OVERVIEW: Despite progress made in the research into and treatment of urinary incontinence, its incidence is rising among older adults. Many reasons for this disturbing finding have been posed: clinicians’ insufficient knowledge of urinary incontinence, the reluctance of patients to discuss it, and inadequately individualized care. Common misconceptions of bladder health in older adults are explored to address these concerns and help prepare nurses in all settings to provide care that prevents and treats incontinence.

I’d like to talk with you about how you’re doing with urination.”

Some clinicians may be uncomfortable uttering this sentence to patients, but many older adults suffering silently with urinary incontinence may be relieved to hear it. Many wrongly believe that, like wrinkled skin, incontinence comes with age. Uninformed of treatment options, incontinent older adults make do, possibly restricting social activities and feeling anxious about when the next episode will occur. Indeed, one study found that one-third of independently living incontinent older adults reported that they had never mentioned their incontinence to a physician. They felt that “it was not important enough” and that treatment was appropriate only for younger people.¹
“Nurses need to cast aside stereotypes about aging,” says incontinence expert Mary Palmer, PhD, RN, FAAN. “Growing old does not cause incontinence. If older adults are incontinent, effective treatments can help them lead vital, active lives.” Photograph taken from Aging in America: The Years Ahead, by photographer Ed Kashi and writer Julie Winokur.

If only they had been asked about it—and informed of the multitude of options.

Over the last two decades, many advances have been made in treating incontinence in older adults, yet the growing consensus is that more is known about the treatment of incontinence than is applied in practice. Certainly, urinary incontinence is a common problem for adults over 65 years old; in fact, the incidence is rising. It affects approximately 45% of all American women; when broken down by age group, the highest incidence (55%) is in 80- to 90-year-old women. An estimated 3.4 million men over the age of 60 are also affected—in fact, Medicare costs for treatment of urinary incontinence in men older than 65 have doubled since 1992. Clearly, it’s a problem that requires significant attention. But how can health care professionals sustain efforts to prevent and treat this problem? How can we best translate research into action?

Understanding the myths surrounding urinary incontinence is the first step. These myths, rooted in the insidious stereotypes and prejudices of ageism, hinder efforts for both patients and providers. Following are some of the most prevalent of these misconceptions.

**MYTH: URINARY INCONTINENCE IS INEVITABLE WITH AGE**

Although urinary incontinence is not an inevitable consequence of aging, older adults are at increased
risk for it. As the body ages, kidneys become less able to concentrate urine and the bladder has less capacity, becomes more irritable, and may not empty completely. These normally occurring changes may lead to increased urinary frequency, urgency, nocturia, and vulnerability to infection; these changes do make it easier for factors like infection to result in urinary incontinence. Other risk factors include chronic constipation, inadequate hydration, smoking, a high number of vaginal births and difficult deliveries, estrogen deficits, cognitive decline, neurologic disease, detrusor muscle instability, benign prostatic hypertrophy, and excessive nocturia.

Delayed sensation can result in urgency and less time to get to a toilet (further complicated by the slower ambulation that can occur with age). Leakage can result from decreased muscle tone in the pelvic floor. Nocturia may occur because kidneys function more efficiently when the older adult is sleeping or at rest.

Urinary incontinence is often preventable and may be reversible using behavioral training methods. Many interventions have been successful in assisting people to reduce the number of incontinence episodes, and many older people are able to remain continent; these facts support the assertion that incontinence is not inevitable with age. Nonetheless, urinary incontinence is often preventable and may be reversible using behavioral training methods. Many interventions have been successful in assisting people to reduce the number of incontinence episodes, and many older people are able to remain continent; these facts support the assertion that incontinence is not inevitable with age.

Myth: There is only one type of urinary incontinence
This erroneous belief is a detriment to the management of urinary incontinence. In fact, there are numerous types of urinary incontinence; without a precise diagnosis, it’s impossible to intervene appropriately. The most common types are reviewed briefly.

