diary*
  - Bowel diary*
  - Food diary*
  - Supporting evidence form if non-core range products are requested
  - Product order form

*select according to type of incontinence

Bladder assessment – what do we need to know?

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- leakage of urine on sneezing, coughing, exercise, rising from sitting, or lifting?
- urgency and failure to reach a toilet in time?
- frequency of urine during the day/at night?
- dribbling of urine after leaving the toilet?
- total loss of bladder control?
- feeling of incomplete bladder emptying?
- pain or burning sensation on passing urine (dysuria)?
- bladder spasms?
- obstetric history (how many pregnancies and births)
- assess functional status (how is the person's mobility/mental awareness etc.)
- do any medications contributes to symptoms?
- is their constipation or diarrhoea that needs treating?

Examination

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- When a patient is assessed for continence problems a physical examination may be helpful.
- Informing the GP or nurse practitioner about a person's incontinence can help them to decide if further investigations are needed.

Women:

- Digital assessment of pelvic floor muscle contraction.
- Assessment for the presence of prolapse
- Look for signs of vaginal atrophy skin changes due to low oestrogen levels)
- Abdominal examination should also be performed
- Post-void residual urine volume

Men:

- Digital rectal examination to assess prostate shape, size and consistency
- Abdominal examination should also be performed
- Post-void residual urine volume

Physical examination may be undertaken by the GP where indicated

Testing

Testing a clean sample of urine is essential to make sure that infection is not the cause of incontinence

The sample should be collected in a clean container after washing the patient to avoid cross-contamination

If there are any abnormalities report to the patient's GP and they can decide if a sample for culture is needed

Urinary dipstick testing

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Assess for blood, glucose, protein, leukocytes and nitrites

Blood further investigations are essential if blood is found in urine as it could indicate impaired renal function or bladder cancer

Protein indicates possible renal disease

Nitrites +ve reaction indicates bacterial infection

Leucocytes +ve reaction also indicates infection

Glucose +ve test indicates possible diabetes. If diagnosed discuss diet/medication

Ketones indicates ketoacidosis to some degree

Treatment options

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Treatments you can plan

Stress incontinence

- Pelvic floor exercises
- Fluid modification
- Avoidance of constipation

Over active bladder/urge

- Fluid modification
- Bladder re-training
- Pelvic floor exercises

Overflow incontinence

- The patient usually needs catheterisation – if in retention of urine they will need to have the first catheter put in by a hospital doctor.

Advanced treatments

Stress incontinence

- Biofeedback
- Duloxetine
- Surgery

Over active bladder/urge

- Botox
- Peripheral or sacral neuromodulation

Overflow incontinence

- Catheterisation
- Surgery
- neuromodulation

Bowel Assessment

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Basic assessment tools:

- Bristol stool scale
- Bowel habit diaries
- Diet and fluid diaries

Examination:

- Digital rectal examination
- Abdominal examination
- Stool sampling

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

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Things to look out for:

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- Frequent visits to the toilet (day or night)
- Has to strain to open bowels
- Requires prescribed laxative regime
- Uses self evacuation techniques
- Is the stool excessively hard or soft (consult Bristol Stool Chart)?
- Pain when opening bowels
- Constant or intermittent soiling
- Blood when opening bowels
- Having to strain excessively to open bowels
- Feels like bladder or bowels are never fully emptied
- Complains of abdominal discomfort or pain
- Not getting to the toilet in time (finds it difficult to hold on)
- Having to strain or push on the tummy to start passing urine

What could go wrong?

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Constipation:

- Diet/fluid intake induced
- Medication induced
- Anatomical disorder (e.g. rectocele)
- Neurological disorder

Faecal incontinence is the involuntary loss of solid or liquid stool. Other bowel problems can include constipation and diarrhoea.

