

The Continence Advisor

Continence Assessment

Issue 1 2010

Continence Assessment An Overview

When conducted in a holistic and thorough manner, continence assessment can enable diagnosis of incontinence symptoms and the development of a highly individualised management plan to reduce the symptoms and severity of incontinence and improve a client's quality of life.

The following outline takes into consideration the factors necessary for the provision of a continence assessment that addresses both clinical and client needs.

Assessment

From a diagnostic perspective, a continence assessment will include the gathering of a detailed history, relevant physical examinations and investigations.

Diagnostic tools such as a bladder diary, models of care, frameworks (DIAPPERS) and TENA Assess will help structure the assessment and obtain information necessary for a diagnosis.

Continence Assessment can be broadly divided into subjective and objective components. The subjective component of an assessment involves obtaining information about the client's bladder and bowel symptoms, onset of incontinence, medical and obstetrics history, living environment, mobility, access to toilet facilities and the effect incontinence has on their quality of life. A medication review is necessary at this stage, especially when assessing the elderly, as a number of prescribed medications cause or aggravate incontinence¹.

The reluctance to discuss incontinence is a major barrier to the diagnosis and treatment of symptoms² so it is important to establish a rapport with the client at the beginning of this stage to

obtain as much information as possible. Employing a caring, non judgemental approach that takes into consideration the patient's age, culture, gender and background will help decrease their feelings of shame and embarrassment and encourage communication.

The BATHE (background, affect, trouble, handle, empathy) technique has been recommended as a useful tool to quickly establish rapport with the client³. "It enables the clinician to find out what part of the problem concerns the individual, what the individual was hoping the clinician would do and why the individual is coming for help"⁴. The BATHE technique "contains many elements of successful

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psychotherapy including establishment of therapeutic alliance, empathy, identification of the central conflict, development of insight and awareness and discouragement of dependency⁴⁵.

A combination of questioning methods should be employed during the subjective phase of the assessment; some people respond better to direct questions, while others are more comfortable with indirect questioning.

When clients don't respond well to direct questioning or it is not appropriate, indirect questions may be useful. Some examples that will help indicate the type of incontinence being experienced include:

Do you have trouble holding on to urine before reaching the toilet?

*Do you sometimes find your underwear gets wet when you cough, laugh or sneeze?*⁶

When discussing incontinence, it is important to use words that are appropriate to the client's educational level and culture. Where English is a second language, clients may use simple and generic words to describe symptoms and an interpreter may be required in some cases⁷.

To encourage the exchange of information necessary for a successful assessment, it is beneficial to learn about and respect cultural differences and attitudes towards what is still considered a socially taboo subject. For instance, those who assess Indigenous Australians will need to understand that incontinence is a shame issue that is not discussed amongst family or friends. It is also necessary for a practitioner of the same sex as the patient to conduct the assessment because incontinence is seen as either men's or women's business and not discussed with members of the opposite sex⁸.

The objective component of the assessment involves the completion of a bladder/bowel diary, urine analysis, assessment of psychological and cognitive status and relevant physical examinations of which a practitioner

should always obtain consent for prior to the assessment⁹. These include abdominal palpitation, examination of perineal and perianal areas, digital rectal examinations and skin integrity. The rapport the practitioner has built with the client during the subjective phase will be of great benefit during these examinations.

Management Plan

Employing a client centred approach throughout every aspect of the assessment process will bring about a thorough and well considered management plan that takes into account patient goals, values and needs. An assessment that encourages informed decision making will encourage greater cooperation and acceptance of interventions^{10, 11}.

Conservative interventions are always recommended before more complex or invasive measures (such as cystometry, ambulatory urodynamics, video urodynamics) and many patients can achieve some relief or eradication of symptoms based on first line conservative measures.

The multifactorial nature of incontinence will most likely mean the management plan combines a multidisciplinary approach that employs behavioural, medical, psychological and environmental measures.

