



Nursing Home Quality  
Initiative

# FAST FACTS: INCONTINENCE Overview

ISSUE 2

SEPTEMBER 2006

**PREVALENCE** Prevalence of urinary and fecal incontinence in nursing homes is reported to be between 30-65%.

**DEFINING INCONTINENCE** Urinary and fecal incontinence are both associated with loss or inability to control excretory functions.

As defined in the CMS State Operations Manual, there are six types of urinary incontinence:

- **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.
- **Urge incontinence** – (overactive bladder) is associated with detrusor muscle overactivity (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.
- **Mixed** – is the combination of stress incontinence 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.
- **Functional incontinence** – refers to the 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).
- **Transient incontinence** – refers to temporary episodes of urinary incontinence that are reversible once the cause(s) of the episode(s) is (are) identified and treated.

The most common cause of fecal incontinence is the constipation/impaction/laxative abuse complex. Identifying the cause of fecal incontinence helps to better define how it will be managed and addressed.

**DISEASE RELATED CAUSES OF INCONTINENCE** Conditions contributing to incontinence are:

- Urinary tract infection
- Congestive heart failure
- Diabetes mellitus
- Decreased vision



**DISEASE RELATED  
CAUSES OF  
INCONTINENCE  
(CONT.)**

- Pedal edema
- Cognitive impairment (i.e. delirium/dementia)
- Obesity/weight loss
- Fecal impaction, constipation or severe diarrhea
- Tumors, lacerations or fistulas
- Decreased tissue/muscle tone (e.g. associated with impaired mobility)
- Neurologic deficits (i.e. stroke, spinal cord injury, Multiple Sclerosis, Parkinson's Disease)
- Psychological (i.e. anxiety, depression, altered level of consciousness, stress)

**MISCONCEPTIONS  
AND BARRIERS  
REGARDING  
INCONTINENCE**

- Misconception that urinary incontinence is a natural part of aging
- Lack of knowledge, training and techniques related to the clinical management of incontinence
- Staffing patterns that do not allow for adequate number of staff when resident need is greatest
- Physical environment not conducive to resident's full participation in toileting regimen (i.e. cluttered hallways, inconvenient location and/or distance to toilet/commode, limited availability of commodes, urinals, raised/low toilet seats, decreased lighting, lack of privacy)
- Resident's wheelchair agility and access

**FURTHER READING  
AND WEB  
RESOURCES**

A more detailed overview of incontinence can be obtained by contacting your state Quality Improvement Organization (QIO). Visit: <http://www.medqic.org/QIOListings>

Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP, Rev. 15, Updated June, 2006. F315 Urinary Incontinence (pp 187-224). Available: <http://cms.hhs.gov/manuals>

Quality Measures Resource Manual, February 2006, Version 5.0. Residents Who Lost Control of Their Bowels or Bladder – Available: <http://www.medqic.org/Chapter6G>

Revised Long-Term Care Resident Assessment Instrument User's Manual, December 2002, Version 2.0, Revised June 2006. Available: <http://www.cms.hhs.gov/RAI>

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Merkelj I. Basic Assessment of Urinary Incontinence. *South Med J*. 2002; 95(2):178-82. Also available online through Medscape. One needs to register on Medscape to gain access to articles. Registration is free. Available: <http://www.medscape.com>



**EVALUATION OF INCONTINENCE**

Incontinence evaluation should be performed upon admission, at regular intervals, when there is a change in medical status or when there are new episodes of incontinence. It should also be conducted in a consistent and thorough manner to ensure that realistic, individualized and effective interventions are planned as part of the resident's daily care.

Components of the evaluation should include:

- List of current diagnoses and identification of risk factors
- Medication review
- Current voiding patterns
- Functional assessment (to determine if resident needs physical assistance in toileting, or has assistive devices that facilitate toileting)
- Past history of incontinence and how it was treated
- Use of a urinary catheter
- Hydration baseline (i.e. average daily fluid intake)
- Cognitive/behavioral status
- Laboratory studies (i.e. PVR, urinalysis, current infections - urinary or GI)

**GOALS OF EVALUATION OF INCONTINENCE**

The goal of the initial evaluation is to identify type and transient causes of incontinence. Transient incontinence is generally reversible if the underlying problem can be addressed adequately (i.e. discontinuing medications, resolution of acute illness, recent removal of indwelling catheter etc.). Even if the cause cannot be reversed, interventions can be tried to reduce its contribution to the incontinence.

