ESTIMA
Brazilian Journal of Enterostomal Therapy

CASE REPORT
https://doi.org/10.30886/estima.v21.1295_IN

PROPOSAL FOR A CLINICAL PROTOCOL FOR THE CONSERVATIVE TREATMENT OF URGE URINARY INCONTINENCE

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ABSTRACT

Objective: To present a proposal for a clinical protocol for the conservative treatment of urge urinary incontinence. **Method:** Experience report based on existing scientific evidence and clinical experience of authors who perform nursing consultations for people with urge urinary incontinence, outlined in accordance with the Brazilian Ministry of Health's proposal for the elaboration of clinical protocols. **Results:** A clinical protocol was proposed with nursing diagnosis and interventions based on the North American Nursing Diagnosis Association (NANDA) and Nursing Interventions Classifications (NIC), with systematized steps to verify the presence of related factors or conditions associated with the diagnosis, namely: hyperactive pelvic floor, anxiety, constipation, urinary tract infection, low fluid intake, inadequate sanitary behavior, diabetes mellitus, pelvic organ prolapse, high consumption of potential bladder irritants and persistence of symptoms. Soon after, the actions that should be implemented by the nurse were described in detail. **Conclusion:** It is considered that the flow and detailing of the actions presented can be adopted by nurses in order to identify and treat people with urge urinary incontinence, thus minimizing the prevalence of the problem and promoting the quality of life of these people.

DESCRIPTORS: Enterostomal therapy. Urinary incontinence. Nursing.

PROPOSTA DE PROTOCOLO CLÍNICO PARA TRATAMENTO CONSERVADOR DA INCONTINÊNCIA URINÁRIA DE URGÊNCIA

RESUMO

Objetivo: Apresentar proposta de protocolo clínico para tratamento conservador da incontinência urinária de urgência (IUU). **Método:** Relato de experiência fundamentado nas evidências científicas existentes e na experiência clínica dos autores que realizam consultas de enfermagem a pessoas com IUU, delineada conforme proposição do Ministério da Saúde para elaboração de protocolos clínicos. **Resultados:** Foi proposto um protocolo clínico com diagnóstico e intervenções de enfermagem baseados na North American *Nursing Diagnosis Association* (NANDA) e na Nursing Interventions Classifications, com etapas sistematizadas em verificar presença de fatores relacionados ou condições associadas ao diagnóstico, sendo eles: assoalho pélvico hiperativo, ansiedade, constipação, infecção urinária, baixa ingestão hídrica, comportamento sanitário inadequado, diabetes mellitus, prolapso de órgão pélvico, alto consumo de potenciais irritantes vesicais e persistência de sintomas. Logo após, as ações que devem ser implementadas pelo enfermeiro são descritas de forma detalhada. **Conclusão:** Considera-se que o fluxo e o detalhamento das ações apresentadas possam ser adotados pelos enfermeiros de forma a identificarem

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Section Editor: Juliano Teixeira Moraes
Received: Aug. 04, 2022 | Accepted: Oct. 31, 2022
How to cite: Assis GM; Coelho MMF; Rosa TS; Oliveira FF; Silva CPC; Brito MLP; Oliveira VAA; Alves CCG; Penha AAG; Penha SEM; Sampaio LRL (2023) Proposal for a clinical protocol for the conservative treatment of urge urinary incontinence. ESTIMA, Braz. J. Enterostomal Ther., 21: e0123. https://doi.org/10.30886/estima.v21.1295_IN

e tratarem pessoas com IUU, minimizando assim a prevalência do problema e fomentando a qualidade de vida dessas pessoas.

DESCRITORES: Estomaterapia. Incontinência urinária. Enfermagem.

