Incontinence Management and Prevention

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Nurse Consultant/Clinical Reimbursement Lead
Objectives

• Review bladder function, age-related changes to bladder function, and risk factors/preventative measures for urinary incontinence (UI).

• Discuss the social, financial, and emotional costs of urinary incontinence among the elderly.

• Define the recognized types of urinary incontinence.

• Identify appropriate assessment tools and interventions to manage urinary incontinence.

• Discuss MDS 3.0 Section H coding guidelines and the Quality Measures associated with urinary elimination.
Review bladder function, age-related changes to bladder function, and risk factors/preventative measures for urinary incontinence (UI).
Overview of Bladder Function

- Ureters release small amounts of urine into the bladder every 10 – 15 seconds
- It takes 2-5 hours for the bladder to become uncomfortably full
  - Capacity – 600 mL
  - Desire – 200 mL
  - Normal Void – 300 mL
- Nerve centers in both the brain and the spinal cord are involved in emptying
- “Normal” voiding is at 4 – 5 hour intervals, without night intervals
Age Related Changes

- Kidneys no longer concentrate urine as effectively
- Bladder capacity decreases
- Bladder’s ability to contract lessens
- Nocturia
- Gender factors
Risk Factors for UI

Urinary Incontinence
Internal Risk Factors

- Atrophic vaginitis
- Bladder/Prostate cancer
- CHF
- Dementia
- Diabetes

- Neurological disorders
- Parkinson’s
- Prolapsed uterus
- Stroke
External Risk Factors

- Call light not within reach
- Inappropriate access to toilet
- Lack of appropriate clothing
- Lack of aids/assistive devices
- Poor lighting
- Physical restraints
- Inadequate staffing
- Reminders to toilet
## Food, Drink, Meds, & Other

<table>
<thead>
<tr>
<th>Food and Drink</th>
<th>Meds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Anticholinergics</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Caffeine</td>
<td>Antihistamines</td>
<td>Constipation</td>
</tr>
<tr>
<td>Foods containing caffeine, salt</td>
<td>Antispasmodics</td>
<td>Delirium</td>
</tr>
<tr>
<td>Acidic beverages</td>
<td>Calcium channel blockers</td>
<td>Depression</td>
</tr>
<tr>
<td>Carbonated beverages</td>
<td>Psychoactive medications</td>
<td>Inadequate urine output</td>
</tr>
<tr>
<td></td>
<td>Narcotics</td>
<td>Dehydration</td>
</tr>
<tr>
<td></td>
<td>Diuretics</td>
<td>Hypercalcemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hyperglycemia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UTI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urethral obstruction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinary retention</td>
</tr>
</tbody>
</table>
Discuss the social, financial, and emotional costs of urinary incontinence among the elderly.
Urinary Incontinence

- Common
- Treatable
- Significant Effect on Quality of Life
Prevalence of Urinary Incontinence

• 53% of homebound older persons
• 50% - 70% of nursing home residents
• UI increases the risk of falls by as much as 26% and bone fracture by as much as 34%
• 22% of continent female residents admitted to a long-term care facility become incontinent within one year of admission

• National Association for Continence, 2014
Urinary incontinence is not a normal part of aging.
Economic Cost of UI

• United States
  – Year 2000
  – Total direct and indirect cost $19.5 billion

• Nursing Facilities
  – Year 1995
  – $5.3 billion
Emotional Cost of UI

- Fear of being wet or of smelling in public
- Shame
- Embarrassment
- Guilt
- Desire to isolate oneself
- Changes in self-image and self-confidence
- Anxiety
- Depression
- Irritability
- Frustration
Define the recognized types of urinary incontinence.
• The involuntary loss of urine which is objectively demonstrable and a social or hygienic problem.
  
  • International Continence Society
Types of Urinary Incontinence

- **Urge**
  - Resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode

- **Stress**
  - Loss of a small amount of urine with physical activity such as coughing, sneezing, laughing, walking stairs, or lifting

- **Mixed**
  - Combination of Urge and Stress incontinence

- **Overflow**
  - Occurs when the bladder is distended from urine retention

- **Functional**
  - Secondary to other factors such as physical weakness, poor mobility, poor dexterity, cognition, environment, diminished vision, aphasia, psychological

- **Transient**
  - Related to delirium, infection, atrophic urethritis or vaginitis, medications, increased urine production, restricted mobility, or fecal impaction

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Types of Urinary Incontinence

Urge

- Resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode
- Abrupt urgency, frequency, and nocturia
- Most common cause of UI in the elderly
- “Overactive Bladder”
The complaint of involuntary leakage accompanied by or immediately preceded by urgency.

