Urinary Incontinence - Full Clinical Guideline
31 October 2023

1. Introduction

Urinary incontinence can be the cause of extreme distress for the sufferer, leading to potential co-morbidities.

2. Aim and Purpose

The purpose of this resource is to provide registered and non-registered practitioners with an evidence based clinical direction in order to assess and manage adult patients who present with urinary incontinence within the trust.

3. Definitions

Urinary incontinence is defined as any involuntary leakage of urine.

Stress incontinence is defined as a leakage of urine with physical activity that increases abdominal pressure such as exercise, coughing and sneezing.

Urge incontinence is defined as a leakage of urine when a sudden, intense urge to pass urine is felt.

Functional incontinence is defined as leakage of urine that happens if there is a delay getting to the toilet due to impaired mobility.

Overflow incontinence is defined as frequent dribbles of urine due to a weak bladder muscle or blockage.

4. Assessment of urinary incontinence

Urinary incontinence is not an illness, it is a sign of an underlying problem. The aim of a continence assessment is to try and define this problem and treat or manage it effectively. Assessment of urinary incontinence should include:

- Accurate history taking, is this a new or longer standing problem. History should also include any pre-disposing factors for incontinence such as reduced mobility, drug side effects etc.
- Urinalysis to rule out or to initiate treatment of proven symptomatic urinary tract infections.
- Post void bladder scan to ensure adequate bladder emptying.
- Fluid intake record to monitor the type and amount of fluid intake.
- Vaginal or rectal examination to assess pelvic floor function and prostate gland size. Rectal examination to exclude constipation and faecal impaction may also be indicated as this can impact on bladder function.

5. Management of urinary incontinence

- **Pelvic floor exercise** (PFE) could help with both urinary leaks caused by stress and urge incontinence, but also help with urge control and reduction in urinary frequency.

Performing Pelvic Floor Exercise

1. Stand, sit or lie with knees slightly apart and imagine you are trying to stop yourself passing wind. Squeeze and lift the muscle around the back passage tightening and lifting, aim to hold for % seconds. Repeat 5 times.

2. Now try to pull the muscles quickly and tightly and relax straight away. Repeat 5 times. These are called fast pull ups.

   Both slow and fast pull ups should be undertaken to ensure an effective workout. They should be performed x 6 daily if possible.

Available as Trust patient information 

Female Male

- **Fluid intake.** If appropriate an intake of between 1.5 - 2 litres over a 24 hour period should be encouraged (6 - 8 drinks taken at regular intervals). This should prevent concentrated urine which is a bladder irritant and could exacerbate urgency and frequency of micturition as well as urge incontinence. Caffeine found in tea, coffee, hot chocolate, cola and energy drinks should be replaced gradually with de- caffeinated drinks. Other bladder irritants such as citrus fruits, pure citrus drinks should also be avoided. If consuming alcohol, it may help to drink extra fluid to dilute the effects on the bladder.

Available as Trust patient information 

Bladder irritants

- **Bladder retraining.** Bladder retraining may help with urinary frequency, urgency and urge incontinence and encourages the bladder to hold onto increasing amounts of fluid. When used in conjunction with pelvic floor exercise and fluid modification, retraining could enable better bladder control. Bladder retraining entails holding onto an urge to pass urine for increasing amounts of time. It could be starting quite conservatively for a few minutes and gradually building up this hold time will improve technique consistency as this is paramount for success. Also avoiding going to the toilet "just in case" without an urge to pass urine will help.

