Assessment and management of urinary incontinence in women
Ellie Stewart

Abstract
Urinary incontinence is a common and usually hidden issue that can affect women of all ages. It is often ignored by the patient because of their misconception that incontinence is an inevitable consequence of ageing and their low expectations of successful treatment. There are various types of incontinence, with symptoms that can significantly affect patients’ quality of life. This article aims to enhance nurses’ understanding of the types of urinary incontinence affecting women, associated risk factors and continence assessment, as well as the initial investigations and conservative treatments that can be instigated by general nurses. It also discusses some of the advanced treatments offered by specialist services. The article emphasises the importance of undertaking a holistic continence assessment to ensure appropriate continence care is provided, and how tailoring this care to the individual can improve adherence to treatment plans.

Aims and intended learning outcomes
This article aims to enhance nurses’ understanding of the types of urinary incontinence affecting women, associated risk factors, continence assessment, and initial investigations and conservative treatments that can be instigated by general nurses. After reading this article and completing the time out activities you should be able to:
» Describe the roles of general and specialist nurses in assessing and treating women with urinary incontinence.
» Recognise the types of urinary incontinence affecting women and the potential effects of symptoms on patients’ quality of life.
» Explain the elements of a continence assessment and the investigations that should be undertaken for women presenting with urinary incontinence.
» Outline the conservative treatments for urinary incontinence in women and advice that should be given to patients.
» Understand when to refer patients to specialist services and the advanced treatments that these services may offer.

Introduction
Urinary incontinence is a common issue among women of differing ages. Many women do not report their symptoms or seek assistance and support from healthcare services for several years because of their misconception that urinary incontinence is an inevitable consequence of ageing (Rantell 2015) and their low expectations of successful treatment. They may also feel embarrassed to admit that they are experiencing...
symptoms of incontinence and may attempt to manage the condition alone for as long as possible.

Urinary incontinence is more common in women than men, experienced by around 10% of all women and more than 20% of women aged over 70 years (Irwin et al 2011). Seeking support and assistance from healthcare services is associated with high levels of symptom bother and severity (Irwin et al 2008); the more symptoms someone has and the greater effect these symptoms have on their life, the more likely it is that they will present to healthcare services.

There are various types of urinary incontinence, including (Haylen et al 2010):

- **Stress incontinence** – involuntary leakage of urine on effort or exertion, or on sneezing or coughing.
- **Urge incontinence** – involuntary leakage of urine associated with urgency or desire to go to the toilet. Urge incontinence may be associated with overactive bladder, which is defined as urinary urgency, usually accompanied by urinary frequency and nocturia, in the absence of other obvious pathology.
- **Mixed incontinence** – involuntary leakage of urine associated with urgency and exertion, effort, sneezing or coughing.
- **Functional incontinence** – where no organic cause for leakage of urine can be identified. This may be a result of cognitive and physical factors.
- **Overflow incontinence** – involuntary leakage of urine associated with suboptimal bladder emptying.
- **Nocturnal enuresis** – loss of urine during sleep.
- **Postural urinary incontinence** – involuntary loss of urine associated with change of body position.
- **Insensible urinary incontinence** – where the woman has been unaware of how leakage of urine occurred.
- **Coxal incontinence** – involuntary loss of urine with coitus. This can be further divided into incontinence occurring with penetration or with orgasm.

### Role of the Nurse

Continent care is a significant aspect of healthcare and should be the responsibility of all nurses (Booth 2013). A nurse undertaking a continent assessment does not have to be a specialist. As long as the nurse has knowledge of incontinence and its treatment pathways, and recognises when to refer patients to specialist services, they should be able to perform an assessment. Specialist care does not necessarily need to be take place in secondary care settings; it can be provided in the community in specialised clinics. There are several continence care courses and useful resources available for nurses, such as the National Institute for Health and Care Excellence (NICE) (2015) guidelines, Minimum Standards for Continence Care in the UK (Rantell et al 2016) and the International Consultation on Incontinence guidelines (Abrams et al 2017). Nurses should be encouraged to contact their local urology department, urology and colorectal nurse specialists, who may be able to provide support and training to develop their skills, for example by observing clinics at the hospital, or providing a forum to discuss complex patients.