Transient incontinence, which appears suddenly and is present for six months or less, is usually caused by treatable factors, including delirium or confusion secondary to an acute illness; infection, particularly urinary tract infection; atrophic urethritis or vaginitis; increased urine production caused by metabolic conditions such as hyperglycemia, hypercalcemia, or Paget disease; and fecal impaction, which obstructs the urethra. Iatrogenic (or treatment-induced) incontinence, one type of transient incontinence, results from use of restraints, limited fluid intake, bed rest, or IV fluid administration. It can also result from certain medications, including diuretics, anticholinergic agents, antidepressants, sedatives, hypnotics, calcium channel blockers, and α-adrenergic agonists and blockers. Transient incontinence, regardless of etiology, is usually easily treatable and should not last six months if appropriate therapy is provided. (After six months, urinary incontinence becomes established and prognosis is poorer.) In one study of 52 nursing homes, investigators identified potentially reversible causes of urinary incontinence in 81% of the residents.

Urge incontinence is involuntary urination that occurs soon after feeling an urgent need to void. Its definitive characteristics are loss of urine before getting to the toilet and an inability to suppress the need to urinate. Stress incontinence is loss of less than 50 mL of urine with increased intraabdominal pressure. Short urethras and poor pelvic floor muscle tone make women more prone to stress incontinence, which, in fact, was the most common type of incontinence found in a classic study of 200 community-dwelling older women. In men, stress incontinence is associated with prostatectomy and radiation. Rates of urinary incontinence after prostate surgery range from 37% to 65%. Overflow incontinence is defined as involuntary loss of urine associated with overdistension of the bladder. It occurs when the bladder becomes so distended that voiding attempts result in the frequent release of small amounts of urine, often in the form of dribbling. Possible causes include an obstruction of the urethra by fecal impaction or an enlarged prostate, smooth muscle relaxants that relax the bladder muscle and increase bladder capacity, or an impaired ability to contract (caused by a peripheral neuropathy secondary to diabetes or a neurologic disease such as multiple sclerosis). Common signs and symptoms include a large amount of residual urine, hesitancy, slow stream, passage of infrequent or small volumes of urine, a feeling of incomplete bladder emptying, sudden leakage of urine when bending or turning, dysuria, and a palpably full bladder. Functional incontinence is the inability to reach the toilet because of environmental barriers, physi-
cal limitations, loss of memory, or disorientation. People with functional incontinence are often dependent on others and have no genitourinary problems other than incontinence. Data also show that higher rates of functional incontinence are present in older adults who are institutionalized.11

**Mixed incontinence** is urine loss having features of two or more types of incontinence. Older adults often experience a mix of both stress and urge incontinence. For example, with increasing age many women who already have stress incontinence begin to experience urge incontinence.

**Reflex incontinence and total incontinence** are less common types. In reflex incontinence, the bladder empties autonomically but the person has no sensation of the need to void. Spinal cord injuries may lead to reflex incontinence. Total incontinence refers to a continuous and unpredictable loss of urine. It usually results from surgery, trauma, or a malformation such as an ectopic ureter. With total incontinence, the reflex control is intact, but urination can’t be controlled because of anatomical abnormalities.

**MYTH: THERE ARE NO EFFECTIVE TREATMENTS FOR URINARY INCONTINENCE—IT’S UNAVOIDABLE IN NURSING HOME RESIDENTS**

On the contrary, there is much evidence showing that urinary incontinence is treatable. In 1996 the Clinical Practice Guidelines for Managing Acute and Chronic Urinary Incontinence identified many effective treatments and recommended their application in practice. Effective treatments were again explored in 2002 and 2003, during the State of the Science on Urinary Incontinence symposium and the International Nursing Summit on Incontinence. Furthermore, as highlighted by these conferences, many interventions fall within nursing’s scope of practice. A number of behavioral interventions have a good research base and can be implemented without extensive and expensive evaluation. These interventions will do no harm and if there’s no improvement, further evaluation can be sought. A comprehensive assessment should be completed before interventions are selected. The following have been tested in long-term care facilities.

