Learning Guide

Incontinence and interventions

28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting (version 1, Level 3, 5 Credits)

Name:

Workplace:
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Introduction

This unit standard is designed for those who have experience of working as a health care assistant or support worker, or have just begun caring for people with continence needs and wish to gain a nationally recognised qualification.

How to use your learning guide

This learning guide supports your learning and prepares you for the unit standard assessment. There are activities to do and scenarios to guide your learning.

This guide relates to the following unit standards:

• 28546 Describe incontinence and interventions to assist a person in a health or wellbeing setting (version 1, Level 3, 5 Credits)

This learning guide is yours to keep. Make it your own by writing notes that help you remember things, or where you need to find more information.

Follow the tips in the notes column.

You may use highlighter pens to show important information and ideas, and think about how this information applies to your work.

You might find it helpful to talk to your workmates or supervisor.

Complete this learning guide before you start the assessment.

What you will learn

When you have finished the learning for this unit standard, you will be able to describe:

• common types of incontinence, observable indicators of incontinence, and factors that may affect a person's ability to remain continent for a person in a health or wellbeing setting

• interventions, products and practices that may assist people living with incontinence in health or wellbeing setting
Structure of this resource

"Hygiene is a very personal issue. From a very young age we are trained to control our urges to go to the toilet, so being incontinent can make it feel as if one is losing control. This can affect a person’s sense of dignity and self-esteem. Many people find it very hard to accept that they need help from someone else in such an intimate area of their life – even (or sometimes, especially) if from someone very close to them."

This resource has three main sections:

1. Types and indicators of incontinence and factors that affect continence
2. Interventions, products and practices that may assist people living with incontinence
3. Infection control practices.

The content of this resource is intended to provide basic knowledge for understanding incontinence and interventions to assist a person with incontinence. Information and guidelines for applying this knowledge in practice can be found in other resources and from the New Zealand Continence Association website at http://www.continence.org.nz/

Incontinence and its effects

Incontinence is the term medical people use to describe the loss of control of the muscles the body uses to get rid of liquid and solid waste products (urine and faeces). It’s not a disease in itself but is often linked to other medical or physical conditions.

Incontinence can severely impact on a person’s quality of life. People can experience urinary or faecal incontinence or a combination of both. However, people can also experience problems with constipation which can also cause problems.

In this section you will learn about:

- common types and causes of urinary incontinence
- common types and causes of faecal incontinence
- observable indicators of urinary and faecal incontinence
- factors that may affect a person’s ability to remain continent
Urinary and faecal incontinence

"Continence is a touchy subject" Andrea Lord – continence specialist educator and advisor.

Urinary incontinence

Urinary incontinence is defined by the International Urogynaecological Association (IUGA) and International Continence 2009, as cited by the NZ Continence Association, as "the complaint of any involuntary leakage of urine".

The Association for Continence Advice, 1993 (as cited by the NZ Continence Association) says "Incontinence is not a disease, but is a symptom of an underlying disorder".

The two main disorders for urinary incontinence are bladder storage dysfunction and bladder voiding dysfunction.

Bladder storage dysfunction is where the bladder can't store urine properly. The dysfunction manifests itself through:

- **Stress incontinence**: the involuntary leakage of urine on effort, exertion, coughing or sneezing. This can be the result of weakness/inefficiencies in the urethral sphincter and may be caused by:
  - childbirth/traumatic obstetric delivery
  - hysterectomy
  - prostate surgery
  - chronic constipation and straining
- **Over active bladder (OAB) syndrome**: This may present itself by a person feeling the need to pass urine even though the bladder may not be full.
  - **Nocturnal enuresis** or bed wetting.
  - **Frequent urination** (more than 6-8 times during the day).
  - **Nocturia** (going more than two times during the night).

OAB syndrome is also known as urgency incontinence or urge incontinence. It may be caused by:

- nerve damage
- surgery
- neurological conditions or diseases (for example, Multiple Sclerosis, Parkinson's disease)
- stroke, spinal cord lesions
• ageing (a lack of oestrogen)
• side effects of drugs
• urinary tract infections (UTI) causing pain or discomfort when passing urine
• bladder stones and tumors

**Mixed urinary incontinence** is a combination of stress incontinence (wetting oneself by sneezing, coughing and exercising) and an over active bladder (OAB).