Review

It is necessary to regularly review the outcomes of the management plan. If symptoms have been successfully managed with the client achieving independent continence or dependent continence (continent with assistance, behavioural treatments, drug therapy¹²) the client can exit the assessment process. If some symptoms still persist, the assessment process may continue until a diagnosis occurs or the client withdraws¹³. Try as health professionals might, at times (especially in the elderly) it is not always possible to diagnose a clear reason for incontinence. After a number of attempts it may be decided that achieving contained continence (controlling incontinence with the use of absorbent aids and appliances) is the best option for the client¹⁴. ◊

Welcome to the May 2010 edition of The Contenance Advisor

This month's edition focuses on the topic of Contenance Assessment, a tool vital to understanding the underlying causes of incontinence and the development of a holistic management plan to improve quality of life. Contenance Assessment encompasses a wide range of diagnostic measures and requires the careful consideration of many factors. These are discussed at length in this issue along with practical and helpful advice on communicating with clients during assessment, kindly provided by Contenance Assessment Manager at The Caulfield Hospital, Janie Thompson. Janie also shares an assessment success story that demonstrates the importance of advising on lifestyle as well as interventions.

If you'd like to make continence assessment easier, read about TENA Assess, the contemporary diagnosis package that fits all requirements for a comprehensive assessment including care planning, evaluation and funding claims support.

I'd like to take this opportunity to both introduce and congratulate Chris Towers, a long standing and valued TENA team member who has recently become a Contenance Nurse Advisor. What Chris most enjoys about being a CNA is the ability to improve quality of life for those who experience incontinence. Chris' clinical and practical expertise will provide a valuable resource to the TENA team and our customers.

We want to hear from you!

Can you provide a case study of up to 500 words on any topic related to continence? We all love case studies that demonstrate a care initiative or help solve a difficult care issue. Please send all case studies and feedback to Anita.Wright@sca.com

Thank you for your continued subscription to The Contenance Advisor. I remind you to continue providing us with your valuable feedback. We hope you enjoy this issue.

Anita Wright
Head of Marketing: TENA Healthcare

Information contained in this outline has been guided by and referenced from 'First Steps in the Management of Urinary Incontinence in Community-Dwelling Older People - A clinical practice guideline for primary level clinicians (Registered Nurses and Allied Health Professionals) Revised Version 2010 <http://www.health.qld.gov.au/mass/resourcescont.asp> and Service Guidelines for Victorian Continence Clinic Services - National Ageing Research Institute 2004 Victorian Health Website http://www.health.vic.gov.au/subacute/om_service.

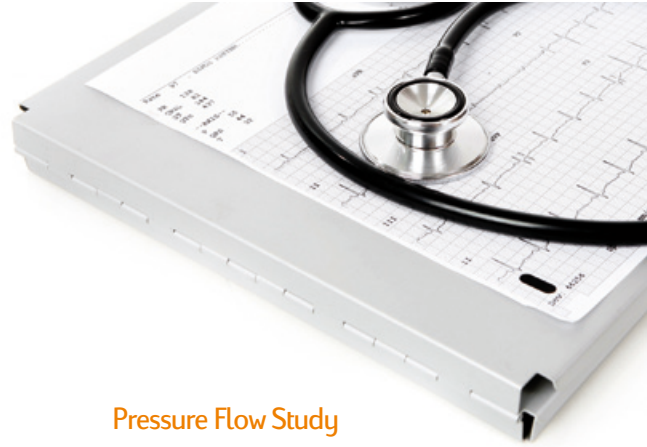
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Urodynamic Investigations



From simple observation to precise measurement, urodynamic studies provide an objective and definitive assessment of lower urinary tract function¹, allowing for diagnosis and appropriate, specific treatments to be implemented.

Urodynamic testing is recommended when an initial assessment has not identified the cause of incontinence, when a conservative management plan has been unsuccessful or when episodes of incontinence that are not otherwise explained persist. It is also recommended for patients being considered for corrective surgery, for those who have previously undergone other lower urinary tract surgery, prostatectomy or pelvic surgery and for those who have neurological disorders.

