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Incontinence: Practical Tips for the OT Practitioner Part 2

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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.
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

Course Objectives:

- Recognize at least two treatment strategies for urinary incontinence.
- Identify appropriate goals for treatment of urinary incontinence.
- Describe appropriate pelvic floor muscle exercises.
Teaching Clients About Pelvic Anatomy and Urinary/Bowel Function

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=US0vNoxsW-k
  https://www.youtube.com/watch?v=qMR-rAVIbV0

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

- Educate on different types of incontinence
  - Stress
  - Urge
  - Mixed
  - Overflow
  - Bowel (Covered in Part 1 of this 2 part series)
  - Functional (Covered in Part 1 of this 2 part series)

- Constipation must be considered in relation to urinary and bowel incontinence as well. (Covered in Part 1 of this 2 part series)

- Initiate a voiding diary—See handout
Voiding Diary

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
Identifying Problem Areas

- Review normal bladder and bowel habits and compare to your client’s performance (Bowel health covered in Part 1).
  - 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.

Bladder Basics

- Analyze the voiding diary related to urination
  - Look for trends
  - Is the client going more than every two hours? Less than every four?
  - What are the client’s habits before bedtime when they experience nocturia?
  - What is the client drinking and eating prior to accidents?
  - Are there times of the day that are more problematic?
  - How much is the client drinking?
- Discuss normal urinary voiding function and compare this to the client’s performance. This may increase the client’s insight into their performance.
- Strategies to use as a general practitioner are most appropriate for stress, urge, or mixed incontinence patients. Others should be referred to a specialist if possible.
Identifying the Type

- Stress
- Urge
- Mixed
- Overflow

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.
- It is 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

- When the bladder can not be completely emptied, it can become very full and lead to overflow often leaking unexpectedly.
- Sometimes people do not feel that they need to void, while others do.
- This is more common in men due enlarged prostate glands.

Treating Stress Incontinence

- Timed voiding schedules
  - Reduce the time in between voids to reduce pressure and leakage
  - Gradually increase time between voids
- Pelvic floor exercise programming
  - Initiate pelvic floor strengthening utilizing Kegels
  - Programs should include quick and long-holding contractions
  - Details of programming included later in the slides
  - Alternate exercises can be done if a client can not isolate the pelvic floor
- Pelvic brace activity
  - Squeeze the pelvic floor before going from sitting to standing, before sneezing/coughing
Treating Urge Incontinence

- Timed voiding schedule
  - Reduce the time in between voids to allow the bladder to avoid experiencing the strong urge sensation
  - Gradually increase the times between voids
- Urge suppression techniques
  - When the client feels the urge, stop and do 4-6 pelvic floor contractions, walk slowly to the bathroom.
  - Give example of answering the phone
- Reduce bladder irritants
  - See list included
- Complete a kitchen assessment with the client to identify irritants

Bladder Irritants

- Alcohol
- Candy
- Caffeine
- Cantaloupe
- Carbonation
- Chilies/Spicy Food
- Chocolate
- Citrus fruits and juices
- Coffee (including decaf)
- Cranberries
- Artificial sweeteners
- Your own urine
- Pizza
- Sugary Foods
- Guava
- Peaches
- Drinks with artificial colors
- Pineapple
- Watermelon
- Plums
- Strawberries
- Tea
- Tomatoes
- Vinegar
- Vitamin B and C
- Smoking
- Milk or dairy after lunch (bedwetting)
Treating Mixed Incontinence

- Start with strategies to treat urge incontinence first
- Combine treatment strategies for both urge and stress incontinence

Treating Overflow Incontinence

- Consider referring to a specialist
- Seek physician advice
  - Urinary retention
- Determine the cause of the overflow
  - Prostate issues
  - Blockage of the urethra
  - Weakness
  - Nerve damage
  - Medications
  - Injury
- Positioning with voiding may effect overflow
Addressing Nocturia

- Nocturia can occur with any and all types of incontinence
- **Tips for reducing nocturia**
  - Stop fluid intake two hours before bed time
  - Reduce irritants
  - Elevate legs 20-30 minutes before bed and then void right before getting into bed
  - Integrate the urge suppression technique in the night
  - Put a bedside commode near the bed

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General Tips for Treatment

- Practice within your scope and comfort
- Consider the functional tasks you are aiming to improve with the client
- Offer 1-2 interventions at time
- Incorporate treatment for incontinence into overall treatment plan
- Allow adequate time to see if interventions are working
- The setting you work in may influence your frequency
  - Home health
  - Skilled nursing
  - Hospital
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

Continued

Exercising the Pelvic Floor

- How do clients recognize the pelvic floor:
- Sit on the toilet. Start urinating and try to stop the flow of urine. Then relax and allow your bladder to completely empty. If you are successful, then you have the basic feel for contracting your pelvic floor muscles. Do not do this on a regular basis.
- Tell clients to insert one finger into the vagina and tighten the pelvic floor to squeeze around the finger. They should feel a tightening around their finger and the pelvic floor move up slightly.
- Tighten the anus as if you were going to stop gas.
- Use the elevator example.
Exercising the Pelvic Floor

- Clients will need to exercise both the fast-twitch muscle fibers and slow-twitch muscle fibers of their pelvic 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

Exercising the Pelvic Floor

- Things to work on with clients to maximize success with the exercise program:
  - Start the program laying down with knees bent, upgrade to doing them sitting and then standing
  - Focus on breathing—no breath holding
    - Count out loud
  - Help clients to reduce dependence on abdominal, thigh, and buttock muscles
  - Integrate the exercises into daily routines—while brushing teeth, during commercials, etc.
  - Provide encouragement—it can take 3-6 months to maximize results
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.

Writing Goals for Treatment

- Client-centered
- Areas that may be measured:
  - How often a client uses the bathroom
  - How many episodes of leakage a client has in a week
  - How many briefs/pads are used in a day or week
  - Intake of irritants
  - Initiating interventions on their own
  - Client’s report of success or non-success
Writing Goals for Treatment

- Goal examples:
  - Client will experience no more than one urinary incontinence episode in a week within 4 weeks.
  - Baseline: Client is experiencing 1-2 episodes of urinary incontinence daily at time of evaluation.
  - Client will use no more than 2 pads a day within 4 weeks to manage urinary incontinence.
  - Baseline: Client is using 5 pads a day at the time of evaluation.
  - Client will reduce coffee intake from 12 cups a day to 1 cup a day within 1 week.
  - Baseline: Client is experiencing significant urge incontinence likely related to bladder irritation.

Writing Goals for Treatment

- Goal examples:
  - Client will independently implement the urge suppression technique and report good outcomes within 2 weeks.
  - Baseline: Client can not go longer than one hour within using the bathroom related to overactive bladder.
  - Client will complete a 10 second contraction 10 times within 6 weeks to improve strength of the pelvic floor and reduce urinary leakage.
  - Baseline: Client is unable to hold the contraction longer than 5 seconds at this time.
  - Client will increase water intake to 50 oz. a day to support bladder health within 1 week.
  - Baseline: Client is drinking no more than 20 oz. of water a day at this time in hopes of reducing his incontinence.
Goal Progression

• Goal examples:
  • Client will experience no more than one urinary incontinence episode in a week within 4 weeks.
  • Baseline: Client is experiencing 1-2 episodes of urinary incontinence daily at time of evaluation.
  • Progression: Client is experiencing 3-4 episodes of urinary incontinence per week by utilizing a timed-voiding schedule of urinating every 2.5 hours during the day. Continue with goal.

  • Client will use no more than 2 pads a day within 4 weeks to manage urinary incontinence.
  • Baseline: Client is using 5 pads a day at the time of evaluation.
  • Progression: Client is using 3 pads a day by utilizing urge suppression techniques, reducing her irritants, and utilizing the pelvic brace activity during sit to stands. Continue with goal.

  • Client will reduce coffee intake from 12 cups a day to 1 cup a day within 1 week.
  • Baseline: Client is experiencing significant urge incontinence likely related to bladder irritation.
  • Progression: Client is continuing to have urge incontinence during the day due to lack of reduction of her irritants. For two days, she was able to reduce to 1 cup a day and reports she did experience less leakage. Downgrade goal to 3 cups a day.

Goal Progression

• Goal examples:
  • Client will independently implement the urge suppression technique and report good outcomes within 2 weeks.
  • Baseline: Client can not go longer than one hour within using the bathroom related to overactive bladder.
  • Progression: Client is able to hold her urine for 2-3 hours at this time using the urge suppression technique. Client was able to ride the bus (2 hours) to the airport within having leakage. Discharge goal-goal met.

  • Client will complete a 10 second contraction, 10 times, within 6 weeks to improve strength of the pelvic floor and reduce urinary leakage.
  • Baseline: Client is unable to hold the contraction longer than 5 seconds at this time.
  • Progression: Client is able to hold the pelvic floor contraction for 8 seconds at 4 weeks. Continue with goal.

  • Client will increase water intake to 50 oz. a day to support bladder health within 1 week.
  • Baseline: Client is drinking no more than 20 oz. of water a day at this time in hopes of reducing his incontinence.
  • Progression: Client is utilizing a measuring system daily and has increased to 50 oz. a day. Upgrade goal to 60 oz. a day.
Tying it to Functional Performance

- Goal examples:
  - Client will experience no more than one urinary incontinence episode in a week within 4 weeks.
  - Baseline: Client is experiencing 1-2 episodes of urinary incontinence daily at time of evaluation.
  - Progression: Client is experiencing 3-4 episodes of urinary incontinence per week by utilizing a timed-voiding schedule of urinating every 2.5 hours during the day. Continue with goal.
  - Functional Improvement: Client is able to sit through a church service without having leakage or anxiety over leakage.

- Client will use no more than 2 pads a day within 4 weeks to manage urinary incontinence.
- Baseline: Client is using 5 pads a day at the time of evaluation.
- Progression: Client is using 3 pads a day by utilizing urge suppression techniques, reducing her irritants, and utilizing the pelvic brace activity during sit to stands. Continue with goal.
- Functional Improvement: Client is able to shop at the pharmacy without leakage and return home without rushing to the bathroom.

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- Progression: Client is continuing to have urge incontinence during the day due to lack of reduction of her irritants. For two day she was able to reduce to 1 cup a day and reports she did experience less leakage. Downgrade goal to 3 cups a day.
- Functional Improvement: None.

Tying it to Functional Performance

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  - Client will independently implement the urge suppression technique and report good outcomes within 2 weeks.
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- Baseline: Client is unable to hold the contraction longer than 5 seconds at this time.
- Progression: Client is able to hold the pelvic floor contraction for 8 seconds at 4 weeks. Continue with goal.
- Functional Improvement: Client is able to shop at the pharmacy without leakage and return home without rushing to the bathroom.

- Client will increase water intake to 50 oz a day to support bladder health within 1 week.
- Baseline: Client is drinking no more than 20 oz of water a day at this time in hopes of reducing his incontinence.
- Progression: Client is utilizing a measuring system daily and has increased to 50 oz a day. Upgrade goal to 60 oz a day.
- Functional Improvement: None
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 pin-point 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/i4a/pages/index.cfm?pageid=1

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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