

This reference guide is to assist Physicians, Practitioners and Clinicians with their role in assisting Long Term Care Facilities with the assessment and treatment regarding urinary incontinence and indwelling urinary catheters.

“Urinary Incontinence” is the involuntary loss or leakage of urine. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time. Some of the common types include:

- “Functional Incontinence” refers to loss of urine that occurs in residents whose urinary tract function is sufficiently intact that they should be able to maintain continence, but who cannot remain continent because of external factors (e.g., inability to utilize the toilet facilities in time).
- “Mixed Incontinence” is the combination of stress and urge incontinence.
- “Overflow Incontinence” is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended.
- “Stress Incontinence” (outlet incompetence) is associated with impaired urethral closure, (malfunction of the urethral sphincter) which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is increased by sneezing, coughing, laughing, lifting, standing from a sitting position, climbing stairs, etc.
- “Transient Incontinence” refers to temporary episodes of urinary incontinence that are reversible once the causes of the episodes are identified and treated.
- “Urge Incontinence” (overactive bladder) is associated with detrusor muscle over activity (excessive contraction of the smooth muscle in the wall of the urinary bladder resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full).

RESOURCES

- www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp (The Sharing Innovations in Quality)
- www.ahrq.gov (Agency for Health Care Research and Quality)
- www.amda.org (American Medical Directors Association)
- www.apic.org (Association of Professionals in Infection Control and Epidemiology, APIC)
- www.cdc.gov (Centers for Disease Control)
- www.mmhc.com (The Annuals of Long Term Care)
- www.afud.org (American Foundation for Urologic Disease)
- www.americangeriatrics.org (The American Geriatrics Society)
- www.medqic.org (Medicare Quality Improvement Community Initiatives)
- www.cms.hhs.gov/medicaid/survey-cert/sc0523.pdf (Centers for Medicare and Medicaid Services)
- www.seekwellness.com (Incontinence Center)

This was developed for implementation of the 2005 Centers for Medicare and Medicaid Services – Urinary Incontinence and Catheter Care Guidelines and Investigative Protocols.

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A Physician's, Practitioner's & Clinician's Reference Guide for Urinary Incontinence, Urinary Tract Infections & Indwelling Catheters

The Physician/Practitioner can assist a facility by:

- Ensuring proper assessment and treatment is provided for residents in LTC. Urinary incontinence (UI) is **NOT** normal. Although aging affects the urinary tract and increases the potential for urinary incontinence, incontinence is **NOT** a normal part of aging.
- Becoming familiar with the facility's policies, procedures and protocols for UI and indwelling urinary catheter assessment and treatment.
- Becoming familiar with current standards of practice for UI and indwelling urinary catheters.
- Taking an active role in assessing and developing a regimen relevant to a medically justified indwelling urinary catheter and treating **only** a symptomatic urinary tract infection (UTI).
- Responding appropriately to any notice of changes in condition (the facility must notify the Physician/Practitioner when a urinary tract infection develops or fails to resolve after treatment).
- Evaluating for UI is to include identification of individuals with reversible and irreversible (e.g., bladder tumors and spinal cord disease) causes of incontinence and those "at risk" for developing incontinence.
- Considering pelvic organ support devices.

At a minimum the following assessment and treatment strategies should be in place:

ASSESSMENT INTERVENTIONS

- A comprehensive risk assessment upon admission, quarterly, and with each change of condition related to cognition, physical ability, or urinary tract function.
- For a resident who is incontinent of urine, determine the type of urinary incontinence.
- Provide individualized programs or interventions to enhance the quality of life and functional status

It is important that staff, when completing the comprehensive assessment, consider the following:

- Prior history of UI and prior voiding patterns, including onset, duration and characteristics, precipitants of urine leakage, associated symptoms (e.g., dysuria, polyuria, hesitancy) and previous treatment and management, including the response to the interventions and the occurrence of persistent or recurrent UTI's.
- **Voiding records** over several days (such as urinary urgency, frequency day or night, voiding patterns, quality of stream) and, for those already experiencing UI, the number of incontinent episodes.
- **Medication review**, particularly those that might affect continence, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedation/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention).
- **Patterns of fluid intake**, such as amounts, time of day, alternations and potential complications, such as decreased or increased urine output.
- Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake).
- Pelvic and rectal examination to identify physical features that may directly affect UI, such as prolapse of the uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, or distended bladder, or bladder spasms.
- Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence, such as impaired cognitive function or dementia, impaired immobility, decrease manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, decreased vision, pain with movement.
- Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination.
- Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders (e.g., M. S., Parkinson's Disease or tumors that could affect the urinary tract or its function).
- Identification of and/or potential of developing complications such as skin irritation or breakdown.

- Tests or studies indicated to identify the type (s) of UI (e.g., post-void residual (s) for residents who have, or are at risk of urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs.
- Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, availability of urinals, use of bed rails or restraints, or fear of falling).

TREATMENT INTERVENTIONS

Facility practices that may promote achieving the highest practicable level of functioning, may prevent/minimize a decline or lack of improvement in degree of continence include treatment/services to address factors that are potentially modifiable, such as:

- Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc.
- Remove/improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet).
- Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion).
- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration).
- Implement a fluid and/or bowel management program and review diet habits to meet the assessed needs.

Options for managing urinary incontinence include **primarily**:

- Behavioral programs and medication therapy

Others measures and **supportive devices** include:

- Intermittent catheterization
- Pelvic organ support devices (pessary device)
- Appropriate incontinence products
- Appropriate external collection systems
- Environmental accommodations/modifications