**Scheduled voiding** is used to treat urge and functional incontinence. This method can be used for people with intact cognition or cognitive deficits. A person establishes a schedule by using a bladder diary or by following common voiding patterns (such as going to the toilet first thing in the morning, before and after meals, mid-morning, mid-afternoon, and at bedtime). Generally, a voiding “appointment” will be scheduled at two-to-four-hour intervals, resulting in a reduction of incontinent episodes. If episodes persist, the schedule is adjusted.

**Prompted voiding** combines scheduled voiding with monitoring, prompting, and praising. When this intervention is used with people who are cognitively intact, the objectives are to increase self-initiated voiding and decrease the number of incontinent episodes. Success requires communication between patient and caregiver as well as the patient’s active participation—responding to questions, agreeing to use the bathroom, or even going there himself when prompted.

When prompted voiding is done consistently with people with dementia, they often begin to anticipate that someone is coming to take them to the bathroom and start preparing on their own; they may get out of bed, head toward the bathroom, or even quip, “It must be time to go to the bathroom again,” when a staff person arrives in the room. Prompted voiding may improve incontinence in 25% to 50% of incontinent residents in long-term care facilities.14 It can also be successful
Fecal Incontinence
What to know about this often-hidden problem.

Harry Stein, a 74-year-old who presented with an exacerbation of eczema, was halfway out the door when his wife stopped and started prodding him to ask me something.

“Harry, go ahead, ask her,” she told him, then looked at me. “Harry has a problem—he’s too embarrassed to ask you about.”

When Mr. Stein remained silent, his wife asked for him.

“He keeps having accidents, you know, bowel movements in his pants. You never know when it’s going to happen. We had to leave our grandson’s birthday party last week—Harry went out to the car without saying a word to anyone and I made up some excuse. It was awful. This is the first time he’s left the house since.”

I closed the door and asked Mr. Stein and his wife to sit down. I told him I understood his reluctance to talk about this subject and that he was not alone.

OVERVIEW
It’s difficult to accurately determine the prevalence of fecal incontinence—defined as the involuntary passage of gas, mucus, or stool—because, like Mr. Stein, so many people with the problem don’t seek help. They hide the problem out of embarrassment or the misconception that nothing can be done about it. Indeed, less than 50% of community-dwelling older adults with fecal incontinence talk to their primary care provider about the problem. Studies show prevalence rates ranging from 2.2% to 19% in this population; in nursing home residents the prevalence can be as high as 50%. Dual incontinence, a combination of urinary and fecal incontinence, is also a problem for many—in one recent study, 14.5% of 4,277 adults over the age of 75 had dual incontinence. After cognitive disorders, fecal incontinence is the second most common reason for nursing home admission.

Types of fecal incontinence. Fecal incontinence can be transient or persistent. The most common causes of transient incontinence are diarrhea, fecal impaction, and acute illness. Any time there is a new episode of incontinence with liquid stool without a recent solid stool, impaction should be the first consideration. Once the underlying condition is resolved, interventions such as dietary changes, behavioral methods, or medication will usually restore continence.

If the incontinence doesn’t resolve, or has been present for one month or more, the patient has persistent fecal incontinence. Risk factors for persistent fecal incontinence include diarrhea, neurologic diseases (including diabetes), poor mobility, decreased functional status, cognitive disorders, irritable bowel syndrome, anorectal pathology, stroke, and injury to the pudendal nerve or sphincter muscles during childbirth. Patients who present with any of these conditions should be questioned specifically about incontinence. If persistent fecal incontinence is revealed, a thorough work-up is necessary.

PATIENT ASSESSMENT
The first step in treating fecal incontinence is to try to identify the cause and to rule out any underlying serious pathology.

