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Urinary incontinence (UI) has a major impact in long-term care facilities. It is the second-leading reason for placement of older adults into institutionalized care,<sup>1</sup> and it is the primary reason why many elderly persons are not accepted into assisted living facilities.<sup>2,3</sup> In long-term care facilities, it has been estimated that about 50% of the residents are urinary incontinent and that many who are continent at admission tend to become incontinent over time.<sup>4</sup> In one study of 430 newly admitted nursing home residents, 22% of women who were continent at admission were incontinent after one year.<sup>5</sup> The conversion rate in men was even higher (56%). The reasons for this increase involve cognitive and mobility impairment and adjustment to the nursing home environment.

In addition to staff, many nursing home residents believe UI is inevitable. Residents will utilize self-management strategies for urine leakage in order to protect social and psychological integrity, privacy, and dignity.<sup>6</sup> Not only does UI have a substantial social effect on residents, it also has associated morbidities, including urinary tract infections (UTI), pressure ulcers, and falls with subsequent injury.<sup>2,7</sup> In addition, caring for residents with UI adds considerably to the burden of nursing staff and can result in morale problems and increased staff turnover.<sup>8</sup> Because of these negative influences, the prevalence of UI is considered an indicator of the quality of care within long-term care facilities,<sup>9</sup> and several clinical practice guidelines have been developed by regulatory agencies and caregiver associations in an effort to improve the recognition, treatment, and outcomes of UI.<sup>10, 11</sup>

In addition to UI, other bladder-related disorders like UTI are common in nursing home residents. The use

# Urinary Incontinence and Indwelling Catheters:

## CMS Guidance for Long-Term Care

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**Table 1. Transient Causes of Urinary Incontinence**

Type	Causes
Delirium	Acute medical illness, such as myocardial infarction, cerebrovascular accident, sepsis, or infection can dull awareness of the urge sensation and lead to an inability or unwillingness to reach a toilet.
Urinary tract infection	Bacteria in the bladder can irritate bladder mucosa, creating bladder overactivity and frequency, leading to UI.
Atrophic vaginitis/urogenital atrophy	Thinning in the skin around the urethra and vagina from loss of the hormone estrogen can lead to complaints of burning, itching, frequency, and UI. Use of topical estrogen (eg, cream, tablets, or ring) can improve symptoms.
Bowel disorders, such as constipation and fecal impaction	Increased pressure on an already weakened bladder causes urinary frequency, urgency, and UI. Fecal impaction of hard feces accumulates in the rectum, putting pressure on the bladder, which causes UI, and can result in overflow fecal incontinence. Chronic straining with defecation and chronic constipation can result in loss of rectal tone, leading to fecal incontinence.
Multiple medications	Certain medications have secondary side effects that cause increased incidence of forgetfulness or confusion. Altering administration time or changing to different medication in the same classification may alleviate the problem.
Diuretics	Rapidly increase urine volume in the bladder and, in combination with decreased resistance in the urethra, can lead to urgency, frequency, and UI.
Adrenergics including antihypertensives	Relax the smooth muscle of the urethra, sphincter, or bladder neck, inducing stress incontinence.
Hypnotics, narcotics, analgesics, and sedatives	Dull or suppress cognitive and physical functioning, thereby decreasing the ability to delay bladder emptying and awareness of the urge to void. Nighttime incontinence is common. Altering dosage, time of administration, and type of drug may alleviate incontinence episodes.
Anticholinergics (antidepressants, antipsychotics, and antihistamines)	Cause incomplete bladder emptying through inhibition of the bladder muscle and weakness and disuse atrophy of pelvic floor muscles, leading to urinary retention with overflow UI. Also, these drugs cause constipation and fecal impaction.
Urinary retention	Obstruction (eg, from an enlarged prostate; hard, impacted stool) or certain medications, such as calcium channel blockers, can cause overflow incontinence.
Dehydration	Urine becomes concentrated, which in turn irritates the bladder wall, and can precipitate UI and urinary urgency and frequency.
Functional changes	Decrease in mobility due to surgery, illness, or physical restraints can interfere or limit ability to reach the toilet. Environmental considerations, such as bedside commode or urinal, and toileting a restrained resident can help avoid UI episodes.
Endocrine disorders	Hyperglycemia (diabetes) and hypercalcemia can cause increased urine output and a delay or lowered state of awareness of the urge sensation to void, contributing to UI.

