Urinary incontinence
Te tururuturu o te mimi

The information in this guide is accurate to the best of our knowledge as of June 2023.

Definition

Urinary incontinence is the loss of bladder control and the involuntary leakage of urine. Age-related changes to the urinary tract may increase the risk of urinary incontinence. For example, older people may produce more urine at night and have higher residual volumes of urine. Women may experience reduced urethral closure pressure and men increased prostatic obstruction that affects urinary continence.

Key point

- Limited research evidence supports the assessment and treatment of urinary incontinence that older people living with frailty experience (Gibson et al 2021).

Why this is important

Urinary incontinence has the potential to impact on all areas of life. However, the degree of distress associated with this condition varies from person to person.

Implications for kaumātua*

Because some kaumātua may experience a sense of **whakamā** (shame, embarrassment) over their urinary incontinence, they may either not disclose it or under-report it. They may be a private person who finds discussing incontinence difficult or they may not want to be a bother. See the *Guide for health professionals caring for kaumātua | Kupu arataki mō te manaaki kaumātua* for more information.

It is essential to work with kaumātua and whānau/family to help them engage in prevention, treatment and management options. For example, you need to explain what is known about incontinence and the importance of nutrition and hydration in maintaining usual function. It is also important to support cultural preferences such as traditional Māori herbal remedies. Using familiar, culturally acceptable words when discussing incontinence and continence products (see table below) may also be helpful. Continence New Zealand has additional Māori language resources: **www.continence.org.nz/pages/Continence-Resources-in-Te-Reo-Māori/260**

* Kaumātua are individuals, and their connection with culture varies. This guide provides a starting point for a conversation about some key cultural concepts with kaumātua and their whānau/family. It is not an exhaustive list; nor does it apply to every person who identifies as Māori. It remains important to avoid assuming all concepts apply to everyone and to allow care to be person and whānau/family led.

Kupu (words) to discuss incontinence

Māori term and pronunciation	English translation
Mimi	Urine
Turuturu	Leak
Māturuturu	Trickle
Kope	Pad
Wharepaku	Toilet

Assessment

A comprehensive assessment is recommended because chronic conditions, mobility, cognitive ability, environment and medications all impact on continence, as the Sixth International Consultation on Incontinence explains (Gibson et al 2021).

History of urinary incontinence

- When did incontinence begin?
- What previous treatments has the person received for urinary incontinence and what were the outcomes?
- Detail the characteristics of voiding: frequency, timing, volume, urgency, hesitancy, awareness.
  - Consider neurological deficit when a person is not aware that their bladder is leaking or their bladder empties without warning.
  - Consider obstruction, eg, prostate enlargement, when the person has trouble starting to pass urine, is straining to pass urine or has poor urine flow.
  - Consider residual urine if dribbling occurs after passing urine.
  - Consider sphincter strength if person cannot stop the flow of urine.
- What are relieving or aggravating factors, eg, diuretics, tea or coffee?
- What adaptive behaviours does the person use? For example, do they like to stay close to the toilet? Do they limit drinking? Do they go to the toilet 'just in case'?
- What urinary continence products do they use?
- How does incontinence impact on the person?

Collect detail of toileting situation (collect information over 3–5 days)

- Urinary toileting habits: Use tools such as a bladder diary and fluid intake record.
- To understand if constipation is influencing urinary incontinence, collect bowel history (using the **Bristol stool chart**).

Medical and surgical history

- Hyperglycaemia increases urine production and can risk neuropathic bladder.
- Heart failure increases production of urine at night.
- Stroke can increase urinary retention.
- Dementia or cognitive impairment can make managing continence more difficult.
- Obstetric history influences urinary tract trauma during delivery.
- Chronic constipation worsens urinary incontinence.
- Previous surgery may impact on continence.

Medication

- Consider all medications, recent changes, any 'as required' medication, diuretic therapy, sedatives, anticholinergics and psychotropics.

Functional history

- Manual dexterity and mobility influence the time it takes to get to and use the toilet.
- Ability to process the complex task influences toileting response time.

Eating and drinking habits

- Coffee and tea can increase frequency of urination.
- Lack of fluids can result in concentrated urine, which can irritate the bladder.
- Urinary continence is improved by avoiding constipation.