The International Continence Society states that a good urodynamic investigation "should be performed interactively with the patient," and establish that the patient's symptoms have been reproduced during the test, which will help to identify a cause².

Additionally, the potential limitations of urodynamic studies should be acknowledged by physicians and "results should not be read in isolation but integrated into the overall clinical picture"³.

Urodynamic testing is made up of multiple components. Together these components help provide a complete picture that enables diagnosis and the development of a suitable, tailored treatment for the patient⁴.

Uroflowmetry

This non invasive, first line screening test records the amount and flow rate of urine in millilitres per second and will provide an assessment of voiding dysfunction⁵. It will help indicate bladder outlet obstruction and weak/underactive detrusor muscle, however, "the main strength of uroflowmetry is in helping to identify patients who need further urodynamic studies to diagnose an underlying problem"⁶.

Post Void Residual

Using an ultrasound or a catheter, the volume of urine left in the bladder following the uroflowmetry will be measured. A residual of under 25ml is considered normal, while a residual over 100ml will warrant further investigation as this has been associated with UTIs.

Cystometry

Cystometry measures bladder capacity, the pressure the bladder can endure and at what volume the patient feels the urge to void which helps determine detrusor overactivity, stress incontinence and overflow incontinence.

Simple cystometry, or Bedside Cystometrogram, involves filling the bladder with sterile water or saline solution to measure maximum bladder capacity and unstable bladder contractions.

A multichannel cystometrogram simultaneously measures the intra abdominal, bladder and detrusor pressures, allowing the practitioner to differentiate between involuntary detrusor contractions and increased intra abdominal pressure⁷. The test is conducted by placing a catheter into the bladder and a balloon catheter in the rectum or vagina⁸.

The filling cystometrogram assesses bladder capacity, compliance and contractions⁹. As the bladder is filled using a catheter, patients are asked about bladder sensation and about their desire to void.

Leak Point Pressure

Leak point pressure is the term used in the measurement of leakage that may occur when the patient is asked to perform actions that place pressure on the bladder such as coughing, straining or the Valsalva manoeuvre¹⁰. Leak point pressure measurement is commonly performed during filling cystometry. Determining the leak point pressure will allow the practitioner to determine whether stress UI is due to urethral hypermobility, sphincter weakness or a combination of both¹¹.

Pressure Flow Study

Usually conducted at the end of a cystometrogram, the patient is instructed to void into an electronic flow meter¹² to measure the bladder pressure required to urinate and the flow rate the pressure generates. It is helpful to diagnose bladder outlet obstruction in men who experience prostate enlargement¹³ and other voiding dysfunctions.

Electromyography

This measurement of nerve impulses is useful to diagnose urologic problems in patients who have neurologic conditions. It will allow the physician to gain information regarding the coordination of the perineal muscles with the detrusor muscle by using electrodes placed near the rectum¹⁴.

Fluoroscopic Urodynamics

Fluoroscopic urodynamics or as it is sometimes known, "video urodynamics"¹⁵, combines all of the above investigations and adds fluoroscopic contrast introduced via the pressure flow catheter, thus allowing X-Ray imaging. This provides the clinician with a real time view of the urinary tract anatomy and the images can be recorded onto the computer for further analysis by the clinician. Fluoroscopic urodynamics exposes the client to X-Ray imaging and takes more time to attend than multi channel urodynamics. Therefore its use is screened for clients with a complex urinary history, failed primary or secondary care treatment and often clients with a neurological history or complex and multiple co morbidities. ◊

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Assessing Incontinence in the Elderly

It is estimated that up to 40% of people over 75 years of age are affected by incontinence¹, yet many suffer in silence due to embarrassment, shame and the erroneous belief that incontinence is an unfortunate consequence of ageing.

