Evidence-Based Best Practices for Managing Urinary Incontinence

Overview

Urinary incontinence (UI) is common in older adults but is not a normal part of aging. Nearly 60% of people living in nursing facilities (NFs) have some form of urinary incontinence:

- Urge incontinence: Sudden uncontrollable urge to urinate
- Stress incontinence: Urine leakage from pressure, such as coughing or sneezing
- Overflow incontinence: Incomplete emptying of the bladder when voiding, leading to urine leakage
- Mixed incontinence: Urine leakage due to a combination of stress and urge incontinence

Other people may experience functional incontinence. With functional incontinence, the person knows they need to urinate, but are not able to get to the bathroom. Conditions that can lead to functional incontinence include:

- Cognitive impairment, dementia
- Neurological disorders
- Impaired mobility
- Physical/environmental barriers
- Medications

Risk factors for developing incontinence include:

- Gender – women are at higher risk than men
- Cognitive impairment/dementia
- Disorders of the urinary tract
- Chronic medical conditions such as diabetes, CHF, arthritis
- Neurological disorders such as stroke, Parkinson’s disease, spinal cord injury

Treatment options will depend upon the type of incontinence and the severity of symptoms the person is experiencing. A thorough assessment will help guide decisions about treatment, in line with the person's goals and preferences.

The facility should implement an educational program for managing urinary incontinence, including continence promotion. The program should be structured, organized, and directed at all levels of staff, the people living in the NF, their families, and other caregivers. The educational program should be updated on a regular basis to incorporate any new information. The program should include:

- Myths related to incontinence and aging
- Definitions of continence and incontinence
- Continence promotion plans such as prompted voiding, schedule toileting and bladder re-training
- Continence assessment and developing individualized continence promotion plans, use of voiding records to identify incontinence patterns
- Impacts of mobility limitations and cognitive impairment on continence
- Relation of bowel hygiene to healthy bladder functioning

A successful program for managing urinary incontinence requires administrative support, opportunities for staff training, active involvement from key clinical staff, and monitoring and evaluation of the program.

The NF must develop an implementation strategy, based on data about the people living and working in the facility, available resources, and existing knowledge. An interdisciplinary/interprofessional approach is encouraged to maximize the chances for successful implementation of a program for managing urinary incontinence.

Assessments for Urinary Incontinence

History and Physical Examination – Physician, Nurse Practitioner, Physician Assistant

Any evaluation for urinary incontinence begins with a history and physical examination (H&P) by the physician or physician extender to identify the type of urinary incontinence and potential reversible causes, the severity of symptoms, duration, and frequency of incontinent episodes.

The person should be asked about other health issues, including:

- Chronic obstructive pulmonary disease, asthma or other respiratory conditions that cause coughing
- Heart failure with fluid overload, requiring treatment with diuretics

- Neurologic disorders, including neurogenic bladder
- Musculo-skeletal disorders that may present a barrier to toileting
- Surgical history, particularly any procedures that could have affected the urinary tract or pelvic innervation
- Gynecological history in women, including number and type of births, estrogen status, issues related to menopause such as atrophic vaginitis
- Current medication regimen

In general, laboratory tests and diagnostic imaging is limited when evaluation a person with urinary incontinence. If there is a suspicion of obstruction, renal ultrasound may be recommended. Labs may be ordered to rule out other conditions, including:

- Urinalysis to rule out urinary tract infection (UTI), proteinuria, or hematuria
- BUN/Creatine to evaluate the person's renal function

A measurement of post-voiding residual (PVR) volume using a bladder ultrasound may be requested if overflow incontinence is suspected. PVRs of greater than 200 ml is indicative of overflow incontinence.

Comprehensive Assessment – NF Staff

The NF's staff should also gather information about the person and their history of incontinence. This data not only informs the care planning process but can also assist the physician/physician extender in their evaluation.

What is the person's history of incontinence?

- Amount, type, and time of daily fluid intake, including any intake of caffeine and/or alcohol
- Normal voiding patterns, based on a 3-day voiding record
- Frequency, nature, and consistent of bowel movements

Are there other issues that should be included in the assessment?

- Relevant medical or surgical history that could impact the person's continence, such as diabetes, stroke, Parkinson's disease, heart failure, or recurrent urinary tract infections
- Medication review, with attention to drug classifications that may affect continence, such as:
  - Diuretics
  - Anticholinergics

    - Calcium channel blockers, ACE inhibitors
    - Alpha blockers
    - Sedatives and hypnotics, antipsychotics
- The person's functional and cognitive abilities

Consider any attitudinal and environmental barriers to continence promotion, such as:

- Proximity and availability of the nearest bathroom
- Accessibility of the toilet/commode
- Use of physical restraints
- Staff expectations and beliefs
    - Incontinence is inevitable in aging
    - Few interventions are available to promote continence

NF staff should determine how the person perceives urinary incontinence and whether he/she believes a continence promotion plan would be beneficial.

