43.1 GENERAL PRINCIPLES

- Urinary continence can be defined as “the ability to store urine in the bladder and to excrete voluntarily where and when it is socially acceptable.”¹
- Urinary incontinence has a significant impact upon an individual’s dignity and self-esteem, thus a sensitive approach to assessment is required.²
- Urinary incontinence has a significant impact on the patient-carer relationship and is one of the main reasons for admission to residential care. Carers should be involved in assessment where appropriate.³,⁴
- Symptoms of urinary incontinence can be improved with basic nursing interventions in up to 70% of patients.³,⁴,⁵
- Constipation, urinary tract infections and urinary retention are the most common reversible causes of urinary incontinence. The symptoms of urinary incontinence may not be related to the palliative diagnosis and may be longstanding.²
- Social stigma, embarrassment and lack of knowledge of health care professionals can all be barriers to recognising and treating urinary incontinence.³,⁵
- Urethral catheters can be a useful containment measure but both the risks and benefits need to be considered when they are used (see Table 43.1).⁶

<table>
<thead>
<tr>
<th>Table 43.1. Considerations when using a urinary catheter.⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blockage / bypass</td>
</tr>
<tr>
<td>Dignity</td>
</tr>
<tr>
<td>Bladder spasms</td>
</tr>
<tr>
<td>Impact on independence</td>
</tr>
<tr>
<td>Confidence</td>
</tr>
<tr>
<td>Source of infection</td>
</tr>
</tbody>
</table>

43.2 GUIDELINES

43.2.1 Assessment

- All patients should be asked about the presence of urinary symptoms on initial assessment and any findings should be documented.³,⁷ [Level 3]
- Assessment of urinary incontinence should focus on identifying reversible causes such as constipation, infection and urinary retention. See Figure 43.1 for further details.³,⁸,⁹ [Level 3]
- Medications which may be contributing to incontinence should be reviewed.³ [Level 4]
- The verbal history from the patient can be confirmed by use of a bladder frequency chart completed for a minimum of 3 days (see Table 43.2).⁸ [Level 4]
- If the patient is too unwell or declines a further continence assessment this should be documented in the notes.³,⁷ [Level 4]
### Table 43.2. Continence history

<table>
<thead>
<tr>
<th>Duration</th>
<th>Changes in severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysuria</td>
<td>Haematuria</td>
</tr>
<tr>
<td>Frequency</td>
<td>Hesitancy</td>
</tr>
<tr>
<td>Leaking</td>
<td>Nocturia / nocturnal enuresis</td>
</tr>
<tr>
<td>Poor stream</td>
<td>Straining</td>
</tr>
<tr>
<td>Urgency</td>
<td></td>
</tr>
</tbody>
</table>

#### 43.2.2 Management

- When discussing the management of urinary incontinence with the patient and their carer, realistic goals should be set and included in their care plan. ¹⁰ [Level 1-]
- Reversible causes should be treated e.g. constipation, urinary tract infection, urinary retention. ³, ⁸, ⁹ [Level 3]
- Where there is impaired mobility, manual dexterity or cognition consider referral to a physiotherapist and occupational therapist. ³ [Level 4]
- For patients with a good performance status, consider referral to specialist continence services following initial assessment and management. They may provide pelvic floor exercise training and advice on referral for urodynamics. ³ [Level 4]
- Where there is no evidence of infection, constipation or urinary retention, or where there is intractable incontinence, containment products should be used. These include pads, male and female urinals, bed-pans, convenes and catheters. Referral to the district nursing team or community continence assessment team may be required to ensure a supply of containment measures. ³ [Level 4]
- The use of catheters should be documented in the case notes, and the care plan communicated when the patient is admitted, transferred or discharged. Table 43.3 lists the documentation required. ³, ¹¹ [Level 4]

### Table 43.3. Documentation required at catheterisation ³, ¹¹ [Level 4]

| Date, time, location and name of professional performing procedure |
| Reason for catheterisation |
| Consent |
| Type and size of catheter |
| Residual volume |
| Date for reassessment |
| Date for renewal |
Figure 43.1 The assessment of urinary incontinence. [Level 4]

Patient reports symptoms of urinary incontinence.

Bowel assessment including PR examination to assess faecal loading.

Patient is constipated

Yes

Treat constipation

No

Urinalysis

Send MSSU for C&S. Commence antibiotics (as per guidelines)

Dipstick +ve for leucocytes +/- nitrites

Yes

Assess residual volume with bladder scan or in-out catheterisation.

>200ml

Review for causes of urinary retention. e.g. faecal impaction, UTI, drugs, spinal cord compression, urethral obstruction. Treat where appropriate

<200ml

Continence history and bladder chart.
43.3 STANDARDS

1. A basic knowledge of continence is required to perform a continence assessment. All units should have a continence link nurse who will attend continence study days and cascade training to the team. 3,4 [Grade D]

2. All patients should be asked about the presence of symptoms of urinary incontinence at initial assessment. This should be documented in the case notes. 3,4,7,9 [Grade D]

3. All patients with urinary incontinence should be assessed for constipation and urinary tract infection excluded. 3,11 [Grade D]

4. All patients with urinary incontinence should be offered a basic continence assessment. This should be documented in the case notes. 3,7,12 [Grade D]

5. The use of catheters should be documented in the case notes, and the care plan communicated when the patient is admitted, transferred or discharged (see Table 43.3). 3,11,12 [Grade D]

43.4 REFERENCES


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