The patient history should include special attention to the gastrointestinal system. Review the duration of incontinence, stool consistency and frequency, use of laxatives or enemas, presence of abdominal pain or bloating, diet, presence of fatigue or weakness, difficulty with performance of activities of daily living, sexual history, surgical history, obstetrical history, changes in medication, bathroom facilities at home (for example, are there stairs on the way to the bathroom), what remedies they have tried, and how the incontinence has affected the patient’s life. Since depression and anxiety are so often associated with fecal incontinence, discuss the signs and symptoms of these conditions and offer the patient an opportunity to talk about the emotional effects of this condition.

A physical examination should include a digital rectal examination to identify the presence of a mass, impaction, or occult blood and to evaluate sphincter tone and integrity. Women should receive a pelvic examination to check pelvic floor muscle tone and for the presence of masses or prolapse of the uterus or bladder. Observe gait, strength, and reflexes. Screen for cognitive impairment using the Mini-Mental State Examination.

Diagnostic tests include X-rays, anal manometry to measure the resting and squeeze pressures of the anal canal, anorectal ultrasonography to view the anal sphincters, anal electromyography to evaluate innervation of the external anal sphincter, and defecating proctography, which visualizes the active process of defecation. Patients who present with diarrhea may need a stool culture. Anyone with changes in their bowel habits should have a sigmoidoscopy or colonoscopy. Referral to a gastroenterologist may be necessary.

TREATMENT
Biofeedback and pelvic floor exercises can enhance muscle control of the sphincter and pelvic floor muscles. Those with nerve conduction deficits of the anal sphincters may benefit from sacral nerve stimulation, in which a low level of electrical current is continuously transmitted to the nerves of the sacral plexus. This is a minimally invasive procedure with low risk and excellent
In the long-term care setting, a bowel-training program should be initiated and residents should be given the opportunity to use the toilet frequently.

Patient education is a crucial aspect of treatment. Always explain what should be expected with any tests that have been ordered. Instruct the patient that it may help to avoid caffeine and lactose, both of which may increase the rate of peristalsis. A daily dietary fiber supplement and the use of medicines such as loperamide (Imodium) can control diarrhea. Care should be taken to maintain skin integrity with thorough cleansing and drying after incontinent episodes and use of a barrier cream if the patient is at risk for skin breakdown.

Provide patients who have fecal impaction with information on diet, fluid intake, activity, and fiber supplements. Consider referring community-dwelling older adults to the local visiting nurse service, which can send a professional to assess the person’s physical environment, review diet and medication, and recommend changes (such as a bedside commode if the patient’s bedroom is far from the bathroom).

Surgical interventions include sphincteroplasty to repair a structurally damaged sphincter. Another option is to replace natural sphincters with artificial sphincters; these have inflatable pumps that the patient activates to open and close the anal canal. Though short-term results have been excellent for both interventions, long-term success is poor and infection rates are high.

Between 15% and 30% of patients who receive artificial sphincters have them removed because of problems. In some cases of severe, intractable incontinence, colostomy is a final option.—Karen Roush, MSN, RN, FNP, clinical editor

REFERENCES

nity-dwelling persons who had at least one incontinence episode a week that resulted in a decrease in incontinence episodes.24

Intermittent catheterization can be used in people with urinary retention related to a weak detrusor muscle (as in diabetic neuropathy), in those with a blockage of the urethra (as in benign prostatic hypertrophy), or in those with reflex incontinence related to a spinal cord injury. Intermittent catheterization is a clean (not sterile) procedure. The goal is to maintain 300 mL or less of urine in the bladder. Although most of the research on this procedure has involved children and young adults with spinal cord injuries and myelomeningoceles, intermittent catheterization has been found to be successful in older adults who are often able to catheterize themselves.25 Intermittent catheterization represents an important alternative to indwelling catheterization.