Incontinence in the elderly is a major contributor to falls, decreased skin integrity, depression, anxiety and social isolation. Due to the significant care burden incontinence places on care givers, it is also one of the major factors responsible for admission to residential aged care homes.

To improve patient and care giver's quality of life, a thorough and holistic assessment that explores the multifactorial nature of UI in the elderly is required².

The assessment should first aim to identify and treat the reversible (transient) causes of incontinence. Transient incontinence is often a symptom of health conditions common amongst the elderly, their prescribed medications and other reversible factors such as UTIs and mobility issues. Identifying these causes first will prevent transient incontinence from becoming chronic and may avert unnecessary institutionalisation. It may also delineate the need to embark on complex and invasive assessment and management options³.

Obtaining a detailed medical history is the first step in a thorough assessment and will highlight potential causes of the transient incontinence. Sometimes it is not possible to obtain the necessary information from an elderly person (due to cognitive or other impairment), so a care giver or family member will need to be present at the assessment. The social stigma that surrounds incontinence may also prevent the provision of a detailed account. According to a report prepared for the Australian Government of Health and Ageing in 2002 titled *Incidence of Incontinence as a factor in Admission to Aged Care Homes*, "55% of respondents estimated that between 0% and 25% of their clients with continence problems had never sought or received a detailed continence assessment".

Reasons for this cited by health professionals included "issues of embarrassment, reluctance to disclose the problem and inadequate identification and assessment". The elderly could also be reluctant to discuss their incontinence as they may believe there is no cure⁴.

Reassuring your patient (or their care giver) that incontinence is a common condition that can be significantly improved or cured will lessen their anxiety. And being empathetic to the impact that incontinence has on their life will make it easier for them to discuss their situation.

When compiling a detailed history, it is necessary to ask about the following:

- urinary symptoms, frequency, severity
- medical history
- intake of fluids
- current management techniques (including incontinence aids)
- mobility
- proximity of toilet
- degree of bother and QOL
- medication review
- previous UTIs
- stones
- bladder tumors
- bladder outlet obstruction
- surgery and bowel habits

Two very helpful tools to identify pre-existing and potentially reversible causes of incontinence during an assessment on an elderly patient are a bladder diary and the mnemonic DIAPPERS. A bladder diary will help establish incontinence patterns while DIAPPERS provides a useful framework for the assessment of transient incontinence⁵.

Bladder Diary

NICE recommends that a bladder diary is kept for a minimum of three days⁶. Seven days is recommended for a detailed overview, however, one day may be more realistic in a care setting⁷.

A bladder diary will allow for:

- the observation and tracking of the number of voids during the day and night
- the number of incontinent episodes and degree of wetness the patient experiences

Fluid intake (type and volume)

When nursing staff complete the diary, a column for the volume of voids is usually included allowing for calculation of the maximum, minimum and average void⁸. The comment field will allow the patient, carer or nurse to comment on the reason for the incontinence.

When completed properly, the bladder diary captures real time objective data which is often a more reliable and accurate guide than the patient's or carer's memory⁹. If a patient or their carer is completing this ensure they are educated on its use and importance to the assessment. It is advised that the diary is kept near the bed or toilet for easy and accurate recording¹⁰.





DIAPPERS stands for¹¹:

Delirium

Acute illness can dull awareness of the urge sensation. The patient may not be able to perform toileting or communicate that they need assistance¹².

Infection

Urinary tract infections can cause urgency, frequency, dysuria and nocturia¹³.

Atrophic vaginitis

The reduced oestrogen production in elderly women can cause the periurethral tissue to become thin and dry¹⁴ which may cause urgency, frequency and dysuria¹⁵.

Psychological causes

The relationship between UI and depression is a bi-directional one¹⁶. While UI can cause or compound existing depression, there has been evidence that it can cause urgency due to altered neurotransmitter function¹⁷.

Pharmaceuticals

Many cause and/or aggravate incontinence. Diuretics contribute to urgency, alpha adrenergic blockers and ACE inhibitors contribute to stress and anticholinergic agents, verapamil and pseudoephedrine contribute to functional incontinence¹⁸.