PROPUESTA DE PROTOCOLO CLÍNICO PARA EL TRATAMIENTO CONSERVADOR DE LA INCONTINENCIA URINARIA DE URGENCIA

RESUMEN

Objetivo: Presentar una propuesta de protocolo clínico para el tratamiento conservador de la incontinencia urinaria de urgencia. **Método:** Relato de experiencia basado en evidencia científica existente y experiencia clínica de autores que realizan consultas de enfermería a personas con incontinencia urinaria de urgencia, perfilado de acuerdo con la propuesta del Ministerio de Salud para la elaboración de protocolos clínicos. **Resultados:** Se propuso un protocolo clínico con Diagnósticos e Intervenciones de Enfermería basado en las Clasificaciones de Intervenciones de Enfermería y Diagnósticos de Enfermería de América del Norte, con pasos sistematizados para verificar la presencia de factores relacionados o condiciones asociadas al diagnóstico, a saber: piso pélvico hiperactivo , ansiedad, estreñimiento, infección del tracto urinario, baja ingesta de líquidos, conducta sanitaria inadecuada, diabetes mellitus, prolapso de órganos pélvicos, alto consumo de potenciales irritantes vesicales y persistencia de los síntomas. Posteriormente, se describieron en detalle las acciones que debe implementar la enfermera. **Conclusión:** Se considera que la fluidez y el detalle de las acciones presentadas pueden ser adoptadas por los enfermeros para identificar y tratar a las personas con incontinencia urinaria de urgencia, minimizando así la prevalencia del problema y promoviendo la calidad de vida de esas personas.

DESCRIPTORES: Estomaterapia. Incontinencia urinaria. Enfermería.

INTRODUCTION

The International Continence Society defines urinary incontinence (UI) as any involuntary loss of urine and can be classified as stress UI (SUI), urge UI (UUI) and mixed UI (MUI). UUI is the involuntary loss of urine associated with urgency, with increased urinary frequency and nocturia[1].

Women are more affected by this condition, considering pelvic anatomy, pregnancy, and climacteric conditions, among other factors. International studies indicate that the prevalence of incontinence in women is higher than 40%, and this indicator may reach 50% in the presence of diabetes mellitus[2–5]. It is estimated that more than 200 million people have some type of incontinence, of which 50% have UUI, thus confirming the magnitude of the problem[6].

It is pertinent to consider that incontinence impacts quality of life, limiting activities of daily living, physical activities, causing sexual dysfunctions, emotional impacts, as well as the appearance of depressive and anxious symptoms[7,8].

The first-line treatment for UUI consolidated in national and international guidelines is based on behavioral modifications based on the identification and control of the factors that cause increased bladder sensitivity or hyperactivity. In the case of MUI, SUI treatment should follow a pelvic floor muscle training (PFMT) protocol in parallel with the behavioral modifications that make up the conservative treatment for UI[6,9].

Conservative interventions are indicated as first line treatment for incontinence; however, it is observed that nurses sometimes do not use all the therapeutic possibilities for people with UUI and end up limiting the treatment to the indication of absorbent products[10].

Despite consolidated practices presented in the literature, there is no systematized protocol indicating actions for the clinical conditions presented by the person with UUI, with precise indications of nursing actions to implement such therapies. Thus, the objective of this study was to present a proposal for a clinical protocol for the conservative treatment of UUI in order to support systematized nursing practice.

METHODS

This is an experience report that presents a proposal for a clinical protocol for the conservative treatment of UUI, based on existing scientific evidence and on the clinical experience of the authors, who provide nursing consultations to people with UUI in health institutions located in three Brazilian states. These services serve patients of both sexes with voiding dysfunctions. This protocol is indicated for use during nursing consultations in specialized outpatient clinics or in primary health care.