**Bladder voiding dysfunction**

**Bladder emptying (voiding) dysfunction** is where the bladder can't empty itself effectively. This may be due to the bladder not contracting effectively to empty itself (an underactive bladder), the urethra not opening when the bladder is contacting (for example, an outflow obstruction) or a combination of both. It may be caused by damage to the lower spinal cord or to the bladder’s peripheral nerves, or neurological conditions like Multiple Sclerosis or Parkinson's disease, or trauma or surgery to the pelvic region.

In men, the potential for bladder emptying (voiding) dysfunction may occur when their prostate gland enlarges and constricts or obstructs the urethra. Common difficulties include:

- Trouble starting the flow.
- A slow stream once started.
- Leaking after passing urine.
- Feeling an urgent need to pass urine.
- Post void symptoms such as dribbling urine immediately after finishing passing urine. For men, this typically occurs after leaving the toilet.
Many people may not experience bladder storage dysfunction and bladder voiding dysfunction, but are still incontinent. This may be due to **functional incontinence**, defined by the Department of Health and Ageing, Australia (2004) "where problems getting to the toilet owing to environmental, physical or mental difficulties cause incontinence".

For example, physical disabilities or handicaps may prevent a person getting to the toilet and/or removing their clothing. Medical problems that may contribute to functional incontinence include dementia, arthritis, Parkinson's disease and diabetes. Other conditions may cause a severe loss of physical and cognitive function, vision and communication and comprehension difficulties and sometimes the inability to communicate in any way.

**Observable indicators** of urinary incontinence include:

- bladder voiding frequency or hesitancy or urgency or nocturia
- poor urinary stream or flow or straining to pass urine
- post void residual urine – 30% bladder volume
- post void dribbling
- overflow incontinence and nocturnal enuresis (bed wetting)
- urinary tract infection
- skin rash or reddening of the skin, due to extended contact with urine
- occasional loss of bladder control from mild (a few drops) to moderate (wet underwear) to severe (wet outerwear)
Incontinence and interventions

- accidents when coughing, sneezing, laughing, bending, lifting and/or doing any physical activity that strains the bladder
- sudden urges to use the toilet and an inability to get there in time
- wet bed clothes, chair or sofa seat
- wet continence products
- anxiety about drinking fluids for fear of wetting oneself

**Faecal incontinence**

"Incontinence is not an illness, but a symptom of an underlying cause." Andrea Lord – continence specialist educator and advisor.

**Faecal incontinence** is defined by Norton (1996) as "the involuntary passage of faeces and/or flatus, (passing wind), at an inappropriate time and in an inappropriate place" and as "any involuntary leakage – solid, liquid or gas" Norton (2004).

Faecal incontinence may be experienced either passively or urgently. **Passive** incontinence includes the unconscious passing of a stool and/or no warning before the leakage occurs (the brain doesn’t register the message that a person needs to go to the toilet). **Urgency** is when a person may suddenly have the sensation of a full rectum and feels a strong urge to go and they may have to rush to the toilet to make it on time.

Some causes can include pelvic floor damage or damage to the back passage (anal sphincter), resulting in weakened muscles.

**Diarrhoea** is defined as the frequent (more than three times per day) passage of unformed stools as per the Bristol Stool Form Scale (type 6) and, in the case of those with chronic diarrhoea, occurrences for over one month (Norton & Chelvanayagam, 2004). Diarrhoea can lead to faecal incontinence.

**Diarrhoea** may be either acute or chronic.

Causes of acute diarrhoea include:

- infections such as:
  - viruses (norovirus or rotavirus)
  - bacteria (E.coli or campylobacter or salmonella)
  - parasites (the giardia intestinalis parasite causes giardiasis)
  - adverse drug reactions
  - overuse of laxatives and antacids
  - tumours
  - colitis
Causes of chronic diarrhoea include:

- diabetes
- anxiety or emotional distress
- excess alcohol and/or coffee
- damage to the intestines (for example, caused by radiotherapy or a hernia)
- a food allergy
- too much fibre
- side effects to various medications, such as laxatives, antibiotics, statins or antacids
- Irritable Bowel Syndrome (IBS), Ulcerative Colitis and Crohn’s disease