Types of Continence Promotion Plans

Continence promotion programs can help reduce the number of incontinence episodes and in some cases, completely reverse incontinence. The decision about which or any plan is appropriate for a particular person must be based on the assessment, as well as the person's goals and preferences.

- Scheduled voiding: Also referred to as timed voiding or habit training, this plan involves toileting at specified times, based on the person's usual habits. Scheduled voiding is not intended to increase the amount of time between voiding intervals and doesn't teach the person to resist the urge to urinate.
- Prompted voiding: Also based on normal voiding patterns, this type of plan involves the caregiver prompting or reminding the person to urinate.
- Bladder retraining: Bladder retraining is much more involved and is not an appropriate intervention for everyone. It requires "retraining" the bladder and sphincter muscles, usually through delaying urination and using Kegel exercises to strengthen the muscles involved in urination.

Person-Centered Care Planning

The Centers for Medicare and Medicaid Services (CMS) defines person-centered planning as a process, directed by the person living in the NF or their family member/surrogate decision-maker. It is intended to not only address the person's

needs and limitations, but also to identify their strengths, capacities, preferences, and desired outcomes. The person is an equal partner in the planning of their care and is involved in developing a care plan that is specific to his/her individual likes, dislikes, and needs.

NF staff must understand that a person-centered care plan is one in which the focus is on what is important to the person, his/her capacities, and available supports. The focus of the person-centered care plan should be the quality of the person's life as he/she defines it.

The person-centered care plan must include specifics about any interventions for managing incontinence, including type of continence promotion plan, if any, toileting schedule, and any devices (such as pessaries or external collections devices) or absorbent products used. These details should be included with every discharge or transfer plan.

Note: While the use of absorbent products may be appropriate, they should not be used as the primary long-term intervention for managing incontinence until a comprehensive evaluation has been completed and other alternatives have been considered, including a continence promotion plan.

Care planning is not a "one and done" process, nor should it be limited to a quarterly update. NF staff should monitor implementation of the care plan to determine the effectiveness of the interventions and whether the care plan should be modified. Appropriate care planning is the beginning, not the end itself.

Implementing Continence Promotion Plans

Not every person who has urinary incontinence is a candidate for a continence promotion plan. There are specific situations in which incontinence management, including the use of absorbent products, may be the most appropriate treatment. Those situations include:

- People in a coma or persistent vegetative state
- People who are unable to get out of bed for any reason at all (assisted or unassisted)
- People with an indwelling bladder catheter
- People with Stage 3 or 4 pressure injuries that prevent toileting
- People who are at end-of-life and decline toileting as part of a palliative plan of care

Anyone living in the NF who has urinary incontinence and does not fall into one of the above categories, should be considered for a continence promotion plan. For most people, the ultimate goal would not be total reversal of incontinence, but

rather decreasing the number of incontinent episodes and improving the quality of life.

Implementation Steps

1. Use MDS data to identify every person who has urinary incontinence.
2. Assess anyone with incontinence as discussed above.
3. Use the results of this assessment to identify those who are not candidates for toileting. Note the reason(s) in the care plan and implement person-centered interventions for managing incontinence.
4. For each remaining person, determine the appropriate type of toileting plan based on the nature of the person's incontinence (stress, urge, functional, etc.) and any clinical factors such as cognitive impairment and mobility limitations.
5. Use a variety of approaches when implementing a behavioral plan for toileting.
6. Repeat this process monthly as part of the NF's program for managing incontinence.
7. Review each chart to identify instances in which care plans and actual care are not congruent.

Provision of Incontinent Care

When incontinent episodes occur – whether the person is on a continence promotion plan or not – NF staff may need to assist with incontinent care. Inadequate care and/or inappropriate technique can lead to undesirable consequences, including urinary tract infections and skin breakdown.

The NF should have a process in place for monitoring staff competency on an on-going basis. This audit tool in just one example of a form that can be used to monitor staff competency in performing incontinent care.

Resources

Urology Foundation: Bladder Diary

International Continence Society: X. Urinary and Faecal Incontinence in Frail Older Men and Women

Registered Nurses Association of Ontario: A Proactive Approach to Bladder and Bowel Management in Adults