- Sphincter incompetency
- Neurological disorder
- Overflow incontinence (chronic constipation)
- Loose stools
- Pelvic floor dysfunction

Treatment options

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- Laxatives
- Antipropulsives
- Diet and fluid modification
- Correct position for bowel opening
- Bowel re-training
- Rectal plugs
- Containment devices
- Sphincter exercises
- Pelvic floor exercises
- Surgery

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Managing incontinence

- Washable padded underwear (for light incontinence)
- Washable bed pads (for occasional night time incontinence)
- Penile sheaths
- Urine collection systems
- Disposable pads
- Faecal collection devices

Advice and training on selection and fitting of sheaths and devices can be obtained from the Bladder and Bowel Service

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Choosing the right pad

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- Most patients will be well managed with a disposable pad and fixation pant system.
- Every resident using pads will have their own allocated prescription of pads and these should not be shared with other residents.
- Pads are chosen by looking at how much someone drinks in 24 hours and how often they are incontinent.
- The product order forms used to request pads show how much a single pad can hold e.g. Tena Comfort Normal will hold 450mls so for a patient drinking up to 1800mls per day, 4 of these pads in 24 hours will be adequate if they are frequently incontinent.
- East Lancashire Bladder and Bowel Service has a core range of products (shaped pads of 3 absorbencies and fixation pants). Requests for any products outside this range will need to be sent with a Supporting Evidence Form.
- A maximum of 4 products in 24 hours is supplied unless the patient has exceptional needs.

Fitting a pad correctly

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- Pads should be folded length ways to create a curved shape
- Fixation pants should always be used to hold the pad in place
- Currently Tena products are supplied in East Lancashire and their website offers fitting guides:

http://www.tena.co.uk/professionals/products/product-fitting-guides/

- To ensure that pads work effectively talcum powder and oil based barrier creams/lotions should be avoided
- If a resident needs extra skin protection Medihoney is the current recommended product (available on prescription)

Risks associated with incontinence – incontinence dermatitis and moisture lesions

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- Urinary incontinence delivers urea and ammonia to the skin increasing the skin's pH and introducing microbes
- Faecal incontinence adds faecal enzymes to the skin also increasing the pH and introducing microbes
- Frequent cleansing can then add chemical irritation and physical irritation to the skin
- The permeability of the skin increases and its barrier function decreases
- Bacterial overgrowth occurs and skin infection can develop
- Incontinence associated dermatitis arises