**Constipation**

**Constipation** is defined by the NZ Continence Association as lumpy, hard stools (types 1–2 on the Bristol Scale) and a sensation of incomplete evacuation which may occur a quarter of the time. It also includes passing two or fewer bowel motions in a week (Norton & Chelvanayagam, 2004).
Constipation may be caused by:

- **internal causes**, such as:
  - a hormonal imbalance
  - medical problems, for example, diabetes
  - a lack of mobility and/or exercise
  - neurological problems, for example, stroke
  - prolapse

- **external factors**, such as:
  - inadequate fluid intake
  - inadequate fibre in the diet
  - the side effects of some medication, for example, antidepressants, pain relief
  - the external environment
  - attitudes of the person, staff, family, whānau or support worker
  - psychiatric/psychological disorders

**Impaction** occurs when the bowel is overloaded with stools (solid or soft-putty like consistency) causing a blockage. Severe constipation can lead to faecal impaction and incontinence.

People most at risk of impaction are those who are relatively immobile (most of their day is spent sitting or in bed), or who have diseases of the brain or nervous system that damage the nerves in the intestine’s muscles, or who are on medication that slow the passage of stools through the bowel.

**Overflow** occurs when the stool stuck in the rectum creates a blockage which allows only a watery discharge to pass around the blockage, leading to leaking. Overflow is most common in people with long-term constipation who may have taken laxatives for a while and the muscles of the intestine forgetting how to move stools/faeces on their own.

**Observable indicators** of faecal incontinence include:

- difficulty/discomfort moving the bowels
- hard bowel motion and irregular habit
- impaction and leakage
- urinary frequency and retention
- abdominal discomfort and bloating
- diarrhoea and frequent need to use the toilet
- sudden urges to use the toilet and an inability to get there in time
- skin rash or reddening due to extended contact with faeces
- involuntary passing of gas, liquid or stools
- loss of appetite, lethargy and discomfort related to constipation or diarrhoea
- soiled underwear or continence products

**Factors affecting incontinence**

The factors that affect a person’s ability to remain continent rely on two things:

1. the normal physiological functioning of the bladder and bowel.
2. the absence of any cognitive, physical, medical and environmental factors that act as barriers.

The factors affecting a person’s ability to remain continent may include, but are not limited to:

<table>
<thead>
<tr>
<th>Factors</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Children up to 2 years of age lack the brain and spinal cord development to be continent. Older adults may be affected by cognitive function and/or memory due to dementia, confusion and inability to identify and/or locate and/or use toilet properly, an inability to remove clothing in time (or at all), unable to wipe themselves and replace clothing, or frailty.</td>
</tr>
<tr>
<td>Environmental</td>
<td>Placement of furniture causing obstruction to toilet, walking aids out of reach, cluttered rooms, poor toilet signage, poor lighting, or a cold toilet.</td>
</tr>
<tr>
<td>Impaired mental function</td>
<td>Severe loss of cognitive ability, vision, hearing and speech loss, or poor spatial awareness.</td>
</tr>
<tr>
<td>Impaired mobility</td>
<td>Use of a wheelchair/walking frames, being overweight, inability to stand or sit on a toilet, inability to wipe themselves or wash hands, inability to remove or replace clothing, or inability to get to the toilet in time.</td>
</tr>
<tr>
<td>Infections</td>
<td>Stomach, bowel and urinary tract infections.</td>
</tr>
<tr>
<td>Medical conditions or diseases</td>
<td>Dementia, diabetes, arthritis, stroke, Multiple Sclerosis, enlarged prostate, prostate cancer, Parkinson’s disease, bladder cancer, bowel cancer, or motor neuron disease.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Weakening of bladder/bowel/pelvic floor muscles due to childbirth, or nerve or muscle damage due to surgery or injury.</td>
</tr>
<tr>
<td>Medication</td>
<td>Use of diuretics, alpha blockers, strong antibiotics, or overuse of laxatives.</td>
</tr>
<tr>
<td>Neurological disorders</td>
<td>Dementia, Parkinson’s disease, motor neuron disease, CVA/stroke, spinal cord injury, or brain injury.</td>
</tr>
<tr>
<td>Overweight</td>
<td>Inability to move easily or quickly.</td>
</tr>
</tbody>
</table>
## Examples of 3 day bladder and 7 day bowel charts

