



Basics of Care for the Resident Who has Urinary Incontinence



Target Audience

Certified Nurse Aide (CNA)

Learning Objectives

- Understand the definition of urinary incontinence
- Identify changes in the aging bladder that increase the risk for urinary incontinence
- Improve and reflect on the approach currently used in caring for residents with urinary incontinence

Purpose

Incontinence is a common issue for many of our residents. In fact, almost 50% of residents in a nursing home present with some type of incontinence. This education will discuss urinary incontinence along with the care and treatment that is an integral part of the care CNAs provide. Once you have reviewed the education, a competency may be conducted to complete the education.

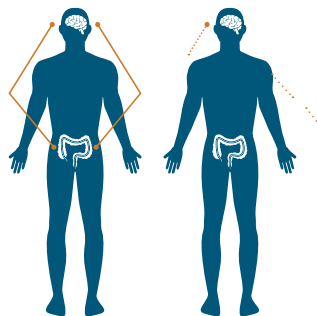
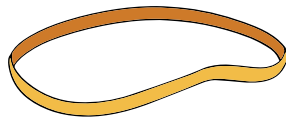
What Is Incontinence?

Cited Source: <https://www.nia.nih.gov/health/urinary-incontinence-older-adults>

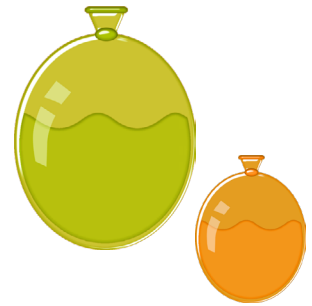
Urinary incontinence is defined as any involuntary leakage of urine. According to the National Institute on Aging, there are many different reasons for incontinence, including changes that happen in the bladder as we age.

Changes in the bladder:

- **Elasticity diminishes** – Over time, the bladder loses its elasticity. It becomes less able to stretch as it fills with urine. This loss of elasticity can cause the bladder to overflow, causing incontinence, as it may push urine out of the bladder.
- **Change in communication to the bladder** – As we age, there is sometimes a decline in how nerves and muscles signal the bladder. If the bladder does not receive the signal to hold in the urine, incontinence occurs.



- **Less capacity** – The average person's bladder capacity is 400-450 ml. However, in older adults, capacity declines to 250-350 ml. This lower capacity inhibits residents' ability to delay urination. They need to urinate more frequently, which can lead to incontinence, especially if they have limited mobility.



- **Weakened muscles** – If a person has a weakened bladder muscle, they have a harder time keeping the urine in the bladder and incontinence occurs.



- **Decrease in bladder sensation** – The bladder does not sense that it is full and overfills, leading to incontinence.



Other conditions that may cause incontinence:

- **Arthritis or other physical limitations** – A person's physical activity may become limited due to pain or other limitations. If they have difficulty moving, getting to the bathroom may become hampered and they may not make it to the toilet in time.
- **Heart conditions** – Certain heart conditions such as congestive heart failure (CHF) may cause the body to retain fluid. This fluid retention, in conjunction with the above bladder changes, may lead to incontinence.



- **Medications** – Certain medications such as diuretics increase the amount of urine that the body produces, which may increase the urge to urinate. Diuretics like Lasix are usually administered in the morning, so the resident may have increased toileting needs during the early part of their day.



✓ Checkpoint

What would you report to the nurse?

Would you report this to the nurse? Check Yes or No

1. The skin on Mr. Johnson's buttocks is red and looks painful.	Yes	No
2. Ms. Fernandez has dark urine with an odor.	Yes	No
3. Mr. Wade, who is usually continent of urine, tells you he's starting to have accidents.	Yes	No
4. The skin on Ms. Chan's buttocks is closed and normal color.	Yes	No

Due to the changes mentioned above, a resident may not know they need to toilet in advance, and the urge to urinate may come upon them suddenly. In such circumstances, a delay in toileting could lead to incontinence. Remember this the next time a resident asks you for assistance with toileting. Asking them to wait and that you will return in a few minutes to help them to the bathroom may not be an option.

Risks Associated with Incontinence

Incontinence can lead to other issues in the elderly, such as an increase in falls, as well as skin issues like dermatitis, fungal infections, pressure injuries, and urinary tract infections (UTI). Residents may also isolate themselves because of embarrassment, depression, or fear of having an "accident." Below are some areas of concern that should be reported to the nurse.

- **New incontinence issues** – Let the nurse know when the incontinence began, if it is present at all times or occasionally, and the amount of urine in the episodes (Is it a small or large amount?).
- **New skin conditions** – The nurse should immediately be made aware of any new skin condition so treatment can be implemented.
- **Symptoms of a UTI** – Any symptoms of infection, such as fever, color, odor, sediment, pain or burning on urination, should be reported.
- **Incontinence between toileting times during a scheduled toileting or bladder retraining program** – If the resident is incontinent between scheduled times, their plan may need to be changed.
- **Resident complaints or concerns** – The nurse should know if the resident has any complaints or concerns that need to be addressed.