Risk awareness
Moisture lesions

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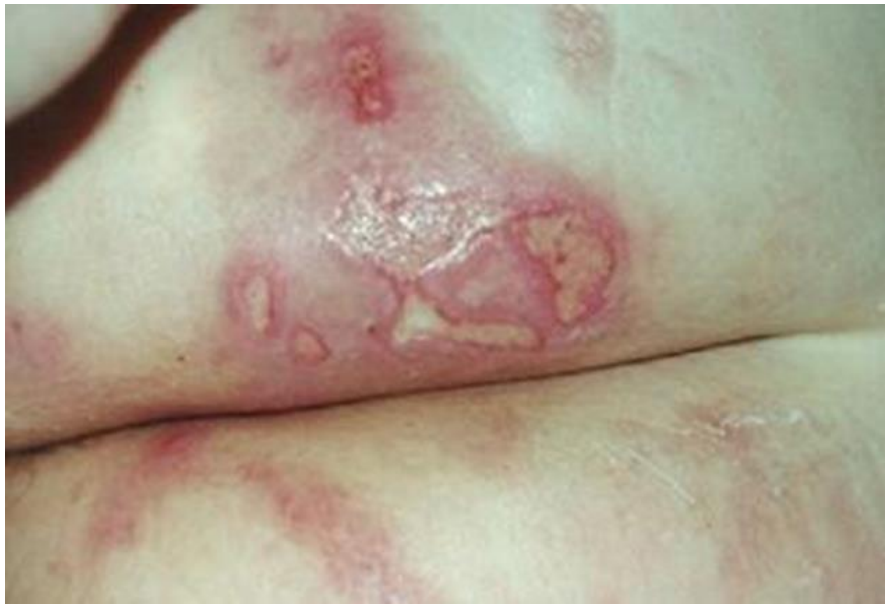
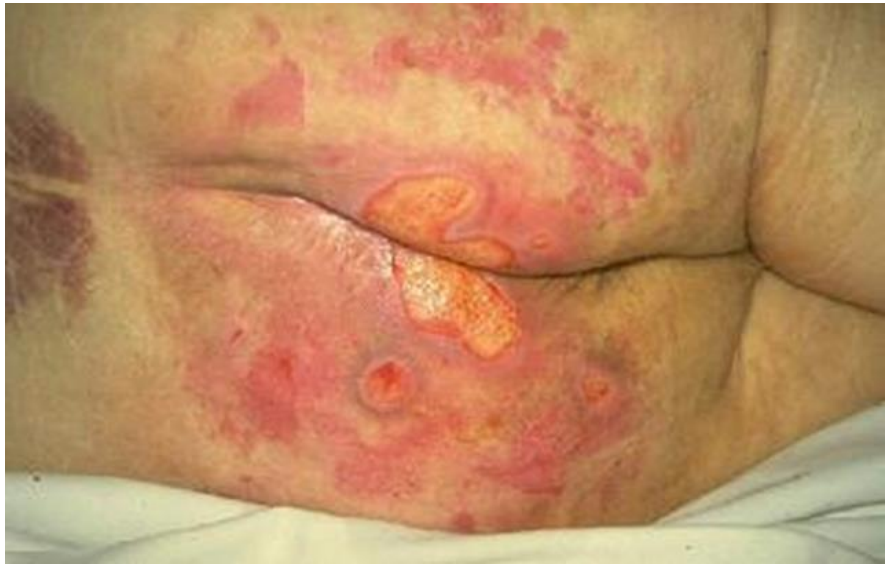
- Incontinence associated dermatitis can lead to moisture lesions and this can also increase the risk of pressure ulcer formation.



- It is estimated that incontinence associated dermatitis affects as many as 41% of adults in long-term care (Nix and Haugen, 2010).



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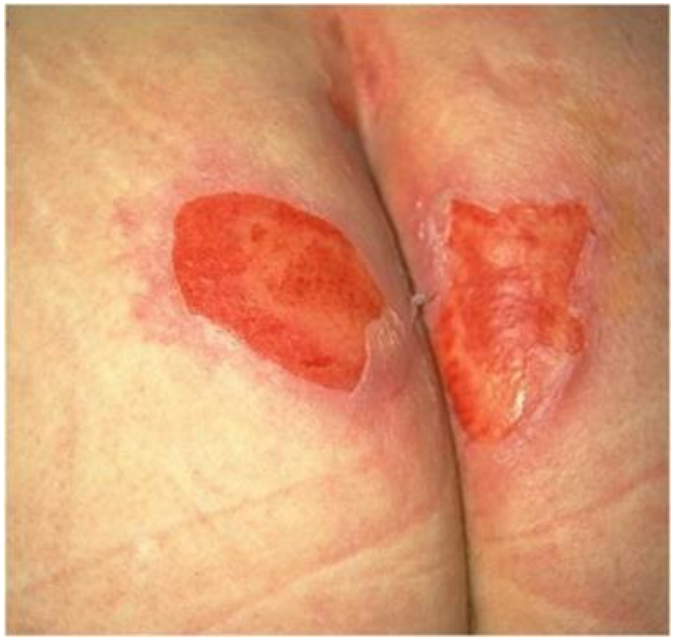
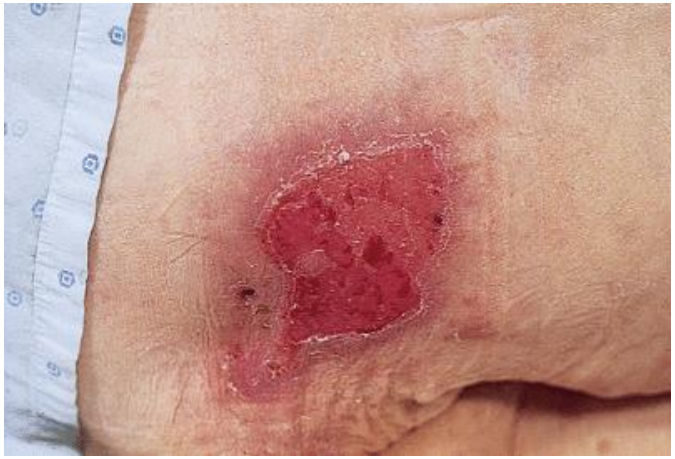
Moisture Lesion



