Subject: Assessment of Urinary Incontinence
Policy #:
Distribution Group:

Policy:

To ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.
To ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Procedure:

1. Assessment:

Complete urinary incontinence/catheter assessments on all residents at time of admission, re-admission, quarterly, or when resident experiences a change in urinary continence status. It should also be conducted in a consistent and thorough manner to ensure that realistic individualized and effective interventions are planned as part of the resident's daily care.

Types of Urinary Incontinence:

Urge:

Urge incontinence is characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). It may be age-related or have neurological causes (stroke, diabetes mellitus, Parkinson's Disease, multiple sclerosis) or other causes such as bladder infection, urethral irritation etc. The resident can feel the need to void but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons.

Stress:

Stress incontinence is the loss of a small amount of urine with physical activity such as coughing, sneezing laughing, walking stairs or lifting. Urine leakage results from an increase in intra-abdominal pressure on a bladder that is not overdistended and is not the result of detrusor contractions. It is the second most common type of urinary incontinence in older women.

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Overflow:

Overflow incontinence occurs when the bladder is distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Urine retention may result from outlet obstruction (BPH, prostate cancer, and urethral stricture, hypotonic bladder or other causes). Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury, or pelvic nerve damage from surgery or radiation therapy. In overflow incontinence, post void residual volume exceeds 200ml. Normal PVR is usually 50 ml or less.

Functional:

Functional incontinence refers to incontinence that is secondary to factor other than inherently abnormal urinary tract function. It maybe related to physical weakness or poor mobility/dexterity (due to poor eyesight, arthritis, deconditioning, stroke, contracture), cognitive problems (confusion, dementia, unwillingness to toilet), various medications (anti-cholinergics, diuretics), or environmental impediments (excessive distance of the resident from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access).

Transient:

Transient incontinence refers to temporary or occasional incontinence that maybe related to a variety of causes, for example: delirium, infection, atrophic urethritis or vaginitis, some pharmaceuticals (such as sedatives/hypnotics, diuretics anticholinergic agents) increased urine production, restricted mobility or fecal impactions. The incontinence is transient because it is related to a potentially improvable or reversible cause.

2. Initiate interventions as indicated

Bladder Re-Training:

A behavioral technique that requires the resident to resist or inhibit the sensation of urgency, to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void. Bladder training consists of education, scheduled voiding with systematic delay of voiding and positive reinforcement. This program is difficult to implement in cognitively impaired resident and may not be successful in frail, elderly, or dependent residents. The

resident who may be appropriate for a bladder rehabilitation program is usually fairly independent in ADLs, has occasional incontinence, is aware of the need to urinate, may wear incontinence products for episodic urine leakage and has a goal to maintain his/her highest level of continence and decrease urine leakage.

Prompted Voiding:

A behavioral technique appropriate for use with dependent or more cognitively impaired residents. Prompted voiding has three components: regular monitoring with encouragement to report continence status: prompting to toilet on a scheduled basis; and praise and positive feedback when the resident is continent and attempts to toilet. Prompted voiding focuses on teaching the resident, who is incontinent, to recognize bladder fullness or the need to void, to ask for help, or to respond when prompted to toilet.

Scheduled Voiding:

A behavioral technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits. Schedule voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for scheduled voiding programs.

Incontinence Care:

In situations where residents cannot benefit from or are not able to participate in toileting programs, appropriate and comprehensive incontinence care must be provided, Standard Practices for incontinence care include:

- Pad/brief change every 2-4 hours
- Cleansing, rinsing, drying of skin during pad/brief change
- Skin inspection for areas of redness, excoriation, infection, skin breakdown
- Application of barrier cream
- Application of clean pad/brief and incontinence pad
- Repositioning of resident (as necessary)

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Medication Therapy:

Medication are often used to treat specific types of incontinence, including stress incontinence and those categories associated with an overactive bladder, which may involve symptoms including urge incontinence, urinary urgency, frequency and nocturia. It is important for the physician to weigh the risks and benefits before prescribing medications for continence management and to monitor for both effectiveness and side effects.

3. **Care plan as appropriate**

The results of a thorough evaluation should be translated into an individualized care plan to prevent/manage incontinence. It is important that direct-care nursing staff (CNAs) suggestions be incorporated in the care plan, as they are key in its implementation.

4. Monitoring

Monitoring will focus on effectiveness of interventions, resident outcomes, and re-evaluations.