PROFESSIONAL GUIDE. . . at a Glance

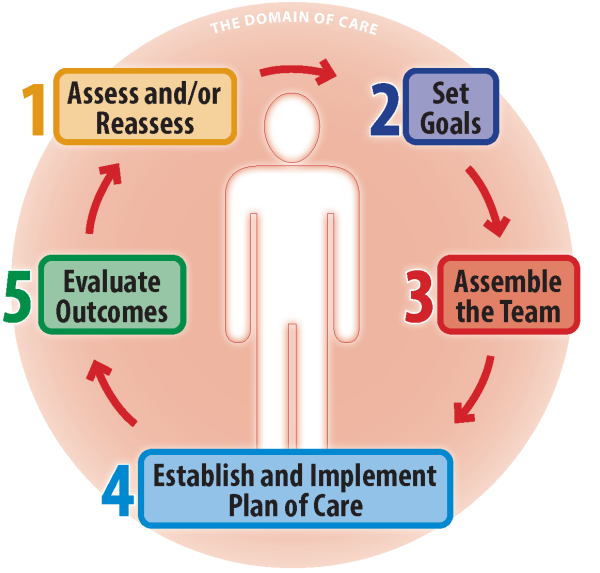
Assessment and Management of Persons Living with Continence Issues

A guide for home care in Alberta with a focus on Indigenous health.

This Professional Guide is focused on the assessment and management of persons with continence issues, with an emphasis on prevention. It also identifies relevant resources for health-care providers to support patients and their families.

This guide is based on a commitment to provide support to patients through their entire community to help them adapt to and self-manage their condition in the face of social, physical and emotional challenges. It is a model based on the premise that cultural sensitivity in care delivery and self-management is an essential element of high-quality health care, as the beliefs, values, traditions and biases on the part of health systems, care providers, patients, families and communities can all influence care.

Figure 1: The Wound Prevention and Management Cycle[1]



This document uses the Wounds Canada Wound Prevention and Management Cycle (WPMC)[1] (Figure 1) as the basis for clinical decision making. For clinicians, this document is meant as a cue for treatment; it provides non-inclusive examples listed below each recommendation. For policy makers, it highlights (in bold italics) actions and policies that support best practice.

For more information on content or tools related to a particular recommendation, click on the links provided.

Introduction

Promoting and maintaining a patient's continence of urine, feces or both should be a major consideration when planning care in any care setting.

Children become continent of urine at approximately five years of age or when they recognize they can contract and relax the pelvic floor muscles controlling voiding.[2] About 15% of children experience night-time voiding, also called wetting (nocturnal enuresis).

Changes to adult bladder and bowel functioning are related to physiological changes and are not considered a normal element of aging.

The prevalence of fecal incontinence in adults is 5% in non-hospitalized populations, and as high as 50% in persons living in nursing homes.[3] Persons experiencing urinary and/or fecal (or both) incontinence may limit their social activities, stay home, be embarrassed, limit travel and avoid sexual activity.

Step 1: Assess and/or Reassess

Assessment of a patient's continence status—urine and feces—is a priority in all care settings. A complete assessment occurs to determine the extrinsic and intrinsic factors that may contribute to incontinence. A thorough patient assessment includes continence history and current health status, including skin status (and ostomies for urine, feces or both), environmental factors and systems factors. ***Tools to assess continence need to be available and in use in all care settings, supported by staff education and policy.***

Discussing continence may be embarrassing or not culturally appropriate, but when trust-filled care and a safe environment are established with the patient and their family/care partners, the assessment can be successful.

1.1 Select and use validated patient assessment tools.

Utilize tools to assess an individual's general health and continence status. If necessary, this assessment should include relevant family members and care partners who support the individual in their care setting. The Registered Nurses' Association of Ontario (RNAO)[4] provides a detailed Bladder and Bowel Continence Assessment Form.

Assessment includes identifying any issues related to psychosocial and lifestyle issues, access to toileting (equipment, space), presence/absence of a support person to assist with toileting (including skin hygiene), mobility issues (arthritis, pain), neurological issues (multiple sclerosis, brain injury, stroke, spinal cord injury), medical conditions (diabetes mellitus, cancer), cognitive changes (delirium, dementia, depression), urinary procedures or surgery, and fecal procedures or surgery.

