December 2020

**Comparing *Promoting Continence Using Prompted Voiding* (2011), Third Edition Best Practice Guideline (BPG) to the current Fourth Edition BPG (2020)**

This document summarizes how the recommendations in the current, Fourth Edition BPG regarding incontinence and constipation compare to the *Promoting Continence Using Prompted Voiding*, Third Edition BPG recommendations, published in 2011. Tables 1, 2 and 3 are a breakdown of the practice, education and organization/system recommendations. It is to note that additional areas that were addressed in the fourth edition of the BPG, that were not included in the third edition of the BPG include the following: bladder training and physical activity (low-intensity and pelvic floor muscle training).

**Table 1: Practice Recommendations**

| Practice Recommendation from Third Edition (2011) | Relevant Information in Fourth edition BPG (2020) |
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| Obtain a history of the client's incontinence | - Good practice statement on assessment of urinary incontinence<br>- Appendix G<br>- Appendix I |
| Gather information on:<br>• The amount, type and time of daily fluid intake, paying particular attention to the intake amount of caffeine and alcohol.<br>• The frequency, nature and consistency of bowel movements.<br>• Any relevant medical or surgical history which may be related to the incontinence problem, such as but not limited to diabetes, stroke, Parkinson's disease, heart failure, recurrent urinary tract infections or previous bladder surgery. | - Good practice statement on assessment of urinary incontinence<br>- Appendix I |
| Review the client's medications to identify those which may have an impact on the incontinence. | - Good practice statement on assessment of urinary incontinence<br>- Appendix J |
| Identify the client's functional and cognitive ability. | - Good practice statement on assessment of urinary incontinence<br>- Appendix I |
| Identify attitudinal and environmental barriers to successful toileting. Barriers include:<br>• Proximity and availability of the nearest bathroom;<br>• Accessibility of commode;<br>• Satisfactory lighting;<br>• Use of restraints; | - Good practice statement on assessment of urinary incontinence<br>- Appendix I |

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| • Staff expectation that incontinence is an inevitable consequence of aging; and<br>• Staff belief that few interventions exist to promote continence. | |
| Check urine to determine if infection is present | - Good practice statement on assessment of urinary incontinence |
| Determine how the client perceives their urinary incontinence and if they will benefit from prompted voiding. Before initiating prompted voiding, identify the client's pattern of incontinence using a 3-day voiding record. | - Good practice statement on assessment of urinary incontinence |
| Ensure that constipation and fecal impaction are addressed. | - There were no recommendations that addressed this. However, Appendix I indicate that severe constipation and fecal impaction can contribute to urinary incontinence. |
| Ensure an adequate level of fluid intake (1500 - 2000 ml per day), and minimize the use of caffeinated and alcoholic beverages where possible. | - Not addressed; inadequate evidence found to support this for urinary incontinence |
| Initiate an individualized prompted voiding schedule based on the client's toileting needs, and as determined by a 3-day voiding record | - Recommendation 1.1<br>- Good practice statement on assessment of urinary incontinence<br>- Appendix M |
| Initiate a 3-day voiding record, a minimum of 3 weeks and a maximum of 8 weeks, after the prompted voiding schedule. | - Voiding record captured in good practice statement on assessment of urinary incontinence |

**Table 2: Education Recommendations**

| Education Recommendation from Third Edition (2011) | Relevant Information in Fourth edition BPG (2020) |
|---|---|
| Implement an educational program on promoting continence using prompted voiding. The program should be structured, organized, and directed at all levels of healthcare providers, clients, family and | - The fourth edition BPG does not address all specific components of the suggested incontinence education program; however, *Education Statements* in |