**Three Day Bladder Chart**

Please complete details for each time the resident passes urine.
Complete each day for 3 complete days (review when done)

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Drink (amt. type)</th>
<th>Continent</th>
<th>Incontinent</th>
<th>No. of pad and/or clothing changes</th>
<th>Comments (e.g., circumstances, effect on daily activity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking to morning tea</td>
<td>7:30 CUP tea</td>
<td>Yes</td>
<td>Pad only</td>
<td>1 change of pad</td>
<td>Unable to get to toilet</td>
</tr>
<tr>
<td>Morning tea to lunch</td>
<td>11:00</td>
<td>No</td>
<td>Yes</td>
<td>1 change</td>
<td>&quot;could n’t get there&quot;</td>
</tr>
<tr>
<td>Lunch &amp; afternoon tea</td>
<td>12:30 Water</td>
<td>Yes</td>
<td>Pad</td>
<td>1 pad change</td>
<td></td>
</tr>
<tr>
<td>Aftemoon tea to dinner</td>
<td>6:00 (6:15 half)</td>
<td>Yes</td>
<td>Pad</td>
<td>1 pad change</td>
<td></td>
</tr>
<tr>
<td>Dinner to bed</td>
<td>7:00 Water</td>
<td>Yes</td>
<td>Pad</td>
<td>1 pad change</td>
<td></td>
</tr>
<tr>
<td>Overnight</td>
<td>10:30</td>
<td>No</td>
<td>Yes</td>
<td>&amp; No</td>
<td></td>
</tr>
</tbody>
</table>
# Seven Day Bowel Chart

Please complete details for each time the resident has a bowel movement.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Type of bowel movement (refer to Bristol Stool Form Scale)</th>
<th>Incontinent of stool</th>
<th>Yes/No</th>
<th>Number of pad/ clothing changes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>am</td>
<td>7</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pm</td>
<td>3</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>am</td>
<td>4</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pm</td>
<td>3</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>am</td>
<td>3</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td>Sleep</td>
</tr>
<tr>
<td>pm</td>
<td>30</td>
<td>3-4</td>
<td>No</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>am</td>
<td>2-3</td>
<td>N</td>
<td>No</td>
<td>No</td>
<td>Stated 'hard to push'</td>
<td></td>
</tr>
<tr>
<td>pm</td>
<td>2</td>
<td>N</td>
<td>No</td>
<td></td>
<td>'Hard to go'</td>
<td></td>
</tr>
<tr>
<td>am</td>
<td>1</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pm</td>
<td>1</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>am</td>
<td>1</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pm</td>
<td>1</td>
<td>N</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The Bristol Stool Form Scale
(Use this as a guide to the stool type)

- **Type 1**: Separate hard lumps like mates from sand
- **Type 2**: Egg-shaped or soft lumps
- **Type 3**: Like a sausage but with cracks on its surface
- **Type 4**: Like a sausage or shape, smooth and soft
- **Type 5**: Soft blobs with clear-cut edges (pasty consistency)
- **Type 6**: Puffy pieces with ragged edges; a mushy stool
- **Type 7**: Heavy, no solid pieces; ENTIRELY LIQUID

![Bristol Stool Form Scale Diagram](image-url)
Interventions, products and practices for incontinence

"It’s important to choose a continence product that meets the individual needs, circumstances and preferences of a person." Andrea Lord – continence specialist educator and advisor.

Common interventions

Investigate and treat underlying conditions

Because incontinence is a symptom of an underlying problem, identifying what conditions may be contributing to the person’s problem is vital.

A thorough health assessment should be conducted by a general practitioner as part of the continence assessment. Common conditions and disorders that may contribute to incontinence include obesity, diabetes, arthritis, pain or delirium.

Urinary incontinence can be a symptom of a variety of reversible conditions. It is important therefore, to identify and treat the reversible causes of incontinence so the issue may resolve or improve.

