Goal:
You will learn about the structures (anatomy) and the functions (physiology) of the urinary (bladder) and gastrointestinal (bowel) systems, the causes and types of incontinence, and select methods for managing incontinence.

Objectives:
At the end of this training session, you will be able to:
1. Describe the structures and functions of the urinary system.
2. Discuss normal aging changes of the urinary system.
3. Discuss factors that need to be present to maintain continence.
4. Compare and contrast the types of incontinence.
5. Identify risk factors for incontinence.
6. Discuss the methods used to manage incontinence.
7. List reasons for catheter use.
8. Describe the structures and functions of the gastrointestinal system.
9. Discuss normal aging changes to the gastrointestinal system.
10. Describe different types of bowel problems.
11. Develop a bowel and bladder management plan.

Take note: Review your organization’s policies and procedures on bowel and bladder assessment/management.

Learning Strategies:
To complete this lesson, follow these steps:
1. Read the materials provided in each unity of this lesson.
2. Complete the practice exercises or questions for each unit.
3. Complete each activity unless instructed otherwise.
4. Read the lesson review.
5. Complete the final content assessment.

After completing all of these steps, print two copies of the completed activity form, one to give to your education coordinator and one for yourself.

Related Topics: Sensitizing Staff to Growing Old
Promoting Self Care
Skin Care and Pressure Ulcer Prevention
Accident Prevention
**Introduction:**
It is a myth that incontinence in aging is normal. Urinary incontinence is defined as the unwanted loss of urine that is sufficient to be a problem. Urinary incontinence affects about 20 million Americans. Over half of persons in long-term care communities are incontinent. The annual cost of incontinence care is $28 billion. Institutional costs for incontinent supplies and services annually are $5.2 billion. For the non-institutionalized individual, the personal cost of pads/incontinence briefs averages between $1,200 to $1,500 annually. Older adults who enter a long-term care community need to be evaluated for bowel and bladder function. In this lesson, you will learn about three general methods for managing incontinence—retraining, toileting, and containment and how to choose the appropriate method for each resident.

**Unit 1:**
**Goal:**
You will learn about the structures and functions of the urinary system, the changes that occur in this system related to aging, and the causes and types of incontinence related to the urinary system. You will also learn about the ways to treat incontinence and about some of the management methods that can be used when caring for residents who are experiencing this problem.

**Bladder Incontinence and Management**

**Structures and Functions of the Urinary System**
The urinary tract consists of the two kidneys, two ureters, one bladder, one urethra and two sphincters. The kidneys filter out waste products from the body fluids and make urine. The ureters are tubes which carry urine from the kidneys to the bladder. The bladder is a muscular sac located behind the pelvic bone that stores urine. When the urge to void is noted, the brain tells the sphincter muscles to relax. The urethral sphincters (internal and external) are a group of muscles that tighten to hold urine in and relax to let urine flow out. Urine travels out of the bladder through a tube called the urethra. The urethra is a small tube leading from the bladder to the outside of the body. It is about 1-1/2 inches long in the female, and about 8 inches long in the male.

The nervous system (brain and spinal cord) coordinates the muscle action necessary to have control of elimination.
Normal Aging Changes of the Urinary System

- Kidneys decrease in size and do not work as efficiently.
- The bladder holds less urine.
- There is an increased amount of urine left in the bladder after voiding.
- The sphincter muscles of the bladder have decreased tone.
- In men, the prostate gland enlarges causing narrowing of the urethra.

These factors cause several changes as people age. They include:
- The need to urinate more frequently.
- A more urgent need to urinate, cannot hold urine for very long.
- Decreased ability to control the bladder.
- Other health-related problems, such as drug reactions or mineral imbalance.

Steps Needed to Urinate and Remain Continent

The urinary system is a complicated process, and there are several steps that must happen for a person to be able to urinate without being incontinent. The person must:

1. Have urine in the bladder. (This requires the kidneys to do their job by producing urine.)
2. Feel that the bladder needs to be emptied. (This requires that the brain give a signal to the person that it is time to void and the person be able to respond to the signal.)
3. Be able to wait until he or she gets to the bathroom. (This requires brain and bladder muscle coordination to prevent the bladder from emptying too soon.)
4. Be able to recognize the bathroom. (This requires knowledge of the appropriate place to void).
5. Be able to get to the bathroom alone or with help, and sit properly.
6. Be able to undo clothing.
7. Send and receive a message from the brain to let the bladder sphincter muscle relax and let urine flow. (This requires brain and bladder muscle coordination.)
8. Empty the bladder.