The proposal was outlined according to the ten steps proposed by the Brazilian Ministry of Health11 for developing clinical protocols:

1) Definition of the topic: Urge urinary incontinence;
2) Title: Clinical protocol for conservative treatment of urge urinary incontinence;
3) Presentation – purpose of the protocol: Conservative treatment of people with UUI;
4) Introduction: Problematization of the clinical situation and its current epidemiological condition, describing the possibilities of conduct;
5) Objective: To support systematized nursing practice;
6) Target population: People with UUI;
7) Approaches included: Nonpharmacological conservative treatment;
8) Research questions: What are the nursing interventions indicated for conservative treatment of UUI? What is the sequence of investigation of related factors or associated conditions for prioritization of actions?
9) Implementation indicators: Number of patients with UUI seen by nurses. Number of consultations per patient with UUI. Number of discharges of patients with UUI without need for referral to second line of treatment;
10) Method of searching for evidence in the literature: Exploratory literature review;
11) References;
12) Documentation;
13) Document format.

Some of these steps such as topic definition, presentation, introduction, objective, target population indication were constituted and presented throughout the structural topics of the manuscript.

The heart of the study is the seventh step, which deals with the approaches instituted in the protocol. It directs nurses to institute nonpharmacological treatment for UUI, which relies on behavioral changes and the use of complementary health practices, as well as conservative interventions for pelvic organ changes (use of pessaries).

For systematization of care, nursing diagnosis proposed by the North American Nursing Diagnosis Association (NANDA)[12] for diagnostic proposition and the interventions proposed by the Nursing Interventions Classifications (NIC) were used.[13]. The nursing diagnosis "Urge Urinary Incontinence" was identified in NANDA and is found in domain 3 (elimination and exchange), class 1 (process of secretion, reabsorption and excretion of urine) under code 00019 and is defined as: Involuntary urine loss in combination with or following a strong sensation of urgency or urgency to void[12:252]. Several related factors and associated conditions were listed considering that this is a multifactorial condition.

After the evaluation through information gathering and physical examination to identify the presence of diagnostic defining characteristics, the nurse should consult the protocol and identify related factors or associated conditions presented by each individual in order to list the interventions that need to be implemented with detailed indication of the actions that should be established.

Thus, a protocol applicable to adults with UUI associated or not with SUI was produced, based on the aforementioned nursing diagnosis, pointing out related factors or more prevalent associated conditions in order to systematize its clinical application by nurses.

Since this is an experience report and does not point to direct or indirect data related to the health services or to the patients there, the study did not require the opinion of the Ethics Committee on Research with Human Beings.

RESULTS

The interventions described are applicable to patients with the diagnosis of UUI, identified by the following defining characteristics:

- Sensation of micturition urgency;
- Increased urinary frequency;
- Urine leakage before reaching the toilet;
- Urine leakage between urinations with urgency;
- Nocturia.

The proposed conservative treatment is associated with the control of related factors or conditions associated with the diagnosis of UUI. As shown in Fig. 1, the proposed flow is based on the systematic investigation and prioritization of actions to control these aspects. The professional should investigate in the proposed order the presence of each related factor or associated condition; in the absence of the investigated item, they should move on to the next, in the presence of the item they should implement the appropriate interventions.

All related factors/associated conditions encountered should be listed, as well as the interventions applicable to each case. The complete list makes up the care plan, prioritizing actions that impact the greatest number of related factors or associated conditions directs the prescription of interventions from that appointment.

It is worth noting that in some cases behavioral modifications will need to be associated with second-line (drug) or third-line (surgical) treatment. In the case of patients with poor glycemic control, behavioral modifications focus on health promotion, such as healthy eating or physical activity guidance; however, they may not achieve the expected glycemic rates by themselves and may require implementation or revision of drug therapy, which goes beyond the scope proposed in this protocol, requiring action by the medical team.

In the case of urinary tract infection (UTI) behavioral modifications aim to prevent recurrence through healthy habits such as water intake (reduces possible bacterial concentration) and proper positioning for urination (promotes healthy emptying), but not to treat symptomatic infections. Patients with a history of recurrent UTI should undergo the related behavioral modification guidelines, and patients with active UTI should be referred for drug treatment.

Women with UUI due to pelvic organ prolapse (POP) may benefit from PFMT (POP grade 2 or less) or the use of vaginal pessaries (POP of all grades), but those who do not adapt to the use of the device may require surgical intervention for correction while continuing with other symptom control measures.