Nurses should be proactive in taking opportunities to ask patients about their continent status, for example when they are seen for cervical screening, medication review or general check-up. Early identification of any symptoms of urinary incontinence will enable prompt treatment, which may prevent deterioration that could result in surgical management, rather than conservative management.

### Risks Factors for Urinary Incontinence

Nurses should be aware of the main risk factors for developing urinary incontinence, which include (NICE 2015, Bardsley 2016):

- Constipation.
- Damage to the bladder during surgery affecting the nerves or surrounding tissue.
- Damage to the pelvic floor during childbirth.
- Fluid intake – excessive intake of caffeinated drinks, insufficient oral intake, excessive oral fluid intake.
- Neurological diseases or conditions affecting the spinal cord or brain, such as multiple sclerosis, Parkinson’s disease, stroke.
- Obesity.
- Some medicines, for example alpha-adrenergic agonists, antipsychotics, antidepressants, diuretics and non-steroidal anti-inflammatory drugs.
- Urinary tract infection.

### TIME OUT 2

Consider the risk factors for urinary incontinence. Do any of the patients you are currently caring for have any of these risk factors? What actions could you take to address these issues?

It is important for nurses to be aware of the risk factors for urinary incontinence and how they might affect the patient’s life and their symptoms. For example, those with Parkinson’s disease may not be physically able to get to the toilet in time, or may have difficulty undoing their clothes to enable them to use the toilet, so experience leakage of urine. Similarly, people with multiple sclerosis may have difficulty emptying their bladder fully, so may need to learn intermittent self-catheterisation to enable them to do so and prevent complications such as UTIs.

### Continence Assessment

A thorough and accurate continence assessment is essential to enable the appropriate treatment pathway to be commenced for the patient. It is important for the nurse to have an understanding of the types of urinary incontinence affecting women, the conservative treatments available and when to refer the patient to specialist services (Bardsley 2016). Effective communication skills are essential for the nurse to obtain the relevant information required to ensure appropriate treatment (Rantell 2015). It is vital that the nurse uses language that is easy to understand and avoids using technical, medical terminology. For example, the nurse should avoid using technical words such as ‘nocturia’ or ‘urge incontinence’ when questioning the patient. Instead, they should use words and phrases that are easily understood, such as ‘How many times do you get up to go...’
to the toilet at night?’ or ‘Do you leak on the way to the toilet if you don’t make it in time?’ It may also be necessary for the nurse to tailor the way they ask questions and the language they use, depending on the age and level of understanding of the patient. The nurse should use open questions to encourage the patient to provide useful information (Bardsley 2014), rather than closed questions, which are easy to answer but provide little information.

It is important for the nurse to consider their own body language during the assessment. Smiling encourages the patient to feel relaxed, as does an open posture and nodding in response to the patient’s comments. The nurse should be empathetic and sensitive. It is important to remember that this may be the first time that the patient has discussed their incontinence. They may be feeling worried or embarrassed, so the nurse should attempt to put them at ease and enable them to talk about their issues openly.

The nurse should also note any concerning body language, such as a lack of eye contact, and have an understanding of when it is appropriate to question further, when to stop questioning and when there are safeguarding concerns. The nurse will develop these skills with experience, and with education and support from experienced colleagues. Effective interpersonal skills will enable a trusting therapeutic relationship to be developed between the patient and nurse (Rantell 2013), which will increase the individual’s adherence to treatment and support symptom improvement.

Questionnaires are often used during the assessment to provide a baseline understanding of how the patient views their symptoms and how their quality of life is affected (Robinson et al 2007). They can be completed again at the end of treatment to evaluate how their quality of life is affected (Robinson et al 2007). They can be completed again at the end of treatment to evaluate how their quality of life is affected (Robinson et al 2007).

It is important to consider how easy they are for the patient to complete and score the results (Hewison et al 2014). Important areas to discuss during a continence assessment: Identifying which issue is the most significant for the patient. Different symptoms will affect different people in different ways. It is important for the nurse to ascertain which issue is the most significant for the patient. For example, the patient may report that it may not be going to the toilet once every hour during the day that bothers her the most, but that she is up five times per night to use the toilet, so she is not achieving adequate sleep for her to do her job safely. If the patient’s most significant issue can be identified and addressed, she may be increasingly likely to adhere to the treatment plan.