If there is a problem with any of these steps, incontinence can occur. Some of the problems can be easily treated; others need to be managed with good nursing care. The most common causes of incontinence for residents in long-term care communities are:

- Dementia or confusion.
- Decreased ability to move around freely.
- Brain or nerve injuries or diseases such as stroke, Parkinson’s Disease
- Metabolic diseases such as diabetes
- Urinary tract problems, such as an enlarged prostate gland in men and pelvic muscle weakness in women. These problems can often be treated with surgery.

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• Urinary tract infections which can be treated.
• Medication side effects which can interfere with the ability to hold and release urine as well as controlling the volume of urine produced.
• Depression which is usually treatable.
• Increased urine production caused by some illnesses. This condition may be able to be controlled.
• Low fluid intake which can be prevented.
• Fecal impaction (a severe form of constipation where a hard, dry stool is “stuck” in the large intestine). This can usually be prevented.
• Vaginal dryness from low estrogen levels in females. This condition can be treated.
• Length of time it takes for call light to be answered.
• Distance to the bathroom/commode.
• Lack of toileting programs.

Different Types of Incontinence

There are several types of incontinence or a mix of types. What follows is a description of each type.

1. **Stress.** Person with stress incontinence lose urine when they exercise or move in a certain way. It can vary from minimal leakage with a sneeze, to a large amount of urine loss with a simple movement as changing positions in bed.

   ❖ For the past several months, Mary, age 68, has been aware that her underwear is damp and at times wet. She has noticed that it is more likely to occur after she laughs, sneezes, or coughs. The leakage has become worse since she started a new exercise program. She does not want to stop the exercise program and believes this is just a part of aging and that she will need to live with it. She wears a small panty liner “just in case” she laughs or sneezes.

2. **Urge.** Persons with urge incontinence are unable to delay voiding after the sensation of bladder fullness is noted. They experience moderate to large amounts of urine loss on the way to the bathroom. They also describe urgency and frequent urination. The “key in lock” syndrome describes this type of incontinence.

   ❖ Susan never had any bladder control problems until after her 58th birthday and now she cannot control the urge to void. Sometimes it is so strong she feels she won’t make it in time if she does not hurry. The other day Susan had an accident. She was driving her car into the garage when she felt the urge. She grabbed her shopping bags, and rushed to her apartment door. She fumbled for her keys, could not get

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them in the lock, and the urge became so strong she “lost it” completely and soaked her pants. She was glad she had made it home and this had not happened at the store. Her husband said she probably had a weak bladder.

3. **Mixed.** This is a combination of stress and urges incontinence. It is common in women, especially the elderly female.

4. **Overflow.** Persons with overflow incontinence experience a variety of symptoms such as frequent or constant dribbling, urge and stress incontinence, as well as urgent and frequent urination. They have frequent night time voiding, produce small amounts of urine with each voiding, and spend a long time at the toilet but produce only a weak, dribbling stream of urine. They often don't know they are leaking urine.

   ![Diagram](image)

   - William is 66 years old and noticed that his urine stream was less forceful, the stream was slower, and never seemed to stop. When he thought he was done, some urine would dribble out and either drip on the floor or on his pants. William’s wife complained about the smell of urine around the toilet. His doctor found that the prostate was blocking the urethra making it difficult for William to empty his bladder. His urine dribbled because the “tube” was narrowed.

5. **Functional.** Functional incontinence occurs when the person is unable or unwilling to use toilet facilities because of decreased mobility and dexterity, mental and psychosocial disability, or side effects of medications. Going to the toilet can be a real hassle.

   ![Diagram](image)

   - Mrs. Smith is 82 years old and is very particular about her appearance and her room furnishings. She refuses to wear slacks with elastic waists and insists on wearing hose. Lately you notice Mrs. Smith changing clothes several times a day and she finally tells you she has trouble undoing the buttons and zippers on her slacks when she needs to toilet. This winter her arthritis has been causing a great deal of pain and swelling in her hands and knees.
The Types of Bladder Management Methods

The key to all bladder management methods is to find out the cause and amount of the incontinence. Sometimes the cause can be treated and the incontinence will get better or stop, such as may be the case with a urinary tract infection.

There are five major ways to treat incontinence. They are:

1. Behavioral modifications (we will only discuss toileting plans in this session)
   - **Scheduled toileting/habit training.** The schedule should be based on a three day voiding diary to determine the resident’s voiding pattern.
   - **Prompted voiding.** At least once an hour when awake, the resident is asked if they need to go to the bathroom (use term familiar to resident). If the resident says yes, take to bathroom.
   - **Bladder training.** Some residents can regain bladder control through education, exercises, and close monitoring and coaching (asking them if they need to go to the bathroom) by staff.

