

URINARY INCONTINENCE

CARE PROCESS STEP	EXPECTATIONS	RATIONALE
ASSESSMENT/PROBLEM RECOGNITION		
1. Did the staff and physician seek and document risk factors for urinary incontinence and any history of urinary incontinence?	<ul style="list-style-type: none"> - On admission and periodically thereafter (at least quarterly and when there is a significant change in urinary function), the staff and practitioner should seek and document factors that have been associated with, or present a risk for, urinary incontinence in each resident. 	<ul style="list-style-type: none"> - Risk factors may include medical conditions (delirium, dementia, urinary retention, uterine prolapse, enlarged prostate, chronic constipation, stroke - see Table 1a), environmental factors (impaired mobility, inadequate access to toilet - see Table 1b), food and beverages that stimulate or irritate the urinary tract or increase urine production - see Table 1c, and medications (diuretics, opioid analgesics, antihistamines, other anticholinergics - see Table 1d).
2. Did staff identify residents with signs and symptoms of urinary incontinence?	<ul style="list-style-type: none"> - The staff should describe the continence problem in detail (for example, voiding patterns, frequency, times of day, urgency, etc.). - The staff and practitioner should differentiate chronic from acute or recent onset, and stable from unstable incontinence. 	<ul style="list-style-type: none"> - Acute or recent onset incontinence may indicate transient or reversible causes. - Patterns of incontinence vary, and a change in a pattern of continence or incontinence may indicate a new or recurrent underlying cause. - Incontinence may be “stable” (that is, patterns are fairly consistent over time) or “unstable” (that is, patterns vary significantly from day to day). Unstable incontinence may imply a new or worsening underlying cause, and may require some additional investigation.
3. Did the staff and practitioner follow up on residents who have urinary incontinence on admission or whose incontinence persists for more than one month, despite pertinent interventions?	<ul style="list-style-type: none"> - If a nursing home resident has urinary incontinence on admission or the new onset of urinary incontinence that persists for longer than one month despite pertinent interventions, the staff and physician should try to obtain a targeted history (or expand existing information) that documents pertinent information {Schnelle et al 2003}, including a) previous interventions for urinary incontinence, and results, b) physical 	<ul style="list-style-type: none"> - Many medications can affect continence, by affecting urine production, bladder function, level of consciousness, cognition, etc; especially those with antihistaminic and anticholinergic properties (see Table 1d). - Environmental factors and assistive devices (for example, grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, walkers) may either impede or facilitate an

	<p>conditions that may affect continence, such as prolapsed uterus or bladder (based on inspection or targeted examination of the pelvic region), or prostate enlargement (see Table 1a), c) risk factors related to the use of an indwelling urinary catheter, d) functional impairments that may affect the ability to maintain continence, e) medications that may affect continence, and f) environmental factors and assistive devices that may either impede or facilitate a resident's ability to access the toilet.</p>	<p>individual's ability to access the toilet. - Complications related to an indwelling catheter may include urinary tract infection, trauma, encrustation, and bladder calculi.</p>
<p>DIAGNOSIS/CAUSE IDENTIFICATION</p>		
<p>4. Did the practitioner and staff seek causes of urinary incontinence or indicate why causes could not or should not be sought or identified?</p>	<ul style="list-style-type: none"> - The practitioner and staff should identify additional diagnostic workup to help define the category, severity, or causes of incontinence, or document why one was not indicated. - The staff and practitioner should categorize the incontinence, or indicate why it is not possible to do so. - Measurement of post-void residual (PVR) is recommended and should be considered (or documented as to why it couldn't or shouldn't be done) for all residents who are assessed to be candidates and would benefit from PVR testing. 	<ul style="list-style-type: none"> - Urinary incontinence may be categorized as urge (often referred to as “overactive bladder”), stress, mixed (combined urge and stress), overflow, functional, or transient (see Table 2). - Depending on the situation, tests might include a urinalysis, urine culture (if a symptomatic UTI is suspected), or pertinent testing (urine cytology) if a bladder tumor is suspected on clinical grounds (see Table 3). Refer also to: CDC 12 Steps to Prevent Antimicrobial Resistance in Healthcare Settings, 2004 and APIC Text of Infection Control and Epidemiology, 2002. - A post void residual (PVR) can be helpful if urinary retention is suspected. When available, bladder ultrasound (by trained staff) instead of urinary catheterization may be helpful. A normal PVR is 50 ml urine remaining post void and without straining. A PVR > 200 ml is abnormal; values between 50 – 200 ml should be interpreted in light of other findings. (AMDA 2005)