The CNA's Role in Treatment

Sometimes incontinence can be eliminated or improved with treatment. Below are three types of treatment plans, along with the role of the CNA in each plan.

What is the type of treatment?	What does the treatment entail?	What is the CNA's role in treatment?
Scheduled toileting	Scheduled toileting is when the resident is prompted (reminded) to go to the bathroom at certain times, such as every two hours, putting them on a regular voiding schedule.	<ul style="list-style-type: none"> • The CNA needs to consistently take the resident to the bathroom to keep the resident dry. • Documenting the following: <ul style="list-style-type: none"> ◦ Incontinence between toileting times ◦ No urination at scheduled toileting times • Anything interfering with the resident's toileting schedule <ul style="list-style-type: none"> ◦ Resident complaints
Bladder retraining	Bladder retraining involves scheduled toileting, but the length of time between trips to the bathroom is gradually increased. This trains the bladder to delay voiding for longer intervals of time, as identified on the interdisciplinary care plan.	<ul style="list-style-type: none"> • The CNA needs to adhere to the determined times for toileting, as this schedule is to train the bladder. Any deviation from the set times can interfere with the success of the training. • Documenting the following: <ul style="list-style-type: none"> ◦ Incontinence between toileting times ◦ No urination at scheduled toileting times ◦ Anything interfering with the resident's toileting schedule ◦ Resident complaints
Kegel exercises	This exercise teaches the resident to tighten the pelvic muscles to help control the elimination of urine. It can be used by itself or in conjunction with other interventions.	<ul style="list-style-type: none"> • The CNA needs to know and understand how to perform Kegel exercises. • The CNA needs to assist the resident to perform Kegel exercises on a consistent basis to ensure tightening of the pelvic muscles. • Documentation of the following: <ul style="list-style-type: none"> ◦ Number of repetitions of exercises completed ◦ How the resident tolerated the exercises ◦ Any reasons why exercises could not be completed ◦ Any complaints from the resident when doing exercises

Skin Care for Residents with Urinary Incontinence

Moisture from urine causes incontinence-associated dermatitis, which is damage to the skin caused by chronic exposure to moisture. It can be painful and also increases the risk of pressure injury and skin infections, so it is important to keep skin clean and dry.

Check the resident for wetness according to the facility policy and/or the resident's care plan. After incontinence episodes, thoroughly cleanse and dry the perineal area. Cleanse the skin with a facility-approved cleanser, rinse well if the product requires, and gently pat dry. Frequent cleaning of the skin may cause drying and irritation, so moisturizing creams approved by the facility may be used to keep the skin moist. It is important to avoid products that contain alcohol because they may further irritate the skin.

Several skin cleansers are specifically designed to cleanse and deodorize the skin without causing excessive dryness or irritation. These products include foams, non-aerosol sprays, and wet wipes (individual disposable towelettes). Be sure to follow the product's instructions. Be aware of those products that require rinsing.

If there is constant exposure to urine or stool, a skin sealant or moisture barrier may be used. There are several creams or ointments that contain lanolin or petrolatum, both of which form a protective barrier on the skin. Some skin care products (often in the form of a spray or towelettes) create a clear, protective film over the skin. Even if you use these products, you must still clean the skin after each incontinence occurrence. Reapply the cream or ointment after cleaning and drying the skin.

Each time you assist in changing the resident, look at the condition of the skin. New skin breaks and redness can occur between changes, and the earlier they are detected, the better the chance of preventing them from becoming serious problems. As previously discussed, it is important that you communicate skin changes to the team for proper and timely intervention.

Incontinence Products

There are many incontinence products to choose from, including liners and briefs. Briefs are not appropriate for all residents. Picking the right incontinence product is important to maintain dignity, provide the maximum absorbency, prevent leaks, and for the overall comfort of the resident. If the correct incontinence product is chosen for the resident, it will be absorbent enough that there will be no need to apply multiple pads or briefs at one time. Applying multiple pads or briefs is a poor practice that will only lead to skin issues for the resident. Your facility leader can provide you with the products that are available, along with guidelines for choosing the correct product for the resident.

Once the correct product has been chosen, the correct size needs to be determined, especially for briefs. This can be done using a measuring tape or by using the resident's height and weight.

McKesson provides the following steps:

Measuring tape method:

1. Measure the resident from hip to hip and multiply by 2, then add 2 inches.
2. Use the measurement from step one and, using a sizing chart, determine the size based on the product the resident is to use.

Height and weight method:

1. Use a product sizing chart to determine the most appropriate size.

Incontinence is a challenge for both residents and staff. Proper care and treatment of residents with incontinence can enable residents to enjoy an active, high-quality life and avoid complications. Knowing and following the resident's care plan; preventing skin breakdown, falls, and other risks; and ensuring these residents are treated with respect will support the high quality of care and high quality of life that residents deserve.

Answer Key for Checkpoint

What would you report to the nurse?

1. Yes
2. Yes
3. Yes
4. No

Perineal Care Competency

Directions: Check the YES boxes below if the Certified Nurse Aide (CNA) completes the step correctly, or check the NO box if they do not complete the step correctly.