Ongoing evaluation of incontinence should be maintained to ensure that interventions remain effective and realistic based on the resident's abilities. Because of their knowledge of residents, nursing assistants may be able to identify obstacles that might affect successful implementation of prevention interventions; or may be helpful in identifying residents at risk for incontinence, or residents that may need a change in interventions to maintain continence.



**FURTHER  
READING AND  
WEB  
RESOURCES**

A more detailed overview of incontinence can be obtained by contacting your state Quality Improvement Organization (QIO). Visit [http://www.ahqa.org/pub/connections/162\\_694\\_2450.cfm](http://www.ahqa.org/pub/connections/162_694_2450.cfm) for contact information for your state QIO.

Brandeis, GH, et al. The Prevalence of Potentially Remedial Urinary Incontinence in Frail Older People: A Study Using the Minimum Data Set. *Jnl Am Geriatr Soc.* 1997;45:179-84.

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Nelson R, Furner S, Jesudasun V. Urinary Incontinence in Wisconsin Skilled Nursing Facilities: Prevalence and Associations in Common with Fecal Incontinence. *Jnl of Aging and Hlth.* 2001;13:4,539.

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*Nursing Home Quality Initiative*

# FAST FACTS: INCONTINENCE *Management*

**ISSUE 1**

**OCTOBER 2004**

**MANAGING INCONTINENCE IN LONG-TERM CARE**

Incontinence is a significant problem among the institutionalized elderly leading to low self-esteem, social isolation and self-perception of poor health. When residents are properly evaluated and treated, incontinence can often be reversed or mitigated. The key to managing incontinence is to identify residents at risk.

**CARE PLANNING**

The results of a thorough evaluation should be translated into an individualized care plan to prevent/manage incontinence. It is important that direct-care nursing staff (CNAs) suggestions be incorporated in the care plan, as they are key in its implementation.

**INTERVENTIONS**

Many intervention approaches can be employed related to the type of incontinence and ability of the resident to participate in incontinence programs. Some intervention approaches include:

- Behavioral techniques - considered highly effective when implemented appropriately. Behavioral techniques target ways in which to change incontinence patterns by modifying the incontinent resident's behavior or environment and can decrease incontinent episodes by 50%. These techniques are most useful in cognitively intact residents.
- Bladder training - also referred to as habit training or scheduled toileting, involves preset, routine voiding times encouraging residents to resist the urge to void between scheduled times. Time intervals between voids are gradually increased.
- Prompted voiding - involves verbal cues from staff to remind residents of the need to toilet and may include physical assistance to toilet if needed. Prompted voiding has reduced incontinence among individuals who fail to void independently due to lack of sensation, immobility or cognitive impairment by 25-40%.
- Physical function training - interventions aimed at improving function may impact incontinence – i.e. decreasing or eliminating use of restraints or providing an exercise program to increase strength and mobility may improve continence status. COMMENT: Restraint reduction is NOT labor intensive, however, does increase resident's quality of life, self-esteem and independence.



## INCONTINENCE CARE

In situations where residents cannot benefit from or are not able to participate in toileting programs, appropriate and comprehensive incontinence care must be provided. Standard practices for incontinence care include:

- Pad/brief change every 2-4 hours
- Cleansing, rinsing, drying of skin during pad/brief change
- Skin inspection for areas of redness, excoriation, infection, skin breakdown
- Application of barrier cream
- Application of clean pad/brief and incontinence bed pad (i.e. chux)
- Repositioning of resident (as necessary)

## MONITORING CARE

The implementation of any program to improve incontinence outcomes should include a system for monitoring the effectiveness of interventions and provide feedback to staff. Monitoring should focus on resident outcomes and process measures related to implementation of the toileting program. Some areas to consider regarding monitoring are:

- Capture of voiding frequency and volume
- Wet/dry status
- Evidence of constipation
- Decreased fluid intake at bedtime
- Problems with implementation of interventions
- Suggestions for altering toileting program related to implementation problems identified
- Necessity for ongoing staff training

## FURTHER READING AND WEB RESOURCES

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