Bladder and Bowel Symptoms – Troubleshooting Tips

Symptom	Importance	Tips
Unwilling to accept assistance with using the toilet	There may be an underlying condition that causes this resistance, or the individual may not understand that care is required.	**Think:** Does the individual understand that the care is required? Do they recognise the toilet and remember how to use it? How might he/she interpret staff actions when they try to assist? Is there an underlying condition causing this (e.g. pain, embarrassment, etc.)? What can you do to avoid the distress this causes? Can you implement a plan that takes a positive approach to communicating with and supporting this individual? **Do:** Try to find ways to promote independence in using the toilet, e.g. looking at signage, etc. Make sure you don't do anything to embarrass the individual. How welcoming is the toilet – would you use it? If the individual doesn't seem to understand try distraction, e.g. talking about a place they know, singing etc. Never force things, go away and come back later trying a different method of explaining, or ask a colleague to take over.

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Voiding urine less than 3 times per day	This could indicate a prostate problem (in a man) or a neurological condition that results in incomplete bladder emptying. This symptom should be considered in relation to other symptoms (i.e. a sensation of incomplete bladder emptying, etc.). It could also be related to inadequate oral fluid intake	Start a timed toileting regime (**see SPHERE information leaflet: Voiding Programmes**). Encourage the individual to practice double-voiding (**see SPHERE information leaflet Successful Bladder Emptying**). Keep a bowel chart and resolve constipation if present (**see SPHERE information leaflet: Constipation and Laxatives**). Discuss with the medical staff for potential further investigation of prostate. A post-void bladder scan should be carried out. Record fluid intake and output over a 24 hour period using a bladder diary and do this for 3 days in a row if possible.
Voiding more than 6 times during the day	This symptom may indicate an underlying health problem that requires attention and should be considered in relation to other symptoms, e.g. urgency, urge incontinence, symptoms of UTI etc. Medical staff intervention may be required.	It could be the person is drinking an excessive amount of fluids, i.e. more than 2,500mls (**see SPHERE information leaflet: Impact of Fluids on Bladder**). They may be reacting to a high intake of caffeine (caffeine should be reduced gradually to avoid caffeine withdrawal headaches). Caffeine is found in coffee, tea, some fizzy drinks such as Cola and Irn Bru and high energy drinks. (**see SPHERE information leaflet: Impact of Fluids on the Bladder**) Is the individual constipated? Encourage the individual to practice double-voiding (**see SPHERE information leaflet: Successful Bladder Emptying**). Ask them if they have any pain or discomfort passing urine. If so, routine checking of urine sample should be done to rule out urinary tract infections.
Voiding more than 2 times in the night	This symptom may indicate an underlying health problem that requires attention.	**See SPHERE information leaflet Types of Incontinence: Nocturia** Find out when they take their last drink of fluids before sleeping and what type of fluids they are taking. Ask them if they have any problems with lower limb oedema during the day.
Passing large volumes of urine that is difficult to contain (flooding) at night	This symptom may indicate an underlying health problem that requires attention.	Could the person be constipated? Constipated faeces can put pressure on the bladder and cause symptoms of frequency and urgency, but it can also cause low urine output during the day, followed by passing large volumes of urine at night, when the pressure on the bladder is released by lying down. Does the person have lower limb oedema? Large amounts of urine passed during the night might be in response to fluid being reabsorbed from the skin when lying down. Is the individual drinking large volumes of fluid (especially caffeine-containing drinks) later in the day?

