



Stroke – Core Skills Training

Continence

Aims

To understand:

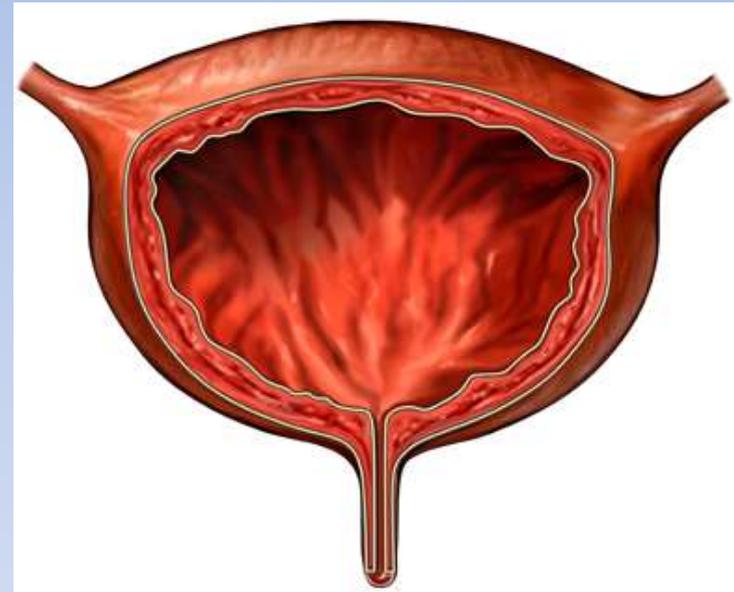
- What is incontinence and the problems associated with it
- Normal bladder and bowel function
- What to assess
- How we can help

Incontinence after stroke

- Incontinence is the loss of bladder or bowel control
- It is common after stroke – affecting around half of all stroke patients

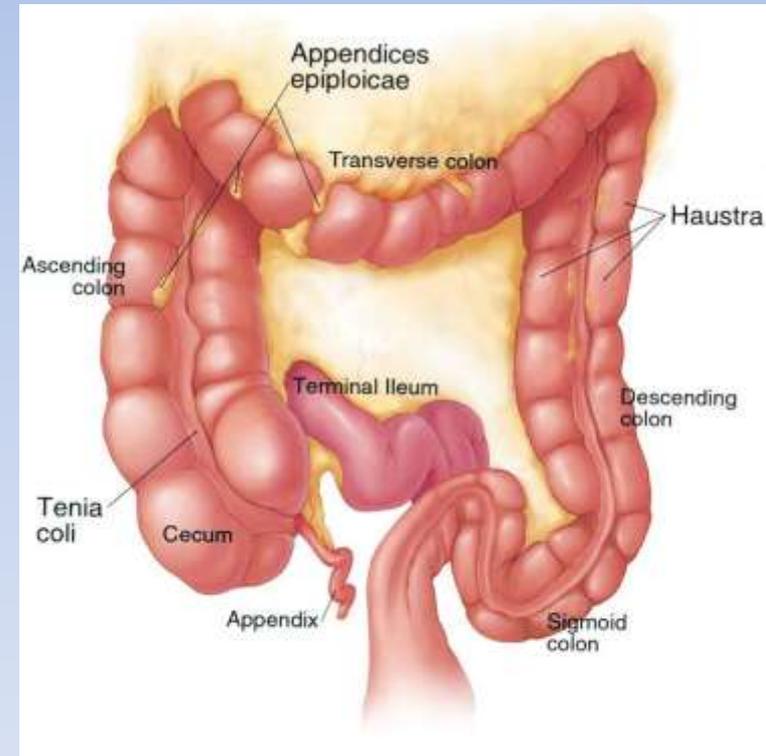
Normal urination

- Urine is stored in the bladder
- Urination is controlled by sensors in the bladder muscle, and messages sent to and from the brain
- Normally, urine can be held in the bladder for a period until it is convenient to go to the toilet
- These can be affected after a stroke and cause incontinence



Normal bowel function

- Food moves from the stomach through the small intestine, then the large intestine, to the rectum
- The intestine contracts in waves to move the stool through – this is often stimulated by eating or by movement
- Relies on nerve signals passing to and from the brain
- Stool needs to be not too hard or soft
- Normally stools can be held in the rectum for a period until it is convenient to go to the toilet



Problems associated with incontinence

- Associated with poorer prognosis
- Risk of skin breakdown
- Increased risk of urinary tract infection
- Embarrassment for the patient
- More work for patient's family or carers
- Limits lifestyle and social interaction

Continence Assessment

The following should be assessed:

- Continenence prior to stroke
- Identify whether the patient has urinary or faecal incontinence now
- Test to make sure patient does not have a urinary tract infection
- Complete urine and bowel charts to see frequency
- Check pressure areas

Types of incontinence

- Patient passes urine or faeces in pad/bed/clothing
- May stop passing urine or not empty bladder fully (retention)
- Stops or has difficulty opening bowels (constipation)

Functional incontinence

Incontinence caused by other problems related to stroke, or hospital environment e.g.

- Communication problems – unable to tell anyone they need the toilet
- Reduced mobility – unable to transfer/walk to toilet or needs assistance
- Reduced arm function – unable to manage clothes/urinal
- Bathroom/urinal/bedpan not accessible
- Nobody to assist



How can we help?

- Ensure patient is visited at least every 2 hours – offer urinal/bedpan if bedbound
- If patient does not recognise urinal or bedpan toilet them at typical toileting times e.g. put on bedpan after waking, after eating
- Observe patient regularly – if restless (or trying to attract attention) may need to use toilet



How can we help?

- If patient can use urinal/toilet themselves ensure this is accessible, and avoid clothing or pads that are difficult to remove
- Remove catheter if patient not in retention – remove at least 2 days prior to discharge to ensure patient passes urine



Constipation

- Stools become hard and difficult to pass, or may not open bowels at all

How can we help?

- Complete bowel charts to monitor frequency
- Ensure adequate fluids
- Add fibre to diet
- Encourage movement
- Laxatives if required

Points to remember

- You can help patients to become continent again by giving them the opportunity to use a toilet (or bedpan/urinal) regularly!
- It is important to complete input/output and bowel charts to help identify any problems
- Catheters should be removed as early as possible prior to discharge

Thank you

Disclaimer

- This presentation was developed collaboratively by the Wessex Ghana Stroke Partnership group in 2013 to support a face-to-face training programme. The content has been designed to be relevant to the Ghanaian setting, and may not have been updated to any reflect changes in policy or evidence-base since this date.
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