DESCRIPTION OF NURSING INTERVENTIONS

Progressive muscle relaxation (PFMT/heat/massage): Focus on relaxation

- Adopt PFMT protocol;
- Limit the PFMT to three sets a day, distributed over the three shifts;
- Focus the orientation on the perception of relaxation and not on the intensity of contraction or holding time;
- Guide relaxation time based on functional assessment (count how many seconds it takes to reach maximum relaxation and include this time between contractions);
- Guide Valsalva maneuver at minimal force (push slightly outward as if to initiate evacuation) after each contraction of the series; if this maneuver contributes to relaxation, this should be investigated in the functional evaluation;
- Important to instruct about thermal therapies for relaxation of the pelvic floor muscles (PFM).

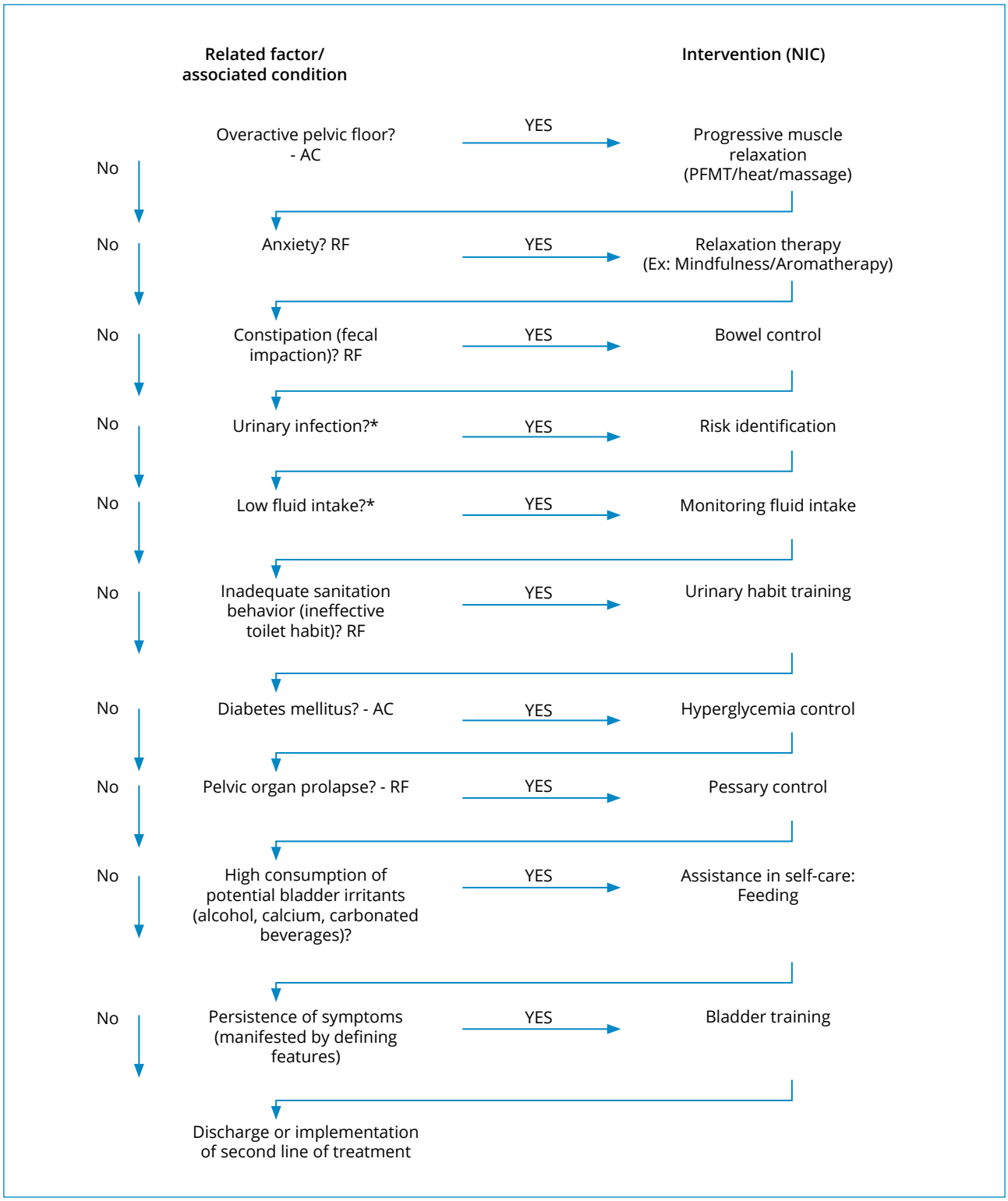

Figure 1. Flowchart of the clinical protocol for the conservative treatment of UUI. Curitiba/PR, Brazil, 2022. RF: related factor; AC: associated condition.

Sitz bath

- Put warm water in a large basin (that fits your hips sitting relaxed in the basin);
- Sit without underwear for as long as the water remains warm until it starts to cool down. Strained, strong chamomile tea can be added to warm water because of its relaxing properties.

If the person is unable to sit on the floor, they should not adopt this option. The practice of placing the basin over the toilet or benches/chairs is not effective, as it does not allow for relaxation. Water vapor also does not act on muscle relaxation, and can be used for other actions that are not the objective of this protocol.

Heating bag

Warm bag (water, gel or seeds), sit on bag with thin clothes on for about 15 minutes, one to three times a day.

Relaxation techniques

Various actions can be instituted for systemic relaxation. For some people, meditation may be an option, while for others, a few minutes of physical activity may achieve better results. It is important to create a connection with the patient and investigate what kind of actions make sense for her. Following are two possible techniques for systemic relaxation, according to the authors' experience. They can be applied alone or in combination with each other or with other measures.

Aromatherapy