The DIAPPERS mnemonic (a method of making items easier to remember) covers some of these conditions:

D – Delirium
I – Infection
A – Atrophic vaginitis/urethra in women (inflammation of the vagina/urethra)
P – Psychological (depression, anxiety)
P – Pharmacological (medications)
E – Excess fluid intake or output
R – Restricted mobility/restricted environmental conditions
S – Stool impaction

Common interventions

There are no limits to the number and type of interventions that can be put in place for people living with incontinence. Even the simplest changes can make a difference.
General fitness

Encouraging the client to maintain and/or regain overall fitness will also contribute to regaining continence. Improvement in mobility enables a client to more easily transfer from bed to chair or walk to the toilet.

For example, toileting issues may be helped by:

- an individualised toileting programme (developed after an individual continence assessment and summarised on a continence care summary)
- the use of toileting aids (a commode in a person’s bedroom, giving them help with their mobility and assistance in removing clothing, wiping and dressing, or providing night lights)
- providing sufficient time for a person to complete their toileting needs and ensuring they are sitting in the right position to go to the toilet
- providing a comfortable, warm toilet environment (not too cold or too hot, no draughts, dim lighting or glaring lighting)

Environmental supports may also be given through:

- the use of signage – ideally pictures – to indicate the location of toilet and bathroom facilities
- removing clutter or floor rugs to enable a clear path and easy access to toilet and bathroom facilities
- hand grip rails near the toilet to support sitting down and getting up
- non-slip mats on the toilet and bathroom floor
- providing a comfortable, warm toilet environment (not too cold or too hot, no draughts, dim lighting or glaring lighting)
- placement of people with bladder and/or bowel problems close to toilet, for example, not in the dayroom in a chair furthest away from the toilet
- ensuring walking frames are within a person’s reach
- ensuring the person can get in and out of chairs with ease
- placing a commode and/or urinal within easy reach of the person
Clothing modifications may support people with mobility issues to toilet with ease through:

- trousers with elasticised waists that are easy to pull up and take down
- velcro fastenings instead of buttons and zips
- tracksuits, which are easier to put on and take off than other clothing

Use of medications

A number of medications can be given by general practitioners to help incontinence by treating bladder storage and bladder voiding issues.

People taking medication should have a regular medication review to identify any side effects that may contribute to urinary or bowel problems.

Information, education and resources on incontinence can also be given to the person and their family or whānau. This can support their understanding of the issue and the interventions that can be used to manage it effectively.

Lifestyle interventions for management and treatment of incontinence

A 'one approach fits all' stance can't be applied to the treatment and management of incontinence. Every person is different (for example, their lifestyle, the degree and severity of their incontinence, their general health, their medical issues) and every person has different needs.

Common lifestyle interventions

Modification of daily food and liquid intake

The person and the support worker may:

- identify the amount of fluid intake required to meet the client’s daily needs (to maintain a healthy bladder function)
- identify types of fluids consumed that may act as an irritant, such as coffee, tea, carbonated drinks or alcohol
- review the timing of fluid intake, for example, have the last drink 2 hours before bedtime for people experiencing problems with nocturi
• record the person's intake of foods that contain adequate levels of fibre (to ensure the nutritional guidelines for 30 grams of fibre per day is met)

• modify fibre intake as required, for example, reduce or increase fibre intake or, if a person is eating a kiwifruit a day to help maintain a regular bowel habit, ensure this can continue

**Maintenance of regular bowel habits**

The aim of this is to help the person maintain healthy bowel elimination and avoid constipation. This requires the support worker to:

• identify the person's regular bowel habit (using the 7-day bowel diary)

• report and record any changes from the person's regular bowel habit

• provide an ideal environment for regular bowel habit, such as:
  • the use of a footstool for people who haven’t had a hip replacement (ensuring the person's safety and preventing falls)
  • enable the person to get to toilet at the time they are most likely to empty their bowels, for example, 15 minutes after a main meal or first thing in the morning
  • prescribed medication to help regulate the bowel habit and motions, for example, laxatives or constipatory agents

**Regular pelvic floor muscle training exercises**

Known as pelvic floor (or Kegel exercises), these specific exercises are designed to help control urine leakage by improving the strength and function of the urethral sphincter and regain bladder and bowel control. They are useful in the treatment of stress incontinence, overactive bladder and faecal incontinence.