**MYTH: URINARY INCONTINENCE FALLS UNDER THE PURVIEW OF PHYSICIANS; NURSES CAN’T DO MUCH TO HELP**

Urinary incontinence can be managed with nonpharmacologic treatments implemented by nurses. A thorough assessment will help determine the type of incontinence, the person’s response to the problem (the course of treatment and emotional responses), and the best interventions. The assessment should include

- **specifics about urine control.** When did the problem begin? When does urine loss occur?
- **a health history** (surgery, bladder or kidney infection, mode of childbirth, menopause, prostate problems, and spinal cord injury or stroke).
- **lifestyle history** (smoking [how long and how much], fluid intake [especially caffeine], physical activity, weight, and bowel habits).
- **functional abilities.** How good is the patient’s eyesight? His mobility? Is he able to transfer out of bed, dress himself, and use the toilet? How much time does it take to get from the bed to the bathroom?
- **mental status.** Can the patient recognize the need to go to the toilet? Is he able to find it?
- **environment.** Is the bathroom accessible? Is there a clear path and sufficient lighting? Does the patient have the physical aids required?
- **physical examination:** presence of rectal or uterine prolapse, condition of skin, height, weight, stool impaction, strength of leg extension, and deep tendon reflexes. Patients should also undergo a provocation test, in which they are asked to cough while wearing a pad. A loss of urine during a provocation test is an indication of stress incontinence.
- **psychosocial effects.** How has incontinence affected the patient’s personal life? What are the patient’s feelings about it?

- **three-day bladder diary.** This should record fluid intake, time and volume of voidings, and whether the patient urinated in the toilet or was incontinent. The diary should be updated every one to two hours. It helps to provide a baseline to evaluate improvement.
- **urinalysis,** to rule out infection.
- **postvoid residual catheterization** to determine if the patient is retaining 150 to 200 mL of urine.

**Assessment tools.** Lekan-Rutledge has developed a rapid assessment instrument that can be used for a tentative diagnosis of the type of urinary incontinence in all settings.26 The Hartford Institute for Geriatric Nursing also includes a urinary continence assessment tool through its “Try This” program, available at www.hartfordign.org/resources/education/tryThis.html. (Although the “Try This” tool may be effective, it also incorporates the unfortunate mnemonic “DIAPERS,” which reinforces a stereotype of childlike loss of control that should not be used when treating older adults.)

**Psychological effects of incontinence** can also be assessed using standardized tools. The Incontinence Impact Questionnaire, developed by Wyman and colleagues, is a well-tested, 26-item questionnaire assessing self-perception, activities of daily living, and social interactions of community-dwelling women.27 The Male Urinary Symptom Impact Questionnaire (MUSIQ) is a 32-item questionnaire based on the instrument developed by Wyman and colleagues.28 MUSIQ measures the health-related quality of life in men with continence problems, assessing their activity, social contact, emotional health, self-confidence, stability of support, and sleep.

**MYTH: URINARY INCONTINENCE IS UNMANAGEABLE IN PEOPLE WITH DEMENTIA**

In a study of 145 nursing home residents with dementia, 48% were incontinent of urine upon admission, and that number rose to 81% six months after admission.29 Mobility, awareness of the need to void, and fewer than six episodes in 24 hours indicated that residents with dementia were in need of intervention and good candidates for scheduled voiding.

Although urinary incontinence is often concurrent with dementia, cognitive impairment alone hasn’t been shown to cause urinary incontinence.30 While impaired cognition may affect a patient’s ability to find a bathroom or to recognize the urge to void, it doesn’t necessarily affect bladder function. Prompted voiding has been demonstrated to be effective in improving dryness in cognitively impaired and dependent nursing home residents.31 The biggest difficulty with implementing and sustaining prompted voiding is sustaining staff efforts.32 In one alternative living setting for people with
dementia, continence was promoted through visible toilets and staff assisting residents to the bathroom at regular intervals or according to individual voiding patterns. Using these methods, continence was maintained in residents with middle-to-late stages of dementia for more than two years. The importance of environment was also highlighted in a study that documented an “eight-fold-increase in the use of toilets” that were visible rather than concealed.31