Adapted from Newman DK. Managing and Treating Urinary Incontinence. Baltimore, Md: Health Professions Press; 2002 and Newman DK. Urinary incontinence. Adv Nurs. 2004;6(3):19–24.

of catheters to manage bladder disorders, such as UI and urinary retention, is a major problem in this setting. Historically, indwelling catheters have been used in the chronic, medically compromised elderly patient, and the prevalence of long-term catheter usage is the greatest in residents with UI residing in skilled nursing facilities (SNF). These devices increase mortality and morbidity in both men and women.<sup>12,13</sup> Urinary tract infections are very common in elderly persons, especially those living in nursing homes. At least 40% of all infections seen in nursing homes are in the urinary tract system; of these infections, 80% are due to urinary tract catheterization and instrumentation. UTI is of major importance because of its effect on outcomes and treatment costs. While many approaches have been used to minimize catheter-induced UTI, elimination of catheter usage remains the best method.

### Federal Tag 315

The Centers for Medicare and Medicaid Services (CMS) plans to issue new surveyor guidance for incontinence and urinary catheters. This new guidance collapses current Federal Tags 315 and 316 into one Tag, which will be Federal Tag 315 (Tag F315). The new guidance contains interpretive guidelines, a new investigative protocol, and compliance and severity guidance. The intent of this requirement is to ensure that:

- Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible
- An indwelling catheter is not used unless there is valid medical justification and, if not medically justified, it is discontinued as soon as clinically warranted
- Services are provided to restore or improve normal bladder function to the extent possible after the removal of the catheter
- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

*...the steps of assessment, monitoring, reviewing, and revising approaches to care (as needed) are essential to managing UI and restoring as much normal bladder function as possible.*



Assessment of incontinence is the key component of this new guidance, and emphasis is placed on identifying the transient and persistent causes of UI (see Tables 1 and 2).

### Criteria for Compliance

The guidance provides information for compliance to this regulation. Whether the resident is incontinent of urine on admission or develops incontinence after admission, the steps of assessment, monitoring, reviewing, and revising approaches to care (as needed) are essential to managing UI and restoring as much normal bladder function as possible.

For a resident with UI, the facility is in compliance with this requirement if it 1) recognized and assessed factors affecting the risk of symptomatic UTIs and impaired urinary function; 2) defined and implemented interventions to address correctable underlying causes of UI (see Table 1) and to try to minimize the occurrence of symptomatic UTIs; 3) monitored and evaluated the resident's response to preventive efforts and treatment interventions; and 4) revised the approaches as appropriate.

For a resident with an indwelling urinary catheter, the facility is in compliance if it has 1) recognized and assessed factors affecting the resident's urinary function and identified the

medical justification for the use of an indwelling urinary catheter; 2) defined and implemented pertinent interventions to try to minimize complications from an indwelling urinary catheter and to remove it if clinically indicated; 3) monitored and evaluated the resident's response to interventions; and 4) revised the approaches as appropriate.

For a resident who has or has had a symptomatic UTI, the facility is in compliance with this requirement if it has 1) recognized and assessed factors affecting the risk of symptomatic UTIs and impaired urinary function; 2) defined and implemented interventions to try to minimize the occurrence of symptomatic UTIs and to address correctable underlying causes; 3) monitored and evaluated the resident's responses to preventive efforts and treatment interventions; and 4) revised the approaches as appropriate.

