## Urinary Continence and Incontinence – Assessment and Management

<table>
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<th>Highlights</th>
<th>Policy Statement</th>
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<tr>
<td>1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence.</td>
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<td>2. Management of incontinence will follow relevant clinical guidelines.</td>
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<td>3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible.</td>
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<td>4. Indwelling urinary catheters will be used sparingly, for appropriate indications only.</td>
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<td>5. Identification and management of urinary tract infections will follow relevant clinical guidelines. Antibiotics will be used appropriately.</td>
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### Policy Interpretation and Implementation

#### Screening for Information

1. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary continence. Examples of sources of such information may include the resident, family, or a hospital discharge summary describing placement of an indwelling urinary catheter during a recent hospitalization.

#### Relevant Information and Observations

2. Relevant information related to urinary continence includes:
   
   a. History of urinary incontinence; factors precipitating incontinence; and associated symptoms (dysuria, polyuria, hesitancy);
   
   b. Previous treatment/management attempts and response to interventions;
   
   c. Pertinent diagnoses, including congestive heart failure, stroke, diabetes mellitus, obesity, neurological disorders (Parkinson’s disease, multiple sclerosis), and tumors affecting the urinary tract;
   
   d. Observations, including wet bed or clothing, prolapsed uterus, use of urinary catheter, evidence of abdominal or urologic surgery, and/or use of diuretics;
   
   e. Functional and/or cognitive capabilities or limitations that could affect continence, including impaired cognitive function or dementia, impaired mobility, decreased manual dexterity, decreased upper and lower extremity muscle strength, impaired vision, and pain with movement;
   
   f. Additional information such as the type and frequency of physical assistance necessary for the resident to access the toilet, commode, or urinal, and the scope of prompting needed to encourage urination; and
   
   g. Environmental factors and assistive devices that may restrict or facilitate a resident’s ability to access the toilet, including grab bars, raised or lowered toilet seat, lighting, distance to toilet or bedside commode, availability of urinal, and use of bed rails or restraints.

#### Defining Level of Continence

3. Periodically (as required and when there is a change in voiding), staff will define each individual’s level of continence, referring to the criteria in the Minimum Data Set (MDS), as follows:

   a. Continent: Complete bladder control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

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Details Related to Continence

4. As part of its assessment, nursing staff will seek and document details related to continence. Relevant details include:
   a. Voiding patterns (frequency, volume, nighttime or daytime, quality of stream, etc.);
   b. Associated pain or discomfort (dysuria); and
   c. Whether incontinence occurs in relation to coughing or sneezing (stress incontinence).

Identifying Risk Factors

5. The nursing staff and physician will identify risk factors for becoming incontinent or for worsening of current incontinence (e.g., immobility, delirium, or diuretics used to treat congestive heart failure).

Reviewing Medications

6. The evaluation will include a review for medications that might affect continence, such as:
   a. Narcotics and medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence);
   b. Sedative/hypnotics (may cause sedation leading to functional incontinence);
   c. Diuretics (may cause urgency, frequency, or overflow incontinence); and
   d. Alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women).

Categorizing Types of Incontinence

7. The staff and physician will summarize an individual’s continence status. For residents deemed incontinent, this includes categorizing incontinence as urge, stress, overflow, mixed, or functional; and relevant causes, risk factors, and complications.

Identifying Complications Related to Incontinence

8. The staff and physician will identify individuals with complications of existing incontinence, or who are at risk for such complications (e.g., skin maceration or breakdown, or perineal dermatitis).

Considering a Detailed Assessment

9. The physician will consider a more detailed assessment if new incontinence is identified or risk factors and reversible causes have not yet been sought or identified. The review should focus especially on possibly treatable causes such as medication side effects, severe constipation, or urinary tract infections (distinguished from asymptomatic bacteriuria).

Identifying UTI

10. The staff and physician will identify the presence of any urinary tract infection that may be related to incontinence.

Urinalysis

11. A urinalysis may detect hematuria and clinically significant pyuria, but otherwise is likely to have limited utility as a screening test because of the high prevalence of asymptomatic bacteriuria in the long-term care population. Urinalysis should not be confused with a urine culture.

Asymptomatic Bacteriuria

12. The presence of bacteriuria without symptoms, whether or not pyuria is present, does not usually merit antibiotic treatment, especially in individuals with indwelling urinary catheters.

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Published criteria for a symptomatic urinary tract infection should be followed. These differ between the catheterized and non-catheterized resident.

If a resident/patient is admitted from the hospital with a newly placed indwelling catheter, the Attending Physician and staff will evaluate the potential for removing it, depending on the current condition and the rationale for its original placement.

The physician and staff will address treatable causes or contributing factors related to urinary incontinence, including:

- Tapering, stopping, or changing medications that may be causing or exacerbating incontinence;
- Managing pain and/or providing adaptive equipment to help mobilize individuals suffering from arthritis, contractures, neurological impairments, etc.;
- Incorporating environmental interventions and assistive devices (e.g., grab bars, raised toilet seats, bedside commodes, urinals, bed rails, restraints, and/or walkers) to facilitate toileting;
- Treating underlying conditions that may impair continence (e.g., delirium causing urinary incontinence related to acute confusion); and
- Implementing a fluid and/or bowel management program to meet assessed needs.

Where indicated, the staff and physician will treat symptoms of a UTI or urosepsis. Eradication of all bacteria may not always be feasible (e.g., in a patient who has an indwelling urinary catheter or other source of chronic bacteriuria).

As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan.

- As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence.
- Toileting programs will start with a 3- to 5-day toileting assistance trial.
- If the individual requires assistance from more than one person to transfer to the toilet, staff will address his or her mobility problems before attempting a toileting assistance trial.
- Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption.
- Prompted voiding is not helpful at night (e.g., between the hours of 10 p.m. and 5 a.m.) and has been shown to disrupt sleep.

The staff will document the results of the toileting trial in the resident’s medical record.

- If the resident responds well, the toileting program will be continued.
- If the resident does not respond and does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a “check and change” strategy.
- A “check and change” strategy involves checking the resident’s continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin.

Individuals who cooperate with prompted voiding and attempt to toilet regularly but have no reduction in incontinent episodes will be identified and referred to the physician for consideration of additional therapy such as a bladder relaxant medication.

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20. For individuals with persistent or recurrent urinary retention despite interventions, the staff and physician will seek treatable causes and consider intermittent catheterization, if feasible, before placing an indwelling catheter.

21. The staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated.

22. The physician will identify and refer, as appropriate, individuals who might benefit from urological procedures to improve continence.

23. The physician will identify situations in which an indwelling urethral or suprapubic catheter are indicated, and will document why other alternatives are not feasible.

24. If an indwelling catheter is needed, staff will monitor for and report complications such as evidence of a symptomatic infection.

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**References**

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<thead>
<tr>
<th>OBRA Regulatory Reference Numbers</th>
<th>483.25(d)</th>
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<tbody>
<tr>
<td>Survey Tag Numbers</td>
<td>F315</td>
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<tr>
<td>Related Documents</td>
<td>Urinary Incontinence – Clinical Protocol</td>
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**Policy Revised**

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