Quality of life

Often, urinary incontinence significantly affects the patient’s quality of life, for example as a result of not being able to wear white jeans in the summer in case of leaking and/or having to wear dark trousers to work or carry a change of underwear at all times. Patients may become depressed, experience sexual dysfunction, loss of respect or self-esteem, and incur additional expenses related to managing their incontinence (Yates 2017).

Obstetric and gynaecological history

The number of births, type of delivery, tears and whether the deliveries were instrumented will affect the pelvic floor (Herbert 2009) and consequently symptoms of urinary incontinence. Women often report such symptoms following a hysterectomy; therefore, it is important to ascertain what gynaecological surgery the patient has had to determine the cause.

Medication review

A review of the patient’s current medicines is a vital aspect of a continence assessment, since several medicines can cause or exacerbate urinary incontinence. It is important to identify if the patient is taking any of these medicines (Harris 2007). Table 1 details some of the common drugs that may affect continence.

Investigations

There are several basic investigations and tests that the nurse should perform as part of the initial continence assessment (NICE 2015).

Urinalysis

Urinalysis should be undertaken for all women undergoing a continence assessment. It is a reliable indicator of a UTI (Davis and Rantell 2017), as well as any haematuria, which is a red flag indication for referral to urology services. Any infection should be treated and the urinalysis repeated to assess if symptoms have improved (Osle 2016). Overactive bladder symptoms are similar to the symptoms experienced with a UTI, so infection should be excluded before initiating treatment for overactive bladder.

Key points

● Urinary incontinence is more common in women than men, experienced by around 10% of all women and more than 20% of women aged over 70 years (Irwin et al 2011)

● Different symptoms will affect different people in different ways. It is important for the nurse to ascertain which issue is the most significant for the patient

● Often, urinary incontinence significantly affects the patient’s quality of life. Patients may become depressed, experience sexual dysfunction, or loss of respect or self-esteem, and incur additional expenses related to managing their incontinence (Yates 2017)

● Medicines can be prescribed if lifestyle changes are not effective in improving the patient’s symptoms. Anticholinergics are the most commonly used type of medicines to treat overactive bladder symptoms of urinary urgency, urinary frequency, urge incontinence and nocturia

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Post-void residual test
A post-void residual test will demonstrate if the patient is emptying their bladder fully. Incomplete voiding can lead to UTIs (Davis and Rantell 2017) and can indicate other issues, such as constipation. A post-void residual test can be performed with an in and out catheter (a catheter that is inserted into the bladder and removed once the residual has been drained) or bladder scanner (Bardsley 2016). Constipation, large fibroids, pregnancy, vaginal prolapse and previous continence surgery can cause voiding difficulties, which may lead to recurrent UTIs, urinary frequency and urinary urgency.

Double voiding is a simple technique that the patient can be taught, which reduces the feeling of urine being left inside the bladder. This involves asking the patient to stand up and sit down, rock forwards and backwards and squeeze the pelvic floor after voiding, to attempt to get rid of any urine left in the bladder after the initial void.

Bladder diary
A bladder diary is a useful tool, since it can provide information about the type and volume of fluids consumed by the patient and the frequency of their micturition (Nazarko 2015), as well as the volumes passed, which will be an indicator of bladder volume. NICE (2015) guidelines recommend that the patient should complete a bladder diary for three days to provide information about their bladder habits. However, bladder diaries are rarely completed fully or at all. They can be challenging to complete and the patient needs to understand what they need to do, so these diaries may not be suitable for people with learning difficulties or memory loss (Price 2011).

Vaginal examination
The vagina should be examined for anterior and posterior wall prolapse and uterine prolapse, skin condition, vagal atrophy and any incontinence, which can be assessed with a cough test (Rantell 2013). A cough test involves asking the patient to cough while lying down and observing if there is any leakage of urine. A digital vaginal examination can also be performed by an appropriately trained nurse to assess the patient’s pelvic floor function and strength. Before undertaking a digital vaginal examination or other invasive investigations, the nurse must ask the patient if they wish for a chaperone to be present.

Rectal examination
The nurse can observe the anal area for skin tags, rectal prolapse and skin condition (Nazarko 2015). Digital rectal examination can be used to diagnose faecal loading (a large volume of stool in the rectum), faecal impaction (a solid, immobile lump of faeces in the rectum, usually as a result of chronic constipation) and squeeze pressure (pressure produced when the anus is squeezing to avoid defaecating). Since the rectum is close in proximity to the bladder, if it is full, this may increase voiding difficulties, urinary frequency and urinary urgency.

