

9 Myths of Incontinence in Older Adults

Despite progress made in the research into and treatment of urinary incontinence (UI), its incidence is rising among older adults. Many reasons for this include clinicians’ insufficient knowledge of UI, reluctance of patient’s to discuss it, and inadequately individualized care. Understanding common perceptions of bladder health in older adults can help nurses provide care that prevents and treats incontinence.

Myth #1: UI is inevitable with age.

Fact: While older adults are at an increased risk for UI to develop due to changes in kidney and bladder function with aging, UI is not an inevitable consequence of this process. Many interventions can prevent, slow the progress or reverse UI.

Myth #2: There is only one type of UI.

Fact: This false belief often leads to ineffective management and treatment of UI. There are many types of UI - transient, stress, urge, overflow, functional, mixed, reflux and total. Without an accurate diagnosis it is difficult to provide effective treatment.

Myth #3: There are no effective treatments for UI – It is unavoidable in nursing home residents.

Fact: There is much evidence showing that UI is treatable in community and long term care settings. Most interventions fall within nursing’s scope of practice and include the behavioral interventions of: scheduled toileting, prompted voiding, bladder training, pelvic muscle exercises, and intermittent catheterization.

Myth #4: UI falls under the purview of physicians: Nurses can’t do much to help.

Fact: UI can be managed by non-pharmacologic treatments implemented by nurses. Thorough health histories, identification of risk factors and implementation of 3 day bladder diaries can provide the foundation for identifying the type of UI and implementing behavioral strategies.

Myth #5: UI is unmanageable in people with dementia.

Fact: Although UI is often concurrent with dementia, cognitive impairment alone has not been shown to cause UI. While impaired cognition may affect a patient’s ability to find a bathroom or to recognize the urge to void, it doesn’t necessarily affect bladder function. Prompted voiding has been demonstrated to be effective in improving dryness in cognitively impaired and dependent nursing home residents.

Myth #6: Complete continence is the only indication of successful treatment.

Fact: Until recently, continence and incontinence were viewed at opposite ends of the spectrum with nothing in between. It was only with the start of clinical trials of urinary interventions, which began in 1982 by Wells and Brink at the University of Michigan, that continence began to be measured on a continuum. Gradation of successful treatment may include dryness at night or during the day, fewer episodes of UI, a greater percentage of dry time, and an increase in the number of times a person urinates in the toilet. Any improvement can be seen as a significant success and caregivers should acknowledge both their own efforts and that of the patient.

Myth #7: Older adults don’t mind being incontinent and wearing pads.

Fact: Studies by Mittness have found that UI represents a loss of control and made older adults feel angry. They grieved the loss and were embarrassed, ashamed and depressed. Many hid their UI fearing nursing home placement. Incontinence pads are often referred to as “diapers” reinforcing the stereotype that a childlike loss of control and dignity accompanies aging. Although, some adults wear pads to enhance a feeling of security, others do so because they haven’t been presented with other options. Routine use of incontinence pads by continent residents in the nursing home communicates the expectation that the resident will become incontinent and is considered a breach of nursing ethics.

Myth #8: Indwelling catheters are the best intervention for intractable UI.

Fact: In an effort to keep patients dry and to protect their skin, particularly in the face of understaffing, indwelling catheters are used frequently. Although the intentions may be good, these catheters are often used without consideration of the consequences. Continuous indwelling catheterization may be an appropriate management strategy for only a few patients and existing recommendations for care are based on short-term (less than 30 days) rather than long-term use. There are no recommendations for long-term indwelling catheters.

Myth #9: Prevention is impossible.

Fact: Continence should be fostered as the norm in all health care settings. Maintenance of the person’s functional abilities is the first step in maintaining continence. Combining wheelchair use with exercise twice daily, visible bathrooms, toileting at regular intervals or according to individual voiding patterns, easy to manage clothing, and CNA involvement in the care plan are key to promoting continence. The availability of necessary equipment such as standing lifts and full mechanical lifts with hygiene slings increase continence as does effective staffing. Education of the patient and their families regarding prevention and management strategies is also key.

Reference: Specht, J.K. – *9 Myths of incontinence in older adults*. American Journal of Nursing, June 2005. Vol. 105, No. 6, pp.58-69.

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