• Loss of a small amount of urine with physical activity such as coughing, sneezing, laughing, walking stairs, or lifting
• Leakage results from an increase in intra-abdominal pressure on a bladder that is not over distended and is not the result of detrusor contractions
• Most common type of UI in older women
The complaint of involuntary leakage with effort or exertion or on sneezing or coughing.

Types of Urinary Incontinence

Mixed

- Combination of Urg and Stress incontinence
- Common in many elderly – especially women
The complaint of involuntary leakage associated with urgency and also with exertion, effort, sneezing, or coughing.

Types of Urinary Incontinence

Overflow

- Occurs when the bladder is distended from urine retention
- Weak stream, hesitancy, incomplete voiding, frequent voiding, constant dribbling
- Due to outlet obstruction, hypotonic bladder, or both
- Increased PVR (Post Void Residual)
Overflow UI

• Urethral blockage
• The bladder is not able to empty properly

Neurogenic/Atonic

Obstruction
• Incontinence that is secondary to other factors such as physical weakness, poor mobility, poor dexterity, cognition, environment, diminished vision, aphasia, psychological
Transient

• Related to delirium, infection, atrophic urethritis or vaginitis, medications, increased urine production, restricted mobility, or fecal impaction
• Transient because it is related to a potentially improvable or reversible cause.
Reversible Causes of UI

**D** - Delirium or Drugs

**R** - Restricted mobility

**I** - Infection, Impaction

**P** - Polyuria
Identify appropriate assessment tools and interventions to manage urinary incontinence.
Thorough Assessment

- Catheter Usage
- Cognitive Awareness
- Elimination History
- Symptoms Affecting Elimination Patterns
- Diagnoses and Medications
- Mobility/Environmental Limitations
- Pain

- Labs
- Possible Reversible Causes
- Toileting Self Performance
- Elimination Patterns (3 Day Diary)
- Bladder Scan/Post Void Residual (PVD)
### Bowel & Bladder Screening (3-day Void)

<table>
<thead>
<tr>
<th>NA Initials</th>
<th>Time</th>
<th>Use of Toilet, Commode</th>
<th>Pad, Brief</th>
<th>Resident Requested Toileting</th>
<th>Bowel Movement (Circle only if had BM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>When placed on toilet/commode, did Resident void?</td>
<td>Refused by Res. to use</td>
<td>Res. not able to use</td>
<td>Dry or Wet</td>
</tr>
<tr>
<td>Date: (day1)</td>
<td>6:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
</tr>
<tr>
<td>Am</td>
<td>7:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
</tr>
<tr>
<td>8:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
<tr>
<td>9:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
<tr>
<td>10:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
<tr>
<td>11:__am</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
<tr>
<td>12:__pm</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
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<tr>
<td>1:__pm</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
<tr>
<td>2:__pm</td>
<td>Voided</td>
<td>Not voided</td>
<td>Refused</td>
<td>Not able</td>
<td></td>
</tr>
</tbody>
</table>

Licensed staff reviewed:

Comments:
## Types of Urinary Incontinence

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<td>Related to delirium, infection, atrophic urethritis or vaginitis, medications, increased urine production, restricted mobility, or fecal impaction</td>
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Treatment of UI in the Elderly

- Behavioral Treatment
- Medications
- Anti-Incontinence Rings
- Minimally Invasive Surgeries
Behavioral Treatment

• Mainstay of institutionalized patients
• Least invasive treatment with no known adverse complications
• Modify resident’s behavior and/or environment

• Critical Success Factors
  – Education of caregiver
  – Education of resident
  – Availability of staff
  – Consistent implementation of the interventions
Behavioral Programs

• Resident Dependent
  – Bladder Rehabilitation/Bladder Retraining
  – Pelvic Floor Muscle Rehabilitation (Kegel Exercises)

• Staff Dependent
  – Prompted Voiding
  – Habit Training/Scheduled Voiding
Bladder Rehabilitation/Retraining

- Requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void
- Intervals between voiding may be increased progressively
- Usually takes at least several weeks

- **Appropriate Resident**
  - Fairly independent with ADLs
  - Occasional incontinence
  - Aware of need to void
  - May wear incontinence products for episodic urine leakage
  - Has goal to maintain his/her highest level of continence
Pelvic Floor Muscle Rehabilitation

• Strengthen the voluntary peri-urethral & peri-vaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs

• **Appropriate Resident**
  – Cognitively intact
  – Able & willing to participate
  – Urge and/or Stress incontinence
• **Find the right muscles.**
  
  – To identify your pelvic floor muscles, stop urination in midstream. If you succeed, you’ve got the right muscles.