2. Pelvic muscle exercises
3. Medications
4. Surgery
5. Biofeedback technology

When these methods fail to manage incontinence, there are other steps that can be taken. **Containment** is the use of pads and adult briefs to absorb the urine.

**Indwelling Urinary Catheters** are used only when absolutely necessary due to risk of infection.

**Condom catheters** fit over the penis of a male resident to drain the urine into a bag.

**Reasons for Catheter Use**

Indications for catheter usage include:

- Residents who cannot empty the bladder on their own, despite medical or surgical treatment.
- Residents with skin rashes, ulcers, or wounds that are irritated by frequent contact with urine.
- Terminally if residents for who frequent bed changes are painful or uncomfortable.
- Residents who are at high risk of skin breakdown due to malnutrition or certain drugs.

If these indications are not present, another form of bladder management should be used.

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Voiding/Incontinence Assessment

1. Complete a Voiding Diary.
   - Review your organization’s policies and procedures for collecting data.
   - Complete documentation that covers a period of 72 hours. If residents are able, have them complete their diary. The diary that is used should include a column to document the time, amount and type of fluid taken, and the activity associated with the incontinent episode.

Analyze the Voiding Diaries and decide on an appropriate plan to decrease incontinence.

1. The team and resident carry out the plan.

2. The team evaluates the effectiveness of the program and, if necessary, revises the plan. It is extremely important that all individuals caring for the resident communicate with each other and be involved in the evaluation of the method(s) used.

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<th>Unit 1: Practice Activity</th>
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<td>List three (3) normal aging changes of the urinary system.</td>
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VOIDING DIARY

Resident Name: __________________    Bedroom #:________          Date: __________

EACH TIME THE RESIDENT IS CHECKED:

1. Mark one of the circles in the BLADDER section at the hour closest to the time the resident is checked.
2. Mark and X in the BOWEL section if the resident has had an incontinent or normal bowel movement.

• = Incontinent, small amount  ■ = Dry  X = Incontinent Bowel

○ = Incontinent, large amount  ☒ = Voided Correctly  X = Normal Bowel

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TOTALS:__________________________________________________________

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Kansas Association of Homes and Services for the Aging 8
Unit 2:

Goal:
You will learn about the parts of the gastrointestinal system, the normal changes that occur with aging that may result in bowel elimination problems and actions you can take to prevent or manage those problems.

Bowel Incontinence and Management

Structure and Function of the Gastrointestinal System

The esophagus is the tube that extends from the mouth to the entrance of the stomach. It transports food from the mouth to the stomach. The stomach holds the food and mixes it with digestive juices. Normal stomach capacity is one to two quarts and empties into the small intestine.

The small intestine is about 12 feet long, and it digests and absorbs nutrients from the food. The small intestine connects to the large intestine in the right lower quadrant of the abdomen. The large intestine is a hollow, muscular tub about five feet long that absorbs water and minerals. The last segment of the large intestine (sigmoid) is a S-shaped storage place for feces until the signal comes to have a bowel movement and feces then moves through the rectum and past the anus (a sphincter muscle) to outside the body.

Normal Aging Changes to the Gastrointestinal System

Aging changes to the gastrointestinal tract include:
- Gag reflex weakened
- Relaxation of the sphincter between the esophagus and the stomach
- Less digestive action and acids in the stomach
- Digested food moves through the intestines more slowly
- Decreased awareness of the need for the bowels to move

These normal aging changes can lead to:
- Choking
- Malnutrition
- Constipation/fecal impaction
- Large intestine inflammation
- Decreased ability to break down food and drugs
- Dehydration

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Different Types of Bowel Problems

Types of bowel problems include:
- No ability or awareness of the need to move bowels, such as in spinal cord injuries.
- Ability but no awareness of the need to move bowels, such as in Alzheimer’s disease.
- Awareness of the need but no ability to move bowels, such as in nerve damage from severe diabetes.

Bowel Management Program

1. The first step is to find out the bowel habits of the resident in order to determine the best plan. The nurse, the CNA, and the resident do this together.
   - Find out when the resident’s bowels usually move. The ingestion of a hot liquid such as coffee or tea in the early morning may stimulate the bowel so that the resident has the urge to have a bowel movement.
   - Find out what the resident has done before that has helped to have a bowel movement.

2. The nursing team and the resident analyze the information and make a plan. The plan might include:
   - Offering a warm drink (coffee, tea, lemon juice) early in the morning.
   - Increasing fluid intake to at least six to seven glasses of fluid a day. Give sips frequently throughout the day, not large amounts at a time.
   - Providing a diet with high fiber content. Note if there are any dietary restrictions.
   - Checking for impaction (hard, dry stool) when there is diarrhea.