Red flag signs and symptoms
Referral to specialist services should be initiated immediately if any of the red flag signs and symptoms listed in Box 1 are identified during the assessment (NICE 2015, Rantell et al 2016). If cancer is suspected, the patient must be urgently referred on a two-week wait pathway.

Special populations
Care should be taken when assessing older adults, people with cognitive impairment, people with reduced mobility and women who are pregnant, because the standard assessment and treatment pathways might not be appropriate for them. For example, in older adults, incontinence is strongly associated with dementia, reduced physical functioning, constipation and UTIs (Byles 2009). Furthermore, Morris and Wagg (2007) stated that urinary frequency, urinary urgency and nocturia increase the risk of falling in older adults, which leads to an increase in fractures and admissions to hospital and nursing homes.

<table>
<thead>
<tr>
<th>TABLE 1. Drugs that may affect continence</th>
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<tbody>
<tr>
<td>Drug type</td>
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<tr>
<td>Alpha-adrenergic agonists, for example</td>
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<tr>
<td>methyldopa</td>
</tr>
<tr>
<td>Antipsychotics, for example haloperidol,</td>
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<tr>
<td>chlorpromazine hydrochloride</td>
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<tr>
<td>Antidepressants, for example amitriptyline</td>
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<tr>
<td>hydrochloride, imipramine hydrochloride</td>
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<tr>
<td>Diuretics, for example bendroflumethiazide</td>
</tr>
<tr>
<td>Calcium channel blockers, for example</td>
</tr>
<tr>
<td>amlopidine, nifedipine, diltiazem</td>
</tr>
<tr>
<td>hydrochloride</td>
</tr>
<tr>
<td>Angiotsensin converting enzyme inhibitors</td>
</tr>
<tr>
<td>(ACE inhibitors), for example enalapril</td>
</tr>
<tr>
<td>maleate, captopril, lisinopril, ramipril</td>
</tr>
<tr>
<td>Opiates, for example codeine phosphate,</td>
</tr>
<tr>
<td>morphine, oxycodone hydrochloride</td>
</tr>
<tr>
<td>Anticholinergics, for example oxybutynin</td>
</tr>
<tr>
<td>hydrochloride, tolterodine tartrate,</td>
</tr>
<tr>
<td>solifenacin succinate</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs, for</td>
</tr>
<tr>
<td>example diclofenac, ibuprofen, naproxen</td>
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</table>

(Adapted from British National Formulary 2017)
An assessment tailored to older patients will ensure that mobility issues, medicines use, and their social networks and social care, are discussed in detail and that realistic treatment options are suggested. For example, it may be more appropriate to refer an older patient for an occupational therapy assessment for a commode to use at night-time, rather than them having to attempt to get to the toilet in time, which increases the risk of falling.

**Conservative treatments**

Conservative treatments are available for all types of urinary incontinence (Table 2) and can be instigated easily by general nurses and in primary care. It is essential that the progress of patients undertaking these treatments is reviewed regularly, and that they are given positive feedback to maintain adherence to the treatment plan. If conservative treatments are not effective and improvements are not identified, the patient can be referred to specialist services for further assessment and advanced treatments.

**Pelvic floor exercises**

NICE (2015) guidelines recommend that supervised pelvic floor exercises should be undertaken for at least three months. These exercises are an effective way of strengthening the pelvic floor muscles and improving symptoms of incontinence. NICE (2015) guidelines suggest that women should perform at least eight contractions three times per day to achieve a noticeable improvement in symptoms. Women whose symptoms do not improve following a course of pelvic floor exercises should be referred to a urogynaecologist for further management options (Ostle 2016).

Weighted vaginal cones can be used instead of, or to augment, pelvic floor exercises; however, the literature indicates there is no difference in the effectiveness of vaginal cones compared with pelvic floor exercises (Haslam 2008). Mobile phone apps are available that are designed to motivate and remind women to undertake their pelvic floor exercises regularly. Whitehouse (2012) suggested that women who are motivated and receive regular feedback are increasingly likely to continue with their exercise programme and notice an improvement in their symptoms and a reduction in incontinence episodes. A device known as an Elvie trainer can be inserted into the vagina; when squeezed, this activates a biofeedback mechanism so that women can monitor how hard they are squeezing their muscles, and how long for, on their mobile phone. Pelvic floor exercise programmes are also available online.