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| caregivers. The educational program should identify a nurse with an interest in and/or advanced preparation in continence care (e.g., nurse continence advisor, nurse clinician, or clinical nurse specialist) to be responsible for providing the educational program. The program should be updated on a regular basis to incorporate current evidence. The program should include information on:<br>• Myths related to incontinence and aging;<br>• Definition of continence and incontinence;<br>• Continence assessment;<br>• Prompted voiding;<br>• Individualized toileting;<br>• The impact of cognitive impairment on ability to be continent and strategies to manage aggressive behaviours;<br>• Relation of bowel hygiene care to healthy bladder functioning;<br>• Use of a voiding record with individualized toileting;<br>• Education about conservative management strategies; and<br>• Rationale for conservative management strategies | Appendix C provides strategies on how academic institutions and health service organizations can promote the uptake of the BPG in their respective settings |
| Nurses should be knowledgeable about community resources for professional development, referral and ongoing assistance. | - Education Statement 2 in Appendix C outlines principles of adult learning including self-directed learning |

**Table 3: Organization and Policy Recommendations**

| Organization and Policy Recommendations from Third Edition (2011) | Relevant Information in Fourth edition BPG (2020) |
|---|---|
| Successful implementation of prompted voiding requires:<br><br>• Management support;<br>• Opportunities for education and training;<br>• Active involvement of key clinical staff;<br>• Gradual implementation of the prompted voiding schedule;<br>• Collection of baseline information about clients, resources and existing knowledge; | - Not fully addressed, however staffing and resources regarding prompted voiding strategy captured under Health Equity in Recommendation 1.1 |

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| • Interpretation of this data and identification of problems;<br>• Development of implementation strategy; and<br>• Monitoring of the program | |
| Organizations are encouraged to establish an interprofessional team approach to continence care. | - Recommendation 3.1 |
| Nursing best practice guidelines can be effectively implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation of the change process by skilled facilitators. The implementation of the guideline must take into account local circumstances and should be disseminated through an active educational and training program. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines*, based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO guideline Promoting Continence Using Prompted Voiding. | - This recommendation was not based on evidence; however, this edition of the BPG provides implementation resources, such as the *Toolkit: Implementation of Clinical Practice Guidelines, Second Edition* |

**Comparing *Prevention of Constipation in the Older Adult Population* (2011), Third Edition Best Practice Guideline (BPG) to the current Fourth Edition BPG (2020)**

This document summarizes how the recommendations in the current, Fourth Edition BPG regarding incontinence and constipation compare to the *Prevention of Constipation in the Older Adult Population*, Third Edition BPG recommendations, published in 2011. Tables 4, 5 and 6 are a breakdown of the practice, education and organization/system recommendations. It is to note that additional areas that were addressed in the fourth edition of the BPG, that were not included in the third edition of the BPG include the following: psyllium fibre supplementation and implementation of a bowel protocol.

**Table 4: Practice Recommendations**

| Practice Recommendation from Third Edition (2011) | Relevant Information in Fourth edition BPG (2020) |
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| Assess constipation by obtaining a client history. | - Good practice statement on assessment of fecal incontinence and/or constipation<br>- Appendix O |
| Obtain information regarding:<br>• Usual amount and type of daily fluid intake with particular attention to the amount of caffeine and alcohol.<br>• Usual dietary fibre and amount of food ingested.<br>• Any relevant medical or surgical history which may be related to constipation such as neurological disorders, diabetes, hypothyroidism, chronic renal failure, hemorrhoids, fissures, diverticular disease, irritable bowel syndrome, previous bowel surgery, depression, dementia or acute confusion. | - Good practice statement on assessment of fecal incontinence and/or constipation<br>- Appendix O |
| Review the client's medications to identify those associated with an increased risk for developing constipation, including chronic laxative use and history of laxative use. | - Good practice statement on assessment of fecal incontinence and/or constipation<br>- Appendix R<br>- Appendix S |
| Screen for risks of polypharmacy, including duplication of both prescription and over-the-counter drugs and their adverse effects. | - Good practice statement on assessment of fecal incontinence and/or constipation<br>- Appendix P |
| Identify the client's functional abilities related to mobility, eating and drinking, and cognitive status | - Good practice statement on assessment of fecal incontinence and/or constipation |