3. Record ALWAYS the number, color, and characteristics of the stools.

4. Record fluid/food intake if there is concern that resident is not eating or drinking adequately.

5. Take the resident to the toilet 20 minutes after the triggering meal. Allow him or her to sit for no longer than 20 or 30 minutes.
   - An upright position is important to help pass a bowel movement.
   - Avoid using a bedpan if at all possible.
   - Put the resident’s feet on a footstool and have him/her bend forward a little. This puts more pressure on the lower abdomen and can help the movement of the bowel.

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Massage or rub the lower abdomen to help push the bowel movement into the rectum. The resident can do this or the caregiver.

- Provide privacy for the resident if possible. Remain close by to provide assistance if the resident requires assistance with transfers and standing.
- Check your organization's policy and protocols for use of suppositories, enemas, or rectal stimulation.

6. Evaluate the plan and revise it if necessary. It is extremely important that all individuals caring for the resident communicate with each other and be involved in the evaluation of the method(s) used.

Psychological Effects of Incontinence

Because of the close relationship with residents, caregivers are in an ideal position to discuss problems of incontinence. A detailed history of the resident needs to be completed when he or she is admitted and when there is a change in his or her continence level. The older person may feel disgust, guilt, or embarrassment about the condition. This can lead to social isolation because the resident is afraid to participate in activities for fear of an accident. Often there are things that can be done to improve or eliminate the resident's problem.

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<td>List three (3) normal aging changes of the gastrointestinal system.</td>
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Lesson Summary

Bowel and bladder assessment and management are very important in the care of the older adult. Incontinence is not normal for the older adult. It takes a team of dedicated workers to gather facts about patterns of elimination and look for the cause of this problem. Once the cause is identified, correction of the problem can often occur. If correction is not possible, there are methods that often work to keep the resident dry and retain his or her self-esteem.

To continue with this lesson, please complete the following individual or group activities.
Activity 1
Problem-Solving Exercise for Bowel and Bladder Incontinence Management

Directions: Read the case study below, and consider the questions that follow. If you are working by yourself, write out the answers and give them to your supervisor. If you are working in a group, discuss your responses with a group in your organization.

Case Study
Mabel Smith is a 75-year old woman who is recovering from hip surgery. Prior to hospitalization, she lived alone in Independent Living and had no problems with incontinence. She was able to walk to the bathroom using a walker. She has returned to the organization from the hospital at 10 a.m. with an indwelling catheter in place. The nurse removes the catheter at 11 a.m. Mrs. Smith is to be evaluated for bowel and bladder function. You are to take Mrs. Smith to the bathroom every two hours during this assessment phase.

- At noon, you take Mrs. Smith to use the bathroom before lunch and she voids 200 cc.
- At 1 p.m., she states she needs to have a bowel movement. She has a large, formed stool, black in color, and voids 100 cc.
- At 3 p.m., the evening shift does a bed check and finds Mrs. Smith incontinent of a small amount of urine. She gets up to use the bathroom and voids an additional 100 cc of urine.
- At 5 p.m., she is dry and gets up for dinner and is unable to void at this time.
- At 7 p.m., she voids 250 cc of urine and has a small bowel movement.
- At 9 p.m., she has been incontinent of a large amount of urine and states, “I couldn’t reach my call light.” She refuses to get up to go to the bathroom.
- At 11 p.m., the night shift does bed check, and Mrs. Smith voids 100 cc into a bedpan.
- At 1 a.m., 3 a.m., and 5 a.m., she is dry and does not need to use the bedpan.
- At 7 a.m., she voids before breakfast 100 cc of dark yellow urine.
- At 9 a.m., she is taken to the bathroom and voids 50 cc and has small bowel movement that is black.
Questions to Consider:

1. What is Mrs. Smith’s pattern of voiding?

2. What is Mrs. Smith’s pattern of having a bowel movement?

3. Which management method would be best for her? Why?

4. Describe the plan and times for toileting that you will set up.

5. What would you report to the charge nurse about Mrs. Smith’s voiding?

6. What would you note specifically to the charge nurse about Mrs. Smith’s stool?
Lesson Assessment

Directions: Select the best answer.

