# Behavioral Programs and Toileting Plans for Urinary Incontinence

## Purpose

The purpose of this procedure is to provide guidelines for the initiation and monitoring of behavioral interventions and/or a toileting plan for the resident with urinary incontinence.

## Preparation

1. Review the resident’s care plan to assess for any special needs of the resident.
2. Conduct a thorough assessment of the resident and his or her environment to determine factors that may have contributed to any recent decline in urinary continence. For example:
   a. A change in the resident’s medical condition, cognitive status, and/or mobility;
   b. New or altered medication regimen (e.g., diuretics, alpha-adrenergic agonists);
   c. Lack of staff familiarity with the resident’s usual pattern of voiding;
   d. Environmental impediments that affect the resident’s continence.
3. Provide treatment and services to address factors that are potentially modifiable. For example:
   a. Managing pain;
   b. Providing adaptive equipment for residents with mobility problems;
   c. Removing or improving environmental impediments (lighting, distance to toilet or commode, etc.);
   d. Reviewing medication regimen and notifying the physician with any concerns.
4. Monitor, record and evaluate information about the resident’s bladder habits, and continence or incontinence, including:
   a. Voiding patterns (frequency, volume, time, quality of stream, etc.);
   b. Associated pain or discomfort (dysuria);
   c. Type of incontinence (stress, urge, mixed, overflow, functional, etc.);
   d. Level of incontinence (use MDS criteria); and
   e. Response to specific interventions.
5. Assess the resident for appropriateness of behavioral programs which promote urinary continence.
   a. The resident must possess some essential skills to be successful with specific interventions attempted. Staff must identify whether the resident can:
      (1) Comprehend educational efforts and follow-through with instructions;
      (2) Identify the urge to urinate;
      (3) Potentially learn to control or inhibit the urge to void until reaching a toilet;
      (4) Physically contract the pelvic floor muscles (Kegel Exercises) to inhibit the flow of urine, lessen urinary urgency/leakage, and/or respond to prompts to void.

## General Guidelines

1. Options for managing urinary incontinence include primarily behavioral programs, toileting plans and medication therapy.
2. Behavioral programs that require the resident’s cooperation and motivation in order for learning and practice to occur include the following:
   a. **Bladder rehabilitation/bladder training**; and
   b. **Pelvic floor muscle rehabilitation**.
3. Toileting Plans that are relatively more dependent on staff involvement and assistance as opposed to resident function include:
   a. **Prompted voiding**; and
   b. **Habit training/scheduled voiding**.

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Equipment and Supplies

1. Assessment tools for measuring the resident’s level of incontinence (MDS criteria).
2. Assessment information that has already been collected (admission data, medical record, etc.).
3. Adaptive equipment to improve the resident’s mobility.
4. The resident’s care plan.

Steps in the Procedure

1. Assess the resident for appropriateness of behavioral techniques or toileting plans being considered.
2. Record the resident’s current voiding pattern, including voiding times and amount.
3. If a post-void residual (PVR) test is ordered, it should be performed within a few minutes after a continent or incontinent void. Preferably, the volume of the void should be measured, but if it is an incontinent void, the amount of incontinence (i.e., small, moderate, large) should be recorded, along with the PVR volume. A residual volume that is not measured within a few minutes after a void is not helpful.
   a. A normal PVR is less than 50 ml of urine remaining in the bladder after voiding and without straining. A PVR greater than 200 ml is abnormal. PVRs between 50 and 200 ml should be interpreted in the light of other clinical findings.
   b. Where available, bladder ultrasound (performed by trained personnel) may be a less invasive alternative to urinary catheterization for determining PVR.

Bladder rehabilitation/bladder training

1. Bladder rehabilitation/training may not be appropriate for the resident with cognitive impairment or those who are frail or dependent on staff for assistance with ADLs.
2. Residents with urge or mixed incontinence and who are cognitively intact are the best candidates for this program.
3. This technique requires that the resident resist or inhibit the sensation of urgency (the strong urge to void) in order to urinate according to a timetable.
4. If the resident is successful in inhibiting the urge to void, the time intervals between voiding can be increased. For example, if the resident feels the need to void every 15 minutes, encourage him or her to wait for 20 minutes. Try to increase the intervals by 10 to 15 minutes each week, in 5 minute increments.
5. The goal is for the resident to void every 2 to 3 hours. This may take several weeks.
6. Visual reminders of the timetable may be helpful for the resident.
7. Use positive reinforcement for delaying voiding and increasing intervals between voiding (praise, encouragement, etc.).

Pelvic Floor Muscle Rehabilitation/Exercises

1. Pelvic floor muscle exercises (PFMEs) are also known as Kegel exercises.
2. These exercises are helpful in dealing with urge and stress incontinence.
3. PFMEs strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment of stress urinary incontinence.
4. PFMEs require residents who are able and willing to participate and the implementation of careful instructions and monitoring provided by the facility. Poor resident adherence to the exercises may occur even with close monitoring.
5. Review techniques of the exercises with the resident:
   a. Instruct the resident to contract and hold the urethral and pelvic floor (pubococcygeal) muscles for 10 seconds, then relax for 10 seconds.
   b. The resident should perform the exercises 30 to 80 times per day.
6. Establish a schedule for conducting the exercises and use visual aids to prompt residents and record progress.
7. Offer positive reinforcement for maintaining the exercise routine.

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Steps in the Procedure (continued)

Toileting Plans

1. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence and/or behavior modification, the staff will initiate a toileting plan.
2. 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.
   a. Toileting programs will start with a 3- to 5-day toileting assistance trial.
   b. 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.
   c. Incontinence care should be individualized at night in order to maintain comfort and skin integrity, and minimize sleep disruption.
   d. 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.

Prompted Voiding

1. Prompted voiding is a technique appropriate for use with dependent or more cognitively impaired residents.
2. Prompted voiding techniques have been shown to reduce urinary incontinence episodes up to 40% for elderly incontinent nursing home residents, regardless of their type of urinary incontinence or cognitive deficit—provided that they at least are able to say their name or reliably point to one of two objects.
3. Prompted voiding has three components:
   a. Regular monitoring with encouragement to report continence status;
   b. Prompting to toilet on a scheduled basis; and
   c. Praise and positive feedback when the resident is continent and attempts to toilet.
4. These methods require training, motivation and continued effort by the resident and caregivers to ensure continued success.
5. Prompted voiding focuses on teaching the resident to recognize bladder fullness or the need to void, to ask for help, or to respond when prompted to toilet.
6. Residents who are assessed with urge or mixed incontinence and are cognitively impaired may be candidates for prompted voiding.
7. As the resident’s cognition changes, the facility should consider other factors, such as mobility, when deciding to conduct a voiding trial to determine feasibility of an ongoing toileting program.

Habit Training/Scheduled Voiding

1. Habit Training/Scheduled Voiding is a technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident’s voiding habits.
2. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges.
3. Habit training includes timed voiding with the interval based on the resident’s usual voiding schedule or pattern.
4. Scheduled voiding is timed voiding, usually every three to four hours while awake.
5. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.

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Steps in the Procedure (continued)

Check and Change

1. 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.
2. 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.

Documentation

1. The staff will document the results of behavioral/toileting trial in the resident’s medical record.
2. If the resident responds well, behavioral/toileting programs will be continued.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

References

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