Pressure Ulcer



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- Moisture lesions primarily occur secondary to incontinence associated dermatitis, maceration and excoriation of the skin
- Good skin care and incontinence management can prevent this painful problem
- Better recognition of moisture lesions as opposed to pressure ulcers enables correct treatment
- Advice from local tissue viability teams is available

Key Risk Factors

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- Intensity and duration of exposure to urine/faeces/sweat
- Extremes of age (i.e. neonates/elderly)
- Immobility
- Obesity
- Diabetes
- Treatment with systemic antibiotics or corticosteroids

Skin Management – healthy skin

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- Gently cleanse, dry and, if necessary, moisturise skin with a pH neutral soap or emollient
- Wash off soap thoroughly
- Dry the skin gently using a towel ensuring it is thoroughly dry
- Address the cause of incontinence
- Use containment devices or pads if indicated
- Cleanse skin after every episode of incontinence

Managing incontinence dermatitis or a moisture lesion

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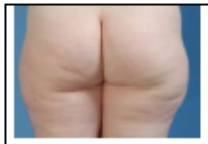
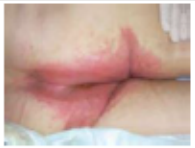
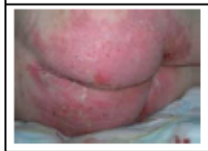
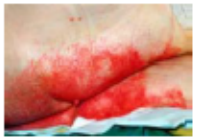
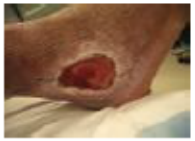
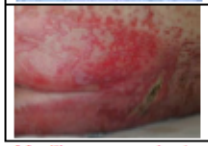
- Gently cleanse, skin with a pH neutral soap or emollient and dry thoroughly
- If the skin is extensively damaged use Proshield Cleanser until the skin has recovered
- Use Medihoney as a barrier
- Only use Proshield as a short treatment option if Medihoney is unsuccessful
- Address the cause of incontinence
- Use containment devices or pads if indicated
- Cleanse skin and apply a barrier cream after every episode of incontinence
- Review care regularly

Management of Moisture Lesions and Incontinence Associated Dermatitis (IAD)

Please manage the reason for any incontinence & ensure appropriate advice obtained / referrals made / products used. See continence & Catheter Care Formulary

	**Healthy skin** Maintain integrity Keep skin clean and dry	Un-perfumed soap and water to cleanse ensuring soap residue is rinsed off. Dry skin should be moisturised to reduce risk of breakdown.
	**Mild excoriation IAD** No broken areas. Erythema(Redness) only	Consider aqueous cream to cleanse (this must be rinsed off) *Use durable barrier cream:-* Medihoney Cream
	**Moderate excoriation IAD** Erythema with less than 50% broken skin	Use aqueous cream to cleanse (this must be rinsed off) *Use barrier cream* Medihoney Cream
	**Severe excoriation IAD** More than 50% broken skin Oozing and / or bleeding	Use aqueous cream to cleanse (this must be rinsed off) *Use barrier cream* Medihoney Cream
	**Peri-wound maceration / excoriation.**	Consider more absorbent dressing or changing dressings more frequently *Use barrier film / spray:-* Sorbaderm Non-sting barrier film
	**Sweat rash in skin folds**	Use aqueous cream to cleanse *Use barrier cream* Medihoney Cream
	**Any skin level of skin damage caused by uncontrolled diarrhoea including erythema**	*Use barrier cream* Medihoney Cream

Medihoney products are first line for all but peri-wound skin breakdown.