1. Which of the following is a nonsurgical, correctable cause of urinary incontinence? (unit 1)
   a) Spinal cord injury
   b) Advanced dementia
   c) Fecal impaction
   d) Enlarged prostate

2. Which of the following can be used to treat incontinence: (unit 1)
   a) Toileting programs
   b) Medication usage
   c) Containment program
   d) Catheter usage
   e) Any of the above, depending on the cause of incontinence

3. For residents, incontinence can cause: (unit 2)
   a) Isolation
   b) Embarrassment
   c) Arthritis
   d) Both a and b

4. Regularly asking residents if they have to go to the bathroom is part of: (unit 1)
   a) Catheter care
   b) Bladder exercise
   c) A toileting schedule
   d) Bladder training

5. Fecal impaction is: (unit 2)
   a) A normal part of aging
   b) A severe form of constipation
   c) An effective treatment for incontinence
   d) Both a and b

6. Mrs. Cardone complains about being constipated. Which of these foods is the best choice to help with this problem? (unit 2)
   a) Cheese
   b) Fresh fruit
   c) White bread
   d) Baked chicken

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7. Knowing that Mrs. Jones cannot hold her urine very long after she feels the urge to void, you would: (unit 1)
   a) Put an incontinent brief on her
   b) Restrict her fluid intake
   c) Answer her call light as soon as possible
   d) Have her sit in a wheelchair close to the bathroom

8. Mr. York has to go to the bathroom almost every hour and it takes him a long time to void. Even then, his underwear is frequently damp. You suspect he has which type of incontinence? (unit 1)
   a) Urge
   b) Stress
   c) Overflow
   d) Functional

9. Your care team determined that Mrs. Miller is becoming dehydrated and needs to be encouraged to drink more fluids. The best way for you to help Mrs. Miller is to: (unit 2)
   a) Only let her drink tap water
   b) Do not let her drink fluids with her meals
   c) Make her drink a whole glass of water every time you go to her room
   d) Remind her to drink several swallows of fluid every time you are near to her

10. The resident is incontinent every morning at 1:00 a.m. To prevent bedwetting, you should plan to: (unit 1)
    a) Limit the intake of fluid after dinner
    b) Apply an incontinence pad at bedtime
    c) Position the call bell within easy reach
    d) Toilet the resident at 12:30 a.m. every night
Bowel and Bladder Assessment/Management
Presenter’s Guide

Purpose:
It is a myth that aging and incontinence is normal. Urinary incontinence is defined as
the unwanted loss of urine that is sufficient to be a problem. Urinary incontinence
affects about 20 million Americans. Over half of persons in long-term care
communities are incontinent. The annual cost of incontinence care is $28 billion.
Institutional costs for incontinent supplies and services annually are $5.2 billion. For
the non-institutionalized individual, the personal cost of pads/incontinence briefs
averages $1,200 to $1,500 annually. Older adults who enter a long-term care
community need to be evaluated for bowel and bladder function. In this lesson, the
participant will learn about three general methods for managing incontinence—
retraining, toileting, and containment and how to choose the appropriate method for
each resident.

Goal:
Learn the structures and functions of the urinary (bladder) and gastrointestinal
(bowel) systems, the changes that occur in this system related to aging, and the causes
and types of incontinence, and three methods that can be used when caring for
residents who are experiencing this problem.

Objectives:
At the end of the training session, the participant will be able to:
1. Describe the structures and functions of the urinary system.
2. Discuss normal aging changes of the urinary system.
3. Discuss factors that need to be present to maintain continence.
4. Compare and contrast the types of incontinence.
5. Identify risk factors for incontinence.
6. Discuss the methods used to manage incontinence.
7. List reasons for catheter use.
8. Describe the structures and functions of the gastrointestinal system.
9. Discuss normal aging changes to the gastrointestinal system.
10. Describe different types of bowel problems.
11. Develop a bowel and bladder management plan.

Learning Activities:
To complete this lesson, the participant should:
1. Attend a lecture/discussion about bowel and bladder incontinence and
management (presented either by designated staff or a guest speaker) and/or read the
Bowel and Bladder Incontinence Management Learner’s Guide.
2. View a videotape on this topic (optional).
3. Participate in the problem-solving exercise found at the end of this section.
5. Review your organization’s incontinence management policies, procedures, and programs.

**Related Topics:**
- Sensitizing Staff to Growing Old
- Promoting Self-Care
- Skin care and Pressure Ulcer Prevention
- Accident Prevention

**Overheads:**
1. Anatomy of GU System
2. Normal Aging Changes
3. Steps in the Voiding Cycle
4. Common Causes of Incontinence in LTC Residents
5. Reversible Conditions Causing Incontinence
6. Bladder Management Method
7. Reasons for Catheter Use
8. Aging Anatomy of GI System (picture)
9. Normal Aging Changes of the GI System
10. Normal Aging Changes Can Lead To:
11. Types of Bowel Problems
12. Steps in Bowel Management Plan

**Answers to Activity 1**

1. What is Mrs. Smith’s pattern of voiding?
   *Answer:* Voids large amounts of urine after lunch and dinner. Voids small amounts every two hours during the day. No voiding from 1 a.m. to 7 a.m.