CNA Name: _____

Date: _____

Female			
Steps of Process	Step Completed Correctly		Comments
1. Perform hand hygiene and don gloves.	Yes	No	
2. Identify self, greet resident, and explain procedure.	Yes	No	
3. Provide privacy to the resident.	Yes	No	
4. Position the resident appropriately.	Yes	No	
5. Cleanse inner legs and outer peri area along the outside of labia, using a clean area of washcloth or wipe for each swipe of peri area. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes	No	
6. Cleanse outer skin folds from front to back, using a clean area of washcloth or wipe for each swipe of peri area. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes	No	
7. Cleanse inner labia from front to back, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes	No	
8a. If resident has a catheter inserted, cleanse catheter tubing, using clean gloves and a clean washcloth; cleanse from the opening of the urethra outward 4 inches (or farther, if needed), not pulling on catheter.	Yes	No	N/A
8b. Gently open all skin folds and cleanse front to back, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes	No	
9. Rinse area starting with the innermost area and proceeding outward.	Yes	No	N/A
10. Cleanse anal area, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes	No	
11. Rinse anal area.	Yes	No	N/A
12. Pat peri area dry.	Yes	No	
13. Apply skin barrier.	Yes	No	N/A
14. Apply incontinence product.	Yes	No	N/A
15. Discard soiled incontinence product and washcloth or wipe.	Yes	No	
16. Doff and dispose of gloves.	Yes	No	
17. Perform hand hygiene.	Yes	No	
18. Document incontinence care.	Yes	No	
19. Notify nurse of any unusual observations.	Yes	No	N/A
Observer:	Date:		

Perineal Care Competency

Directions: Check the YES boxes below if the Certified Nurse Aide (CNA) completes the step correctly or check the NO box if they do not complete the step correctly.

CNA Name: _____

Date: _____

Male		
Steps of Process	Step Completed Correctly	Comments
1. Perform hand hygiene and don gloves.	Yes No	
2. Identify self, greet resident, and explain procedure.	Yes No	
3. Provide privacy to the resident.	Yes No	
4. Position the resident appropriately.	Yes No	
5. Cleanse peri area using a circular motion and cleaning from tip of penis downward, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes No	
6. If uncircumcised, retract (pull back) foreskin, cleanse, and dry, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones. Then, pull foreskin over end of penis.	Yes No N/A	
7. If resident has a catheter inserted, cleanse catheter tubing, using clean gloves and a clean washcloth; cleanse from the opening of the urethra outward 4 inches (or farther, if needed), not pulling on catheter.	Yes No N/A	
8. Cleanse scrotum, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes No	
9. Rinse the resident's scrotum.	Yes No N/A	
10. Cleanse other areas between legs, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes No	
11. Rinse other areas between the resident's legs.	Yes No N/A	
12. Wash anal area, using a clean area of washcloth or wipe for each swipe. Visibly soiled gloves and washcloths or wipes exchanged for clean ones.	Yes No	
13. Rinse the resident's anal area.	Yes No N/A	
14. Pat the resident's peri area dry.	Yes No	
15. Apply moisture barrier to the resident's peri area.	Yes No	
16. Apply incontinence product to the resident.	Yes No N/A	
17. Discard soiled incontinence product and washcloth or wipe.	Yes No	
18. Doff and dispose of gloves.	Yes No N/A	
19. Perform hand hygiene.	Yes No N/A	
20. Document incontinence care.	Yes No N/A	
21. Notify nurse of any unusual observations.	Yes No N/A	
Observer:	Date:	

Incontinence Product Competency

Directions: Check the YES boxes below if the Certified Nurse Aide (CNA) completes the step correctly or check the NO box if they do not complete the step correctly.

CNA Name: _____

Date: _____

Incontinence Product				
Steps of Process	Step Completed Correctly			Comments
Choosing Incontinence Product				
1. Chooses appropriate incontinence product for resident utilizing the facility formulary.	Yes	No		
Fitting for an Incontinence Brief: Measuring Tape Method				
1. Identify self, greet resident, and explain procedure.	Yes	No	N/A	
2. Perform hand hygiene and don gloves.	Yes	No	N/A	
3. Position resident comfortably on his or her back.	Yes	No	N/A	
4. Utilize tape measure to measure resident from hip to hip.	Yes	No	N/A	
5. Multiply hip measurement by 2.	Yes	No	N/A	
6. Add 2 inches to sum.	Yes	No	N/A	
7. Utilizing the final measurement, refer to the product sizing chart for correct size.	Yes	No	N/A	
8. Return resident to his or her requested position.	Yes	No	N/A	
9. Discard gloves and perform hand hygiene.	Yes	No	N/A	
10. Document correct incontinence product size.	Yes	No	N/A	
Fitting for an Incontinence Brief: Weight and Height Method				
1. Obtain current weight and height from medical record.	Yes	No	N/A	
2. Refer to product sizing chart and choose correct size for the resident's weight and height.	Yes	No	N/A	
3. Document correct incontinence product size.	Yes	No	N/A	
Observer:	Date:			