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Incontinence: Practical Tips for the OT Practitioner Part 1

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Introduction

- Krista Covell-Pierson, OTR/L, BCB-PMD: Founder and owner of Covell Care and Rehabilitation, Occupational Therapist specializing in home safety, low vision, cognitive therapy and incontinence. Board certified in biofeedback for pelvic muscle dysfunction. Previous president of the Occupational Therapy Association of Colorado.
- Covell Care and Rehabilitation is a one-of-a-kind mobile therapy practice offering OT, PT, SLP, counseling, fitness training, private care management, driving rehabilitation and pelvic floor therapy to adults and older adults in their home, communities and office settings.
Continence…
Let’s Talk About It!

Definition: Voluntary control over urine and fecal discharge. Any deviation can be considered INCONTINENCE!

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Did You Know?

• One-third of men and women ages 30-70 believe incontinence is a part of aging.
• Information on healthy bladder function can help promote the understanding that incontinence is not a normal part of aging but a symptom of another problem.
• The social sacrifices of UI are high and even mild symptoms affect social, sexual, interpersonal, and professional function.
• UI affects 200 million people worldwide.
• Based on expert opinion, 25 million Americans experience transient or chronic UI.
• Consumer research reveals that one in four women over the age of 18 experience episodes of leaking urine involuntarily.
• Of men and women ages 30-70 who awaken during the night to use the bathroom, more than one-third get up twice or more per night to urinate, fitting the clinical diagnosis of nocturia. Of these adults, one in eight say they sometimes lose urine on the way to the bathroom.
• Two-thirds of men and women age 30-70 have never discussed bladder health with their doctor and do not receive treatment. Men are the least likely to talk about it.
• On average, women wait 6.5 years from the first time they experience symptoms until they obtain a diagnosis for their bladder control problem(s).
Course Objectives:

After this course, participants will be able to:
- Identify healthy vs. unhealthy bowel and bladder habits.
- Recognize the difference between urge, stress, mixed, functional and bowel incontinence.
- List at least two treatment strategies for bowel incontinence.

What is Incontinence?

- Any non-intended loss of urine or stool
- The loss may be in large quantity or small
- "We found that half the population experienced urinary leakage or accidental bowel leakage, and about 25 percent had moderate, severe or very severe urinary leakage. And about 8 percent had moderate, severe or very severe bowel leakage," said lead researcher Yelena Gorina, a statistician at the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.
- Incontinence is not a normal part of aging
Impact of Incontinence

- Depression
- Social Withdrawal
- Anxiety
- Fatigue
- Increased fall risk
- Restricted sexual activity
- Increased expenses for supplies
- Higher risk of infection
- Skin irritation

Why Should OT Address Incontinence?

- Incontinence negatively impacts occupations
- Urinary and bowel leakage can reduce goal achievement and quality of life
- 45% of clients receiving home health care reported having difficulty with bladder and/or bowel control.

Why Should OT’s Address Incontinence?

- OT evaluations address multiple areas of occupational performance directly related to incontinence including:
- Context
- Cognition
- Safety
- Transfers
- Musculoskeletal deficits
- BADL and IADL routines
- Activity tolerance
- Mood
- Positioning
- Pain
- Fine motor control
- Hygiene
- Balance
- Equipment needs

Unique Role of an OT in a Hospital Setting

- Incontinence may be of new onset related to surgery, illness or injury and can increase a client’s anxiety and decrease positive gains in rehabilitation
- OT’s can initiate training related to incontinence, educate patients that there are options for treatment
- OT’s are already addressing ADL’s and this is a natural segue to discuss bowel and bladder health in a practical, non-threatening way
Unique Role of an OT in a SNF

- OT professionals spend extensive time with clients building trust which allows a comfortable setting to talk about personal issues
- Treatment planning must consider incontinence issues in relation to goal achievement
- The interdisciplinary team can be led by an OT. For LTC residents, receiving ongoing support can reduce incontinence which can lead to decreased negative behaviors, skin breakdown, staff burnout and residents’ loss of dignity. Departments that may benefit from training and being part of an incontinence program include:
  - Dietary
  - Nursing
  - Activities
- ADL’s are a part of the OT assessment and treatment process and incontinence must be considered.

Unique Role of a Home Care OT

- Working together in the client’s home builds trust allowing clients to feel more comfortable to discuss this topic
- Observing and assessing the home can help OT’s determine what issues a client may be having related to incontinence
- OT’s are already addressing ADL’s and this is a natural segue to discuss bowel and bladder health in a practical, non-threatening way
- Meaningful activities for a client may be negatively impacted by incontinence and require attention from the OT professional
Unique Role of a Home Care OT

OT professionals can develop a client-specific caseload to treat incontinence, pelvic pain, prolapse, and more.