- Drip one to two drops of essential oil into the palm of the hand;
- Spread to release the aroma;
- Position the hands in a shell in front of the nose and mouth;
- Inhale deeply, hold for comfortable time, exhale fully, hold for comfortable time. Repeat for three to five minutes or as long as the aroma is more intense.

For anxiety, one of the essential oils is lavender, while for people with a more depressive profile, the best indication are citrus essential oils like sweet orange, lemon, and bergamot. They can be used once or twice a day on waking and before bedtime.

Mindfulness

The practice consists of guiding the patient to spend a few seconds with attention completely focused on something specific, which can be the sensations of the body, the movement of the breath, or the sounds of the environment.

It is important to point out that during the practice, thoughts will arise all the time, that this is expected, as it is the natural activity of the mind, but that the practice consists in recognizing that you have been distracted by the thought, letting it go, and returning your attention to the chosen point as many times as necessary. Keeping the eyes closed makes it easier to practice, but it is not mandatory.

Several videos and audios are available free of charge for guided practice. This can be an option for patients who find it difficult to perform the practice.

Intestinal control

It is critical to provide guidance on fiber intake as well as monitoring fluid control (next intervention).

- Assess whether the patient has a daily diet rich in fiber;
- Eat four servings a day of fiber-rich foods (whole-grain products and vegetables), giving preference to insoluble fibers (fruit pulp, legumes, vegetable peelings).

The orientation to consume oranges with pomace is a strategy of low cost, good availability, and good compliance by patients. It is a fruit rich in insoluble fiber, available regardless of the season or geographical region, and at a lower cost when compared to other sources of fiber.

Regulate bowel routine (orthocolic and gastrocolic reflexes)

For people with constipation, a good control measure may be to choose a time to try to evacuate daily. This time should be 20 minutes after one of the regular meals.