In a recent systematic review[5] several tools met validity, reliability and/or acceptability of bladder health screening, including:

- International Prostate Symptom Score (IPSS)
- International Consultation on Incontinence Questionnaire Urinary Incontinence Short-Form

1.2 Identify risk and causative factors that may impact continence and related skin care.

1.2.1 Patient: Physical, emotional and lifestyle

Bladder and bowel assessment tools for all individuals need to be available to identify which interventions to promote and maintain continence will be most appropriate.[6] This assessment is important as some factors contributing to changes in continence are preventable. Assessment must include risk factors and address:

- Health history and current health status, including chronic and critical disease (cardiovascular disease, diabetes mellitus, obesity); changes to activities of daily living (ADLs); psychological, lifestyle and mental health issues; and cognitive changes such as delirium, depression and dementia
- Nutritional assessment: intake of solids and fluids, including caffeinated beverages, alcohol, carbonated drinks, juices and artificial sweeteners and intake of reversible causes of incontinence
- Dental status, including gum health and swallowing issues
- Mobility status and toileting equipment used (e.g., grab bars, transfer devices, commodes, bedpans)
- Current toileting schedule (days, evenings, night) (independent, minimal assistance, full assistance); determination if a prompted voiding protocol is in place
- Consider a urinalysis and conduct a post-void residual urine test
- Clothing worn (this may impact ability to remove undergarments to toilet in a timely manner, or to reapply undergarments after toileting)

- Containment devices used to promote continence: hygiene products, briefs, peri-pads worn in undergarment, mesh pants with a liner, condom catheter system, incontinent pouches (urinary, fecal, both)
- Medication(s) (over the counter and prescribed)
- Traditional medicines, ointments, creams, products used orally and on skin
- Skin status, including perineum and perianal skin changes related to urine or feces (see Foundations of Best Practice for Skin and Wound Management: Best Practice Recommendations for the Prevention and Management of Moisture-associated Skin Damage for more information)
- Cultural variables (individuals' privacy, trust and preferences)

For a detailed list of risk factors for urinary and fecal incontinence and constipation, please visit the Registered Nurses' Association of Ontario document A Proactive Approach to Bladder and Bowel Management in Adults.

1.2.2 Environmental: Socio-economic, care setting and potential for self-management

Assess access to toileting facilities, equipment and skin hygiene products. Assess duration of changes to continence (one week, less than one month, 2–5 months, greater than 6 or 12 months). Assess for socio-economic determinants, including income, employment and working conditions, food security, environment and housing, early childhood development, education (including education on continence) and literacy, social supports and connectedness, health behaviours, access to health care and services. It is critical to provide a culturally sensitive environment for care. Assess patient for risk of isolation due to incontinence (odour, lack of products).

1.2.3 Systems: Health-care support and communication

Assess access to funding, availability of services and supplies and equipment, use of restraints, diagnostic services (including bladder and bowel), service delivery personnel and co-ordination of care.

1.3 Complete a continence assessment, if applicable.

Urinary Continence

Engage the patient along with the appropriate family member and/or care partner in a urinary continence assessment. This takes trust and time. Listen to the patient's story. Completion of a symptom checklist may assist in building trust with the patient when discussing continence. The Canadian Continence Foundation has prepared a checklist to support this assessment.

A bladder/voiding diary may be helpful as well. Two examples are available from the Canadian Continence Foundation and the Canadian Nurse Continence Advisors.

In addition the Registered Nurses' Association of Ontario (RNAO) lists validated questionnaires and scales to support screening for urinary urgency (Urgency Perception Score; Urgency Questionnaire; Urgency Severity and Life Impact Questionnaire: Quality of Life; Urgency Severity and Life Impact Questionnaire: Severity Symptoms; Urgency Perception Scale; Indevus Urgency Severity Scale; Patients' Perception of Intensity of Urgency Scale; Urinary Sensation Scale; and Urgency Rating Scale). Note: These questionnaires and scales require a formal request for permission to use from the creators of the tools.

Other examples include:

- Overactive Bladder Assessment Tool
- Indevus Urgency Severity Scale (IUSS)

For a detailed list of risk factors for urinary incontinence, please visit pages 133–36 in A Proactive Approach to Bladder and Bowel Management in Adults.

Once the assessment data have been collected the type of urinary incontinence the individual is experiencing can be determined, after which goals to promote and maintain continence can be established. The most common types of urinary incontinence are stress incontinence, urge (urgency) incontinence and a mix of the two. Other types include:

- an overactive bladder
- overflow incontinence
- functional incontinence
- nocturnal enuresis (night voiding)
- reflex incontinence
- transient incontinence
- total incontinence
- iatrogenic incontinence

For more information about the different types of urinary incontinence, please see Appendix 1: Signs and Symptoms of Different Types of Urinary Incontinence on page 12, the RNAO document Urinary Incontinence Defined and the RNAO Glossary of Terms (pages 89–95).