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Bowel movements less than 3 times per week	Individuals vary widely in the frequency with which they empty their bowels and any change to the normal routine and/or eating patterns will have an impact. However, most people have their bowels open at least 3 times per week.	Healthy bowel elimination is characterised by regular bowel movements (every 1-2 days), a soft, formed stool that is easy to pass (no straining). If they have their bowels open less than 3 times per week and pass a hard stool that is difficult to pass, this is likely to be due to constipation. An increase in fibre, fluid, activity or laxatives may be required to achieve healthy bowel elimination. (**see SPHERE Information leaflets: Constipation and Laxatives; Gastro-Colic Reflex; Medication Impact on the Bowel**)
Pain and discomfort when opening bowels	Pain and discomfort is not normal and should be investigated. It may indicate an underlying pathology, such as haemorrhoids or constipation (or both) or other underlying bowel disease	Help the patient to establish a regular bowel pattern, which might improve symptoms. Aim for a daily bowel movement, type 4 or 5 on the Bristol Stool Scale. **See SPHERE Information leaflets: Gastro-Colic Reflex; Constipation and Laxatives** **See NICE Guideline on Colorectal Cancer – Diagnosis and Treatment**
Straining to use bowels	Straining indicates constipation and/or an underlying problem. Keep in mind that people with acute or chronic health conditions may have difficulty in achieving abdominal pressure that facilitates full bowel emptying.	Straining must always be discouraged. If an individual is unable to have a bowel movement without straining this should be investigated (even if it is normal for them). Help the patient to establish a regular bowel pattern, which might improve symptoms. Aim for a daily bowel movement, type 4 or 5 on the Bristol Stool Scale. **See SPHERE Information leaflets: Gastro-Colic Reflex; Constipation and Laxatives; Bowel Incontinence and NICE Guideline on Colorectal Cancer – Diagnosis and Treatment**
Bleeding when bowels open	Bleeding during defeacation is not normal.	It may indicate haemorrhoids or another underlying medical condition and should be discussed with GP/medical staff. **See information leaflets and guidelines above**.
Hard, dry bowel movements	Bowel movements should be soft and formed - refer to the Bristol Stool Scale for assistance in differentiating between a healthy and unhealthy stool.	**See SPHERE Information leaflets: Gastro-Colic Reflex; Constipation and Laxatives; Medication Impact on the Bowel**
Very fluid bowel movements		**See SPHERE information leaflet, Types of Incontinence: Bowel Incontinence**
Constipation	Constipation can impact on bladder emptying and can cause symptoms of frequency and urgency and can contribute to nocturnal urinary frequency and/or incontinence and urinary retention	Bear in mind what the individual's normal bowel pattern is and try to encourage a regular daily bowel movement utilising what you know about the gastro-colic reflex. Aim for a daily type 4 on the Bristol Stool Scale. Remember that a change of routine, different food etc. can adversely impact on the regularity of bowel movements. Check that the individual person it taking adequate fluid intake and passing urine regularly during the day and if not a post void bladder scan should be carried out.

Symptom	Importance	Tips
Impaired skin integrity	To prevent further risk to the skin the individual will require a care plan that addresses this issue.	Urine and faeces can be very damaging to the skin, so it is essential that a toileting regime is put into place to minimise contact with the skin by urine and/or faeces. **See Voiding Programmes and Gastro-colic Reflex.**
Urinary tract infection	Can cause symptoms of urgency and frequency.	Make sure the urine is dipstick tested and if the patient shows signs of UTI initiate treatment: antibiotics if prescribed; encourage fluids; avoid faecal incontinence and make sure if faecal incontinence occurs, that the perineal and anal area is washed from front to back to avoid contamination of the urethral orifice with faecal matter.
Atrophic vaginitis	Atrophic vaginitis is caused by a lack of oestrogen and occurs in women after the menopause. It can lead to symptoms of frequency and urgency and stress incontinence.	This condition can be treated with topical oestrogen in the form of a cream or small pessaries which are inserted into the vaginal area. This treatment it can settle the symptoms of urinary frequency and urgency when other treatment options have not helped.
Unstable diabetes	This can lead to urinary frequency, urgency and urge incontinence because of the presence of glucose in the urine, which can irritate the bladder wall. Longstanding diabetes can also lead to damage of the nerves supplying the bladder and/or bowel and affect ability to pass urine/open bowels.	If a patient has symptoms of urinary frequency and urgency, dipstick urinalysis will highlight any abnormalities that can be reported to the GP/medical staff for a review of their condition by Diabetes Specialist Nurse. Keep in mind that there are medications used to treat diabetes that will excrete glucose in the urine, please check with GP/medical staff.
Enlarged prostate	As men age their prostate can increase in size and in some cases lead to voiding problems. Symptoms include urinary frequency, hesitancy (difficulty in passing urine), nocturia and a sense of incomplete emptying. Some men also experience post-void dribbling incontinence. Constipation will add to the discomfort.	Make sure you ask about all symptoms and report to medical staff if you suspect a male patient has symptoms of enlarged prostate, complete an **IPSS score sheet (see Hints and Tips section of SPHERE website)** There are medical treatments available, but some useful tips to pass on can be found in the following **SPHERE Information leaflets**: - **Impact of Fluids on the Bladder** **Medications for Bladder Dysfunction** **Successful Bladder emptying** **Urge Control Techniques** **Double voiding and penile milking – see SPHERE Self Management Booklet for Men**