OT’s are looking at the client holistically and tying clients’ abilities to engage in ADL and IADL to their treatment plans in ways other disciplines may not.

OT professionals
Evaluations and Inquiry: Where It All Begins...

- Normalize the conversation and build rapport
  - “Do you ever have a hard time getting to the bathroom on time?”
  - “When you need to urinate do you feel a strong urge and that you need to rush to the toilet?”
  - “Do you ever experience leakage when you cough or sneeze?”
- Assess the client’s environment related to incontinence
- Identify risk factors
  - Medication, stress, neurologic diseases, diabetes, pelvic floor disorders, history of childbirth, hemorrhoids, smoking
- Identify if further assessment is needed
- Request additional medical records related to incontinence
- Communicate with the physician to determine treatment regime and type of incontinence

When to Refer to a Specialist

- When a client presents with complex pelvic health issues, it is recommended the basic practitioner refer to a therapist with more advanced training.
- This would occur when a client experiences:
  - Prolapse
  - Pelvic Pain
  - Urinary Retention
  - Neurological Dysfunction
  - Infection
  - Prostate dysfunction
- Therapists with more advanced training can provide digital exams and integrate biofeedback and electrical stimulation to a treatment plan.
Teaching Clients About Pelvic Anatomy and Urinary/Bowel Function

- Pictures, videos or models of pelvic anatomy and urinary/bowel function

Educate on the Role of the Pelvic Floor Muscles

The pelvic floor is a set of muscles that are spread across the bottom of the pelvic cavity like a hammock. The pelvic floor has three openings that run through it for females: the urethra, the vagina and the rectum. There are two openings for males: the urethra and the rectum. The functions of the pelvic floor include:
  - Support the pelvic organs
  - Help provide sphincter control for the bladder and bowel
  - Facilitate opening and voiding of the urethral and anal canal
  - To withstand increases in pressure that occur in the abdomen such as coughing, sneezing, laughing, straining and lifting
  - To enhance the sexual response
Home Review for Therapists

- Anatomy, Micturition and Defecation—Review on your own

Review of pelvic floor anatomy:
https://www.youtube.com/watch?v=P3BBAMWm2Eo

Micturition: https://www.youtube.com/watch?v=US0vN0xsW-k
https://www.youtube.com/watch?v=qMR-rAVIbV0

Defecation: https://www.youtube.com/watch?v=37a_CXKEj5M

Identifying Problem Areas

- Review normal bladder and bowel habits and compare to your client’s performance
  - Bladder Health Review
    - The average bladder can hold 2 cups of urine before needing to be emptied.
    - We should urinate 6-8 times in 24 hours. As we age, we may need to go more because our bladder shrinks but should not need to go more than every 2 hours.
    - Urine should flow out easily without straining and should come out in a steady stream.
    - An urge is the sensation you feel as the bladder stretches and fills. It does not always mean your bladder is full and urges should be controlled.
    - Your bladder should be completely emptied when you use the toilet. Relax and be sure you have completely voided.
    - Holding your bladder for an excessive time (more than 4 hours) may be more convenient for you, but it is NOT healthy for your bladder.
Identifying Problem Areas

- Review normal bladder and bowel habits and compare to your client’s performance

  - Bowel Health Review
  - People should have a bowel movement as little as every three days or as often as three times a day
  - Heavy straining should be avoided
  - People should feel when they need to go and know when they are finished
  - Stool should be the size, shape and consistency of a ripe banana—Level 4 of the Bristol Scale

Types of Incontinence

- Educate on different types of incontinence
  - Stress (Covered more in Part 2 of this series)
  - Urge (Covered more in Part 2 of this series)
  - Mixed (Covered more in Part 2 of this series)
  - Overflow (Covered more in Part 2 of this series)
  - Bowel
  - Functional

  - Constipation must be considered in relation to urinary and bowel incontinence as well.

  - Initiate a voiding diary—See handout
Stress Incontinence

- Stress incontinence occurs when there is more pressure through the abdomen than the bladder and pelvic floor can handle and leakage occurs.
- Urine lost may be a small or large amount.
- Sneezing, coughing, laughing, exercise, standing up can all cause stress incontinence.
- Stress incontinence is the most common type of incontinence.
- Typically caused by weakness of the pelvic floor muscles.