Because caregivers often have problems coping with incontinence, special attention should be given to address them. Often, the only advice caregivers are given is that the patient should wear pads or use incontinence aids; scheduled voiding or other potential interventions may never be discussed. In fact, such interventions have proven successful even in cognitively impaired homebound older adults. For example, Jirovec and Templin initiated a scheduled voiding protocol that significantly decreased episodes of incontinence in a group of memory-impaired adults.14 Engberg and colleagues used a prompted voiding protocol that reduced episodes of daytime incontinence by 60% in treatment subjects compared with 37% in the control group.15

**MYTH: COMPLETE CONTINENCE IS THE ONLY INDICATION OF SUCCESSFUL TREATMENT**

Until recently, continence and incontinence were viewed as opposite ends of a spectrum with nothing in between. It was only with the start of clinical trials of urinary interventions, which began in 1982 with studies on pelvic muscle exercises by Thelma Wells and Carol Brink at the University of Michigan School of Nursing, that continence began to be measured on a continuum. Gradations of successful treatment may include dryness at night or during the day, fewer episodes of incontinence, a greater percentage of dry time, and an increase in the number of times a person urinates in a toilet.

In fact, any improvement can be seen as significant progress. For example, a patient who reduces episodes of incontinence in a 24-hour period from six to two will be more comfortable. Caregivers should consider such improvements a success and acknowledge both their own efforts and those of the patient. Skin breakdown on the perineum and buttocks (which occurs in as many as 35% of incontinent hospitalized adults and 41% of incontinent adults in long-term care32) will improve, and the patient will spend less money on protective garments and less time worrying about accidents and changing clothes or pads. Other improvements can be seen in self-esteem, social interaction, mood, and odor. Nursing outcomes and interventions for specific types of incontinence are described more fully in the chapter by Specht and Maas in *Nursing Care of Older Adults: Diagnoses, Outcomes, and Interventions and Nursing Care of Older Adults: Diagnoses, Outcomes, and Interventions and Nursing Outcomes Classification.*

**EVERYONE’S INCLUDED**

The Jewish Home of Rochester provides a model for continence care.

The staff at the Jewish Home of Rochester, a 362-bed long-term care facility in upstate New York, understands the importance of teamwork when it comes to helping residents maintain continence. This is not surprising—the facility, first opened in 1920, was built on “a foundation of community service and family-oriented care.” It is a goal of the facility, which achieves higher rates of continence than the state average, to keep residents continent. They achieve this with a comprehensive plan that includes all members of the staff.

Continence care at the Jewish Home begins with a thorough assessment upon admission (or with any newly diagnosed incontinence). Risk factors, cognitive state, functional status, fluid intake, and medications are assessed, and a five-day monitoring tool is used to check timing, frequency, and amount of voiding. The information gathered is used to develop individualized care plans that include voiding plans.

Cindy Lovetro, RN,C, BS, CDONA/LTC, director of nursing at the Jewish Home, says, “Our facility is fortunate to have a low staff turnover rate, and we don’t use outside agency staff, which allows for increased consistency in resident care.” Also important is “having good staffing levels and providing staff with the supplies and equipment they need.” At this facility, the necessary equipment includes standing lifts and full mechanical lifts with hygiene slings. According to Lovetro, “not having adequate staff or the proper equipment decreases the resident’s chance of maintaining continence.”

In addition to having “expectations that are developed and communicated to all nursing staff,” Lovetro believes that one of the most influential factors in achieving a high rate of continence is the inclusion of certified nursing assistants (CNAs) in care planning. “CNAs will be more willing to take the extra time in toileting . . . when they are included in the plan. The CNA is the person on the team who spends the most time with residents and knows what will work best with each.” With CNAs, nurses, and medical staff working toward the same goal, the Jewish Home of Rochester is a model of success.