Symptom	Importance	Tips
Needs pads for containment	**Please remember that pads do not replace assistance to use the toilet.** A full clinical assessment should be carried out by a Registered General Nurse with knowledge of containment products. This type of containment should only be considered once intractable incontinence has been diagnosed and social containment is the only option To provide the incontinent person with full containment of urine and or faeces. When the correct style and absorbency of pad is prescribed and fitted correctly, it will prevent leakage and prevent skin breakdown. Bigger isn't always better. It should be the smallest pad, which is comfortable to wear to meet the person's absorbency needs.	Pads should be changed when the wetness indicators on the back of the pad have changed. The blue line will disappear and the yellow line will turn blue/green. Fixation pants must always be worn with Form pads (shaped pads). Pads are waterproof so liquid will not flow from one pad to another. There is no benefit from wearing more than one pad!! It is uncomfortable for the wearer and can compromise the person's skin. Pads can be reapplied after toileting or personal care as long as the pad is intact and there is no faecal soiling, the wetness indicators have not reached their maximum capacity and there is no other medical reason for the pad to be changed. Pads should not be shaken prior to fitting. Doing so will cause the pad to 'break up' and result in the pad not working as efficiently as it should, and could result in patient discomfort. If the pad is leaking check the following is correct- • Fitting of the pad, size of pad, absorbency, size of fixation pants, application of barrier cream. • Wetness indicators – have they reached the maximum absorbency or not?

Symptom	Importance	Tips
Would like to try a urosheath	A full clinical assessment should be carried out by a Registered General Nurse with knowledge of suitable anatomy, sizing and fitting, skin preparation and application of a urosheath. This type of containment should only be considered once intractable incontinence has been diagnosed and social containment is the only option, or for men who are continent with impaired mobility who are unable to get to the toilet without assistance. Assessment should give consideration to: - •Manual dexterity of patient/client or carer •Motivation and willingness to use a urosheath •The right product for clinical need.	**When not to use a urosheath** • If the individual has anatomy that would not be suitable, e.g. a retracted penis (if unsure, contact SPHERE for advice) • Skin irritation: redness, soreness or penile discharge (report to GP/medical staff) • Known allergy to the product • Urinary retention: the urosheath simply collects urine and does not enter the urethra or bladder, so is not suitable for patients/clients who have difficulty passing urine. **Ensure measurement for the urosheath is carried out correctly**: - • Measure mid shaft of flaccid penis. • There are measuring guides available from the manufacturers in the form of scooped cards. Fit the penis into the scoop to determine the most snug fit – this is the correct size. • Some manufacturers provide tapes to use for measurement – again the tape should fit snugly around the penis to obtain the correct size. • Alternatively, use a disposable tape measure to measure the circumference of the mid shaft of the penis in millimetres and convert this to the diameter by dividing the circumference by 3.14. • Determine suitable length of urosheath: - Thumb length penis = short length urosheath Finger length penis = longer length urosheath **Skin preparation** • Make sure all pubic hair is away from the base of the penis, to avoid getting it caught in the urosheath, trimming it if necessary but do not shave the pubic area • Wash the skin of the penis with a non-moisturising soap or shower gel • Make sure the skin is thoroughly dried before applying urosheath **DO NOT** use talcum powder, moisturising soap, creams, any other fixation aid that is not part of the urosheath. **For information on correct fitting please see SPHERE information leaflet: Urosheaths**