Urge Incontinence (a.k.a. Overactive Bladder)

- Urge incontinence occurs when there is a sudden urge to urinate and leakage occurs.
- Urine lost may be in large or small amounts.
- “Key in the Door Syndrome”
- Explain the bladder temper tantrum.
Mixed Incontinence

- Clients will experience urge and stress incontinence issues in varying degrees

Overflow Incontinence

- Overflow incontinence occurs when a client is unable to completely empty the bladder causing urine to leak unexpectedly.
- This is a common issue for men with an enlarged prostate.
Bowel Incontinence and Constipation

- Fecal Incontinence – reoccurring episodes of loss of control of stool which may be due to impaired sensation or weakened pelvic floor muscles.
- Constipation – infrequent (fewer than three) bowel movements per week. About 80% of people experience constipation during their lifetime and brief periods of constipation is normal. Common symptoms include a decrease in amount of stool, need to strain to have a bowel movement (BM), a sense of incomplete emptying, and need for enemas, suppositories and/or laxatives in order to maintain regularity.
- Any persistent change in bowel habit, such as an increase or decrease in frequency or size of stool, blood in stool, or an increased difficulty in evacuating, warrants a medical consultation.

Bowel Incontinence and Constipation

- Constipation may be the result of several, possibly simultaneous factors including:
  - Limited fluid and fiber intake
  - Imbalances in the diet (too much sugar and animal fat)
  - Sedentary lifestyle
  - Repeated ignoring the urge to have a bowel movement
  - Slow movement of stool – too much water absorption in the colon
  - Lifestyle changes, such as pregnancy and travel
  - Laxative abuse
- Constipation can be caused by medications you are taking for other conditions. Common medications include: pain medicines, antidepressants, psychiatric medications, high blood pressure medication, diuretics, iron supplements, calcium supplements, tranquilizers and antacids containing aluminum.
Functional Incontinence

- A client experiences a loss of urine or stool because of physical or mental limitations.

- For example:
  - A client can not reach the toilet in time due to advanced Parkinson's Disease as the client has delayed motor movement, difficulty with fine motor skills. The client loses urine while walking to the bathroom and has a complete loss of urine while undoing the buttons on his pants.
  
  - The bathroom door is not wide enough to accommodate for a client to use their wheelchair to and from the toilet, and they must transfer to their walker and then walk side stepping into their bathroom. They experience urine and stool loss in this process.

Where to Start?

- If a client is experiencing bowel and bladder issues, the clinician should begin with treating the bowel issues first.
- The bowel can irritate the bladder and reduce the effectiveness of interventions for the bladder if they are not addressed. Sometimes, urinary function will improve as bowel issues improve.
- When the rectum is full of stool, it may disturb the bladder. Chronic constipation and/or straining can lead to excessive stress on the pelvic organs and nerves. This condition also contributes to bladder dysfunction.
- Address these issues first when someone experiences bowel and bladder incontinence:
  - Bowel incontinence
  - Constipation
  - A combination of bowel incontinence and constipation
Bowel Basics

- Increase understanding of the impact the bowel has on the bladder
- Review client’s bowel habits through conversation and 3-5 day voiding diary analysis
  - Look for trends
    - Times of incontinence and/or constipation
    - Foods and fluids that are ingested 1-3 hours prior to accidents
    - Bowel irritants
    - Times of eating and drinking
    - Water intake
    - Medication management strategies a client is using
    - Analyze fiber intake—people often have a deficiency
  - Identify the concerns—take time to explain them to clients
  - Ask questions

- Utilize the Bristol Stool Chart for assessment—goal is type #4
Bristol Stool Chart


**BRISTOL STOOL CHART**

- **Type 1**: Separate hard lumps - **SEVERE CONSTIPATION**
- **Type 2**: Lumpy and sausage like - **MILD CONSTIPATION**
- **Type 3**: A sausage shape with cracks in the surface - **NORMAL**
- **Type 4**: Like a smooth, soft sausage or snake - **NORMAL**
- **Type 5**: Soft blobs with clear-cut edges - **LACKING FIBRE**
- **Type 6**: Muddy consistency with ragged edges - **MILD DIARRHEA**
- **Type 7**: Liquid consistency with no solid pieces - **SEVERE DIARRHEA**

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Bowel Basics: Integrating Fiber

- **Why do we need fiber?**
  - Food we eat enters our large and small intestines and our bodies start to absorb what we need from the food and leaves behind what we don’t.
  - Digested material moves through the body via peristalsis. The more bulk stool has, the better and faster it will move because the intestinal walls can push against the stool.
  - There are two types of fiber:
    - **Soluble**: Helps to slow the digestive process and keep blood sugar at a steady level
      - Examples include oatmeal, nuts, beans, apples, and blueberries
    - **Insoluble**: Affects bowel movements because it remains unchanged in the digestive process, bulks up the stool.
      - Examples include wheat bran, vegetables, and whole grains
Bowel Basics: Integrating Fiber

