GUIDELINES FOR SPECIALTY NURSING SERVICES (Continence Care)

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** Names are in alphabetical order
GUIDELINES FOR SPECIALTY NURSING SERVICES (Continence Care)

Table of Contents

1. Introduction ............................................................................................................. 1
2. Philosophy of Continence Care ............................................................................. 1
3. Goals of Continence Care ..................................................................................... 2
4. Target Client Groups ............................................................................................ 2
5. Scope of Service and Practice .............................................................................. 3
6. Levels of Care Provision in Hospital Authority .................................................... 4
   6.1 Primary and Community Care ........................................................................ 4
   6.2 Secondary Care ............................................................................................... 4
   6.3 Tertiary Care .................................................................................................... 4
7. Standards of Continence Care Nursing Service Provision ..................................... 5
   Standard No. 1 Care of Patient with Urinary Incontinence ................................ 5
   Standard No. 2 Care of Patient with Fecal Incontinence ...................................... 6
   Standard No. 3 Care of Patient for Pelvic Floor Exercises ................................... 7
   Standard No. 4 Care of Patient requiring Bladder Training ................................ 8
   Standard No. 5 Care of Patient requiring Clean Intermittent Catheterization ...... 9
   Standard No. 6 Care of Patient with Suprapubic Catheter .................................. 10
   Standard No. 7 Maintaining Patient's Frequency Volume Chart ....................... 11
   Standard No. 8 Care of Patient undergoing Urodynamic Study ....................... 12
   Standard No. 9 Care of Patient undergoing Bladder Scanning ....................... 13
8. Specialty Competencies of Continence Nurses ....................................................... 14
   8.1 Competent Behavioral Clusters .................................................................... 14
   8.2 Specialty Competency .................................................................................... 14
      8.2.1 Key Responsibility : Perform Nursing Assessment and Develop Management Plan ........................................................................................................ 14
      8.2.2 Key Responsibility : Implement Nursing Management Plan ................ 15
      8.2.3 Key Responsibility : Evaluate Client Outcomes .................................... 15
9. Contributions of Nurses in Terms of Client Outcomes in Continence Care .......... 17
   9.1 Subjective Outcome Measures ..................................................................... 17
   9.2 Objective Outcome Measures ...................................................................... 17

Glossary ..................................................................................................................... 18

Reference .................................................................................................................. 20
1. **INTRODUCTION**

Incontinence is defined as involuntary loss of urine or feces which is objectively demonstrable and a social or hygienic problem.

Incontinence affects people of all ages, male and female. It is an unpleasant and distressing symptom of an underlying disorder. Many people are not aware of the problem of incontinence and failed to seek help from health care providers and thus suffer in silence. Incontinence can have widespread ramifications for the individual and family, and society. People suffer from incontinence may experience anxiety, embarrassment, sexual difficulties, impaired social and mental well being and are unwilling to attempt a wide range of activities.

In recent years, there are many positive advances in the treatment and management of incontinence. In many instances incontinence will respond to appropriate treatment and the quality of life of the incontinence clients are significantly improved.

With more understanding, the management of incontinence is now by multidisciplinary team approach and changing towards a positive problem-solving approach for each client. The continence nurse, as member of the team, is responsible to identify the unique problems, needs and potentials of clients and their families and to provide the holistic care through multidisciplinary collaboration, both for the promotion of continence and the management of incontinence, and foster a positive approach amongst carers.

2. **PHILOSOPHY OF CONTINENCE CARE**

The philosophy of continence care is of paramount importance as it presents an outline framework for the provision of care and quality service for client with urinary and/or bowel incontinence. The working group believes that:

- Everybody has the right to be continent whenever that is achievable.
- When true continence is not achievable, people have the right to the highest standards of continence care and incontinence management.
- People are entitled to a complete interdisciplinary assessment to establish the cause of the urinary and / or bowel incontinence; investigation and intervention will then be initiated to enable them to achieve the continence.
• Individuals have the right to maintain their quality of life, self-esteem, physical and social well being.
• The existence of positive attitude of staff and caregiver towards incontinence, the possession of skills and knowledge in promoting continence and managing incontinence will enable us to enhance the quality of life and care for our clients.