—Lisa Melhado, associate editor

**MYTH: OLDER ADULTS DON’T MIND BEING INCONTINENT AND WEARING PADS**

It’s not unusual to hear an older adult say “I’m such a baby” or “I’m just no good for anything anymore” after an episode of incontinence. In an early study that found that incontinence represented a loss of control and made older adults angry; they grieved the loss and were embarrassed, ashamed, and depressed.6 The feeling of loss of...
control is even greater when incontinence is unpre-
dictable.37 (While people who are incontinent most
of the time expect it, those with partial incontinence
don’t know when to expect it and therefore have
trouble planning for it—adding to the sense of a loss
of control.) Furthermore, because incontinence
often precipitates nursing home placement, it’s often
feared and hidden. On the other hand, many com-
community-dwelling older women, unaware of treat-
matic options, have found ways to cope and view
urinary incontinence as a social rather than a med-
ical problem.1, 37

Incontinence pads are often referred to as “dia-
pers,” reinforcing the stereotype that a childlike loss
of control and dignity accompanies aging. This is an
important consideration. Although some older
adults wear pads to enhance a feeling of security,
others do so because they haven’t been presented
with other options. As one resident of a long-term
care facility said during a recent study, “When you
come here you can forget having control over your
life. Here your life is controlled by the way the place
is run.”38 The authors noted that the resident
claimed to be voicing the opinions of many other
residents of the facility.

In fact, Maas told me in a personal communica-
tion that when people in nursing homes ask to go to
the bathroom, they are often told, “You have a pad
on; just go in it. That’s what it’s there for.” The use
of incontinence pads communicates the provider’s
expectation of residents’ incontinence—before
assessment, diagnosis of incontinence, and treat-
ment are attempted. The result is infantilizing,
disseverice to older adults. Such use of incontinence
pads constitutes a breach of nursing ethics because
it presumes that the patient is incompetent and that
his feelings don’t matter. It also forces patients to be
incontinent when they don’t have to be, and contin-
ence is better for the patient both psychologically
and physically. Ethical principles call for nurses to
do no harm—such reliance on pads is harmful.

Other concerns about pads or briefs are their bulk-
iness and the noise they make with movement. In
addition, these products often make it difficult or even
impossible to toilet independently (for example, those
who have serious arthritis may be unable to remove
the brief), thus ensuring incontinence. Furthermore,
pads that aren’t changed frequently enough contribute
to skin breakdown, urinary tract infections, and odor.
Thus, pads must not be used in lieu of treatment, and
their effectiveness must be carefully evaluated.

**MYTH: INDWELLING CATHETERS ARE THE BEST INTERVENTION FOR INTRACTABLE URINARY INCONTINENCE**

In an effort to keep patients dry and to protect their
skin, particularly in the face of understaffing,
dwelling catheters are used frequently. Although
the intentions may be good, these catheters are often
used without consideration of the consequences. In
the vast majority of cases, indwelling catheters—the
most common cause of bacteriuria—are not appro-
priate for long-term management (more than 30 days)
of urinary incontinence.39 Continuous indwelling
catheterization may be an appropriate management
strategy for only a few patients: some who are termi-
nally ill, some with severely impaired skin integrity,
and those with urinary retention unchanged by inter-
mittent catheterization or surgical and pharmacologic
interventions.12 The practice of indwelling cather-
ization of all people receiving hospice or palliative care is
unacceptable, exposing the dying person to increased
risk and discomfort.

Gokula and colleagues reviewed catheter use in
one midwestern teaching hospital for one year.40 They
found the majority of inappropriate catheterization
was of people over age 65. However, they also found
that only 1% of patients were discharged with a
inewth catheter in place. Yet because people are discharged
from the hospital with catheters, use in nursing
homes increases. In addition, one recent study found
that 4% of older adults receiving home care were
using indwelling catheters.41 Recommendations for
the care of people with indwelling catheters (for
example, when to change the catheter) are based
upon short-term rather than long-term use. There is
no evidence base for the care of people who have
long-term indwelling catheters.19

Condom catheters are a good alternative to
indwelling catheters for men, but again, they should
be used only after attempts are made to help the
patient regain continence. Men often find the con-
don catheter more comfortable, less painful, and less
restrictive.42 Good hygiene is essential to prevent mac-
eration and irritation of the skin on the penis, and
vigilant attention must be paid to ensure the penis is
not constricted.
MYTH: PREVENTION IS IMPOSSIBLE