Fecal – Incontinence and Constipation

Engage with sensitivity the patient, family member and/or care partner in a continence assessment focused on bowel care and history of constipation. Fecal incontinence is infrequently reported to primary care providers due to embarrassment and lack of time to talk to care providers.[7] Discussing the type of stool the patient passed can be assisted by using The Bristol Stool Chart.[8] This is a visual tool that helps patients and family members describe the consistency and quality of stool passed. As well, ask the patient and family member to keep a bowel elimination record such as that developed by the RNAO (available on pages 148–49).

To screen for fecal incontinence, use a validated questionnaire such as:

- The Modified Manchester Health Questionnaire, a tool to help assess the severity of fecal incontinence on the patients' quality of life.[9]
- The International Consultation on Incontinence Questionnaire (ICIQ-B)[10,11]
- St. Mark's Incontinence Score,[12] a tool to help assess stool consistency and frequency, gas (flatus being passed) and the effects on quality of life.

Fecal incontinence is more prevalent in people with diabetes, inflammatory bowel disease, celiac disease and irritable bowel syndrome. As well, many medications can also cause constipation. For a detailed list of risk factors for fecal incontinence and constipation, please see A Proactive Approach to Bladder and Bowel Management in Adults.

Types of Fecal Incontinence

Three main types of fecal incontinence are described in the literature. Each exists in varying degrees depending on the underlying causes.

- **Urge:** The patient is aware they need to defecate but are unable to reach the toileting facilities/washroom in time.
- **Passive:** The patient has no awareness they need to defecate and describe fecal incontinence as having no warning.

- **Seepage:** Patients have seepage or leaking of feces followed by a normal bowel movement, then have more leakage after defecating that often occurs without warning.[13]

Visit the RNAO Glossary of Terms (pp. 89–95) for more on terminology.

During the assessment discuss the use of products used to contain feces and liquid feces and assess the condition of surrounding skin. Discuss the use of equipment and how the patient and family members have been coping with the situation.

Step 2: Set Goals

2.1 Set goals for for prevention of urinary and fecal incontinence.

Goals of care need to be centred on the patient. Achieving goals will depend on the interplay of the patients' health status and lifestyle, the availability of resources and the knowledge and ability of care partners to provide optimal interventions. If these factors are not taken into consideration the goals of care may be unrealistic and unrealizable.

A key element of the goal setting is to remind the patient and family that incontinence (urine, feces or both) is not a normal part of aging and that there are interventions that can promote and support one's continence health across the lifespan.

Prevention of urinary and fecal incontinence should always be considered a priority for the patient. Based on identified risk factors and a complete patient, urinary and fecal incontinence assessment, goals need to be set in collaboration with the patient, family and/or care partner. Appendix 2: Focus on Prevention on page 13 contains a helpful list of items that can be considered when setting goals.

2.1.1 Identify goals based on prevention of incontinence.

Goals need to be set with the patient in relation to any underlying medical conditions that may affect continence status. As incontinence is not a part of aging, this should be reviewed regularly with the patient, family and care partner(s). Potential goals for prevention might include:

- A toileting schedule is implemented within one day.
- Pelvic floor muscle training begins within one day.
- A new diet plan is implemented within one week.
- New toileting equipment is delivered and used within one week.

2.1.2 Identify quality-of-life and symptom-control goals.

Promoting continence is a priority to prevent complications such as urinary tract infections and constipation. Individuals may experience psychosocial distress related to incontinence. Potential goals for quality of life might include:

- Protective garments are worn at all times.
- A regular skin cleansing schedule is established, and barrier products are used to protect skin.
- Odour control and/or reduction strategies are in place to support comfort in social interactions.

Step 3: Assemble the Team

An integrated team is necessary for case management, to implement, adjust and sustain a plan to meet the patient-specific goals. The team should include the relevant health-care professionals and other service providers as required as well as the patient, family and their support system.

3.1 Identify appropriate health-care professionals and service providers.

Promotion of continence requires a collaborative and integrated team that supports fluid and food intake, fibre intake, physical activity and provision of appropriate toileting equipment and products to promote skin cleansing and hygiene. This includes registered dietitians, pharmacists (medication reviews), care workers, nurses, family physicians, nurse continence advisors, nurses specialized in wound, ostomy and continence, physiotherapists, occupational therapists (for equipment assessment and prescription), social workers and mental health professionals.