**Retraining the bladder**

This is a treatment for people experiencing symptoms of overactive bladder. The aim is to increase the amount of time between toilet visits, increase the volume of urine passed at each visit and increase bladder control. This is achieved through:

• use of a bladder diary – a frequency/volume chart (noting time and volume output)

• deferment techniques (distractions, pelvic floor muscle exercises)

• relaxation techniques and stress management techniques
• weight loss and/or the treatment of any underlying conditions
• increasing general fitness and avoiding constipation
• the addition of medication

**Develop an individualised toileting programme**

An individualised programme is documented after an individual continence assessment is completed and the findings listed on a continence care summary.

The person is encouraged to follow the programme with the support of their support worker. This may include:

• the use of toileting aids (a commode in a person’s bedroom, helping clients with their mobility and giving assistance to remove clothing, wipe and dress, or providing night lights)
• providing sufficient time for the person to complete their toileting needs, ensuring they are sitting in the right position to go to the toilet

**Use of medications**

Medications can be prescribed by general practitioners to help incontinence by treating bladder storage and bladder voiding issues. People on medications should have a regular medication review to identify any side effects which may contribute to urinary or bowel problems.

**The use, care, removal and disposal of continence products**

The NZ Continence Association says the ideal continence product measures an A to F on the alphabet. Yes, truly!

The ideal product should:

A – always work.
B – be easy to use or manage.
C – comfortable to wear and protects skin.
D – disguise or contain odour.
E – easily concealed under clothing.
F – finally ... easy to dispose of or wash and at a reasonable cost and availability.
A number of other factors that will influence the use of continence products include:

- The type of incontinence experienced (for example, are products needed for daytime or night time use?).
- The preference of the person and their support worker. (This may be influenced by the choice of clothing and lifestyle options.)
- The person's physical characteristics (their mobility, vision, hearing, weight).
- Their person's health (for example, they may have infections or other health issues and conditions).
- The state of the person's mental function, the effectiveness and availability of the product itself.
- Storage and cost factors.

Appropriate products are many and varied. Absorbent or containment aids can be either disposable or reusable.

Disposable pads include: mesh briefs with pads or liners; slip-on/pull-up pants; all-in-one briefs. Some pads have an adhesive strip backing and require firm fitting underwear. These products are designed for small to large volume urine loss and may have wetness indicators which help indicate when the product needs to be changed.

Reusable pads include pockets, pants with an integral pad/washable gusset, or all-in-one briefs and liners.

There are also bed pads and chair pads (to protect beds and chairs). Bed pads provide additional backup for products worn on the body.

**Common collection aids**

**Common collection aids** include:

- A commode – a chair with a waste collection bowl under the seat.

- Absorbable granules or sachets which can be placed in urinals and commodes to absorb urine and minimise problems with accidental spills.

- Urinals – a hand held urinal for both men and women. (There's a special attachment for women.)
• **Bedpan** – a portable container (either reusable or disposable) used on the bed.

• **Urodomes and drainage bags for men.** Urodomes are external, disposable, self adhesive latex or plastic sheaths fitted over the penis to collect and drain urine into a drainage bag. They may also be referred to as external catheters.

• **Urinary catheters and drainage systems.** A catheter is a hollow tube inserted into the bladder via the bladder for the purpose of draining urine or instilling fluid as part of a treatment.

  Internal catheters can be used in one of three ways:

  1. **Intermittent.** A catheter is passed into the bladder via the urethra to drain the urine. It is removed once the bladder has drained or medication has been effective.

  2. **Urethral indwelling catheter.** A catheter is passed into the bladder via the urethra to drain the urine and remains in place. The duration of catheterisation may be short term or long term.

  3. **Suprapubic indwelling catheter.** The catheter is passed into the bladder via the abdominal wall. A suprapubic catheter may be chosen for people who are wheelchair bound and sexually active, or unable to tolerate urethral catheters.

**Closed drainage systems.** Indwelling catheters are connected to a closed drainage system, which includes a leg bag and/or a night bag. Once the catheter is connected to a leg bag, the connection shouldn’t be broken until the bag needs changing. A larger capacity night bag may be attached to the leg bag for night time use. The closed drainage system is a vital part of the infection control procedures.