Continence should be fostered as the norm in all health care settings, but this is not the case. One 1998 unpublished report by Brighthous, which examined 20,000 records of nursing homes in Missouri, found that 63% of residents who were continent upon admission were incontinent just one year later. Clearly, a higher priority needs to be given to maintaining continence. The first step in maintaining continence is to maintain a patient’s functional abilities. A recent randomized, controlled trial of 256 incontinent nursing home residents found that an exercise and continence program resulted in significant improvements when compared with the control group. Thus, in a long-term care facility, the use of wheelchairs should be combined with prescription for and assistance with walking at least twice each day. In addition, environmental modifications must be addressed.

A recent randomized, controlled trial showed excellent promise for community-dwelling older adults. The study investigated whether a behavior modification program forcontinent women, 55 years and older, would decrease the incidence of urinary incontinence, increase pelvic muscle strength, and improve voiding control. The intervention was a two-hour classroom presentation on pelvic muscle exercises and bladder training, followed in two to four weeks by individualized evaluation to test knowledge, adherence, and skills and to provide reinforcement of the technique as needed. Follow-up was done by telephone and mail every three months. At 12 months, all participants had in-person clinical evaluations; 195 treatment and 164 control subjects finished the study. Data showed that the treatment group had statistically significant improvements in continence, pelvic muscle strength, and voiding frequency. The researchers report that this is the first randomized, controlled study of the prevention of incontinence in older women in the community. Interventions like this are especially needed for people in transitional living arrangements, and similar efforts need to be made for people who arecontinent when admitted to nursing homes.

REFERENCES


**GENERAL PURPOSE:** To explore common misconceptions about bladder health in older adults and provide registered professional nurses in all settings with information essential to promote continence and treat incontinence.

**LEARNING OBJECTIVES:** After reading this article and taking the test on the next page, you will be able to

- discuss the etiology, diagnosis, and treatment of urinary incontinence.
- outline the characteristics of the specific types of urinary incontinence.
- plan at least five behavioral interventions for patients who have urinary incontinence.

To earn continuing education (CE) credit, follow these instructions:

1. After reading this article, darken the appropriate boxes (numbers 1–16) on the answer card between pages 48 and 49 (or a photocopy). Each question has only one correct answer.

2. Complete the registration information (Box A) and help us evaluate this offering (Box C).*

3. Send the card with your registration fee to: Continuing Education Department, Lippincott Williams & Wilkins, 333 Seventh Avenue, 19th Floor, New York, NY 10001

4. Your registration fee for this offering is $22.75. If you take two or more tests in any nursing journal published by Lippincott Williams & Wilkins and send in your answers to all tests together, you may deduct $0.75 from the price of each test.

Within six weeks after Lippincott Williams & Wilkins receives your answer card, you’ll be notified of your test results. A passing score for this test is 12 correct answers (75%). If you pass, Lippincott Williams & Wilkins will send you a CE certificate indicating the number of contact hours you’ve earned. If you fail, Lippincott Williams & Wilkins gives you the option of taking the test again at no additional cost.

All answer cards for this test on “Nine Myths of Incontinence in Older Adults” must be received by June 30, 2007.

This continuing education activity for 3.5 contact hours is provided by Lippincott Williams & Wilkins, which is accredited as a provider of continuing nursing education (CNE) by the American Nurses Credentialing Center’s Commission on Accreditation and by the American Association of Critical-Care Nurses (AACN 00012278, category A). This activity is also provider approved by the California Board of Registered Nursing, provider number CEP11749 for 3.5 contact hours. Lippincott Williams & Wilkins is also an approved provider of CNE in Alabama, Florida, and Iowa, and holds the following provider numbers: AL #ABNP0114, FL #FBN2454, IA #75. All of its home study activities are classified for Texas nursing continuing education requirements as Type 1.

*In accordance with Iowa Board of Nursing administrative rules governing grievances, a copy of your evaluation of this CNE offering may be submitted to the Iowa Board of Nursing.