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| related to abilities to communicate needs, and follow simple instructions. | - Appendix O |
| Conduct a physical assessment of the abdomen and rectum. Assess for abdominal muscle strength, bowel sounds, abdominal mass, constipation/fecal impaction, hemorrhoids and intact anal reflex. | - Good practice statement on assessment of fecal incontinence and/or constipation<br>- Appendix O<br>- Appendix S |
| Prior to initiating the constipation protocol, identify bowel pattern (frequency and character of stool, usual time of bowel movement), episodes of constipation and/or fecal incontinence/soiling, usual fluid and food intake (type of fluids and amounts), and toileting method through use of a 7-day bowel record/diary. | - Good practice statement on assessment of fecal incontinence and/or constipation |
| Fluid intake should be between 1500-2000 milliliters (ml) per day. Encourage client to take sips of fluid throughout the day and whenever possible minimize caffeinated and alcoholic beverages. | - Recommendation 5.2 |
| Dietary fibre intake should be from 21 – 25 grams of dietary fibre per day. Dietary intake of fibre should be gradually increased once the client has a consistent fluid intake of 1500 ml per 24 hours. | - Recommendation 5.1 |
| Promote regular consistent toileting each day based on the client's triggering meal. Safeguard the client's visual and auditory privacy when toileting. | - A systematic review is needed to support or refute this recommendation – it was not prioritized to be a research question by the expert panel but may be an important area to explore in the next edition of the BPG |
| A squat position should be used to facilitate the defecation process. For clients who are unable to use the toilet (e.g., bed-bound) simulate the squat position by placing the client in left-side lying position while bending the knees and moving the legs toward the abdomen. | - Recommendation 4.1 discussion of evidence (benefits & harms) |

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| Physical activity should be tailored to the individual's physical abilities, health condition, personal preference, and feasibility to ensure adherence. Frequency, intensity and duration of exercise should be based on client's tolerance. | - Recommendation 4.1 |
| Walking is recommended for individuals who are fully mobile or who have limited mobility (15-20 minutes once or twice a day; or 30-60 minutes daily or 3 to 5 times per week). Ambulating at least 50 feet twice a day is recommended for individuals with limited mobility. | - Recommendation 4.1 |
| For persons unable to walk or who are restricted to bed, exercises such as pelvic tilt, low trunk rotation and single leg lifts are recommended. | - A systematic review is needed to support or refute this recommendation – it was not prioritized to be a research question by the expert panel but may be an important area to explore in the next edition of the BPG |
| Evaluate client response and the need for ongoing interventions, through the use of a bowel record that shows frequency, character and amount of bowel movement pattern, episodes of constipation/fecal soiling and use of laxative interventions (oral and rectal). Evaluate client satisfaction with bowel patterns, and client perception of goal achievement related to bowel patterns. | - Good practice statement on assessment of fecal incontinence and/or constipation |

**Table 5: Education Recommendations**

| Education Recommendation from Third Edition (2011) | Relevant Information in fourth edition BPG (2020) |
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| Comprehensive education programs aimed at early identification of individuals at risk for constipation, reducing and managing constipation, and promoting bowel health should be organized and delivered by a nurse with an interest in or advanced preparation in continence promotion (e.g., Nurse Continence Advisor, Clinical Nurse Specialist, Nurse Clinician). These programs should be aimed at all levels of healthcare providers, | - The fourth edition BPG does not address all specific components of the suggested education program; however, *Education Statements* in Appendix C provides strategies on how academic institutions and health service organizations can promote the uptake of the BPG in their respective settings. |

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| clients and family/caregivers. To evaluate the effectiveness of the constipation program, built in evaluation mechanisms such as quality assurance and audits should be included in the planning process. | |

**Table 6: Organization and Policy Recommendations**

| Organization and Policy Recommendation from Third Edition (2011) | Relevant Information in fourth edition BPG (2020) |
|---|---|
| Organizations are encouraged to establish an interprofessional team approach to prevent and manage constipation. | - Recommendation 6.1 |
| Nursing best practice guidelines can be effectively implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation of the change process by skilled facilitators. The implementation of the guideline must take into account local circumstances and should be disseminated through an active educational and training program. In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the Toolkit: Implementation of Clinical Practice Guidelines, based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline Prevention of Constipation in the Older Adult Population. | - This recommendation was not based on evidence; however, this edition of the BPG provides implementation resources, such as the *Toolkit: Implementation of Clinical Practice Guidelines, Second Edition* |