3. **GOALS OF CONTINENCE CARE**

The goals of continence care include:
- To provide primary health care in the community.
- To reduce the prevalence of bladder and / or bowel problems in hospitals, institutions and community.
- To prevent or reduce the adverse effects associated with incontinence.
- To provide the continuity of care by close monitoring of client's health progress and appropriate care management.
- To meet the clients' and care givers' satisfaction related to their physical and psychosocial needs.
- To improve the client's quality of life.
- To conduct nursing research to promote evidence-based practice.

4. **TARGET CLIENT GROUPS**

Incontinence can affect people of all ages irrespective of sex or social class. Some groups are identified as in high risk. These groups include newborns and infants with severe congenital anomalies or acquired illnesses affecting their continence mechanisms, women, mothers who have had multiparity or large babies by forceps deliveries, people with impaired mobility and cognitive impairment, and frail elderly persons especially those in acute hospital and institution.
5. SCOPE OF SERVICE AND PRACTICE

A comprehensive continence service should include professional and public education, prevention strategies, comprehensive assessment and investigation, a range of treatment and intervention options, counseling and support to help clients improve their bladder and/or bowel control and quality of life.

The service encompasses primary prevention strategies as well as rehabilitative and management strategies.

Therefore, the main functions of continence nurse should involve:

- Provision of education to professionals and public in order to raise awareness and change their negative attitude towards incontinence.
- Provision of individualized care based on client needs through comprehensive assessment, implementation of intervention as well as effective evaluation.
- Provision of education on management strategies and behavioral modification to help clients to manage their incontinence.
- Provision of counseling and support to motivate clients and their caregivers towards achieving positive outcome.
- Provision of education, training and support for caregivers.
- Supervision of nurses and/or supporting staff as appropriate.
- Provision of domiciliary home visit to assist clients in making environmental modification to the home to ensure appropriate toileting facilities.
- Provision of recommendation in the selection of continence aids when indicated.
- Provision of outreaching care to the community settings such as institutions and community centers.
- Maintenance of good liaison with other interdisciplinary professionals and making appropriate referrals.
- Contribution to the development of clinical guidelines and protocols to enhance the standardization of care.
6. LEVELS OF CARE PROVISION IN HOSPITAL AUTHORITY

The continence nurse provides care to clients with incontinence problems in the community, institutions, clinics and hospitals. The practice ranges from primary to secondary and tertiary levels of care.

6.1 Primary and Community Care
Primary and community care aims at promotion of public awareness, provision of preventive measures and identification of the people at risk. The care involves the basic education and screening assessment. The basic education includes provision of knowledge about bladder function, healthy bladder, bowel and fluid habits, skin care, pelvic floor exercise and provision of information about access of care. The initial assessment includes history taking, residual urine monitoring, urinalysis and bladder diary.

6.2 Secondary Care
Secondary care aims at reduction of severity of the incontinence by early diagnosis and treatment. The care involves conduction of comprehensive assessment, such as collection of urine specimen for laboratory test, bladder scanning, urodynamic studies to confirm the diagnosis. The treatment encompasses bladder training, biofeedback, teaching of pelvic floor exercise as well as surgical or pharmacological treatments.

6.3 Tertiary Care
Tertiary care aims at preventing and managing complications and assisting client to maintain social continence after secondary care. The care includes bladder and / or bowel program, selection of continence aids, client and caregiver education, monitoring of medication regimes, prevention of complications, lifestyle and home environment modification.
7 STANDARDS OF CONTINENCE CARE NURSING SERVICE PROVISION

Standard No. 1

Care of Patient with Urinary Incontinence

Standard Statement
Patient receives appropriate care in improvement of urinary incontinence.