Environmental issues

- Where the person is placed relative to the toilet location influences their toileting response time.
- Access issues include toilet seat height and space in toilet room.
- Consider the colour of the toilet suite for visually or cognitively impaired residents.

Staffing issues

- Consider availability of staff at toileting times and location of older person relative to the location of the staff hub.

Types of urinary incontinence

Type	Description	Potential treatments
Stress	Occurs with increased intra-abdominal pressure, eg, coughing, sneezing May occur from weakened pelvic floor muscles or malfunction of urethral sphincter Often occurs with urgency in women	• Scheduled toileting • Oestrogen cream • Pelvic floor muscle exercise
Urge	Sudden need to pass urine due to bladder contractions, not dependent on volume of urine in bladder Multiple causes, including neurological conditions, urinary tract infection, bladder pathology	• Bladder retraining; scheduled toileting • Pelvic floor muscle exercise • Anticholinergic medication
Overactive bladder	No cause found for repeated, uncontrolled bladder contraction Causes urgency, frequency and nocturia	• Bladder retraining and/or anticholinergic medication
Overflow	Lack of sensation to urinate, bladder does not empty and small amount of urine leaks continuously; can present with inability to void Most strongly associated with enlarged prostate; residual volume measured with bladder scanner or in/out catheter	• Intermittent self (or nurse) catheterisation or indwelling catheter • Alpha blockers for benign prostatic hypertrophy • Scheduled voiding and double voiding • General practitioner or nurse practitioner monitoring kidney function
Functional	Associated with limitations in thinking, moving and communicating about need to reach toilet due to issues such as confusion, cognitive impairment, neurological conditions and vision/hearing difficulties	• Scheduled toileting in line with individual's observed pattern • Bedside toileting (commode, urinal or co-located bathroom)

Urinary incontinence assessment questions: QUID: Questionnaire for female urinary incontinence diagnosis. Questions 1–3 relate to stress incontinence and questions 4–6 to urge incontinence (Bradley et al 2010).

Do you leak urine (even small drops), wet yourself or wet your pads or undergarments ...

1. When you cough or sneeze?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

2. When you bend down or lift something up?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

3. When you walk quickly, jog or exercise?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

4. While you are undressing to use the toilet?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

5. Do you get such a strong and uncomfortable need to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

6. Do you have to rush to the bathroom because you get a sudden, strong need to urinate?

☐ None of the time ☐ Rarely ☐ Once in a while ☐ Often ☐ Most of the time ☐ All the time

Further assessment resources

People living in aged residential care are entitled to a continence assessment from a continence nurse specialist. The Continence NZ website hosts a range of tools for residential aged care: **www.continence.org.nz/pages/Continence-Information-Adults/18/** (scroll to the bottom of the webpage).

Treatment

Containment

- Urinary continence products are recommended over urinary catheterisation because they have a lower risk of infection. Choose the product based on its match with urine volume.

Physical therapy

- Pelvic floor exercises can be helpful.
- Support general mobility to help the person get to and use the toilet.

Pharmacology

- Antimuscarinic medications (oxybutynin and solifenacin) reduce symptoms of urge incontinence and increase bladder capacity. They may be helpful. However, they also have many adverse effects, including increasing the risk of falls, constipation and urinary retention (New Zealand Formulary nd).
- Local oestrogen therapy (applied to vagina) can help with incontinence related to vaginal atrophy.
- Laxatives can help avoid constipation, a condition that worsens urinary incontinence.

Treat potentially reversible conditions

- Avoid hyper- and hypoglycaemia in diabetes.
- Treat urinary tract infection and inflammation.
- Manage functional limitations.
- Optimise fluid management.

Care planning

Individual assessment is required to understand the impact of incontinence on the person and the capacity to implement interventions.