Available as Trust patient information 

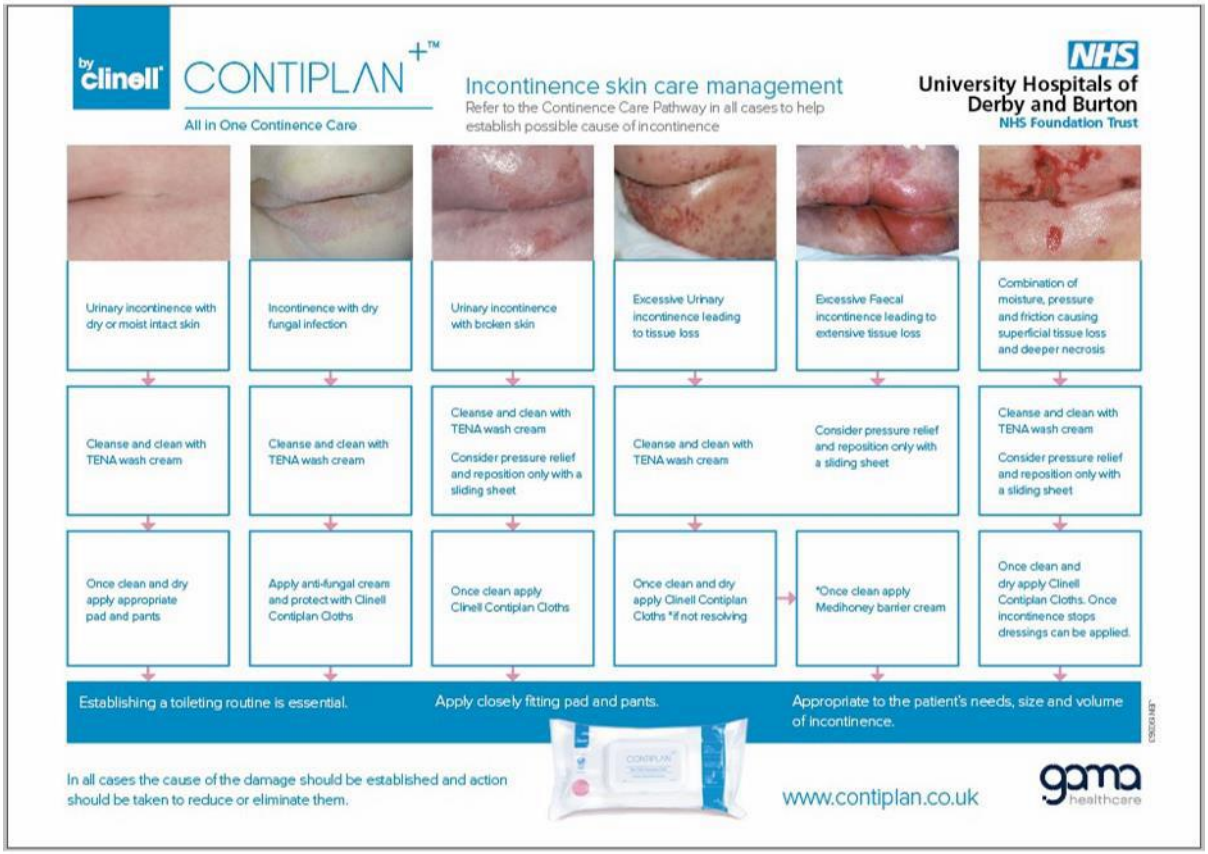
Bladder re-training

- **Absorbent pads and pants.** Products should never be used as a first line management of urinary incontinence and certainly should never be offered as an alternative to performing an assessment and utilising basic advice. However, if a product is deemed to be appropriate, care to choose the right type and absorbency of pad in line with the Trust's current pad formulary must be taken. Pads should always be secured in close fitting underwear or net pants as on formulary. Procedure sheets (under pads) should not routinely be used to manage urinary incontinence as they offer very little protection against moisture lesions.

- **Catheters.** Catheterisation is an absolute last option management of urinary incontinence as indwelling catheters pose a significant risk of infection and trauma. They may be considered if skin integrity is an issue or if poor bladder emptying is a root cause, in which case intermittent catheterisation should be explored as the first line of treatment, so reducing the risks of an indwelling catheter.

- **Medication**. If appropriate anticholinergic and antimuscarinic medication may be useful for management of frequency, urgency and urge incontinence. They should be prescribed if conservative treatment strategies are not successful. Alpha blockers or 5 alpha reductase inhibitors may be useful with lower urinary tract symptoms associated with benign prostate enlargement. A review of medication may also be helpful if necessary, such as the timing of loop diuretics and minimising or modifying the use of drugs that have sedative effects or compound mobility problems.

- **Skin care and urinary incontinence.** The tissue viability team have produced the following skin care algorithms to initially prevent but then correctly treat moisture lesions. Correct and appropriate pad usage when indicated is also an important component of this care.



- **Continence Advisory Team.** The team are based at RDH but are available for support and advice throughout the Trust. Patients that are referred to us will be assessed in one of our outpatient clinics as we do not routinely undertake ward visits. Contact details are available on NETi.

- **Referrals.** RDH and FNCH - written referrals will be accepted either by mail, email (dhft.continence@nhs.net) or via ExtraMed (in patients only). We will then triage the referral to see if the patient would be more appropriately assessed in a community or hospital continence clinic. If referring via ExtraMed, the referral will not be processed unless all the first line assessment information is recorded (urinalysis, post void residual, frequency, DRE if appropriate).

  QHB, SRP, SJ - if patients are able/wanting to attend appointments at RDH, we will accept paper or e-referrals. It may however be more convenient to refer to local community continence or district nursing services.

6. References (including any links to NICE Guidance etc.)

National Institute for Health and Care Excellence. Urinary incontinence and pelvic organ prolapse in women: management [NG123], 2019.

National Institute for Health and Care Excellence. Lower urinary tract symptoms in men: management [CG97], 2015.

Public Health England. Diagnosis of urinary tract infections (UTI). Quick reference tool for primary care consultation and local adaptation, 2020.

7. Documentation Control

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	1	25/4/23	Anita Counsell	Formatted to replace archived Burton only site guidelines
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Training and Dissemination: Relevant Matrons, Clinical Nurse Specialists, Medical Staff. Document will be signposted on Learning Passport and Intranet				
Development of Guideline: Anita Counsell **Job Title: Lead CNS Urology/Continence**				
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