Structure / Process Standard
1. Assess patient's physical and psychological status
2. Review medical and drug history
3. Review patient's fluid and dietary regime
4. Document patient's voiding patterns on frequency volume chart
5. Perform physical examination to detect abnormalities such as abnormal bowel sounds, bladder distention and fecal impaction
6. Document the possible causes for urinary incontinence
7. Formulate the investigation and management plan
8. Explain reasons and procedures of all investigations and management plans to patients / caregivers
9. Implement the management plan
10. Monitor and document patient's response to the management plan
11. Evaluate the effectiveness of the management plan
12. Document and report the patient's progress

Outcome Standard
1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient receives appropriate management
3. Patient experiences decreased episodes of urinary incontinence
4. Incontinence related complications are identified early and managed accordingly
5. Accurate records are maintained
Standard No. 2

Care of Patient with Fecal Incontinence

Standard Statement
Patient receives appropriate bowel care in improvement of fecal incontinence.

Structure / Process Standard
1. Assess patient's physical and psychological status
2. Review medical and drug history
3. Review patient's fluid and dietary regime with attention to daily fiber intake
4. Document patient's bowel patterns, stool nature and amount on bowel charts
5. Perform physical examination to detect fecal impaction
6. Identify and document the possible causes for fecal incontinence
7. Formulate the bowel management plan
8. Explain reasons and procedures of bowel training to patients / significant others
9. Perform fecal disimpaction if fecal impaction is present unless contraindicated
10. Implement the bowel training program
11. Monitor and document patient's response to the bowel training program
12. Evaluate the effectiveness of the bowel training program

Outcome Standard
1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient receives appropriate bowel training
3. Patient experiences decreased episodes of fecal incontinence
4. Incontinence related complications are identified early and managed accordingly
5. Accurate records are maintained
Standard No. 3

Care of Patient for Pelvic Floor Exercises

Standard Statement

Patient understands and demonstrates the ability to perform pelvic floor exercises correctly.

Structure / Process Standard

1. Explain reasons and procedures of pelvic floor muscle assessment and pelvic floor exercises to patient and significant others
2. Assess pelvic floor muscles
3. Provide an individualized program of pelvic floor exercises
4. Review the progress of pelvic floor exercise regularly (evaluate the strength, endurance, and repetition of pelvic floor muscle contraction)
5. Document the progress accurately

Outcome Standard

1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient performs pelvic floor exercise correctly
3. Patient increases the muscular strength and endurance of pelvic floor
4. Patient restores continence or reduces the number of incontinent episodes
5. Patient decreases the reliance on pads or other absorbent products
6. Accurate records are maintained
Standard No. 4

Care of Patient requiring Bladder Training

Standard Statement

Patient receives appropriate bladder training program.

Structure / Process Standard

1. Explain the reasons and procedures to patient / significant others
2. Identify patient's voiding and fluid intake pattern
3. Plan appropriate type of bladder training
4. Educate patient to perform the program
   4.1 Reinforce patient about the fluid intake pattern
   4.2 Educate patient the relaxation and distraction technique
   4.3 Ask patient to try and hold bladder until the time period is up
5. Observe and document the progress

Outcome Standard

1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient demonstrates reduction in frequency of voiding
3. Patient increases urine volume during each voiding
4. Patient establishes normal voiding pattern
5. Accurate records are maintained
Standard No. 5

Care of Patient requiring Clean Intermittent Catheterization

Standard Statement

Patient / significant others receive appropriate training on intermittent catheterization and can perform the procedure properly.

Structure / Process Standard

1. Explain the reasons and procedures to patient / significant others
2. Assess patient's cognitive function and manual dexterity
3. Determine suitability of self-intermittent catheterization / intermittent catheterization to the patient
4. Formulate an individual plan for frequency of catheterization based on patient's ability of spontaneous voiding, functional bladder capacity, and fluid intake patterns
5. Educate patient / significant others on technique of hand washing, identification of urethral opening, lubrication and insertion of catheter, equipment maintenance, catheterization schedule, fluid intake patterns, record keeping and observation on possible complications
6. Monitor patient's / significant others' catheterization technique
7. Evaluate the effectiveness of the clean intermittent catheterization program
8. Document and report patient's progress

Outcome Standard

1. Patient / significant others demonstrate proper technique on self-intermittent catheterization / intermittent catheterization
2. Patient does not experience over-distention of bladder
3. Accurate records are maintained
4. Urinary tract infection is minimized
5. Complications are identified early and managed accordingly
Standard No. 6

Care of Patient with Suprapubic Catheter

Standard Statement

Patient with suprapubic catheter receives proper catheter care.

Structure / Process Standard

1. Explain the reasons and procedures to patient / significant others
2. Perform aseptic technique dressing to new suprapubic catheter site before the channel is formed, and then use social clean technique afterwards
3. Cover the catheter site with appropriate dressing and secure in position
4. Secure the suprapubic catheter in position
5. Maintain a patent and closed urinary drainage system below the level of patient's bladder
6. Encourage fluid intake of 2L / day unless contraindicated
7. Detect any signs and symptoms of urinary tract infection, catheter site complication and take appropriate action if necessary
8. Change suprapubic catheter according to protocol
9. Observe, document and report the condition of suprapubic catheter site, the characteristics and amount of urine, and care given
10. Advise patient / significant others on catheter care

Outcome Standard

1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient experiences minimal discomfort throughout catheter site dressing
3. Patient's suprapubic catheter is patent and is connected to a closed urinary drainage system
4. Patient's catheter site hygiene is maintained
5. Complications are identified early and appropriate actions are taken accordingly
6. Urinary tract infection is minimized
7. Accurate records are maintained
Standard No. 7

Maintaining Patient's Frequency Volume Chart

Standard Statement

Patient's fluid intake, voiding patterns and incontinence episodes are monitored and recorded accurately.

Structure/ Process Standard

1. Explain the reasons and procedures to patient / significant others
2. Measure and record patient's fluid intake
3. Document patient's voiding patterns including volume, frequency and episodes of leakage

Outcome Standard

1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient's fluid intake and voiding patterns are measured accurately
3. Accurate records are maintained
Standard No. 8

Care of Patient undergoing Urodynamic Study

Standard Statement

Patient undergoing urodynamic study receives safe and proper care with minimal discomfort.

Structure/ Process Standard

1. Explain the reasons and procedures to patient / significant others
2. Obtain an informed consent
3. Empty the bowel before the day of procedure
4. Remove the indwelling urethral catheter 4 hours before the procedure if necessary
5. Instruct patient to have full bladder before uroflowmetry
6. Ensure privacy of patient
7. Provide psychological support throughout the procedure
8. Observe any abnormalities and take appropriate action accordingly
9. Encourage fluid intake after the procedure
10. Educate patient / significant others to observe the possible complications after the procedure

Outcome Standard

1. Patient/ significant others express understanding and satisfaction with the explanation and care given
2. Patient experiences minimal discomfort
3. Complications are minimized
4. Accurate records are maintained
Standard No. 9

Care of Patient undergoing Bladder Scanning

Standard Statement
Patient undergoing bladder scanning receives safe and proper care with minimal discomfort.

Structure/ Process Standard
1. Explain the reasons and procedures to patient / significant others
2. Advise patient to empty bladder before the procedure
3. Ensure privacy of patient
4. Assist patient in a proper position
5. Prepare the bladder scan
   5.1 Ensure the battery is charged
   5.2 Select correct gender
   5.3 Prepare the scanhead by using ultrasound transmission gel
6. Find the correct site and scan the bladder. If the crosshairs are not centered on the bladder, adjust the probe and rescan until they are centered
7. Help patient to clean the scanned area
8. Observe, report and document the volume of residual urine

Outcome Standard
1. Patient / significant others express understanding and satisfaction with the explanation and care given
2. Patient's residual urine is correctly monitored
3. Accurate records are maintained
8. **SPECIALTY COMPETENCIES OF CONTINENCE NURSES**

The key responsibility of continence nurses is to identify and manage clients with urinary and/or bowel problems in order to optimize their quality of life. Nurses are also responsible for promotion of continence care services in the hospitals and community.

### 8.1 Competent Behavioral Clusters

- **Demonstrate knowledge of:**
  - signs and symptoms of urinary and/or bowel problems
  - clinical diagnosis on different types of incontinence
  - management of incontinence
  - preventive measures
- **Deliver individual continence care management including nursing assessment, management plan, on-going evaluation on client outcomes.**
- **Educate and support client and family members**
  - provide explanation on causes of incontinence problems, the management plan and possible client outcomes
  - educate on appropriate skills
  - make appropriate referral to other agencies
- **Demonstrate clinical competence and expertise in the management of complex cases**
- **Establish and promote continence care**
  - provide advice and guidance to colleagues in clinical practice
  - provide training and professional support to the colleagues
  - raise the awareness of relevant organizations and public on the importance of continence care
  - participate in research/nursing audit on continence care

### 8.2 Specialty Competency

#### 8.2.1 Key Responsibility: Perform Nursing Assessment and Develop Management Plan

**Specialty Competencies**

Conduct a comprehensive assessment in respect of special focus on mental status, mobility, medical history, drug history and other possible causes of incontinence

**Key Components**

- Identify incontinence symptoms and effects on quality of life
- Understand client’s chief complaints
- Assess client’s mental status, manual dexterity, mobility and accessibility of toilet facilities
◆ Perform urinalysis to screen for urinary tract infection
◆ Review existing medication that may precipitate incontinence
◆ Perform physical examination:
  ♦ Abdominal examination to detect palpable mass or urinary retention
  ♦ Perineal examination to identify prolapse or excoriation
  ♦ Vaginal or rectal examination to assess pelvic floor muscle contraction
  ♦ Rectal examination to exclude fecal impaction and test for anal tone on adult client
◆ Develop individualized management plan in respect of client’s incontinence problems and cultural beliefs
◆ Make appropriate referral to other health care professionals

8.2.2 **Key Responsibility: Implement Nursing Management Plan**

**Specialty Competencies**
Provide holistic care based on the formulated management plan

**Key Components**
◆ Advise client or care givers on fluid and dietary intake to achieve healthy living
◆ Enhance appropriate toileting behavior by improving access to toilet facilities and client’s mobility
◆ Advise on drug administration and monitor its effectiveness
◆ Implement appropriate bladder and / or bowel training
◆ Document client incontinence and voiding episodes on frequency and volume chart
◆ Manage constipation and fecal impaction
◆ Prevent and manage stress incontinence by teaching pelvic floor exercise, for examples, during and after pregnancy, before and after prostatectomy
◆ Teach self-intermittent catheterization to client with urinary retention
◆ Advise on home catheter care to client with indwelling urethral or suprapubic catheter
◆ Provide appropriate information on incontinent products to clients and care givers

8.2.3 **Key Responsibility: Evaluate Client Outcomes**

**Specialty Competencies**
Monitor effectiveness of treatment and review management plan on regular basis
Key Components

- Review frequency and volume chart and/or bowel charts
- Assess client's subjective perception on changes of incontinent status and treatment outcomes
- Ensure appropriate usage on absorbent products
- Monitor skin integrity
- Assess effect and side effect of medication
- Evaluate caregivers' ability on caring of the client
- Monitor client's compliance on management plan
9. CONTRIBUTION OF NURSES IN TERMS OF CLIENT OUTCOME IN CONTINENCE CARE

Outcome may be one of the methods we use to justify continuity of care or even expanding the continence service. Evaluation by measurable criteria should be built into every continence program. Subjective or objective outcomes should be initiated at the first assessment of the client so that comparison can be made before and after the treatment.

The nursing outcomes of continence care are as follows:

9.1 Subjective Outcome Measures
- The client's opinion of treatment outcome
- The impact on quality of life
- The client's satisfaction survey

9.2 Objective Outcome Measures
- Structured questionnaire on monitoring the attitude of client and/or caregiver towards incontinence in order to evaluate the effectiveness of primary and community education
- Structured micturition and/or bowel history and/or questionnaire to monitor the improvement of incontinence episodes, micturition frequency, urinary symptoms as well as constipation
- Frequency volume chart is a significant indicator to monitor the effectiveness of client undergoing bladder training. The records enabled regular review of incontinence episodes, the reduction of voiding frequency, the improvement of urge syndrome by the increase of interval between voids, and the increase of urine amount of each voiding
- Biofeedback reading to monitor the strength and endurance of pelvic floor muscle
- Bladder scanning to monitor the residual urine
- Estimation of the cost associated with the consumption of absorbent products
GLOSSARY

- **Biofeedback**
  A technique by which information about a normally unconscious physiological process is presented to the patient and the therapist as a visual, auditory or tactile signal. The signal is derived from a measurable physiological parameter, which is subsequently used in an educational process to accomplish a specific result. The signal is displayed in a quantitative way and the patient is taught how to alter it and thus control the basic physiological process (ICS, 2001).

- **Bladder Scan**
  A B-mode ultrasonic device, portable and battery operated, intended for the non-invasive measurement of urinary bladder volume. Utilizing a mechanical sector scanning transducer to provide cross-sectional images of the bladder from twelve scanplanes, the machine automatically calculates the estimated bladder volume in milliliters and displays it on a screen (BVI 2500 Operator's Manual).

- **Bladder training / Bladder retraining**
  A behavioral technique that requires the patient to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone voiding and to urinate according to a timetable rather than the urge to void (Button et al., 1999).

- **Bowel Training**
  A training program which is based on assessment of the person's functional ability, cognitive status, motivation, current bowel habits and stool consistency, current and past use of bowel stimulants, and dietary intake. A bowel training program is developed in collaboration with the patient or care-giver; the program should offer a practical approach to restoring regular bowel movements and eliminating fecal soiling and incontinence (Doughty, 2000).

- **Continence Nurse**
  Registered Nurse who has received specialty training on continence care.

- **Fecal Incontinence**
  Involuntary loss of feces which is objectively demonstrable and a social or hygienic problem.

- **Frequency / volume chart (bladder chart)**
  Record the fluid intake and urine output per 24 hour period. The chart gives objective information on the number of voiding, the distribution of voiding between daytime and night-time and each voided volume. It can also be used to record episodes of urgency and leakage and the number of incontinence pads used (ICS, 2001).
• **Intermittent Catheterization**
  Drainage or aspiration of the bladder or a urinary reservoir with subsequent removal of the catheter. There are four types of intermittent catheterization:
  1. Intermittent self-catheterization: performed by patient himself / herself
  2. Intermittent catheterization by an attendant (e.g. doctor, nurse or relative)
  3. Clean intermittent catheterization: use of a clean technique. This implies ordinary washing techniques and use of disposable or cleaned reusable catheters
  4. Aseptic intermittent catheterization: use of a sterile technique. This implies genital disinfection and the use of sterile catheters and instruments / gloves (ICS, 2001)

• **Pelvic Floor Exercise**
  Repetitive selective voluntary contraction and relaxation of specific pelvic floor muscles. This necessitates muscle awareness in order to be sure that the correct muscles are being utilized, and to avoid unwanted contractions of adjacent muscles groups (ICS, 2001).

• **Residual urine**
  The volume of fluid remaining in the bladder immediately following the completion of micturition (ICS, 2001).

• **Suprapubic Catheter**
  A catheter inserted directly into the bladder via the anterior abdominal wall. It is always inserted by a medical practitioner in the first instance, either under general or local anaesthetic (Norton, 1996).

• **Urinary Incontinence**
  Involuntary loss of urine which is objectively demonstrable and a social or hygienic problem (ICS, 2001)

• **Urodynamic study**
  Involve the assessment of the function and dysfunction of the urinary tract by any appropriate method. Aspects of urinary tract morphology, physiology, biochemistry and hydrodynamics affect urine transport and storage (ICS, 2001).
REFERENCES:


