# Assessment instruments for continence in long-term care

Adrian Wagg


The environment in the nursing home may require residents to overcome greater physical and cognitive challenges to maintain participation, autonomy, and dignity in toileting, bathing, and dressing than might be expected had they been at home

Scand J Caring Sci. 2004;18:376e386.

# Foundational continence assessment

**Identify**

the levels of support the resident requires for optimal continence, or to manage their incontinence, that is in line with their (or their representative's) preferences, goals for care, and beliefs about dignity

bladder and bowel signs and symptoms that warrant further attention

socio-cultural and environmental factors that contribute to incontinence

**Provide**

targeted and individualized continence care

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# What are the goals of care?

## Person centred care

- an approach that prioritises the person's individual needs, preferences and values. PCC treats patients as equal partners in the care processes, actively involving them in their care, and takes into consideration their personal context, experiences and goals

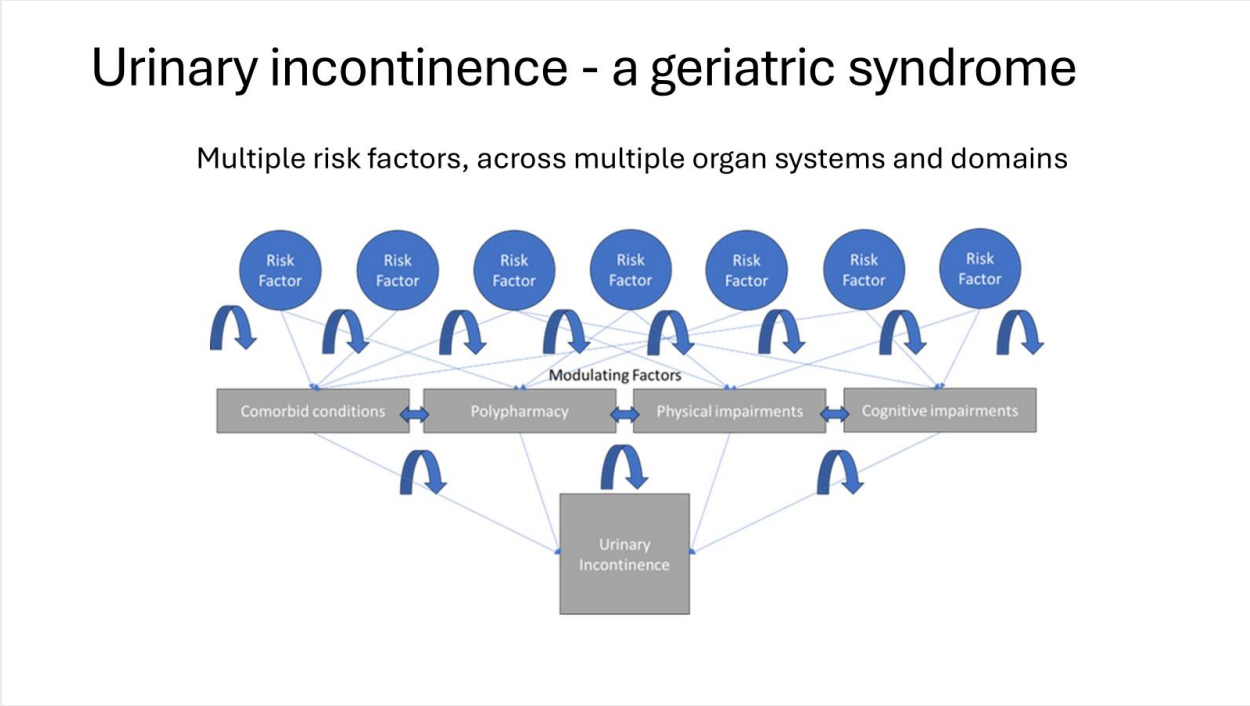
## Preservation of dignity and self

- Many older adults report that the approach of care professionals affects their feeling of dignity in close-to-body care and in communication in relation to continence care.
- This may lead to them becoming fearful of asking care professionals for assistance and illustrates the vulnerability of care recipients, their vulnerability to care related harms and a lack of their participation in own continence care.

Person-Centred Nursing: Theory and Practice Oxford, UK: Wiley-Blackwell; 2010. p. 21–39.
Person-Centred Practice in Nursing and Health Care: Theory and Practice West Sussex, England: Wiley Blackwell 2017
Asian Nursing Research. 2019;13(2):130–6.
Nursing & Health Sciences. 2010;12(3):345–51.
Scandinavian Journal of Caring Sciences. 2018;32(2):612–21.

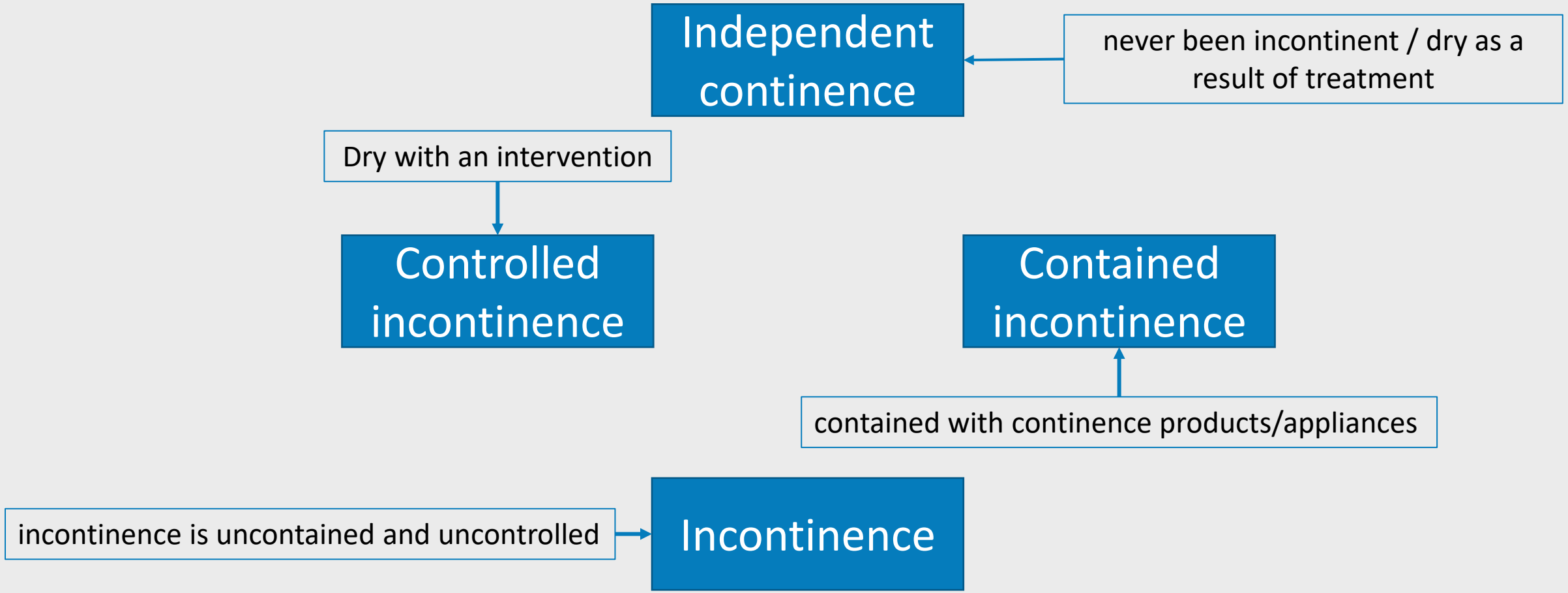
# Identify reversible / modifiable factors

Up to 81% of nursing home residents have potentially reversible causes of UI that are rarely investigated or treated (old study though- there's a research gap here)




J Am Geriatr Soc 2003;51(12):1779–1786

# The continence model




Incontinence: 6th International Consultation on Incontinence. 2017

# Older adults' views

- Older people desire physical comfort when using UI aids in terms of comfort, convenience and functional simplicity
- Life felt easier when they had easy to use products.
- Simplicity of use makes older people with UI feel safe and confident, especially when they can manage change of products independently.
- Those who fear they will leak outside their continence garment feel unsafe.


Urol Nurs. 2008;28(1):36–47.
J American Geriatrics Society. 2001;49(6):710–8.
J Gerontol Nurs. 2007;33(1):14–20.
J Adv Nurs. 2000;31(1):68–77.
Journal of Midwifery & Women's Health. 2006;51:388.
Ann Ist Super Sanita. 2019;55(1):26–33

- Older adults with UI value being listened to by care professionals.
- This improves care professionals' awareness of them as individuals, created relationships and discussed their needs.
- Strong relationships with their family members and care professionals are prerequisites for effective management of incontinence and helped initiate and facilitate the creation of strategies for continence care on their terms.
- Relationships between older people and care professionals can be positively or negatively influenced by the attitudes and approaches of care professionals

# What Assessment Tools & Processes Have Evidence?

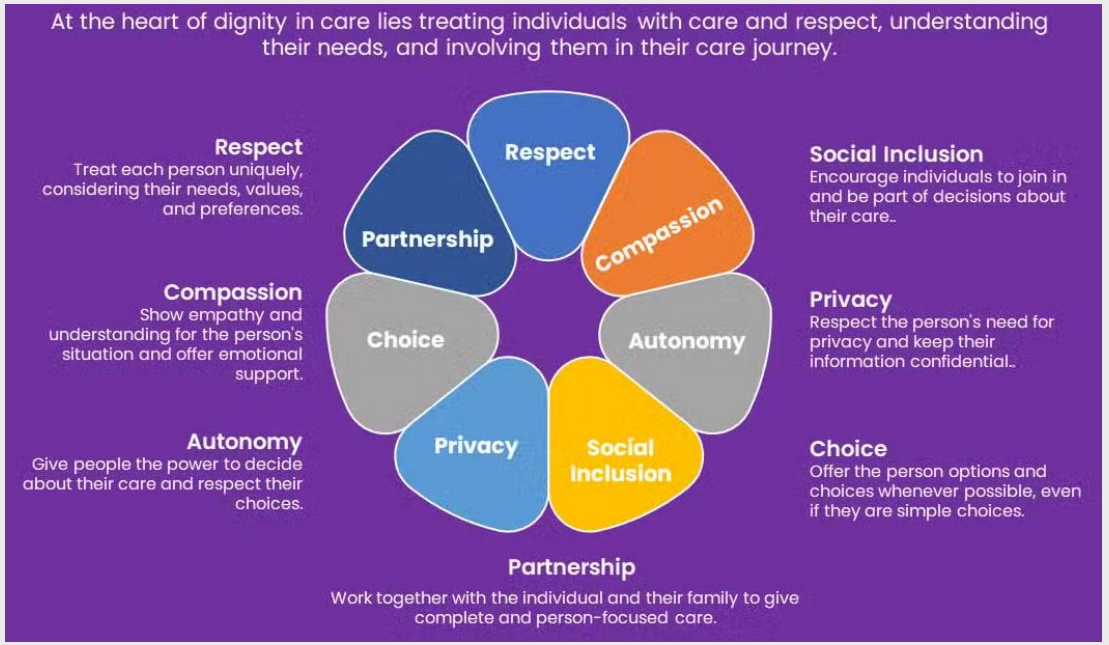
| | | |
|---|---|---|
| **Standardized Resident Assessment Instruments** (e.g. Minimum Data Set (MDS), Resident Assessment Protocol (RAP)) | Good reliability, especially for extremes of incontinence; RAP has moderate diagnostic accuracy for distinguishing lower-tract causes of UI in women. | While interrater reliability is high, accuracy in intermediate severity or mixed aetiology less so. Requires staff training. Not a substitute for clinical assessment in all cases. |
| **Risk factor / correlates assessment** | Age, female sex, cognitive impairment/dementia, mobility/ambulation status, urinary tract infection history are strong correlates. Dependency, being bedfast, etc. | These help in screening and targeting assessment but do not replace functional/clinical assessment of UI type, severity, triggers. |
| **Bladder diaries / voiding/frequency-volume charts** | Less evidence in nursing home residents - help characterize UI type (urge, stress, mixed), frequency, volume, nocturia, triggers | May be hard to implement in residents with severe cognitive impairment; requires cooperation and documentation. Staff time |
| **Physical/Functional Assessment** | Has been less consistently effective when used alone | Physical mobility, strength, transfer ability strongly influence UI |
| **Assessment of Environmental & Organizational Factors** | Staff knowledge, staffing ratios, consistency, training, availability of toileting assistance, scheduling, hydration and nutrition status | These are often ignored or under-resourced; assessment should try to capture “does the environment allow what is needed” (e.g. staff availability, physical access) |
| **Resident and Family Perspectives** | Evidence shows that many residents believe UI is an inevitable part of ageing, have low expectations for improvement, may not request treatment. Their dignity, mood, autonomy are strongly affected. | Assessment should include asking resident (or proxy) about their perceptions, preferences, goals. Important especially in cognitive impairment to engage family/carers. |

| Tool / Instrument | Focus | Evidence / Use in Practice | Notes |
|---|---|---|---|
| Continence Assessment Suite (Australia) | Urinary & fecal incontinence | Tested in 18 facilities; staff found clear & user-friendly | Tailored to aged care, includes education |
| Nursing Outcomes Classification (NOC) | Outcomes (continence, elimination, toileting self-care) | Validated nursing outcome measures | Useful for monitoring intervention effects |
| CHA Screening Tool | Stress vs urge incontinence | Good validity & inter-rater reliability | Short, feasible for staff |
| Joseph Continence Assessment Tool | Structured urinary continence assessment | Content validity examined | Older tool; less recent evidence |
| Clinical Measures (UA, PVR, exam) | Causes, comorbidities | Guideline-recommended | Needs equipment/skills |
| Electronic Monitoring Systems / Sensor briefs | Real-time leakage detection | Evidence quality low; potential staff benefit | Cost and acceptability issues |

# Promotion of dignity

**Table 4** Antecedents and attributes of dignity-protective continence care at the individual level

| Domain | Attributes |
|---|---|
| Respect | Treating the person as an individual not as an episode of care, i.e. respect for personhood/humanity<br>Ensuring the person's body is kept clean<br>Adopting a partnership approach that includes listening to and involving family members, carers and the person being cared for in continence care decisions<br>Showing compassion<br>Taking time to address the person's needs (not rushing care) |
| Empathy | Conveying kindness i.e. offering reassurance, showing tenderness and compassion,<br>Being gentle, i.e. washing with care and using touch appropriately,<br>Acknowledging the impact of stigma |
| Trust | Establishing a trusting relationship before care happens,<br>Knowing and understanding the person's biography and pre admission history, understanding the person's inner experience,<br>Understanding the person's unique behaviours,<br>Knowing the person's values and beliefs,<br>Gathering the person's narrative to develop an individualised continence care plan,<br>Responding to the person's continence care needs in a timely manner, Ensuring the person feels emotionally and physically safe in continence care interactions |
| Privacy | Closing doors, closing curtains,<br>Ensuring incontinence products remain hidden so they are not visible to others,<br>Concealing the person's incontinence from others,<br>Being discreet |
| Autonomy | Providing individualised care that includes offering the person a choice and supporting them to make decisions about the gender of carers, toileting preferences and choice of products |
| Communication | Managing one's emotional responses and body language,<br>Speaking in a calm, soft tone,<br>Picking up on verbal and nonverbal cues<br>Using touch appropriately,<br>Using appropriate language (eg: 'do you mind' if as opposed to 'I must'),<br>Adopting a friendly and gentle attitude,<br>Maintaining a sense of calm and normality about the situation<br>Minimising the socially taboo nature of the problem in the context of the setting<br>Using humour judiciously,<br>Maintaining eye contact |




BMC Geriatr 2020 Jul 29;20(1):266.