3.2 Enlist the patient and their family and care partners as part of the team.

When possible, patients can work with health-care providers to promote continence and prevent constipation. Engage the patient in self-care behaviours, oral hydration and intake of fibre to prevent constipation. Engage family members to support the care plan. Provide education and informational resources as necessary.

3.3 Ensure organizational and system support.

Supporting an individual successfully requires proactive, risk-based interventions at a variety of levels—individual, organizational and cultural. To secure successful outcomes:

- ***Decision makers must establish, train and support an integrated team composed of interested, skilled and knowledgeable persons to address and monitor all elements related to the promotion of continence, and prevention and management of incontinence.***
- ***Frontline clinicians must communicate with decision makers through appropriate channels about the needs and concerns of their patients, as well as about workplace issues that may impact their ability to deliver best-practice-based care.***

Step 4: Establish and Implement a Plan of Care

A care plan that promotes continence requires education and training for the patient, family members and care partners and is introduced based on trust and respect. They need to know their family members and health-care providers are committed to prevention of complications using interventions that are based on their particular needs, as identified during the assessment step.

4.1 Identify and implement a personalized, evidence-informed plan to correct the causes or co-factors that affect continence (urinary and fecal) and skin integrity, including patient needs (physical, emotional and social), the wound (if applicable) and environmental/system challenges.

The plan of care must be patient-driven, based on assessment and risk, and supported by available resources and policy. Elements to consider in a plan of care include:

- Prevention strategies: Treatment plans for urinary and bowel health may include oral hydration, food intake with a focus on fibre, regular time(s) to use the toilet and physical activity.
- Promotion of bladder health with Kegel exercises, bladder diaries and bladder retraining in consultation with team members.
- Using an individual and group/community approach that considers traditional foods that support health and wellbeing and the individuals' and family's preferences of food choices.[14-16] This approach must take into account household food security (insecurity) and past and current experiences accessing food (funds, hunting, fishing, harvesting).

4.2 Optimize oral hydration and food intake, including fibre.

In collaboration with the patient and family, consistently and at each visit with the person maximize intake of oral fluids. A registered dietitian can support the assessment and planning of interventions. Patient preferences are important to consider. Build trust by listening carefully; a one-size-fits-all approach is not effective.

4.2.1 Optimize physical activity.

In collaboration with the patient and family, optimize physical activity. A physiotherapist and/or occupational therapist can support activity and promote safe mobility with the most appropriate equipment. Family and care partners can assist in managing daily activity routines. Activity in relevant community centres can promote both wellness and engagement with other persons.

4.3 Select the appropriate interventions.

Promotion of continence (urinary, fecal, both) should be the care team's priority. Encourage the patient and family to utilize bladder-voiding diaries to record activities over time. This is an important tool the patient can use to heighten their understanding of their bladder and bowel health.

Note: Use of advanced incontinence products is not considered a first-line response unless the above interventions have been considered. Consult a nurse continence advisor or nurse specialized in wound, ostomy, and continence if the patient requires the use of a pad, mesh panties or a continence brief for urine, feces or both. It is important to have a trained professional assess and determine the appropriate fit of any incontinent product.[17,18] As well, use of any product requires a regular reassessment to ensure the product still meets the patient's needs. It is important that all of the conservative strategies above be considered before the use of any peri-products. Team members need evidence-based bladder and bowel education to correctly utilize products, as their use may impact the dignity of the person using the product and lead to further complications such as bladder infections (urinary tract infections) and skin issues in the peri-anal area.

4.4 Engage the team to ensure consistent implementation of the plan of care.

The health of the person's bladder and bowel will change over time. It is important to conduct regular bladder and bowel health assessments and discuss findings with the patient, family and other team members.

Team members might include primary care physicians; registered dietitians; physiotherapists (mobility, bladder health); occupational therapists (equipment); nurse continence advisors (education and advanced therapies); nurses specialized in ostomy, wound, and continence; and therapists with education and training in pelvic floor muscle training (PFMT), Kegel exercises, bladder retraining approaches.