If problem persists consider Proshield products following discussion with Tissue Viability / Bladder and Bowel Specialist.

Medihoney Derma Sciences	NHS Codes	2g Cream ELY374 £6.00 box 20	50g Cream ELY 289 £4.80 each	
Sorbaderm Aspen Medical	NHS codes	1ml Applicator ELY327 £4.45 box of 5	28ml Spray ELY328 £5.99 each	
Proshield H&R Healthcare	NHS codes	235ml Foam Spray Cleanser ELZ536 £6.54 each	115g Cream ELZ537 £9.84 each	This is a 2 part system and both items should be used

Designed by Liz White Tissue Viability in collaboration with Polly Harris Manager Continence Services 2016 . For review 2018

Table 1: **Skin Conditions in the Proximity of the Perineal/Perianal Region**

	IAD	Candidiasis	Herpes simplex	Pressure ulcers
Location	Perineum Buttocks Inner thighs Groin Low abdominal Skin folds	Perineum Buttocks Inner thighs Groin Low abdominal Skin folds	Perianal Buttocks Genital	Near bony tissues Prominences Coccyx, sacrum Ischium Under device/tube
Confirmed risk factors	Urinary and/or faecal incontinence	Moisture Antibiotics Immunosuppression	Immunosuppression	Impaired mobility Dependent on others for positioning and/or transfers
Blisters	Yes	No	Initially	Sometimes
Distribution pattern	Confluent or patchy irregular edges with erythema, shallow denudement, and/or maceration	Confluent or patchy rash Small round pustules, plaques and/or satellite lesions	Clusters or isolated individual shallow lesions or blisters	Isolated individual lesions on or near a bony prominence or pressure-causing device Damage ranges from intact discolouration to partial or full thickness wounds
Colour	Pink/red (in African-Americans and others with darker skin tones, inflammation is not necessarily red, but is a different colour than the surrounding tissue).	Pink/red	Initial: pink/red Later: crust	Pink, red, yellow, tan, grey, brown, black
Discomfort	Pain may be mild to severe	Itching and burning	Initial tingling can become very painful	Pain may be absent to severe

Adapted from: Bryant, R. Nix, D. Co-editors: *Acute and Chronic Wounds: Current Management Concepts.* 4th ed. St. Louis, MO: Mosby Elsevier; 2011

What else can help?

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- Telfa Clear can be prescribed and used to prevent two layers of skin rubbing against each other
- Air drying skin
- Altering micro-climate factors (e.g. the local temperature and moisture conditions of the skin

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With the right care, incontinence can be well managed so that residents are comfortable and their dignity and independence is maintained.

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Bladder and bowel incontinence

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- Write down another six words that you associate with incontinence
- How do those words make you feel?
- Are they positive or negative?
- Have your thoughts changed during this training?

Resources – key clinical guidance

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NICE Guidance (2012) CG 148 Urinary Incontinence in Neurological Disease

NICE Quality Standard (2013) QS45 Lower urinary tract symptoms in men

NICE Quality Standard (2014) QS54 Faecal Incontinence

NICE Quality Standard (2015) QS77 Urinary incontinence in women

https://www.nice.org.uk/guidance/qs90

https://cks.nice.org.uk/urinary-tract-infection-lower-women and men
https://cks.nice.org.uk/urinary-tract-infection-lower-men

This page shows what NICE has added since 2015 and what is in development:

https://www.nice.org.uk/guidance/conditions-and-diseases/urological-conditions/urinary-tract-infection

Who cares? Uncovering the incontinence taboo in social care
http://www.aca.uk.com/files/3414/3282/7812/Expert_Group__Who_Cares__Uncovering_the_incontinence_taboo_in_social_care.pdf

Royal College of Nursing CONTINENCE CARE IN CARE HOMES: A framework to gather and share key
informationhttps://www2.rcn.org.uk/__data/assets/pdf_file/0011/78743/003139.pdf

All Parliamentary Group for Continence Care Report (2011)
http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf