



Australian Government  
Department of Veterans' Affairs



# Continence with care

A resource reference for  
Personal Care Workers



## Introduction

The Department of Veterans' Affairs (DVA) is focused on promoting a person-centred approach across all programs delivering services to veterans and their families. By 'person-centred', I mean care that is determined by the needs of the veteran, or entitled family member. DVA is committed to assisting Community Nurses and Personal Care Workers deliver the very best person-centred care. I trust this resource will support you in the delivery of community nursing services and thank you for your care of our veterans and their family members.

**Dr Trish Batchelor**

Deputy Chief Health Officer

Department of Veterans' Affairs

DVA requires community nursing and support services for entitled persons to be driven by person-centred approaches. By 'person-centred', we mean care that is determined by the needs of the person, rather than the needs of the health service provider.

As a Personal Care Worker (PCW), being continence-aware in your role is very important. How you communicate with the person about their continence and support them in their continence management has a direct impact on their physical and emotional health.

PCWs report that supporting people with incontinence is one of the most difficult aspects of their jobs. They can feel helpless, frustrated, irritable and discouraged. If you feel this way, try to see it from the perspective of the person you support with incontinence. Things they once took for granted about their bodies are not the same, and they may feel frightened, overwhelmed, or ashamed.

When supporting someone with continence, remember the whole person – their dignity, identity, values, self-worth and comfort. With your respect and understanding, the person will feel more confident and in control of their situation.

If you notice changes in a person's continence, report this as soon as possible. Sudden changes to a person's continence can be a sign of more serious problems. This resource will show you what to look out for, and when to report changes.



**In supporting a person with continence, always observe the principles of standard precautions, including hand hygiene.**

# Continence, incontinence and risk factors

## Continence and incontinence

**Continence** or **being continent** is the ability to retain urine or faeces until the appropriate time for their discharge.

This means a person can delay urinating (emptying the bladder) or defecating (emptying the bowel) until it is acceptable to do so. This includes:

- Reaching a toilet in time
- Having time to adjust their clothing and position themselves correctly
- Sending the correct message to brain and body that it is an appropriate time and place to empty the bladder or move the bowels.

When a person is **incontinent**, it means they have difficulty with one or all of these functions. **Incontinence** can range from an occasional small leak of urine, through to complete loss of control of both the bladder and bowel.

Uncontrolled loss of urine from the bladder is called **urinary incontinence**. Uncontrolled bowel movement is called **faecal incontinence**.

## Who can develop incontinence?

People of all ages experience incontinence. Although older people experience incontinence more often than other age groups, it is not always a part of growing older.

## Risk factors for incontinence

There are many different reasons why someone may be incontinent. Some people are more at risk of incontinence than others. Risk factors for urinary and faecal incontinence include:

- Neurological diseases including Parkinson's disease and multiple sclerosis
- Spinal cord injury
- Ageing
- Pregnancy and childbirth
- Prostate problems (men)
- Obesity
- Urinary tract infections
- Chronic constipation
- Medication such as blood pressure tablets
- Surgery, such as hysterectomy or prostate surgery
- Reduced mobility preventing someone from using a toilet in time
- Reduced dexterity affecting ability to adjust clothing to use the toilet
- Reduced cognitive function, such as dementia
- Stroke, heart conditions, respiratory conditions, and diabetes

Over 4.8 million Australians currently live with some kind of bladder or bowel control problem.

# Urination and urinary incontinence

## Urination

Urination, or emptying the bladder, is a complex reflex that requires many body systems to be working together well.

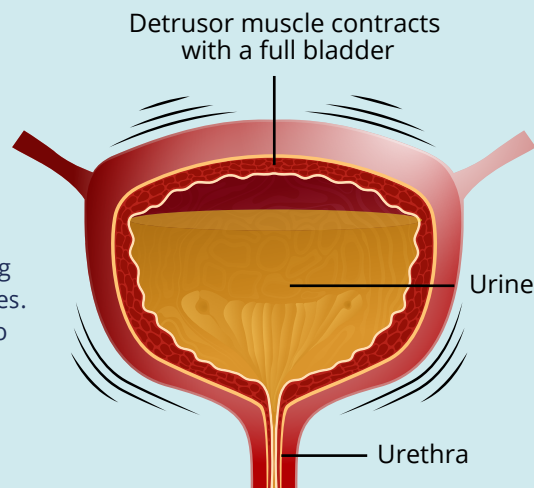
In a healthy person, the bladder is continuously filled with urine from the kidneys at an average rate of 1–2mls per minute. At 170mls a person feels the bladder filling, followed by a normal desire to void the bladder at 250mls. A strong desire to urinate is at 400mls.

In a person with one or more risk factors, these normal urinary reflexes can be compromised, resulting in urinary incontinence.

The colour of a person's urine can indicate hydration levels. Light, straw-coloured urine usually indicates adequate hydration whereas dark urine can indicate dehydration.

### Normal bladder

When a person decides it is time to urinate, their brain triggers the micturition reflex (shown left). This is a coordinated and sustained contraction of the muscle surrounding the bladder, while the sphincter relaxes. The urine is released and empties into the urethra, allowing urination.



## Types of urinary incontinence

There are five main types of urinary incontinence:

1. Stress incontinence
2. Urge incontinence
3. Overflow incontinence
4. Functional incontinence
5. Transient or reversible incontinence.

A person may have 'mixed' urinary incontinence, which is a combination of two or more incontinence types, most commonly stress and urge incontinence.

If the person you support has incontinence, managing this will be part of their personal care plan. Refer closely to the plan and be sure to report any changes or variances in the person's continence status.

## Immediately report any of the following:

- Sudden deterioration in existing continence status
- Pain on passing urine
- Urine with strange colour or smell
- Blood in urine
- Person not being able to urinate
- Increased need to urinate, accompanied by excessive thirst
- Red, itchy or painful urethral, perineal, groin or anal area.

## Stress and urge incontinence

### Stress incontinence

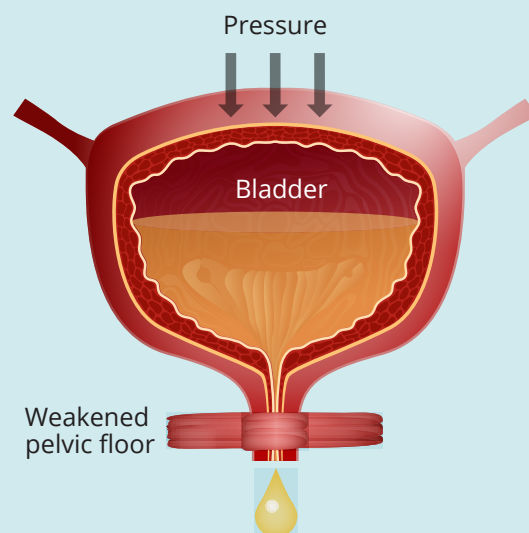
Stress incontinence occurs during activities that increase pressure inside the abdomen and push down on the bladder, causing urine to leak out. This is often made worse when the 'hammock' of pelvic floor muscles, tissues and ligaments that support the sphincter are weakened. The combination of pressure on the bladder, and the weakened pelvic floor, causes urine loss.

Stress incontinence occurs mainly in women, but many men develop stress incontinence after prostate surgery. Diabetes, chronic cough, constipation and obesity also contribute to stress incontinence.

Pressure on the bladder can be caused by any activity; including laughing, coughing, or jumping up and down. Leakage can range from lightly wetting underwear to completely emptying the bladder.

#### Stress incontinence

Activities that increase pressure inside the abdomen push down on the bladder. A weakened pelvic floor fails to support the sphincter, and urine loss results.



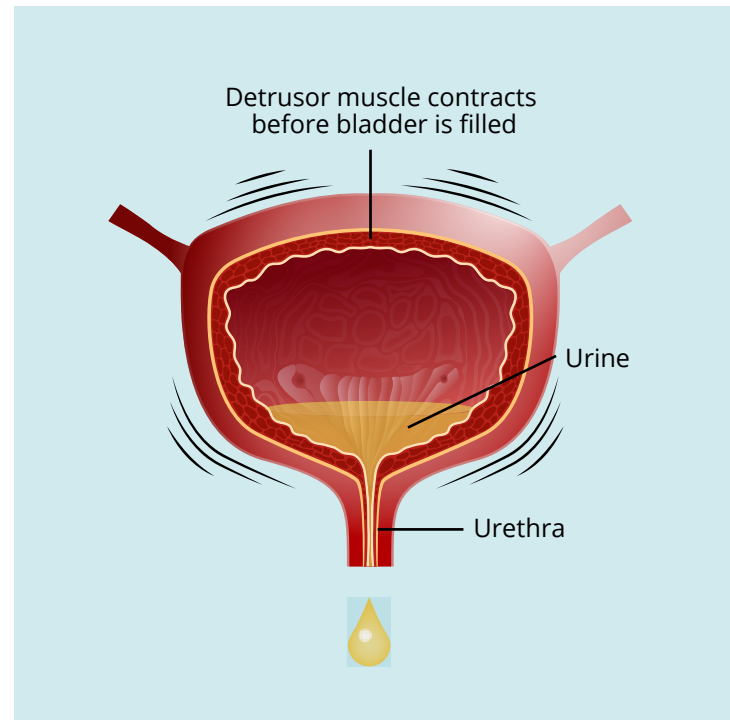
## Urge incontinence

Urge incontinence is a sudden and strong need to urinate. It is sometimes called unstable or overactive bladder.

With urge incontinence, the detrusor muscle surrounding the bladder suddenly contracts. This creates a sense of urgency to urinate, and the bladder may leak before the person reaches the toilet.

Urge incontinence can be caused by a number of conditions, including an enlarged prostate (in men), neurological disorders, spinal cord injuries, stroke, bladder inflammation and cancer. In some cases, there may be a blockage or infection.

Urge incontinence requires a thorough medical investigation. Sometimes, no cause is found. It is more common as people age, although why this happens is not fully understood.



## Overflow, transient and functional incontinence & nocturia

### Overflow incontinence (urinary)

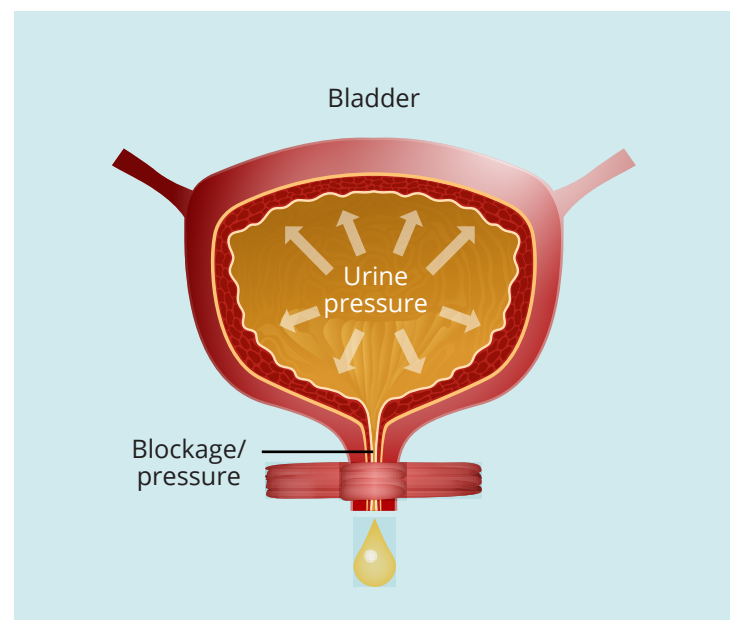
Overflow incontinence occurs when the bladder is full and cannot squeeze itself empty, or when there is an obstruction preventing the urine draining from the bladder. In both cases, this means that after the person urinates, there is still some urine left in the bladder (residual urine).

Symptoms of overflow incontinence include:

- Feeling the need to strain to pass urine
- A weak or slow urine stream
- Feeling as if the bladder is not empty just after going to the toilet
- Little or no warning when the person is passing urine while asleep
- Frequent urinary tract infections or cystitis
- Dribbling of urine after urination.

Causes of overflow incontinence can include constipation, enlarged prostate (men), nerve damage, diabetes, multiple sclerosis, stroke, Parkinson's disease, and side-effects of medication.

Overflow incontinence affects older people more than other age groups, and a full assessment is recommended to find the cause.



## Transient or reversible incontinence

People may experience short-term incontinence due to illness or a medical condition.

Causes include:

- Urinary tract infection (UTI)
- Constipation
- Chronic cough
- Medication

If a person suddenly becomes incontinent, or their incontinence becomes worse, report this immediately to your nursing supervisor.

## Functional incontinence

Sometimes a person with normal bladder function can be incontinent because of physical, intellectual or environmental issues. Dementia, intellectual disability and loss of mobility can cause functional incontinence, but other factors include lack of access to a toilet, poor lighting, low chairs that are difficult to get out of, poor eyesight, or clothes that are difficult to remove.

Always consider that the physical environment may be a barrier to someone being able to manage their continence. Simple measures may help enhance independence and dignity.

## Nocturia

Nocturia is when a person wakes up in the night because they have to urinate. It is a common problem, and even more common as people age. Where someone is waking more than once to urinate in the night, medical assessment is required. This is because nocturia can be part of a number of medical conditions including heart problems, kidney problems, and poorly managed diabetes.



# Healthy bowels

## Healthy bowels

What we refer to as 'the bowel' is made up of the small and large intestine, a tube-like organ that starts at the stomach and ends at the anus. Food is absorbed in the stomach and small intestine, also called the small bowel. The small bowel takes the nourishment the body needs from food and passes the remaining waste to the large intestine (or large bowel).

Faeces enter the large bowel as liquid. The large bowel absorbs water back into the body and the faeces become more solid. When faeces reach the lower part of the large bowel (rectum), a person feels fullness or the urge to pass a bowel motion (stool) through the anus. Eliminating faeces is called *defecation*, but can also be referred to as 'moving the bowels', 'opening the bowels', 'passing a motion', 'bowel motion' or simply, 'doing a poo'.

In describing what faeces looks like, the term 'stool' is used.

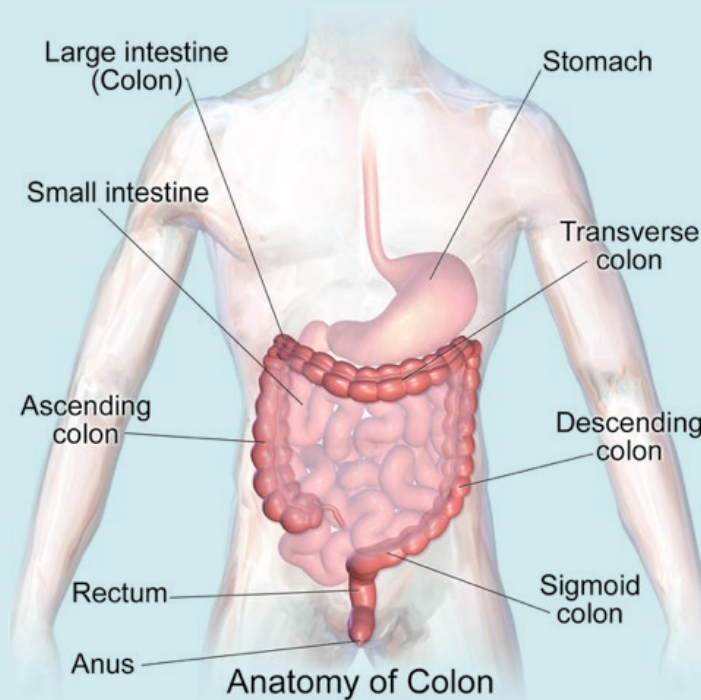


Image of bowel used with  
acknowledgement: Blausen.com staff



## What are 'regular' bowel habits?

People often think having 'regular' bowel habits means a daily bowel movement, but it really means that soft, yet well-formed bowel motions are easily passed. This can happen anywhere from one to three times a day to three times a week.

There is more to good bowel function than just 'being regular'. A healthy person can usually:

- Hold on for a short time after feeling the first urge to go to the toilet
- Pass a bowel motion about a minute after sitting down on the toilet
- Pass a bowel motion easily and without pain
- Completely empty the bowel when he or she passes a motion.

All of these functions are important to faecal continence. If someone cannot hold on for a minute, for example, they may soil their clothes before they reach the toilet. If someone cannot pass a stool easily, they are experiencing constipation, which can lead to poorer continence over time.

**Diarrhoea** is when bowel movements become loose or watery. The definition of diarrhoea is passing loose or watery bowel movements three or more times a day. Acute diarrhoea is common and usually goes away without treatment, but in people with chronic or other conditions, it may be more serious.

If a person with diarrhoea has a fever, dehydration, abdominal pain and/or blood in their stools (they may appear dark or black), refer this to your nursing supervisor immediately. If they have dementia and are showing abnormal behaviour, report this immediately, as they may have delirium.

Diarrhoea is often caused by infection, so observe strict hygiene standards and wash your hands thoroughly after being with a person who has diarrhoea.

# Constipation

## Constipation

People say they are constipated when they can't empty their bowels as often or as easily as they would like (usually less than three times a week). If a person is constipated, stools are usually hard, dry and difficult to eliminate. This is accompanied by bloating and the uncomfortable sensation of a full bowel. Other symptoms include:

- Excessive straining during bowel movements
- Passing hard or lumpy stools
- The feeling of incomplete evacuation or of a blockage.

Constipation is often caused by a diet lacking in fluids and fibre. Medications like painkillers can also cause constipation, as well as neurological disorders like stroke and Parkinson's disease.

If stools are very hard, dry and large, it may cause a small split in the lining of the rectum/anus (anal fissure) and result in pain and stinging in the area as well as some bright red bleeding, often seen on the toilet paper and sometimes also in the toilet.

If you notice a person has changes in bowel habits, excessive straining, bleeding, pain or obstruction; write this in their progress notes and notify your nursing supervisor as soon as possible.

## Preventing constipation through diet and habit

A first step to treating constipation is to look at a person's diet, because inadequate fluid and fibre are common causes of constipation.

A nurse or doctor can review the person's recommended fibre intake per day as set out in the Australian Dietary Guidelines. There is no set amount for fluid intake, but a minimum of six cups of fluid (with no more than three cups of tea or coffee) is recommended.

The colour of a person's urine can indicate hydration levels. Light, straw-coloured urine usually indicates adequate hydration, whereas dark urine can indicate dehydration.

Other lifestyle changes can also prevent constipation. These include:

- Physical activity, appropriate to age and ability
- Setting up the toilet so the person can be more in a squatting position, to avoid straining (see figure opposite)
- Going to the toilet on waking or shortly after meals, as the bowel is most active at these times

By having knees higher than the hips, the bowels are easier to open. Ensure the person does not hold their breath as this encourages straining.

If the person is frail or unsteady, assist them with placing and removing the foot stool. Ensure the foot stool is safe and has non-slip feet. An occupational therapist can provide further advice on modifying toilet areas.

Consider the person's mobility to assess and minimise the risk of any falls. The person may require an occupational therapist assessment for a toilet raiser or rails in the toilet.



## Medications to treat constipation

If changes to diet and bowel habits do not relieve constipation, a doctor or nurse may talk to a person about medication or supplements to relieve it.

If a person is taking medications to treat bowel problems, check whether this is part of their care plan. If not, ask the person the name of the medication, the amount taken each day, and how long they have been taking the medication. Write this down in their progress notes. If you have concerns, refer to your nursing supervisor.

## Faecal incontinence, responsive behaviours & dementia

### Causes of faecal incontinence

Where someone has faecal or bowel incontinence, it may be due to one or more of the following problems:

1. Faecal impaction
2. Lack of sphincter control
3. Impaired cognition
4. Nerve damage

## Faecal impaction

When a large stool gets stuck in the rectum, it begins to stretch the rectum muscles, weakening them and leading to a loss of awareness of the need to pass a motion. Watery stools can leak around the stool and out of the anus, causing what looks like faecal incontinence. This condition is called faecal impaction with overflow incontinence and requires medical attention and monitoring.

## Lack of sphincter control

The sphincter muscles around the anus hold faeces in until it is time to discharge it. If these muscles become weakened or damaged, faecal incontinence can occur. Sphincter muscles can become damaged through injury, childbirth or from bowel or rectal surgery.

## Impaired cognition

Conditions such as delirium, dementia and depression often limit a person's ability to control their bowel movements, particularly in an unfamiliar environment.

## Nerve damage

Problems with the nerves connecting the brain and the rectum can also lead to bowel incontinence. A damaged connection can mean the body is unaware of stools in the rectum and may make it difficult for the person to control his or her sphincter muscles.

Damage to these nerves can be caused by several conditions, including stroke, multiple sclerosis, diabetes and spinal injury.

## Responsive behaviours

Continence problems can cause or escalate responsive behaviours.

'Responsive behaviours' are where someone's actions, words and gestures are a response (often intentional) to express an unmet need, or something important about their personal, social or physical environment.

If the person is angry, agitated, yelling and hitting or being disruptive with constant repetitive questions, they may be expressing pain or discomfort. Many factors could be triggering the behaviour, but common causes are constipation, urge incontinence, or feeling distressed about being incontinent.

If the person is restless and wandering, this may be because they feel hungry, feel thirsty, feel the need to pass urine or a bowel motion urgently, or are unable to find the toilet.

If a person has unexplained tiredness, is excessively irritable or thirsty, or has a sudden change in continence status, notify your nursing supervisor.

## Dementia and incontinence

When a person is living with dementia, incontinence may become more of a challenge. Because of changes to their brain, the person may be disoriented and unable to find the toilet. They may resist or refuse assistance with toileting. They might also feel ashamed of having to be helped. A professional continence assessment is required to plan appropriate management of co-existing health problems and behaviour factors.

Check the person's individual care plan to see if there are specific instructions on assisting them with toileting.

**Delirium** is a serious condition that can develop in people living with dementia and can also be a sign of infection or reaction to medication. Signs of delirium include a sudden change in the person's behaviour, for example, someone who is outgoing and friendly becomes withdrawn or aggressive. If you suspect delirium, notify your nursing supervisor.

# Continence Plans

## Continence plans

A continence plan is a person-centred process that aims to maintain the person's dignity and allows them to participate in as many activities as possible.

A person-centred continence plan works in a continuous cycle of assessment, implementation and monitoring. This allows for adjustment to changes, and for the person to be a partner in their own continence management. A continence plan should be developed by a continence nurse or registered nurse in discussion with the care team, person and family.



Above: A person-centred cycle of continence assessment and monitoring. Where the person cannot express their wishes, a representative of the person can speak for them.

If observation and charting show a predictable pattern of urination and bowel movements, then an individual program can be tailored for the person. If there is no predictable pattern, the plan may be to try a fixed toileting program.

Continence plans are usually prepared by a registered nurse or continence nurse advisor. A continence plan may include changes to fluid and fibre intake, pelvic floor exercises, bladder retraining, a toileting program, and specifying which continence products (such as pads) are required. Equipment and changes to the physical environment may be specified, such as bathroom and toilet grab rails, commodes, portable urinals, catheters and better toilet accessibility.

The continence plan becomes part of the person's individualised plan and requires regular review and updating by the registered nurse to remain current.

## Implementing the plan

The aim of a continence plan is to support individuals to manage their own continence as long as possible. While it may not be possible to achieve continence for all people, it is still important to encourage them to actively take part in toileting sessions. This is so that they can remain as mobile and independent as possible.

Some people may find it difficult to know when they need the toilet, and where the toilet is located. In this case, remind them on a regular basis and, if need be, take them or point the way. The plan may also require signs to the toilet.

Continence plans need to be continually monitored and reviewed. Continence can change particularly if someone's overall health status changes. If you see changes, such as a person having more problems with leakage, wet pads or bowel incontinence, report this to your nursing supervisor.

## Toileting programs

Toileting programs aim to retain a person's good bladder and bowel habits as long as possible. The program will ask carers and Personal Care Workers to anticipate, schedule or prompt the person to visit the toilet. If it is too risky or painful for the person to walk to the toilet, the plan may specify alternatives like bedpans, commodes and portable urinals.

Where a person wears pads, the continence plan will specify what type of pads they are to wear, and how often they are to be checked and changed. Changing continence pads is determined by the persons' individual plan and needs, not by other people's schedules.



# Observation charts, skin integrity & catheter care


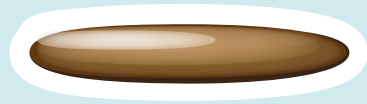

## Observation charts

Sometimes a bladder or bowel observation and monitoring chart is used to assess a person's continence over a period of days, usually up to a week. The person may be able to provide the information to complete the chart, but where this is not possible, care staff or family carers may need to discreetly observe. If the person is wearing pads, you can check the wetness indicators (usually on the outside of the pad) at the designated time periods.

Information gathered from the bowel observation chart includes how often the person has a bowel motion, what time of the day, the type of bowel movement (using the Bristol Stool Form Scale below) and whether pad or clothing changes were required.

### The Bristol Stool Form Scale (BSFS)

Types 1 and 2 indicate constipation; types 3 and 4 are ideal as they are soft consistency and easier to pass. Types 5, 6 and 7 indicate urgency and diarrhoea.

TYPE 1	Separate hard lumps, like nuts (difficult to pass)	
TYPE 2	Sausage-shaped but lumpy	
TYPE 3	Like a sausage but with cracks in its surface	
TYPE 4	Like a sausage or snake, smooth and soft	
TYPE 5	Soft blobs with clear-cut edges (passed easily)	
TYPE 6	Fluffy pieces with ragged edges: a mushy stool	
TYPE 7	Watery, no solid pieces, entirely liquid	

## Skin integrity

Constant exposure to urine and faeces may cause the person pain and skin irritation or infection. A continence plan will have a skin integrity plan to minimise the chances of irritation and infection.

In supporting the person with skin care, take note of any skin that is reddened; unusually pale; has a discharge or bad smell; appears broken or ulcerated; has a rash or unusual appearance, or is thin or fragile. If you have concerns, report these to your nursing supervisor immediately.

## Catheter care

When a person is unable to empty their bladder, a soft thin tube called a catheter is inserted into the bladder, allowing urine to flow freely into a bag. Catheters are mostly used short-term, following injury or severe illness.

People with a significant injury or ongoing illness may need urinary catheters for a longer time, sometimes permanently.

There are three types of catheter: external, urethral and supra-pubic:










- External catheters (e.g. urodome) are attached outside the penis and secured with a band of adhesive.
- Urethral catheters (IDC) drain urine directly from the bladder via a tube inserted through the urethra and are usually used short-term.
- Supra-pubic catheters (SPCs) are inserted directly into the bladder and have a surgical opening into the abdomen. Depending on the client and type of catheter they have, it can be in place for up to three months.

The person's continence plan will detail how to support them with managing a catheter. Fluid intake is important to keep the catheter flushing though. If the person has an SPC, the care plan will detail how and when to wash around the catheter. Never use talcum powder if someone has a catheter.

Personal hygiene is extremely important. Always follow the standard precautions for hygiene when supporting someone who has a catheter.

If there is no urine draining, there is urine leaking around the catheter, the person is having pain, or there is blood in the urine, contact your nursing supervisor immediately.

## Contacts and other resources

DVA general enquiries	 1800 555 254
DVA provider enquiries	 1800 550 457
DVA community nursing	 <a href="mailto:nursing@dva.gov.au">nursing@dva.gov.au</a>  <a href="http://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing">www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing</a>
Department of Health – National Continence Helpline	 <a href="http://www.health.gov.au/contacts/national-continence-helpline">www.health.gov.au/contacts/national-continence-helpline</a>
DVA Rehabilitation Appliance Program (for continence aids)	 <a href="http://www.dva.gov.au/providers/health-programs-and-services-dva-clients/rehabilitation-appliances-program">www.dva.gov.au/providers/health-programs-and-services-dva-clients/rehabilitation-appliances-program</a>
Open Arms – Veterans and Families Counselling	 1800 011 046
Continence Foundation of Australia helpline	 1800 330 066 (8.00 am to 8.00 pm (AEST) Monday to Friday)
Continence Foundation of Australia	 <a href="http://www.continence.org.au">www.continence.org.au</a>

## Disclaimer

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