2. What is Mrs. Smith’s pattern of having a bowel movement?
   *Answer:* Bowel movement after each meal.

3. Which management plan would be best for her? Why?
   *Answer:* Bladder retraining plan. The bladder is retaining urine probably because a catheter has just been removed. She is aware of her need for toileting. She is able to walk to the bathroom. She is generally cooperative.

4. Identify the times for toileting that you would set up.
   *Answer:* Suggested toileting schedule:
   - Before breakfast
   - Mid-morning
   - After lunch
   - After supper

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Mid-evening
Before bed
11 p.m.

5. What would you report to the charge nurse about Mrs. Smith’s voiding?
Answer: The amounts of urine voided each time.

6. What would you note specifically to the charge nurse about Mrs. Smith’s stool?
Answer: The color of the stool (black)

Answers to Quiz:

1. Which of the following is a nonsurgical, correctable cause of urinary incontinence? (unit 1)
   a) Spinal cord injury
   b) Advance dementia
   c) Fecal impaction
   d) Enlarged prostate

Answer: c
Rationale: Spinal cord injury is not reversible; advanced dementia cannot be altered; and an enlarged prostrate usually requires a surgical procedure.

2. The way to treat incontinence is: (unit 1)
   a) Toileting programs
   b) Medications usage
   c) Containment program
   d) Catheter usage
   e) Any of the above, depending on the cause of incontinence

Answer: e
Rationale: a. can be used after assessment of the resident’s voiding pattern to keep dry; b. medications can assist in better bladder control; c. if all other methods fail, this can be used to keep the resident dry; d. if there is a problem getting the urine out of the bladder or there’s a need to keep a wound dry, this may be the method of choice.

3. For residents, incontinence can cause: (unit 2)
   a) Isolation
   b) Embarrassment
   c) Arthritis
   d) Both a and b

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Answer: d
*Rationale*: Arthritis is not directly related to incontinence except that painful joints may make it more difficult for the resident to move.

4. Regularly asking residents if they have to go to the bathroom is part of: (unit 1)
   a) Catheter care
   b) Bladder exercise
   c) A toileting schedule
   d) Bladder training

Answer: d
*Rationale*: a. Catheter care is the care of a tube placed in the bladder to drain urine from the body; b. bladder exercises assist in strengthening pelvic muscles; c. toileting schedule is taking the resident to the bathroom at a predetermined time based on his or her habits.

5. Fecal impaction is: (unit 2)
   a) A normal part of aging
   b) A severe form of constipation
   c) An effective treatment for incontinence
   d) Both a and b

Answer: b
*Rationale*: a. It is not a normal part of aging’ b. fecal impaction can be a cause of urinary incontinence; c. is not a treatment.

6. Mrs. Cardone complains about being constipated. Which of these foods is the best choice to help with this problem? (unit)
   a) Cheese
   b) Fresh fruit
   c) White bread
   d) Baked chicken

Answer: b
*Rationale*: Fresh fruit contains roughage/fiber which adds bulk to stool. White bread, cheese and chicken do not contain roughage or fiber.

7. Knowing that Mrs. Jones cannot hold her urine very long after she feels the urge to void, you would: (unit 1)
   a) Put an incontinent brief on her
   b) Restrict her fluid intake

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c) Answer her call light as soon as possible  
d) Have her sit in a wheelchair close to the bathroom

Answer: c
Rationale: Because of the normal aging changes, the bladder cannot hold as much urine, the feeling of a full bladder does not happen as soon, and the sphincter is not as strong. Therefore, the older person cannot “hold it” as long as a younger individual.

8. Mr. York has to go to the bathroom almost every hour and it takes him a long time to void. Even then, his underwear is frequently damp. You suspect he has which type of incontinence? (unit 1)
   a) Urge  
   b) Stress  
   c) Overflow  
   d) Functional

Answer: c
Rationale: Mr. York has the signs of an enlarged prostate that is closing off the opening of the bladder. He cannot empty his bladder and retains most of the urine in his bladder. He is voiding and dribbling the overflow—what the bladder cannot hold.

9. Your care team determined that Mrs. Miller is becoming dehydrated and needs to be encouraged to drink more fluids. The best way for you to help Mrs. Miller is to: (unit 2)
   a) Only let her drink tap water  
   b) Do not let her drink fluids with her meals  
   c) Make her drink a whole glass of water every time you go to her room  
   d) Remind her to drink several swallows of fluid every time you are near to her

Answer: d
Rationale: It is difficult for anyone to drink a large amount of fluid at one time. The best way is to encourage Mrs. Miller to take frequent swallows of a fluid she likes. This will also prevent the bladder from filling quickly which could cause an incontinent episode.