**Bladder retraining**

Bladder retraining aims to increase the time in between trips to the toilet by encouraging the patient to ‘hold on’ when they need to go, whether this is for 30 seconds or ten minutes. This aims to improve the patient’s control of their bladder (Nazarko 2015). Over time, this can reduce symptoms of urinary frequency, urinary urgency and nocturia.

**Fluid advice**

Guidelines recommend that patients reduce their caffeine intake to improve overactive bladder symptoms (NICE 2015, Syan and Brucker 2016). Citrus drinks, fizzy drinks and alcohol are also known bladder irritants (Stewart 2011). Patients should be advised to avoid or reduce these to see if their symptoms improve.

A fluid intake of around 1.5-2.0 litres per day is recommended. If the patient’s fluid intake is insufficient, their urine can be strong and irritate the bladder, causing urinary frequency and urinary urgency, while if their fluid intake significantly exceeds the recommended amount, they may experience urinary frequency. Modifying fluid intake can improve these symptoms (Ostle 2016). If a patient experiences nocturia, they should be advised to restrict their

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**BOX 1. Red flag signs and symptoms requiring referral to specialist services**

- Visible haematuria (urology)
- Microscopic haematuria in women aged over 50 years (urology)
- Voiding difficulties (urology)
- Persistent bladder or urethral pain (urology)
- Suspected neurological disease (urology)
- Complex symptoms such as a combination of storage and voiding symptoms (urology)
- Recurrent urinary tract infections (urology or urology) (NICE 2015)
- Previous pelvic cancer or suspected malignancy (urology or urology) (NICE 2015)
- Previous pelvic cancer surgery or radiation therapy (urology or urology) (NICE 2015)
- Previous pelvic incontinence surgery or radiation therapy (urology or urology) (NICE 2015)
- Previous incontinence surgery (whichever service undertook the previous surgery)
- Associated faecal incontinence (colorectal)

(Adapted from National Institute for Health and Care Excellence 2015)

**TABLE 2. Conservative treatments for urinary incontinence**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Conservative treatment</th>
</tr>
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<tbody>
<tr>
<td>Stress incontinence</td>
<td>Pelvic floor exercises, vaginal cones, Squeezy NHS Pelvic Floor mobile phone app, electrical stimulation of the pelvic floor muscles, Elvie trainer</td>
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<tr>
<td>Functional incontinence</td>
<td>Occupational therapy referral for commodes or aids to assist with toileting, clothes with elasticated waists or Velcro so they can be removed quickly for toileting</td>
</tr>
<tr>
<td>Mixed incontinence</td>
<td>Pelvic floor exercises, bladder retraining, fluid advice, constipation management, anticholinergics</td>
</tr>
<tr>
<td>Overactive bladder</td>
<td>Bladder retraining, pelvic floor exercises, fluid advice, anticholinergics</td>
</tr>
<tr>
<td>Voiding difficulties</td>
<td>Intermittent self-catheterisation, double voiding, constipation prevention advice</td>
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Fluid intake during the evening to reduce these episodes.

**Timed or prompted voiding**

Patients with dementia may benefit from regular verbal reminders to establish a toileting routine and to assist them in recognising the signs of needing to go to the toilet (Price 2011). Morgan et al (2008) suggested that a personalised toileting programme (timed voiding) is effective in pre-empting the need to go to the toilet. However, this type of intervention is labour intensive. Timed voiding ensures that the bladder is emptied at regular intervals, rather than only when the patient feels the urge to void. This assists in preventing the bladder from overfilling and void. This assists in preventing when the patient feels the urge to go to the toilet. However, this type of intervention is labour intensive. Timed voiding aims to improve bladder control using verbal prompts, reminders and positive reinforcement (Eustice et al 2000).

**Weight loss**

Obesity is a significant modifiable and reversible risk factor for stress incontinence (Faiena et al 2015). Subak et al (2009) suggested that moderate weight loss may decrease episodes of urinary incontinence. The nurse should support women in their attempt to lose weight and inform them of the general health benefits as well as the potential reduction in their incontinence episodes.