Endocrine causes

Large volumes of urine caused by diabetes or congestive heart failure can cause frequency and urge.

Restricted mobility

Environmental barriers to toileting include proximity to toilet, restraints, the use of walking aids and difficult to remove clothing.

Stool impaction/constipation

Increased pressure on the aged bladder from faecal impaction can compress the urethra, resulting in a distended bladder causing frequency and urgency^{19, 20}.

During this assessment stage, examinations of the abdomen should occur to check for enlarged bladder or pelvic masses, the vagina for atrophic changes and the rectum for faecal impaction²¹.

If the bladder is distended, a postvoid residual urine volume test should be conducted to test for incomplete bladder emptying²². Should a UTI be suspected, a urine specimen will need to be obtained and tested for signs of bacteriuria.

Management

The dominant symptom and type of UI the patient is experiencing will guide the choice of treatment. This must however take into account overall health, functional status and any illness the patient is experiencing²³. Based on the findings of the assessment, first line conservative measures to correct transient incontinence in the elderly may involve the adjustment of environmental barriers, topical oestrogen for vaginal atrophy, dietary modifications, reducing constipation and ensuring adequate fluid and correct types of fluids such as low or non caffeinated beverages²⁴.

Where possible, these interventions must be discussed with the patient to gauge both their willingness and ability to participate in the plan²⁵. The patient will be more willing to follow these recommendations if their goals and lifestyle have been considered.

Once transient causes of incontinence have been attended to, many patients may find an eradication or reduction in their urinary symptoms. If the conservative management plan has been unsuccessful and episodes of incontinence that are not otherwise explained persist (even after a review, reassessment and consideration of further interventions), a more detailed evaluation may be required using cystourethroscopy²⁶. Of these investigations "urodynamics provides the most definitive assessment of lower urinary tract function and is generally well tolerated by the elderly"²⁷. Immediate specialist referral should occur when urinary incontinence is associated with pain, haematuria, prolapse and post prostatectomy issues.

For those who experience chronic incontinence, quality of life can be improved through achieving dependent continence using drug and/or behavioural strategies (bladder retraining, medications) or where necessary, contained continence using absorbent continence aids²⁸.

Due to age related bladder changes, increased ill health and risk factors, incontinence is more common and severe in the elderly. It is not however a normal or inevitable part of the ageing process²⁹. All patients presenting with incontinence should be offered an assessment that first explores all reversible factors. And while the multifactorial nature of UI in the elderly can make diagnosis difficult³⁰, a thorough assessment can ensure that symptoms are eradicated or at the least, lessened and more manageable and thus a better quality of life for the patient. ◊