### Surveyor Steps

The guidance outlines areas that will be of importance during the survey process. The assessment, care plan, and orders identifying facility interventions will be scrutinized and corroborated through observations by interview and record review. The surveyor will determine if staff consistently implemented care plan interventions across various shifts and will note and/or follow up on deviations from the care plan or from current standards of practice as well as potential negative outcomes. Surveyors will determine if staff made appropriate resident accommodations for residents whose assessments indicate that a toileting program is most appropriate (eg, placing the call bell within reach, responding to the call bell, and maintaining a clear pathway and ready access to toilet facilities). Toileting programs will be scrutinized to determine if assistance (eg, prompting, transfer, stand-by assist to ambulate) is required for toileting and/or the resident is on a program to restore continence or a scheduled toileting program. Also, surveyors will check to see whether the patient is generally continent and observe whether assistance has been provided to try to prevent incontinence episodes. Many residents will not be candidates for

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**Table 2. Common Causes of Persistent and Long-Term Urinary Incontinence**

Type	Definition	Causes	Symptoms
Urge or overactive bladder	Involuntary and uninhibited bladder contractions (commonly referred to as overactive bladder) characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis)	<ul style="list-style-type: none"><li>• Age-related, neurological (eg, stroke, diabetes, Parkinson's disease, multiple sclerosis), or other causes (eg, bladder infection, urethral irritation, etc.)</li><li>• The resident can feel the need to void but is unable to inhibit voiding long enough to reach and sit on the commode</li><li>• Most common cause of UI in elderly persons</li></ul>	<ul style="list-style-type: none"><li>• Sudden, intense urge to pass urine</li><li>• Usually little warning time, so the patient is unable to delay or postpone voiding after sensation of bladder fullness (urge) is perceived</li><li>• Moderate to large amounts (several milliliters) of leakage</li><li>• Urine loss on way to bathroom</li><li>• Timing of urine loss is unpredictable</li><li>• Associated with other symptoms, such as frequency and nocturia</li></ul>
Stress	Urine leakage results from an increase in intra-abdominal pressure (physical exertion) on a bladder that is not over distended and is not the result of detrusor (bladder) contractions	<ul style="list-style-type: none"><li>• Urethral sphincter dysfunction due to relaxation and weakness of the pelvic floor muscles and reduction in urethral resistance (as women age, many develop intrinsic urethral sphincter dysfunction)</li><li>• Second most common type of UI in older women</li></ul>	<ul style="list-style-type: none"><li>• Urine leakage in small amounts or drops occurs with physical activities or exercises (eg, coughing, sneezing, laughing, walking stairs, or lifting) or any action that increases intra-abdominal pressure</li></ul>
Mixed		<ul style="list-style-type: none"><li>• A combination of bladder and urethral dysfunction, causing stress and urge incontinence</li></ul>	<ul style="list-style-type: none"><li>• Combination of above symptoms</li></ul>
Overflow	Occurs when the bladder is distended from urine retention	<ul style="list-style-type: none"><li>• Urine retention may result from outlet obstruction (eg, benign prostatic hypertrophy, prostate cancer, and urethral stricture), hypotonic bladder (detrusor under activity) or both</li><li>• Hypotonic bladder may be caused by outlet obstruction, impaired or absent contractility of the bladder (neurogenic bladder), or other causes</li><li>• Neurogenic bladder may also result from neurological conditions, such as diabetes mellitus, spinal-cord injury, or pelvic nerve damage from surgery or radiation therapy</li></ul>	<ul style="list-style-type: none"><li>• Post void residual (PVR) volume (the amount of urine remaining in the bladder within 5–10 minutes following urination) exceeds 200mL (normal PVR is usually 50mL or less); a PVR of 150–200mL may suggest a need for retesting to determine if this finding is clinically significant</li><li>• Interrupted urinary flow (start and stop voiding)</li><li>• Post-void dribbling</li><li>• Continual leakage of small amounts of urine</li></ul>
Functional	Refers to incontinence that is secondary to factors other than inherently abnormal urinary tract function	<ul style="list-style-type: none"><li>• Physical weakness or poor mobility/dexterity (eg, due to poor eyesight, arthritis, deconditioning, stroke, contracture), cognitive problems (eg, confusion, dementia, unwillingness to toilet), various medications (eg, anticholinergics, diuretics), or environmental impediments (eg, excessive distance of the resident from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets)</li></ul>	<ul style="list-style-type: none"><li>• Leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended</li></ul>

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