**Medicines**

Medicines can be prescribed if lifestyle changes are not effective in improving the patient’s symptoms. Anticholinergics are the most commonly used type of medicines to treat overactive bladder symptoms of urinary urgency, urinary frequency, urge incontinence and nocturia. NICE (2015) guidelines suggest that oxybutynin hydrochloride, tolterodine tartrate or darifenacin should be offered as a first-line treatment, or a lirinel patch for those unable to tolerate oral medicines. The most common side effects of anticholinergics are constipation, blurred vision and dry mouth (Robinson and Cardozo 2012). These potential side effects should be considered when selecting the appropriate medicine.

**Vaginal pessaries**

Vaginal prolapse is often treated with pelvic floor exercises and/or vaginal pessaries. There are various types of silicone and plastic vaginal pessaries available, which provide support and reduce the feeling of heaviness, which is one of the main symptoms of vaginal prolapse. Anantawat et al (2016) demonstrated that the use of a vaginal pessary for six months improves vaginal symptoms and quality of life in women with prolapse. Ring pessaries are the most commonly used type of pessary. They are inserted into the vagina and should be changed every six months. They are a useful management option for women of childbearing age with a vaginal prolapse who wish to have children, or those who do not want to consider surgical management or for whom surgical management is not an option (Storey et al 2009). Pessaries can be inserted and managed by non-specialist nurses who have completed appropriate training, but they are often managed by specialist nurses. Training in the use of pessaries can be received from the urogynaecology team. Nurses should be aware to observe for vaginal bleeding in those who have a pessary. If this occurs, the patient should be referred to the oncology team for assessment of the endometrial thickness and investigation of possible endometrial cancer.

Silicone pessaries are easy to insert and remove, and last for up to five years. They can be used by younger pre-menopausal women who do not require the condition of their vagina to be checked for ulceration and bleeding every six months. Patients can be shown how to insert and remove their pessaries as and when they want to (Kearney and Brown 2014), but should be advised to remove them to clean them at least once every six months. Some women remove them to have sexual intercourse, while others use them for extra support and symptom relief, for example if they know they will be spending the day walking or standing on their feet for long periods. Others use them and do not remove them. Patients with pessaries who are pre-menopausal do not require face-to-face clinic follow-up appointments; they can manage their pessaries independently with a telephone follow-up appointment every six months.

**Intravaginal oestrogens**

Vaginal atrophy, also known as atrophic vaginitis, occurs when the vaginal tissues lack oestrogen and as a result can become dry, thin and may bleed (Domoney 2014). It can lead to decreased strength in pelvic floor muscles and urge incontinence (Bardsley 2014). Vaginal atrophy is commonly experienced by post-menopausal women (MacBride et al 2010), who frequently report that their vagina feels dry and uncomfortable, and that sexual intercourse is not as pleasurable (Domoney 2014). Furthermore, vaginal atrophy is the most common cause of vaginal bleeding in post-menopausal women with a vaginal pessary. If vaginal atrophy occurs, the movement of a pessary in the vagina can cause ulceration and bleeding.

Intravaginal oestrogens may be beneficial in maintaining normal structure and function of the urogenital tissue. However, NICE (2015) guidelines recommend that systemic hormone replacement therapy is not offered to treat urinary incontinence, but intravaginal oestrogens can be considered to treat overactive bladder symptoms in post-menopausal women with vaginal atrophy. Women with vaginal atrophy and a vaginal pessary are often started on a low dose of intravaginal oestrogen (Bulchandani et al 2015).

**TIME OUT 3**

Conservative treatments are available for all types of urinary incontinence in women. Reflect on what these are and how experienced and confident you are in providing these treatments. Which do you need support and practice in to develop your skills, and how would you achieve this?

**Urodynamic investigations and advanced treatments**

Many patients who undertake conservative treatments for incontinence do not experience significant improvement in their symptoms or quality of life. These women should be referred to the urogyaecology service for further assessment and treatment.
Urodynamic investigations are recommended to diagnose the type of incontinence (Thuroff et al 2011, NICE 2015) and to determine if surgical management is an option (Syan and Brucker 2016). They are often performed by a specialist nurse in the hospital setting.

Botulinum toxin (Botox) injections are available for those who have tried two different types of anticholinergics and not noticed any significant symptom relief. It is important that a specialist nurse teaches the patient intermittent self-catheterisation before the injections, because there is a risk of retention or complete voiding post-operatively.