To optimize outcomes, the patient, family and the rest of the care team need to be in regular communication, sharing information and updating the care plan as needed. To ensure patient and family participation in a meaningful way, education on the topic is essential.
Approaches may include:

- Information exchange with the patient and family to emphasize the importance of food and fluid intake to prevent bladder infections and constipation, weight management (if overweight or obese) and addressing underlying health issues such as lung capacity (smoking, second-hand smoke), diabetes and cardiovascular disease.

- Teaching via the appropriate 'Eating Well with Canada's Food Guide' in English, Inuktitut, Ojibwe, Plains Cree, or Woods Cree. Consider accessing the prepared presentation slides describing Canada's Food Guide[16]
- Teaching that uses Indigenous terminology as appropriate. Examples of Indigenous dictionaries include:
  - Cree Medical Dictionary (2011)
  - University of Alberta. Medical Dictionaries and Glossaries
- Teaching that uses person-centred education materials such as:[19]
  - Nutrition Criteria for Healthy Food Guidelines for First Nations Communities
  - Preparing Food Safely
  - Colour It Up (Seasonally available vegetables and fruits)
  - Guide to Storage of Vegetables and Fruits
  - Label Reading
  - Focus on Fat – What to Cut
  - What's in your glass?
  - Safer User of Plastics
  - Handouts to send home
  - Twenty-one - 21 Ways to help your body
  - Tips for preparing a community feast

These can be found in a presentation entitled Ready-to-Use Presentation for Nutrition Educators on Eating Well with Canada's Food Guide - First Nations, Inuit and Métis[19]

As well, consider recipes and tips for food harvesting, canning and storing foods.[19]

Step 5: Evaluate Outcomes

Evaluation of the plan of care should be routine and ongoing to identify whether the plan is effective in meeting the goal(s). If, after the cycle has been completed, goals of care have not been fully met, reassessment (Step 1) must take place, followed by the rest of the Wound Prevention and Management Cycle steps. ***The plan of care needs to be revisited at transfer between care settings and at discharge to ensure that self-management strategies are in place to support the patient to sustain the outcomes achieved after discharge.***

5.1 Determine if the outcomes have met the goals of care.

Reassessment of a patient with urinary and/or bowel issues requires regular review of the continence care plan. ***Outcomes need to reflect goals of care, and sustainability needs to reflect continuity of care; both need to be included in the plan of care and supported by policy.*** Reassessment of all components is necessary to ensure success. When any component of the care plan is not effective, it is necessary to reassess, re-evaluate and establish new goals.

5.2 Reassess patient, wound, environment and system if goals are partially met or unmet.

When goals of care are partially met or unmet, go back to Step 1 of the Wound Prevention and Management Cycle. Reassessment needs to consider gaps in care or the patient's ability to adapt to their condition and engage in self-management activities. Inclusion of the team members is important in reassessment, exploration of modifiable factors and patient involvement and ability to support the care plan. Timely referrals may be necessary if complications develop.

5.3 Ensure sustainability to support prevention and reduce risk of recurrence.

Sustainability may depend on access to appropriate equipment and services and collaboration among

the person with or at risk for incontinence, their families, care partners, service providers and the interprofessional team of health-care professionals. By identifying and managing the causes of urinary and bowel incontinence and patient barriers to self-management, the risk and prevalence of incontinence can be reduced. Promoting and sustaining bladder and bowel health behaviours are essential for the prevention of recurrence and complications throughout the management process. For more information on how to promote continence at home, please visit the Appendix 3: Promoting Continence in the Home Setting on page 13.

Additional Resources:
- Wounds Canada: Foundations of Best Practice for Skin and Wound Management: Best Practice Recommendations for the Prevention and Management of Moisture-associated Skin Damage
- Wounds Canada: BPR Briefs: Moisture-associated Skin Damage.

Additional Resources

The following resources provide additional information about continence health.
- Health Canada: Information about seniors and incontinence

Clinics

- Cura Physical Therapies (Edmonton)
- Glenrose Rehabilitation Hospital (Edmonton)
- Kaye Edmonton Clinic (Edmonton)
- Lois Hole Hospital for Women (Edmonton)
- Misericordia Community Hospital (Edmonton)
- Pelvic Floor Clinic - Foothills Medical Centre (Calgary)

Pessary Clinics to Support Continence

The following clinics may be helpful for supporting clients with continence management and pessary support.