1 Australian Government Department of Health & Ageing National Continence Management Strategy Phase Three Action : 2006 – 2010 Australian Government Department of Health & Ageing website <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-continence-phasesthreea.htm> Accessed 11/02/10 2 Wilkison K, A Guide to Assessing bladder function and urinary incontinence in older people Nursing Times. nursingtimes.net accessed 11/01/10 3 Dowling – Castronovo A, Specht JK, Assessment of Transient Urinary Incontinence in Older Adults American Journal of Nursing, February 2009 Vol 109 No 2 p 63 4 Griebeling TL, Urinary Incontinence in the Elderly, Clinics in Geriatric Medicine 25, 2009 445 – 457 5 Boltz, M., Urinary Incontinence Assessment in Older Adults Part 1 – Transient Urinary Incontinence, Try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, College of Nursing, New York University, 6 NICE (June 2006) Urinary incontinence: the management of urinary incontinence in women—information for the public. NHS: London. Ref: CG040. NHS Website <http://www.nice.org.uk/page.aspx?o=CG40> Accessed 04/02/2010 7 Dowling – Castronovo A, Specht JK, Assessment of Transient Urinary Incontinence in Older Adults, American Journal of Nursing, February 2009, Vol 109 No 2 p 64 8 Wilkison K, A Guide to Assessing bladder function and urinary incontinence in older people, Nursing Times Website <http://www.nursingtimes.net>. Created 9/10/09, accessed 11/01/10. 9 Ibid 10 Dowling – Castronovo A, Specht JK, Assessment of Transient Urinary Incontinence in Older Adults, American Journal of Nursing, February 2009, Vol 109 No 2 p 70 11 Yap, P, Tan, D, Urinary Incontinence in Dementia, A practical Approach Australian Family Physician Vol 35, No 4 April, 2006 p240. 12 Newman D, Urinary Incontinence, catheters and urinary tract infections: An overview of the CMS Tag F315, Ostomy/Wound Management, Vol. 52 No 12, 2006 p 34-44 13 The Royal Australian College of General Practitioners, Medical Care of older persons in residential aged care facilities (4th edition), Guidelines, RACGP website – www.racgp.org.au/silverbook accessed 18/02/10 14 Ibid 15 Whishaw, Dr DM, How to treat Urinary Incontinence in the frail elderly Australian Doctor, 25th July 2008 p 29 16 Melville, J, et al; Incontinence Severity and Major Depression in Incontinent Women American College of Obstetricians and Gynaecologists 106:3, September 2003 p 589 17 Nygaard, L., et al; Urinary Incontinence and Depression in Middle Aged United States Women, Obstetrics and Gynecology, 101:1, Jan 2003 p 153 18 The Royal Australian College of General Practitioners, Medical Care of older persons in residential aged care facilities (4th edition), Guidelines, RACGP website – www.racgp.org.au/silverbook accessed 18/02/10 19 Dowling – Castronovo A., Specht JK, Assessment of Transient Urinary Incontinence in Older Adults, American Journal of Nursing, Vol 109 No 2 February 2009 p 65 20 Newman D, Urinary Incontinence, catheters and urinary tract infections: An overview of the CMS Tag F315, Ostomy/Wound Management, Vol. 52, No 12, 2006 p 34-44 21 The Royal Australian College of General Practitioners, Medical Care of older persons in residential aged care facilities (4th edition), Guidelines, RACGP website – www.racgp.org.au/silverbook accessed 18/02/10 22 Dowling – Castronovo A., Specht JK, Assessment of Transient Urinary Incontinence in Older Adults, American Journal of Nursing, Vol 109 No 2 February 2009 p 65 23 Griebeling TL, Urinary Incontinence in the Elderly, Clinics in Geriatric Medicine 25, 2009, 445 – 457 24 Wilkison K, A Guide to Assessing bladder function and urinary incontinence in older people, Nursing Times Website <http://www.nursingtimes.net>. Created 9/10/09, accessed 11/01/10. 25 Ibid 26 Whishaw, Dr DM, How to treat Urinary Incontinence in the frail elderly Australian Doctor, 25th July 2008 p 33 27 Ibid 28 Fonda, D et al., Managing Incontinence in frail older patients. In: Abrams, p, et al, editors. Incontinence - 3rd International Edition; Consultation on Incontinence. Health Publication Ltd, 2005. And Whishaw, Dr DM, How to treat Urinary Incontinence in the frail elderly Australian Doctor, 25th July 2008 p 33 29 Wilkison K, A Guide to Assessing bladder function and urinary incontinence in older people Nursing Times. nursingtimes.net accessed 11/01/10 30 Whishaw, Dr DM., How to treat Urinary Incontinence in the frail elderly Australian Doctor, 25th July 2008 p 30

Helpful Advice on Continence Assessment

Helpful Advice on Continence Assessment with Janie Thompson, Continence Service Manager at the Caulfield Continence Service, Melbourne, Australia.

How you communicate with your clients will have a bearing on the success of your continence assessment. Janie Thompson, service manager of the Caulfield Continence Service, shares with The Continence Advisor what she believes makes a good continence assessment and provides some valuable advice to help you get the information you need.