Decision support

History of urinary incontinence
- ☐ Onset and previous treatments
- ☐ Characteristics of voiding
- ☐ Aggravating and relieving factors
- ☐ Behaviours and products to manage continence
- ☐ Impact on person

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Usual toileting habits and continence details
- ☐ 3-day bladder diary to establish routines
- ☐ 7-day Bristol stool chart to establish routines
- ☐ Collect symptom detail

Determine:
- severity of issue
- bowel management plan
- incontinence type

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Medical and surgical history
- ☐ Surgery (prostate, bowel, gynae, back)
- ☐ Obstetric (births and associated trauma)
- ☐ Whānau/family history
- ☐ Medical chronic conditions
- ☐ Constipation and bowel management history
- ☐ Gynaecological (vaginal atrophy, thrush)

- Note risk associated with surgery
- Note risk from childbirth
- Note whānau/family history and screen/refer
- Optimise management (refer GP/NP)
- Manage constipation
- Manage atrophy or thrush (refer GP/NP)

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Review available tests
- ☐ Ultrasound (residual urine)
- ☐ Blood tests (renal)
- ☐ Urinalysis results

- Consider intermittent catheterisation (CNS continence)
- Consider impact of this
- Treat current UTI but not asymptomatic bacteriuria

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Medication
- ☐ Prescribed medications
- ☐ Recent changes in medication
- ☐ OTC, herbal or self-administered
- ☐ Drugs and alcohol
- ☐ Laxative use (include PRN doses)

- Check NZF: do medications worsen incontinence?
- Is change in continence coincidental?
- Review for impact or interactions
- Alcohol increases urine production
- Consider effectiveness and regularity

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Cognitive function
- ☐ Does person recognise need to toilet?
- ☐ Can they locate toilet?
- ☐ Do they recognise toilet?
- ☐ Can they manage toileting processes?

- Regular toileting may be necessary
- Use signage, colours, staff direction
- Consider lifestyle: did they use out-house in past?
- Provide support, easy-access clothing

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Physical function
- ☐ Manual dexterity (manage clothing, zips, buttons)
- ☐ Mobility: get to and on/off toilet, reach call bells
- ☐ Visual acuity

- Easy-access clothing
- Mobility aid and physio referral
- Colours, lighting, glasses in place

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Usual eating and drinking habits
- ☐ 3-day fluid diary to establish routines (volumes and type)
- ☐ 5-day food diary (compare with stool chart)

- Determine effect on continence
- Determine how food affects bowel

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Review environment
- ☐ Impediments to reaching and using toilet (distance from toilet, distance from staff, mobility aids, call bells, shared facilities)

- Consider environmental adaptations

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Review staffing
- ☐ Is staffing sufficient at peak toileting times? Is toileting prioritised? Are isolation precautions impacting staff availability?

- Consider staffing adaptations

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Impact of continence or incontinence

How does this impact on the person's:
- ☐ mana and self-esteem
- ☐ day-to-day activity and quality of life
- ☐ goals and expectations

- Use to plan person-centred approach to intensity of treatment/investigation

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Physical exam
- ☐ General health and vital signs
- ☐ Abdominal and genital exam (refer as needed to NP/GP)
- ☐ Bowel exam (refer as needed to NP/GP)

- Use to aid diagnosis and plan treatment or referral in collaboration with GP/NP

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Use collected information to develop holistic continence plan, including referral to MDT

Review every 3 months

CNS = clinical nurse specialist
GP = general practitioner
MDT = multidisciplinary team
NP = nurse practitioner
NZF = New Zealand Formulary
PRN = 'as needed' (pro re nata)
OTC = over the counter
UTI = urinary tract infection

References | Ngā tohutoro

Bradley CS, Rahn DD, Nygaard IE, et al. 2010. The questionnaire for urinary incontinence diagnosis (QUID): validity and responsiveness to change in women undergoing non-surgical therapies for treatment of stress predominant urinary incontinence. *Neurourology and Urodynamics* 29(5): 727–34. DOI: 10.1002/nau.20818.

Gibson W, Johnson T, Kirschner-Hermanns R, et al. 2021. Incontinence in frail elderly persons: Report of the 6th International Consultation on Incontinence. *Neurourology and Urodynamics* 40(1): 38–54. DOI: 10.1002/nau.24549.

New Zealand Formulary. nd. Urinary incontinence in women. URL: **nzf.org.nz/nzf_4287?searchterm=urinary%20continece**.