Edmonton Zone:

- Glenrose Rehabilitation Hospital - Continence Clinic | Alberta Health Services
- Northern Alberta Continence Services Clinic, Misericordia Community Hospital - Covenant Health
- Physioclinics.pdf
- Synergy Medical Women

Calgary Zone:

- Ambulatory Community Physiotherapy Contracted Clinics Calgary Zone May 2021 (registration required)
- Pelvic Floor Clinic | Alberta Health Services
- Physiotherapy Alberta College + Association: The Movement Specialists: Physiotherapist Directory
- Consider a referral to the Spinal Cord Injury Rehabilitation Program

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Funding for this resource provided by FNIHB ISC - Alberta Region.

Indigenous Services Canada
Services aux Autochtones Canada

Appendix 1: Signs and Symptoms of Different Types of Urinary Incontinence

Type of Urinary Incontinence	Sign and Symptoms
Stress incontinence	Individual leaks urine when they put pressure on their bladder such as when one laughs, coughs, sneezes, exercises or lifts heavy weights. This is the most common type of incontinence in women. It is more unusual in men, except after some types of prostate surgery.
Urgency (Urge) incontinence	The loss of urine involuntarily. You may only have a few seconds to get to the toilet. People with urge incontinence may also need to urinate often, sometimes getting up several times in the night.
Mixed incontinence	This is a combination of stress and urgency (urge) incontinence.
Functional incontinence	This type of incontinence is most common in the elderly. This is related to mental or physical disability (such as severe arthritis, Alzheimer's disease, or a neurological problem like Parkinson's disease) that prevents people from getting to the toileting facilities on time.
Overactive bladder	Involuntary loss of urine associated with bladder spasms, and a strong desire to void in combination with the inability to delay voiding long enough to access toileting facilities. This occurs without any warning, especially at night.
Overflow incontinence	Individual has a frequent or constant dribble of urine. This happens because the bladder is overfilled. People with overflow incontinence never completely empty their bladder and may only produce a small amount of urine when they go to the bathroom.
Nocturnal (night) enuresis (voiding)	Night-time voiding is the term used to describe (bed) wetting in children who are old enough to be toilet-trained and adults who experience loss of bladder control at night.
Reflex incontinence	Involuntary loss of urine with diminished or no sensation of urge, voiding, or bladder fullness (e.g., caused by changes to the central nervous system, due to stroke).
Transient incontinence	Sudden onset of incontinence that may be caused by reversible symptoms (e.g., acute illness)
Total incontinence	Continuous unpredictable loss of urine without distention or awareness of bladder fullness (e.g., three types - overactive bladder, mixed and functional incontinence)
Iatrogenic incontinence	Source of bladder incontinence not known.

Adapted from The Canadian Continence Foundation[6] and Registered Nurses' Association of Ontario[20]

Note: Stress, urge and mixed incontinence are most common.

Appendix 2: Focus on Prevention

Areas to Consider	Urinary	Fecal
Ongoing promotion of continence and prevention of incontinence	X	X
Personalized prevention plan: regular toileting plan, appropriate toileting equipment, quiet and safe location with cleansing products and skin protectants available	X	X
Use Prompted Voiding Protocol	X	
Dietary assessment (as per patient's culture) using a food and fluid intake diary. Consider:	X	X
• regular eating times	X	X
• prevention of constipation	X	X
• water/fluid intake (24-hour record)	X	X
• soluble fibre (oral type)		X
Activity, walking plan	X	X
Pelvic floor muscle exercises – Kegel exercises	X	
Toileting routines	X	X
Medication review	X	X
Urinalysis	X	
Post-void residual	X	
Bowel sample to lab		X
Team Referrals		
Dietary assessment and intervention – registered dietitian	X	X
Pelvic Floor Muscle Training (PFMT): physical therapist, continence advisor/specialist	X	X
Biofeedback: physical therapist, continence advisor/specialist	X	X
Rectal Irrigation: continence advisor/specialist		X
Continence care specialist (urology teams for further testing and investigation)	X	
Teams specializing in gastrointestinal (bowel) health for further testing and investigation		X

Appendix: 3: Promoting Continence in the Home Setting

- Ensure patient has safe access to toileting facilities.
- Ensure appropriate toileting equipment such as grab bars, raised toilet seats, commodes, pans.
- Allow patient time in the toileting facilities so they are not rushed and have a sense of dignity and privacy.
- Ensure appropriate skin cleansing products to promote hygiene.
- Ensure appropriate skin protectants/barriers to promote skin health.
- Use clocks and electronic reminders to promote toileting routines throughout the day and night.
- Use visual reminders to promote use of the bathroom, such as signage and prompts.
- Ensure use of consistent language when describing the need to use the toilet.