Another option for clients using an indwelling catheter may be a **catheter valve.** A valve can be used on its own or a larger capacity night bag may be attached to the valve for night time use.

**Ostomy pouches.** An ostomy is an opening created on the abdominal wall though the skin surface for discharge of body waste (urine and/or faeces). An ostomy is created though surgery to maintain a person’s normal urinary and bowel function if they don’t have a rectum or have a diseased colon or bladder.
• A colostomy is an artificial opening in the colon (large intestine) which is brought to the surface of the abdomen.

• An ileostomy is where part of the ileum (small intestine) is brought to the surface of the abdomen. This is usually done when the colon is diseased.

• A urostomy is where urine is diverted from the urinary tract to the surface of the abdomen.

Ostomy pouches come in one-piece systems (where the ostomy pouch and skin barrier protection are joined together permanently) and two-piece systems (where the ostomy pouch and the skin barrier protection are separate).

In one-piece systems, the skin barrier and pouch or bag are bonded together and applied as a single unit. In two-piece systems, the skin barrier and pouch or bag are clipped together and may be applied in two steps; firstly, the skin barrier/wafer and then the pouch is clipped into position.

Skin care

• People using continence products should have their skin checked regularly as skin in contact with urine or faeces leads to skin breakdown.

• Skin that has had contact with urine or faeces should be gently washed with soap and water.

• Specialised cleansers and skin moisturisers that provide skin barrier and protection should be used for people with vulnerable skin.

• Skin care products should be applied sparingly and according to manufacturer’s instructions. For example, a thick application of barrier cream may affect the absorbency of continence products.

Every continence product and collection aid available has their own specific instructions about application, care of the product and product removal. Support workers need to be familiar with the products, their specific characteristics (application and care, and various benefits and limitations), their shelf life, their working life and appropriate disposal methods.
Infection control practices

Support workers must adopt and consistently use basic infection control practices. Organisations will have their own specific, documented policies and procedures in this area. The following points generally apply.

- Always wash your hands before and after any and every contact with a person you support.
- Deal with incontinence events promptly. Do not allow the person to be unattended for any length of time.
- Do not place urinary drainage bags directly onto the floor.
- When handling catheter bags, changing bags or emptying bags, avoid touching the connections at the end of the catheter and drainage bag.
- Empty catheter bags carefully into a toilet or designated container. Hold the container at an angle to avoid splashes and bubble formation.
- Ensure catheter outlets are clean and dried after emptying.
- Always check catheter bags for leakage and replace them if they're worn or damaged.
- When changing continence products such as pads, remove them from the person's back, that is, away from the urethral opening. Ensure soiled items are removed immediately and either promptly disposed of, cleaned and/or sterilised.
- Always ensure that urinary drainage bags are placed lower than the client's bladder.

Think about

Did you know that 42.5% of all people with incontinence suffer from skin problems? (Junkin and Selekof (2007), as cited by NZ Continence Association).
For people experiencing incontinence, skin care management is very important for maintaining skin integrity. Good hygiene is essential to prevent odour, maintain a healthy skin environment and avoid infection.

Ageing skin is generally more vulnerable and needs continual care and assessment in relation to incontinence. As people age, the skin becomes thinner and its ability to act as a barrier to the external environment is reduced. It also contains less collagen and is often dry which creates cracks where bacteria may multiply.

Because ageing skin is more prone to damage, good skin care management for a person with bladder or bowel problems is essential. Urine and faeces can cause damage to the skin causing redness, irritation and soreness. The skin areas most at risk are the perineum (the general region between the anus and the genital organs), the inner thighs and between the buttocks.

It is important to make sure that the person's skin is both clean and dry when changing continence products. It is also very important to regularly check to make sure that the person is not suffering from any skin breakdown as a result of their incontinence.
References

Continence Foundation of Australia. (n.d.). Pelvic Floor Muscle Training For Men. 05. (Brochure). Australia.

Continence Foundation of Australia. (n.d.). Pelvic Floor Muscle Training For Women. 06. (Brochure). Australia.