Janie Thompson believes a good continence assessment is one that is very thorough and client centered. She stresses the need to understand exactly why your client is there and recommends asking them at the start of the assessment what their goals are. This question opens up the lines of communication, promotes shared responsibility and sets a respectful, positive tone for the assessment. It allows the client to explain in their own words how incontinence is affecting their life which can be very helpful when gathering a detailed history. It also helps you tailor resulting interventions to suit the client's lifestyle.

Janie states that it is necessary to regularly reflect on the client's goals to make sure that you are heading in the right direction, that what you're trying to do for them is what they want to achieve. "Be careful not to impose what you think on your client," says Janie. "Obviously make them aware of the choices and options. But involve them in the decision making process."

Janie adds that sometimes Continence Nurses can get caught up in what they want their clients to achieve, and often worry that clients are not doing what we want them to. "Maybe we're looking to move a mountain, they just want to climb a little hill. Go back and make sure you match them," she says.

When it comes to gathering historical information, Janie states that often very simple language needs to be used. "If

you are not receiving the information you require, try asking the question in different ways," she says. This helps the client understand what you are asking and determines if you are on the same wavelength.

Most people that visit the Caulfield Continence Service are willing to discuss their incontinence, having been referred. However there are those that don't, which present a great challenge. Janie deals with this by attempting to build a rapport from the very beginning and finds that getting to know the client as an individual first is very helpful when it later comes to asking specific and personal questions. Janie always uses visual cues to start a conversation, so she may comment on their outfit. She may also mention something she has read about in their file. And when assessing men, Janie will talk to them a little differently to women. "Men are more results driven, whereas women can be happy for the acknowledgement and support," she says. However, each individual case will be different; let the client be the guide rather than their gender.

When assessing the aged, Janie mentions that some women may not have a full understanding of their anatomy. This means that you need to communicate very clearly about the anatomy concerned and explain how it works in order for the outcomes of the assessment to be a success.

Another challenge that Janie is experiencing on a more regular basis is the assessment of clients with mental health issues. Janie recommends giving these patients plenty of time to express themselves and discuss what is bothering them. She states that it is necessary to always be very clear on what each part of the assessment involves and why, to encourage client cooperation. The patient's care givers and case managers are a valuable source of information when required.



Finally, Janie believes that an interdisciplinary approach to continence assessment will provide the best outcome and management options for the client. Therefore the Caulfield Continence Service schedules a case conference every week. This multidisciplinary discussion provides a forum where everyone can raise issues in regards to particular clients for peer feedback, advice, support and recommendations. A geriatrician, physiotherapist and CNAs are present. Issues are also raised monthly with a visiting urologist. "This interdisciplinary approach provides invaluable support for the CNAs," says Janie.

Janie's Tips for CNAs starting out in Continence Assessment:

Don't worry about what you don't know, it will come with time. I learn every day. It's a constant and evolving process. Don't be afraid. And don't worry about getting it wrong. Discuss findings with colleagues, read and research all the time. Keep on learning and have confidence in your own ability. Being hesitant is going to stop you from learning.

Get yourself a mentor and develop a support network. New Caulfield CNAs spend a lot of time with their colleagues to build confidence. Remember, it takes a while to build up a reasonable knowledge base! ◊

A Continence Assessment Success Story

A Continence Assessment Success Story from Janie Thompson, Continence Service Manager at the Caulfield Continence Service, Melbourne, Australia.

A woman in her 40s with a neurogenic bladder following spinal surgery was undertaking intermittent self catheterisation which she had previously been told to conduct four times a day. She was experiencing urinary leakage and extreme difficulty using her bowels, which she was trying to alleviate by taking a large amount of laxatives.

The intermittent self catheterisation and laxative use resulted in her having to stay at home all day which was having a major impact on her quality of life. It was undermining her confidence and restricting her from undertaking the most simple of everyday tasks such as running errands, meeting friends and going shopping. It left absolutely no room for spontaneity or travel, as much planning and preparation had to occur before she left her home for an extended period of time. Ultimately, the management of her bladder and bowels was ruling her life.