- Determine the client’s fiber intake through voiding diary or with a specific fiber diary
  - According to the Mayo Clinic, women should try to eat at least 21 to 25 grams of fiber a day, while men should aim for 30 to 38 grams a day
  - Consider a fiber diary or calendar for tracking

Fiber Diary
Bowel Basics: Integrating Fiber

- Facilitate potential increase or decrease in fiber through education
  - Prepare a grocery list
  - Identify how to determine how much fiber is in a food item
    - Food packages will contain fiber grams
    - Provide a list of fiber properties for various foods and review it with clients
  - Set up a fiber station in the home
  - Allow at least 2 weeks for improved bowel habits with fiber alteration
  - Continue with the fiber calendar or diary with goals to increase their intake

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Pam in the kitchen
Fiber Station Example

Bowel Basics: Positioning on the Toilet

- Educate clients on the negative impact of straining to have a bowel movement
- Demonstrate appropriate positioning on the toilet to reduce strain
Bowel Basics: Positioning on the Toilet

Positioning on the Toilet
Bowel Basics—Modifying Bowel Routines

- Integrate the gastro-colic reflex into daily routines to help with constipation
  - Natural response in which intestinal contractions are triggered by eating or drinking. Each of the following can serve to strengthen the intensity of colonic contractions triggered by the reflex.
    - Eat a meal
    - At this meal, consider foods with a high-fat content
    - Drink any kind of hot beverage
    - If possible, do some sort of physical activity like walking
    - Wait 20-30 minutes and sit on the toilet
  - Use this reference on how to integrate the reflex into a client’s routine
    https://www.verywell.com/gastrocolic-reflex-1944913

Bowel Basics—Reducing Irritants

- Milk and milk products
- Alcohol
- Tomatoes and tomato based foods
- Fried foods
- Greasy foods
- Artificial sweetener
- Caffeinated fluids
- Chocolate
- Eggs
- Salads
- Citrus fruit/ juice

- See handout for foods that thicken stool, cause gas, loosen stools, cause odors, etc.
Exercising the Pelvic Floor

- Improving or providing maintenance of strength tone and elasticity of the pelvic floor muscles (this helps support the abdominal and pelvic contents against gravity)
- Helps with bladder and bowel control
- Improves sexual response for both you and your partner

Exercising the Pelvic Floor

- If clients are not making progress, have pain, or worsening symptoms, stop the program and refer to a specialist and the physician.
- Specialists can work with clients with biofeedback and internal and external electrical stimulation
- For clients with cognitive impairments:
  - Consider using the program The Roll for Control to incorporate accessory muscles into pelvic floor muscle training
  - Incorporate pelvic floor muscle exercises into therapy groups in long-term care or memory care units. Activity staff may be able to help implement this.
Exercising the Pelvic Floor

- Clients will need to exercise both the fast-twitch muscle fibers and slow-twitch muscle fibers of their public floor for maximum benefit.
- Once a client has identified how to do a pelvic floor contraction correctly, initiate a home exercise program.
- This program can be down-graded for clients to build up to if they can not tolerate or complete this many repetitions or hold the contraction for as long as directed.
- Complete the following:
  - 25 quick flicks once a day
  - 10, 10 second holds twice a day
Discharge and Resourcing

- Provide follow up recommendations
- Encourage continued treatment with an outpatient specialist if issues are continuing
- Communicate with the physician
- Don't let it get lost in the shuffle!

Biofeedback and Electrical Stimulation

- Biofeedback is used in treatments provided by therapists to help clients do pelvic floor muscle contractions correctly and efficiently.
- It can help determine what is the main issue with the pelvic floor and pinpoint what needs to be done more definitively.
- Biofeedback is done by using a sensor to measure the muscle activity in your pelvic floor and your abdomen. It allows you and your therapist to see how your pelvic floor is functioning. This can not be done without biofeedback.
- E-Stim can be used to reduce urge sensations, increase strength of the pelvic floor, or a combination of both. E-stim is used with the same sensor used for biofeedback. Home units are available through some insurance carriers.
Biofeedback

- Biofeedback and other interventions are to be provided by specialists only.
- Biofeedback Certification International Alliance can help you find practitioners near you or facilitate you in becoming a certified practitioner.
  
  http://www.bcia.org/ida/pages/index.cfm?pageid=1

Keep the Conversation Going!

- Provide education to your peers
- Offer to teach your nursing staff what you know
- Create a screening tool with simple yes/no questions
- Learn as much as you can
Make a difference!

My life has improved so much since you’ve helped me. I feel like I have my life back. 
Client in Northern Colorado

References

Questions?

- Email: krista@covellcare.com