• **Perfect your technique.**
  
  – Once you’ve identified your pelvic floor muscles, empty your bladder and lie on your back. Tighten your pelvic floor muscles, hold the contraction for five seconds, and then relax for five seconds. Try if four or five times in a row. Work up to keeping the muscles contracted for 10 seconds at a time, relaxing for 10 seconds between contractions.

• **Maintain your focus.**
  
  – For best results, focus on tightening only your pelvic floor muscles. Be careful not to flex the muscles in your abdomen, thighs or buttocks. Avoid holding your breath. Instead, breathe freely during the exercises.

• **Repeat 3 times a day.**
  
  – Aim for at least three sets of 10 repetitions a day.
Prompted Voiding

- Teaches the resident to recognize bladder fullness or the need to void, ask for help, or respond when prompted to toilet
- 3 Components
  - Regular monitoring with encouragement to report continence status,
  - Using a schedule and prompting the resident to toilet, and
  - Praise and positive feedback when the resident is continent and attempts to toilet.

- Appropriate Residents
  - Can be used with dependent or more cognitively impaired residents
    - Must be able to say their name or reliably point to one of two objects
  - Urge or Mixed incontinence
  - Reduces episodes up to 40%
Habit Training/Scheduled Voiding

• Scheduled toileting at regular intervals on a planned basis to match the resident’s voiding habits
  - Habit Training
    • Timed voiding based on the resident’s usual voiding pattern
  - Scheduled Voiding
    • Timed voiding, usually every 3 – 4 hours while awake
    • No systematic effort to encourage the resident to delay voiding and/or to resist urges as with bladder re-training.

• Appropriate Residents
  – Residents who cannot self-toilet
• **Anticholinergics**
  - Calm an overactive bladder; so useful for urge incontinence
  - Oxybutynin (Ditropan), tolterodine (Detrol), darifenacin (Enablex), fesoterodine (Toviaz), solifenacin (Vesicare), and trospium (Sanctura)
  - Possible Side effects include dry mouth, constipation, blurred vision, and flushing.
  - Elderly have increased vulnerability to toxicity (cognitive side effects)
• Topical Estrogen
  – Low-dose topical estrogen in the form of a vaginal cream, ring, or patch may help tone and rejuvenate tissues in the urethra and vaginal areas.
• Imipramine
  – Tofranil, a tricyclic antidepressant
  – Has anti-cholinergic side effects
  – Urge and/or stress incontinence
Meds for UI (4 of 4)

• Duloxetine
  – Cymbalta, an antidepressant (SSNRI)
  – Unknown mechanism on the bladder
  – Stress incontinence
Rings: Stress or Mixed Incontinence

If we find one that fits, Efficacy is 50%
Risks: Erosion, Cleaning
Minimally Invasive Surgeries

- Stress and/or Urge UI
- Types
  - Bulking agents
    - 50% - 75% success at 1 year
  - Sling surgery
    - 75% - 80%
  - Botox injections
    - 75% at 8 months – 1 year
  - Bladder pacemaker
    - 75% for 4 years
Discuss MDS 3.0 Section H coding guidelines and the Quality Measures associated with urinary elimination.
• **Urinary Incontinence**
  – The involuntary loss of urine

• **Urinary Continence**
  – Any void that occurs voluntarily, or as a result of prompted toileting, assisted toileting, or scheduled toileting

• *Episodes of incontinence and continence*

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<table>
<thead>
<tr>
<th>H0300. Urinary Continence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enter Code</strong></td>
</tr>
<tr>
<td><strong>Urinary continence</strong> - Select the one category that best describes the resident</td>
</tr>
<tr>
<td>0. <strong>Always continent</strong></td>
</tr>
<tr>
<td>1. <strong>Occasionally incontinent</strong> (less than 7 episodes of incontinence)</td>
</tr>
<tr>
<td>2. <strong>Frequently incontinent</strong> (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)</td>
</tr>
<tr>
<td>3. <strong>Always incontinent</strong> (no episodes of continent voiding)</td>
</tr>
<tr>
<td>9. <strong>Not rated</strong>, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days</td>
</tr>
</tbody>
</table>
• Urinary Toileting Program
  – Look back period
    • For H0200A is since the most recent admission/entry or re-entry (A1600) or since urinary incontinence was first noted within the facility (whichever is most recent)
    • For H0200C is 7 days
## Team Approach