TREATMENT/PROBLEM MANAGEMENT		
<p>5. Did the staff and practitioner identify and initiate appropriate general interventions?</p>	<p>- The staff should institute pertinent general interventions, a fluid intake plan consistent with identified needs, and measures to try to minimize clinically significant constipation.</p>	<p>- General interventions may include an easily accessible toilet, commode, or urinal; reminders to toilet, assistance with toileting if necessary, assistive devices to facilitate proper toileting including elevated toilet seats or a walker for safety (see Table 1b). - Significant constipation or impaction can affect urinary function.</p>
<p>6. Did the staff and practitioner address transient causes of incontinence?</p>	<p>- The staff and practitioner should address a symptomatic UTI (and distinguish it from asymptomatic bacteriuria, which should not ordinarily be treated with antibiotics, especially in a catheterized individual). - If treating a UTI, the staff and physician should identify appropriate treatment goals (especially in catheterized resident), and should show that they followed pertinent standards of practice for identifying and treating UTIs. (AMDA Common Infections in the long-term care setting CPG 2004.)</p>	<p>- Transient causes are those that arise fairly abruptly and may be improved or corrected by specific interventions; for example, medication side effects (see Table 1d), or symptomatic UTI (see Table 4). - Asymptomatic bacteriuria generally does not require treatment, unless it is suspected to be associated with unstable chronic incontinence or with the onset of possibly transient incontinence. - Although urosepsis may cause acute symptoms such as delirium or anorexia, bacteriuria <u>alone</u> has not been shown to be associated with these or other acute symptoms. “Clinical manifestations of UTI in the elderly are often nonspecific. Along with classic signs and symptoms of UTI (fever, dysuria, frequency, suprapubic or flank pain), the clinician should carefully evaluate someone with increased confusion, failure to eat, and failure to get up and move around in a previously mobile patient.” (APIC 2002)</p>

<p>7. Did the staff initiate a toileting or "check and change" program for an incontinent resident, especially if incontinence remains after addressing transient causes?</p>	<ul style="list-style-type: none"> - If a nursing home resident remains incontinent after treating transient causes, then the staff should initiate a toileting program, starting with a 3- to 5-day toileting assistance trial (see Table 5). - For residents who: a) cannot state their own name, or, if aphasic, cannot point reliably to one of two objects; b) cannot transfer to the bathroom safely with assistance; c) during prompted voiding are found wet > 20% of the time over a 3- to 5-day period, staff should initiate a "check and change" strategy. (ACOVE, Annals of Long Term Care, 2000) - The staff should consider modifying approaches based on variable patterns or fluctuations in continence or overall resident function. After the resident with an indwelling catheter has been treated for infection and all the other treatable conditions, a voiding trial can be attempted unless the resident is in a coma, has terminal illness, a Stage 3 or 4 pressure ulcer in an area affected by incontinence, untreatable urethral blockage. (RAI Version 2.0 Manual p. C-37) 	<p>Prompted voiding is a technique useful for dependent or more cognitively impaired residents who can state their name, or reliably point to one of two objects. (CMS 2005)</p> <ul style="list-style-type: none"> -Prompted voiding attempts to teach 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. -Residents who are not able to participate in prompted voiding may be candidates for habit training programs (scheduled toileting at regular intervals to match the resident's voiding habits, without trying to delay voiding). -A check and change involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.
<p>8. Did the staff and practitioner identify residents who might be candidates for bladder retraining or pelvic floor muscle rehabilitation?</p>	<ul style="list-style-type: none"> - If a cognitively intact, willing nursing home resident remains incontinent after basic measures are instituted, the staff and practitioner should identify those who might benefit from bladder retraining or pelvic floor muscle rehabilitation. 	<ul style="list-style-type: none"> -Bladder retraining requires the resident to resist or inhibit the sense of urinary urgency, to postpone or delay voiding and to urinate according to a timetable. Training consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This resident should be fairly active in ADLs, have occasional incontinence, be aware of the need to urinate and be motivated. Bladder retraining usually takes at least several weeks. (CMS, 2005)