10. The resident is incontinent every morning at 1:00 a.m. To prevent bedwetting, you should plan to: (unit 1)
    a) Limit the intake of fluid after dinner  
    b) Apply an incontinence pad at bedtime  
    c) Position the call bell within easy reach  
    d) Toilet the resident at 12:30 a.m. every night.

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Answer: d
Rationale: This provides the resident the opportunity to void prior to becoming incontinent; if effective, it will contribute to self-esteem and personal hygiene.

More Information:
You can have your staff read the following for more information about bowel and bladder training, or these resources may be used in preparing an inservice.

Articles


The state of the science on urinary incontinence. American Journal of Nursing, March 2003, Vol. 103, no. 3. (This article is the executive summary of the full report of the symposium. The report is available at www.nursingcenter.com/ui.


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Books


Videotapes

This program highlights a dietary plan that reduces the intake of foods and beverages that may create bladder irritation. It also discusses the inclusion of high-fiber foods to decrease problems with constipation. (2000) $259 purchase. 1-800-233-9910 or www.insight-media.com.

*Nursing Assistant Techniques: Toileting and Incontinent Care*. (18 minutes).
This program demonstrates techniques that help maintain resident hygiene and dignity. It covers assisting with using the toilet, offering the bedpan or urinal, using a portable bedside commode, changing briefs, and bowel and bladder training. (2003) $179 purchase. 1-800-233-9910 or www.insight-media.com.

*Management of Urinary Incontinence in Long-Term Care*. (20 minutes).
This program covers evaluating residents to identify potential causes of incontinence, documentation, behavioral interventions and other management programs. Support print materials. Purchase $150, rental $75. 1-800-328-7450 or www.videopress.org.

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Management Strategies for the Incontinent Ambulatory Elderly. (20 minutes).
This program outlines basic anatomy of the urogenital system and defines incontinence. Behavioral treatment approaches are presented for staff to teach the ambulatory elderly. Topics include Kegel exercises, bladder retraining, education to retrain daily habits, and understanding faulty voiding patterns that contribute to incontinence. Purchase $150, Rental $75. 1-800-328-7450 or www.videopress.org.

Toileting and Perineal Care. (17 minutes)
This video explores the nursing assistant’s role in helping residents with toileting needs and perineal/incontinent care, considering the embarrassment that often accompanies toileting problems. It also discusses the importance of cleansing techniques, standard precautions when handling excretions and disinfection. (2002) $259 purchase. 1-800-233-9910 or www.insight-media.com.

Treating Urinary Incontinence. (17 minutes)
An upbeat video that informs nurses, nursing assistants, and people with urinary incontinence about behavioral interventions to help control the problem. Teach people in your center how to exercise their pelvic muscles, set up a bladder management program, and eat and drink properly for urinary control. $99, 23-page guide + inserts and includes in-house broadcast permission. 1-888-337-8808 or www.healthpropress.com.

Web Sites

American Foundation for Urologic Disease, Inc.
www.afud.org/conditions/ui.asp

Debunking Myths About Incontinence
www.drdonnica.com/today/00006745.htm

Diagnostic Evaluation of Urinary Incontinence in Geriatric Residents (includes a resident information handout on urinary incontinence
www.aafp.org/afp/980600ap/weiss.html

Merck Manual of Geriatric. Incontinence
http://www.merck.com/pubs/mm_periatrics

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Product web sites:
  www.seekwellness.com/incontinence
  www.depend.com
  www.qualityhomecareproducts.com
  www.arcusmedical.com
  www.curonmedical.com

The Impact of Incontinence
www.drdonnica.com/articles/00003198.htm

Note: Instructor should review F tag 315 in the Guidance to Surveyors found in the
State Operations Manual

Self-Help Groups and Resources

National Association for Continence (NAFC)
P. O. Box 544
Union, SC 29379
1-800-BLADDER (800-252-3337)
803-579-7900
www.nafc.org

The NAFC is a not-for-profit organization dedicated to improving the quality of life of people with incontinence. NAFC’s goal is to be the leading source of education, advocacy, and support to the public and to the health professional about the causes, prevention, treatments, and management alternative for incontinence. In addition to a newsletter and educational brochures, NAFC’s services include an audiocassette tape and booklet that coach pelvic muscle exercises, a slide/tape program that health professionals can use in giving talks to resident and community groups, a continence referral service that puts people in touch with local health professionals, and a 100-page resource guide, Products and Services for Incontinence.