If the choice is for breakfast and it happens right after getting up, the orthocolic reflex will also assist in bowel movement. It is important to emphasize that even if defecation does not occur, it is important to keep up the regularity of your attempts, staying on the toilet for no more than 10 minutes, in a relaxed manner, waiting for evacuation without abdominal straining.

Orient evacuation positioning

- Orient the use of a footrest (stool) of a height that is approximately half of the toilet bowl, in order to elevate them, simulating the squatting position. The elbows should rest on the knees and the feet should not be too close together.

Fluid volume monitoring

- Suggest drinking 30 mL of water per kg of body weight per day, distributed in small portions (100 to 300 mL) from the time a person wakes up until two to three hours before bedtime.

Drinking liquids near bedtime or during the night should be discouraged in order to control episodes of nocturia.

Training of urinary habit

- Plan to go to the bathroom after the first urge to urinate;
- Avoid any waiting time after the second urge to urinate;
- Sit on the toilet in a relaxed way every time before urination.

Hyperglycemia control

- Guide the patient to the relationship between increased blood glucose and increased bladder sensitivity and activity;
- Review the patient's understanding of the need for dietary control and regular physical activity;
- Reinforce the need for strict follow-up of the prescribed drug therapy, when applicable.

Pessary control

One of the conservative treatments for prolapse, which is still little explored, is the use of support devices made of hypoallergenic silicone inserted vaginally, called pessaries. The use of pessaries should be associated with PFMT.

Assistance in self-care: Feeding

Carry out gradual withdrawal of bladder irritants

- Identify the potential bladder irritant liquids (PBILs) ingested daily by the person: caffeinated, citrus, carbonated, artificially sweetened, and alcoholic;
- Test the withdrawal of a PBIL every week or fortnight and evaluate response. In case of reduction of symptoms with the reduction of some PBIL, discuss its action and the need to control intake.

Bladder training

Guide inhibition of urination desire

Technique employed in moments of urinary urgency or in moments of desire suppression for not yet being at the moment of urination defined by the training. It is about acting in the opposite way to the conventional way of running to the bathroom at the first sign of urgency. These are the steps:

- Loosen the body;
- Take deep and conscious breaths;
- Perform a few contractions of the PFM until the urinary urgency ceases.

Implement bladder training

Bladder training is based on the micturition interval shown in the bladder diary. It starts from the smallest interval presented by the patient and a negotiation of the possible interval. For example, if the patient has a bladder diary in which some intervals are 15 minutes, it is negotiated that, between one appointment and another, the patient does not urinate in intervals shorter than 30 or 45 minutes (according to the evaluation and willingness to train). The intervals are gradually increased with each visit.

It should be associated with a technique to inhibit the urinary urge. In addition to inhibiting cravings, distracting activities such as reading, watching, or leaving the house, may be necessary for as long as it takes until urination is allowed.

Orient water restriction and urination before bedtime

- Cease drinking any liquid two hours before bedtime.
- Perform urination before going to bed.

In case of edema of the lower limbs, one can adopt elevation of the limbs in the lying down position, 30 to 60 minutes before bedtime, with extension and flexion movements of the feet, in order to drain the edema and stimulate urination before the night rest period.

DISCUSSION

Regarding the defining characteristics and factors related to the diagnosis of UUI, it was chosen to initially present the hyperactivity of the pelvic floor considering that, when PFM is hyperactive, it directly interferes with the relaxation process compromising urination, besides promoting involuntary contractions in the detrusor and dyssynergia between bladder and pelvic floor. Since detrusor contractions should happen upon pelvic relaxation, the absence of this alters the perception of a full bladder as well as leads to contractions in the storage phase. That said, relaxing the local musculature by means of perineal massage and heat application are effective measures for treating the problem[1].

It is worth remembering that this treatment guided by exercises for the training of the PFM is considered as a first line in the treatment of overactive bladder, as is cognitive-behavioral therapy. PFM training is considered the gold standard for the treatment of UUI, showing a high level of scientific evidence, however patient compliance to training protocols represents the greatest threat to the success of therapy[14].