Following the completion of a bladder chart and assessment, I quickly discovered that the issue was more to do with her personality than physiology. Because she was a very diligent and literal person she was strictly following the advice she had been given to use the catheter four times a day, often at the expense of everything else.

I explained to her that she could be more flexible with her routine, and that she needed to fit the catheter around her life, not the other way around. My investigation found that she needed to use the catheter five or six times a day, (rather than four times a day), so I advised her to undertake it in between her daily activities. She now catheterises before she goes out so she doesn't have to worry about leakage. She is also conscious of when and what she drinks and how much, understanding that it has a bearing on her catheter routine.

To manage her bowels, I changed her regime and was able to get more formed bowel action, more regularly and without loss in between which has given her

freedom and relief.

Finally, this attractive and vibrant lady is no longer housebound and goes about her life in a way that pleases her. Most importantly, she is able to visit her daughter who lives a few hours away. This once rare event is now a more regular occurrence!

This case illustrates the importance of advising on lifestyle as well as interventions, particularly for younger clients. When conducted thoroughly, the assessment should give you a good indication of your client's lifestyle and personality. It also demonstrates why it is important to ask at the beginning of the assessment what they want to achieve, as interventions can then be adjusted to their lifestyle.

Remember that you need to teach people about the intervention/s you've recommended and exactly why they're doing it. Make sure that the client knows that they can ask for help and that it's ok to come back and say things didn't work for them or that they didn't understand exactly what you had recommended. Encourage them to ask questions and to make sure your recommendations can work with their lifestyle. Don't just tolerate it because the expert told you to do it! ◊



TENA Assess makes Continence Assessment Easier

The multifactorial nature of incontinence can make assessment a complex and challenging process. To ensure you are getting the best from your assessments use TENA Assess, a contemporary diagnosis package that fits all of your requirements for a comprehensive assessment including care planning, evaluation and funding claims support. TENA Assess is fully supportive of ACFL.

TENA Assess ensures the key principles of good practice continence assessment are adhered to:

- Data collection
- Data analysis
- Care planning
- Directives for High Level Care
- Data evaluation
- Guidelines and clinical resources

TENA Assess identifies all relevant diagnoses and issues contributing, or likely to contribute to altered continence function as well as frequency of incontinence, QOL and behaviour. Its Summary of Findings function funnels data into care strategies and provides nursing directives for high level care to aid the delivery of appropriate, effective and measurable continence management interventions.

TENA Assess also re-evaluates care using sensitive indicators for minor change. In all, it is an invaluable clinical and education resource for identification of diagnoses, dysfunction and their impact on continence. To find out more about TENA Assess contact Christine Towers chris.towers@sca.com or phone 0409 404 476.

Changes to CAAS

As of 1 July 2010 the Medicare managed Continence Aids Payment Scheme (CAPS) will replace the current Continence Aids Assistant Scheme (CAAS) managed by Intouch, the commercial arm of the Spinal Injuries Association.

Under the new scheme, the funds for continence aids (up to \$489.95) will be paid directly into recipients' bank accounts allowing them to source continence products from a supplier of their choice including pharmacy or retail outlets. Under the current scheme Intouch delivers continence products to recipients' homes.

Eligibility for the CAPS will remain the same as the current CAAS. People who are five years of age or older and have permanent and severe incontinence due to an eligible neurological condition or have permanent and severe incontinence caused by another eligible condition (provided they have a Centrelink Pensioner Concession Card) will continue to be eligible.

With a comprehensive range tailored to suit individual needs, TENA makes choosing the right product easy. For help finding the right product under CAPS, visit our website www.TENA.com.au or call our Customer Service Team.



HELP FOR POOR BLADDER AND BOWEL CONTROL

The National Continence Helpline – a free service providing advice, referrals and leaflets on many aspects of incontinence

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