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Responsibility for Continence Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>Gather data for assessment; individualize plan of care; educate resident, family, &amp; staff on individual care needs; carry out program</td>
</tr>
<tr>
<td>Therapy</td>
<td>Evaluate environment, adaptive devices; adjunctive therapies</td>
</tr>
<tr>
<td>Social Services</td>
<td>Assist gathering data from resident &amp; family on environmental needs, history &amp; review of resident’s previous living situation, &amp; identification of mood or behaviors affecting bowel &amp; bladder status</td>
</tr>
<tr>
<td>Dietary</td>
<td>Assist with review of fluid and fiber intake for healthy bowel and bladder function</td>
</tr>
<tr>
<td>Therapeutic Recreation</td>
<td>Review voiding patterns to assist resident with individualized activity program and plan of care</td>
</tr>
</tbody>
</table>
Bowel Definitions

• Bowel Incontinence
  – The involuntary loss of feces

• Bowel Continence
  – Any defecation that occurs voluntarily, or as a result of prompted toileting, assisted toileting, or scheduled toileting

• Constipation
  – If the resident has 2 or fewer bowel movements during the 7 day look back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements)
### H0400. Bowel Continence

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Bowel continence - Select the one category that best describes the resident</td>
</tr>
<tr>
<td>0</td>
<td>Always continent</td>
</tr>
<tr>
<td>1</td>
<td>Occasionally incontinent (one episode of bowel incontinence)</td>
</tr>
<tr>
<td>2</td>
<td>Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</td>
</tr>
<tr>
<td>3</td>
<td>Always incontinent (no episodes of continent bowel movements)</td>
</tr>
<tr>
<td>9</td>
<td>Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days</td>
</tr>
</tbody>
</table>

### H0500. Bowel Toileting Program

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Is a toileting program currently being used to manage the resident's bowel continence?</td>
</tr>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### H0600. Bowel Patterns

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Constipation present?</td>
</tr>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Bowel Training

• At risk for constipation due to:
  – Decreased activity
  – Decreased fluid intake
  – Medication side effects
  – Functional concerns
  – Many residents “hold” as long as they can due to staff not available when they need to defecate
Bowel Assessment

• What is the resident’s bowel history?
• What medications or interventions used previously have been effective? Ineffective?
• Has the resident overused bowel preparations in the past?
• What was their diet, fluid, exercise history?
Bowel Training

• Offer diet that includes adequate fiber
• Encourage adequate hydration
• Exercise
• Talk with dietary about prunes, prune juice, "power cookies," bran, etc.
• Medication Management
  – Talk to physician or physician extender regarding a bowel management plan to include, if necessary, regularly scheduled stool softeners, PRN medication to include suppositories or enemas
Low risk residents who lose control of their bowel or bladder

- Long Stay Residents
  - 101 or more days within the episode
- Loss of bowel or bladder control
  - Determined from Section H on the target assessment
- Low risk
  - Determined by eliminating high risk
• **High-risk:**

  – Severe cognitive impairment on the target assessment as indicated by (C1000 = [3] and C0700 = [1]) OR (C0500 ≤ [7]).

  – Totally dependent in bed mobility self-performance (G0110A1 = [4, 7, 8]).

  – Totally dependent in transfer self-performance (G0110B1 = [4, 7, 8]).

  – Totally dependent in locomotion on unit self-performance (G0110E1 = [4, 7, 8])
• Inaccurate or incomplete documentation on the 3 Day Diary
• Program is not individualized according to resident’s comprehensive assessment
• Staff do not follow the program as identified for the resident
• Incontinence numbers do not improve
Key Tips for Success

- Ensure Nurse Manager oversight of 3 Day Diary each day, each shift
- Review/Audit an identified number of assessments per month to determine if the diary and assessment are consistent with the plan
- Observe staff during the shifts to identify if the individualized plan is consistently implemented
- Licensed nurse should check documentation weekly and summarize monthly
Holding Staff Accountable

• What is your system for staff noncompliance with your policies, procedures, care plans?
  – Do staff consistently complete the process as indicated?
  – Are C.N.A.s missing shifts of documentation?
  – Are the forms or E.H.R.s being completed at the end of the shift (or the beginning) rather than during the shift?
  – How are we holding staff accountable?
In Summary

- Policies and Procedures
- Assessments
- Staff Education
- Plans of Care
- Program Implementation and Evaluation
REFERENCES AND HELPFUL WEBSITES:


http://www.amda.com/tools/guidelines.cfm#incontinence

https://www.qtso.com/download/qis/forms/CMS-20068_UrinaryIncontinenceCatheterUTI_CE.pdf
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Thank You For Attending Today’s Presentation!

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