Anxiety and depression can be causative of muscle tension, including PFM. In this case, besides local actions of pelvic relaxation, systemic actions must be applied with a focus on emotional control. These actions must be chosen according to the patient's profile and the availability of techniques and practices in the place where the patient is being cared for. Thus, local muscle relaxation exercises, such as heat application or massage, and systemic health practices such as aromatherapy, meditation, and mindfulness techniques should be oriented[15,16]. The practice of mindfulness

can be applied in various contexts such as mindful eating or doing physical activities with focused attention. In this case, it should be applied as meditation practice, which can be done for the time tolerated by the patient, according to their profile[15].

Even without muscle tension, anxiety and depression should be looked at carefully and actions should be applied as a form of control in the UUI patient. Integrative (complementary or alternative) practices have emerged in the Western world as systemic treatment strategies. There are several techniques and many are already contemplated by the Brazilian National Health System[17].

An overactive pelvic floor also contributes to constipation by preventing proper relaxation for evacuation. Other important conditions are fecal impaction and constipation, indicated by several studies as an important risk factor and related to incontinence[18-21]. Constipation is classified into primary and secondary, and its primary causes are associated with nonrelaxation of the anorectal PFM, inadequate fiber intake, colon inertia, incorrect diet, poor control of bowel habit; secondary causes involve neurological factors, caused by traumatic or systemic neuropathies, endocrine diseases, and drug treatments[22].

The use of fiber and adequate hydration is fundamental to promote healthy bowel function[23,24]. The correct position adopted with the adoption of a support for elevation of the feet when sitting on the toilet facilitates colonic transit by changing the anorectal angle and promoting stretching of the anal canal favoring the expulsion of feces[25].

In addition to these indications, the maintenance of a healthy bowel habit is fundamental in the treatment of constipation as an effective intervention for the treatment of UUI, as it favors constant bowel movements, relieving the overload on the pelvic floor, and avoiding bladder stimulation, which occurs through fecal accumulation in the rectum. Thus, the patient should be encouraged to benefit from the orthocolic and gastrocolic reflexes (promote colon motility—mass propulsion) that occur after meals and move the fecal bolus with greater intensity and speed toward the rectum[26].

Toilet behavior refers to the urination habit, related to the preference for specific places to urinate, the habit of urinating in the absence of the need, of delaying urination, when necessary, of forcing to urinate, and the preference for specific positions to urinate (for example, not sitting on the toilet). It is known to be related to the emptying of urine, and associated with cognitive and emotional processes influenced by social, environmental, interpersonal, and cultural factors, in which the feeling of a full bladder is a factor. In this perspective, being in different and unfamiliar environments leads the individual, for example, to postpone urination despite the need to urinate. These behaviors favor UTI-specific signs and symptoms, such as increased or reduced bladder sensitivity, especially UI[27].

In all settings, behavioral interventions such as bladder training, habit changes, and pelvic training to treat or control UI and overactive bladder, associate with prevention of poor sanitary behavior, where knowledge and perceptions about healthy behavior are important to optimize bladder health[28].

Among the diseases that influence urinary symptoms, diabetes mellitus deserves to be highlighted, both for the prevalence of UUI in this group, and for the role that nursing plays in the guidance for the control of the disease. A Brazilian study demonstrated a 60% occurrence of UUI symptoms in a group with type 2 diabetes mellitus. The fact that these symptoms are associated with high rates of glycated hemoglobin points to the cause: poor glycemic control. Glycosuria resulting from hyperglycemia acts as an irritant to the urothelium, resulting in bladder hypersensitivity or overactive bladder, regardless of the time of disease progression and the presence of more severe urinary complications such as diabetic cystopathy, which occurs when hyperglycemia has already led to peripheral neural destruction, resulting in voiding symptoms[29].