Percutaneous tibial nerve stimulation and sacral nerve stimulation can also be offered for those with overactive bladder where conservative treatments have been unsuccessful (Syan and Brucker 2016). Patients requiring these advanced treatments must first undergo urodynamic investigations and be discussed in multidisciplinary team meetings with urologists and clinicians with an interest in pelvic floor dysfunction (NICE 2015).

TIME OUT 4
A female patient who is experiencing urinary incontinence asks you what advanced treatments may be offered by a specialist urogynaecology service. How would you explain these treatments to them? You may wish to discuss this with a colleague.

Conclusion
It is often several years before a woman with urinary incontinence presents to healthcare services for treatment and support. Nurses are well-placed to identify patients who are experiencing incontinence and to provide initial investigations and treatments. Initial conservative treatments can be provided following a thorough continence assessment by a suitably skilled nurse. Adherence to clinical guidelines enables a structured assessment and treatment pathway to be commenced, with appropriate referral to specialist services if required.

TIME OUT 5
Consider how the assessment and management of incontinence in women relates to The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing and Midwifery Council 2015) or, for non-UK readers, the requirements of your regulatory body.

TIME OUT 6
Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account: rcni.com/reflective-account

References
Urinary incontinence in women
TEST YOUR KNOWLEDGE BY COMPLETING THIS MULTIPLE-CHOICE QUIZ

1. Which statement is false?
   a) Urinary incontinence is more common in women than men  
   b) Urinary incontinence is an inevitable consequence of ageing  
   c) Patients are often embarrassed to admit that they are experiencing symptoms of incontinence  
   d) Seeking support and assistance from healthcare services for incontinence is associated with high levels of symptom bother and severity

2. Which of the following types of urinary incontinence is defined as the involuntary leakage of urine associated with suboptimal bladder emptying?
   a) Overflow incontinence  
   b) Stress urinary incontinence  
   c) Nocturnal enuresis  
   d) Coital incontinence

3. Which of these is not a risk factor for urinary incontinence?
   a) Obesity  
   b) Urinary tract infection  
   c) Hypertension  
   d) Constipation

4. During a continence assessment, the nurse should:
   a) Identify which issue is the most significant for the patient  
   b) Review the patient’s current medicines  
   c) Ascertain what gynaecological surgery the patient has had, if any, to assist in determining the cause of their incontinence  
   d) All of the above

5. Which type of medicines may affect continence by decreasing smooth muscle contractility in the bladder, causing urinary retention and constipation?
   a) Antidepressants  
   b) Calcium channel blockers  
   c) Diuretics  
   d) Antipsychotics

6. One disadvantage of using a bladder diary when assessing a patient’s bladder habits is:
   a) They are expensive to complete  
   b) They do not provide any information about the type and volume of fluids that the patient consumes

7. A patient should be referred to a urology service if they have which of the following red flag signs or symptoms?
   a) Benign pelvic masses  
   b) Visible haematuria  
   c) Associated faecal incontinence  
   d) Symptomatic urogenital prolapse

8. What is the most commonly used type of medicine to treat overactive bladder symptoms?
   a) Anticholinergics  
   b) Opiates  
   c) Beta blockers  
   d) Anxioylytics

9. Vaginal pessaries can be used to:
   a) Assist patients when undertaking pelvic floor exercises  
   b) Encourage patients to empty their bladder at regular intervals, rather than only when they feel the urge to void  
   c) Provide support and reduce the feeling of heaviness that women with vaginal prolapse may experience  
   d) Treat vaginal atrophy and bleeding

10. Which of the following is an advanced treatment for incontinence that may be offered in specialist services?
    a) Percutaneous tibial nerve stimulation  
    b) Sacral nerve stimulation  
    c) Botulinum toxin (Botox) injections  
    d) All of the above

How to complete this quiz
This multiple-choice quiz will help you to test your knowledge. It comprises ten questions that are broadly linked to the CPD article. There is one correct answer to each question. 
- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions.

Further multiple-choice quizzes are available at rcni.com/cpd/test-your-knowledge

This multiple-choice quiz was compiled by Alex Bainbridge

The answers to this multiple-choice quiz are:
1. b 2. a 3. c 4. d 5. b 6. c 7. b 8. a 9. c 10. d

This activity has taken me minutes/hours to complete. Now that I have read this article and completed this quiz, I think my knowledge is:

Excellent ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor ☐

As a result of this I intend to:

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