		-These interventions may benefit willing, cognitively intact residents with stress, urge, or mixed incontinence.
9. Did the staff and practitioner justify and manage use of medications, where indicated, to treat incontinence?	- If the physician prescribes medications to treat incontinence, the medications should be targeted to the type of incontinence and the resident's risks and existing medication regimen.	- Incontinence medications vary in their effectiveness and may have significant anticholinergic side effects.
10. Did the staff and practitioner justify and manage use of incontinence products and catheters?	<ul style="list-style-type: none"> - If a resident remains incontinent despite the preceding efforts, the staff and practitioner may consider incontinence products or catheters. - If a resident is admitted with an indwelling catheter, or has one inserted after admission, the staff and practitioner should justify continuing the catheter, or remove it. - Prior to inserting an indwelling catheter for urinary retention or overflow incontinence, the staff and physician should try intermittent catheterization or document why it was not feasible or did not work. See Table 6 for indications and care of chronic indwelling catheters. 	<ul style="list-style-type: none"> - Disposable absorbent products and, rarely, external urine collection devices (e.g., external catheters) may be helpful, but they should not be used as the primary long term approach to continence management until the resident has been appropriately evaluated and other approaches that are feasible and appropriate have been considered. (CMS, 2005) -Sterile insertion and removal of a catheter through the urethra every 3-6 hours for bladder drainage may be appropriate for the management of acute or chronic retention in appropriate individuals. Residents with new onset of atonic or hypotonic bladder (usually seen after indwelling catheterization in the hospital) may benefit from intermittent catheterization (up to 7 days) until bladder tone returns. A voiding trial and post-void residual can help identify when bladder tone returns. (CMS, 2005) -Indwelling catheters increase the risk of bacteriuria and urosepsis, and may be uncomfortable and socially distressing. - Other less common approaches to continence management may include a pessary and surgical approaches.

MONITORING		
11. Did the staff appropriately implement approaches to incontinence management?	- The staff should consistently and correctly implement the individualized plan of care related to managing incontinence.	- Interventions should be initiated and modified based on individualized resident assessment. If an individual's incontinence patterns vary significantly, then different interventions and approaches may be appropriate at different times.
12. Did the staff and physician evaluate and document the progress of a resident's continence and justify continuing existing approaches?	<p>- Monitoring should include: responsiveness to treatment, possibility for changing to a less obtrusive or lower-risk intervention, and resident satisfaction with treatment.</p> <p>- For a resident with an indwelling catheter, the staff and physician should periodically document medical justification for its continued use (or removal if clinically indicated), re-evaluate and define interventions in place to minimize complications from catheter use, and assess consistency with resident's condition, and goals. (CMS, 2005)</p>	<p>- Some residents may remain incontinent despite various attempted interventions.</p> <p>- The fact that someone remains incontinent is not alone a sufficient justification for an indwelling catheter.</p>
13. Did the staff and practitioner monitor, and address, complications of incontinence and of higher risk interventions such as indwelling catheters and medications?	- The staff and practitioner should monitor for, and manage, complications of incontinence and of higher risk interventions such as indwelling catheters and medications.	<p>- Complications of catheters may include, but are not limited to, pain, urethral erosion, or symptomatic UTIs with or without sepsis.</p> <p>- Side effects of incontinence medication treatment can include, but are not limited to, dry mouth, constipation, confusion, and agitation.</p>