Simon Foundation for Continence
P. O. Box 835
Wilmette, IL 60091
1-800-23 SIMON (Resident Information)
708-864-3913 (Headquarters)
www.simonfoundation.org

The Simon Foundation for Continence is an international not-for-profit organization. Its mission is to bring the problem of incontinence into the open, remove the stigma surrounding it, and provide education for people with incontinence. By calling the

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toll-free number, you can receive a free information packet that includes a sample of the foundation’s newsletter and a list of resource materials. The foundation also coordinates a nationwide network of lectures on the causes of and treatments for incontinence. Videos on incontinence and information about bedwetting are also available.

National Bladder Foundation
1-877BLADDER
www.bladder.org

National Women’s Health Resource Center
www.healthywomen.org

Stress Urinary Incontinence
www.SUI.com
Anatomy of a GU System
NORMAL AGING CHANGES

- Kidneys decrease in size, work less efficiently.
- Bladder holds less urine.
- Increased amount of urine left in the bladder after voiding
- Sphincters muscles of the bladder lose their tone.
- In men, the prostate enlarges, causing narrowing of the urethra.
STEPS IN THE VOIDING CYCLE

Urine in the bladder.

Recognize the “need to go”.

“Hold it” until reaches bathroom.

Recognize the bathroom.

Able to get to bathroom alone/with help.

Undo clothing.

Relax bladder sphincter muscle.

Empty the bladder.
COMMON CAUSES OF INCONTINENCE IN LTC RESIDENTS

- Dementia or confusion
- Decreased ability to move around freely
- Brain or spinal cord injuries/diseases
- Metabolic diseases
- Urinary tract obstruction
- Urinary tract infection
- Medication side-effects
- Depression
- Increased urine production caused by certain illnesses
- Low fluid intake
- Fecal impaction
- Vaginal dryness from low estrogen levels in females
- Unable to get to the bathroom in time
- Staff lack of attention to incontinence management
REVERSIBLE CONDITIONS CAUSING INCONTINENCE

- Urinary tract infections
- Vaginal dryness from low estrogens levels
- Prostate enlargement
- Stool impaction
- Medication side effects
- Increased urine production caused by certain diseases
- Impaired ability or willingness to reach a toilet
BLADDER MANAGEMENT MODELS

Behavioral modifications

- Toileting plans:
  - Scheduled toileting/habit training
  - Prompted voiding
  - Bladder training

Pelvic muscle exercises

Medications

Surgery

Biofeedback technology

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REASONS FOR CATHETER USE

- Cannot expel urine voluntarily.

- Skin rashes, ulcers, or wounds that are irritated by frequent contact with urine.

- Frequent bed changes that are painful or uncomfortable.

- High risk of skin breakdown due to malnutrition or certain drugs.
NORMAL AGING CHANGES TO THE GI SYSTEM

- Weaker gag reflex
- Relaxation of the sphincter between the esophagus and the stomach
- Less digestive action and acids in the stomach
- Digested food moves through the intestines more slowly
- Decreased awareness of the need for the bowels to move
NORMAL AGING CHANGES CAN LEAD TO:

Choking

Malnutrition

Constipation

Large intestine inflammation

Decreased ability to break down food/drugs
TYPES OF BOWEL PROBLEMS

- No ability or awareness of need to move bowels (e.g. spinal cord injury)
- Ability, but no awareness of the need to move bowels (e.g. Alzheimer’s disease)
- Awareness of the need, but no ability
BOWEL MANAGEMENT

1. Assess resident’s bowel habits.
   - When do bowels usually move?
   - What has worked before to prompt a bowel movement?

2. Analyze the information and make a plan—such as:
   - Offering warm drink early morning
   - Increasing fluid intake to 6 to 7 glasses a day (frequent swallows throughout the day).
   - Providing a diet with high fiber content (note dietary restrictions).
   - Checking for impaction (hard, dry stool) when there is diarrhea.

3. Record ALWAYS number, color and characteristics of stools.

(continued on next overhead)
4. Record fluid/food intake (report swallowing problems, spitting, vomiting)

5. Take resident to toilet 20 minutes after triggering meal.
   - Do not allow to sit on toilet for more than 30 minutes
   - An upright position is important, avoid using bedpan
   - Place feet on low footstool
   - Massage/rub lower abdomen
   - Provide privacy when possible
   - Check your organization’s policy/protocols for suppositories, enema, and rectal stimulation use.

6. Evaluate the plan and revise if necessary. This must be a team effort!