Associated with the incontinence condition are sometimes genital dystopias. Pelvic organ dystopias or prolapses (POPs) occur when a woman has changes in the anatomical position of pelvic organs with exteriorization of the anterior wall of the vagina (bladder prolapse), posterior (rectum prolapse), apical (vaginal apex prolapse), and uterus (uterine prolapse). UUI in these cases may be a response of the bladder to its displacement or by failure to empty the bladder in POPs that cause urethral obstruction[30].

Treatment options for POPs comprise surgery and pessary apposition as a conservative alternative. In general, the choice of therapy should be guided by the woman's general condition, degree of discomfort and desire[31]. A clinical trial evaluating incontinence treatment combined with a pessary for 6 months showed an 80% success rate in reducing incontinence[32].

Among some adopted behaviors, the ingestion of PBILs, such as caffeinated, artificially sweetened, citrus, or alcoholic, is associated with urgency symptoms[33]. Caffeine is present in beverages such as coffee, tea, and cola sodas. Individuals with symptoms of overactive bladder should be assessed for consumption of PBILs and in cases of association between consumption and symptoms of urgency and frequency, should be motivated to reduce their consumption[34].

Although reduction of PBIL is contemplated in guidelines for treatment of UI or other urinary tract dysfunction (UTD) as part of behavioral modifications, little is published on the subject specifically and in isolation from other measures. Thus, little is known about the direct action of these substances on the manifestation of UTD or the effect of reducing consumption in isolation from other measures on symptoms.

A prospective study sought to identify whether elimination of all PBILs reduced symptoms of overactive bladder, as well as the outcome of partial reintroduction of these substances. Low compliance was observed in complete elimination, but even with partial ingestion, the symptoms of urgency, frequency, and urge incontinence reduced significantly. It was concluded, therefore, that counseling the patient about the need to eliminate PBILs may be an unattainable goal; however, halving usual consumption is a reasonable option and should be encouraged, and patient complaints about symptom improvement should be noted[33].

Even after the control of conditions associated with UUI, it is possible that the patient will still present with increased urinary frequency due to urinary urgency. This is due to a neurological pattern established by the period of the condition. In these cases, adequate bladder training, inhibition of urgency by means of PFM contractions, and training of these muscles should be used.

A clinical trial demonstrating that urgency suppression by pelvic floor contractions and mental distraction showed that 83.5% of women experienced an improvement in urgency sensation, demonstrating that this practice is a good adjuvant in the management of detrusor overactivity[35]. Considering that PFMT inhibits detrusor muscle contractions by repeated and conscious muscle contractions, the importance of such nurse-assisted intervention stands out[36,37].

The literature shows that nocturnal bladder symptoms are commonly associated with sleep disturbances. It is important for the nurse to advise the patient about the need to distribute the hydric intake during the day, in small volumes, and to restrict this intake on average two to three hours before bedtime in order to minimize nocturia and improve sleep pattern[38]. Randomized clinical trial found that reducing total daily water intake by 25% also minimizes nocturia[39].

CONCLUSION

This report presents a clinical protocol for the conservative treatment of UUI to systematize nursing care, with the proposition of nine nursing interventions and details of their actions. It is considered that the flow and the detailing of the actions presented can be adopted by nurses in order to identify and treat people with UUI, thus minimizing the prevalence of the problem and fostering the quality of life of these people.

AUTHORS' CONTRIBUTION

Conceptualization: Assis GM and Coelho MMF; **Methodology,** Assis GM and Coelho MMF; **Investigation:** Assis GM; Coelho MMF; Rosa TS; Oliveira FF; Silva CPC; Brito MLP; Oliveira VAA; Alves CCG; Penha AAG; Penha SEM and Sampaio LRL; **Writing – First Draft:** Assis GM and Coelho MMF; **Writing – Review & Editing:** Assis GM and Coelho MMF; **Supervision:** Assis GM.

AVAILABILITY OF RESEARCH DATA

Data sharing is not applicable.

FUNDING

Not applicable.

ACKNOWLEDGEMENTS

Not applicable.

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