

# BOWEL AND BLADDER PROGRAM

# Objectives

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Upon completion of the program the participants will be able to:

1. Identify regulatory requirements related to bowel and bladder care of residents in the SNFs.
2. Interpret the intent of the regulations as it applies to clinical practice.
3. Define terms as it relates to the evaluation & treatment of urinary incontinence & catheter use.

# Objectives

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4. Analyze the regulatory components and necessary resources to be considered in meeting guidance for implementation.
5. Discuss assessment considerations, interventions for care planning and program considerations.

# Presentation

# Regulatory Review

§483.25(e)(1)-(3) Bowel/Bladder Incontinence,  
Catheter, UTI

Based on the resident's comprehensive assessment,  
the facility must ensure that –

§483.25(e) (1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

# Regulatory Review

483.25 (e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that:

- a. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

# Regulatory Review

- b. A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
- c. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

# Regulatory Review

- d. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

# Intent of Regulation

The intent of this regulation 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;
- An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted;

# Intent of Regulation

- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter; and
- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

# Definitions

- Definitions are provided to clarify clinical terms related to evaluation and treatment of urinary incontinence and catheter use.
- Bacteremia - is the presence of bacteria in the bloodstream.
- Bacteriuria - is defined as the presence of bacteria in the urine.

# Definitions

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 more 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);

# Definitions

- Mixed Incontinence - 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;
- 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; and

# Definitions

- 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).
- Urinary Retention - is the inability to completely empty the urinary bladder by micturition.

# Definitions

- Urinary Tract Infection - (UTI) is a clinically detectable condition associated with invasion by disease causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (urethritis), and/or kidney (pyelonephritis). An infection of the urethra or bladder is classified as a lower tract UTI and infection involving the ureter or kidney is classified as an upper tract UTI.

# Definitions

- Urosepsis - refers to the systemic inflammatory response to infection (sepsis) that appears to originate from a urinary tract source. It may present with symptoms such as fever, hypotension, reduced urine output, or acute change in mental status.

# Overview of Regulation

- Incontinence is not normal.
- Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence is not a normal part of aging.

# Overview of Regulation

- In the older individual, urinary incontinence generally involves psychological, physiological, pharmacological and/or pathological factors or co-morbid conditions (e.g., later stages of dementia, diabetes, prostatectomy, medical conditions involving dysfunction of the central nervous system, urinary tract infections, etc.).

# Overview of Regulation

- Because urinary incontinence is a symptom of a condition and may be reversible, it is important to understand the causes and to address incontinence to the extent possible. If the underlying condition is not reversible, it is important to treat or manage the incontinence to try to reduce complications.

# Overview of Regulation

- Many older adults are incontinent of urine prior to admission to a nursing home. Urinary incontinence and related loss of independence are prominent reasons for a nursing home admission.

Articles 1 and data currently available, including CMS data (e.g., MDS Active Resident Information Report (Item H0300) at

[http://www.cms.gov/MDSPubQlandResRep/04\\_activeresreport.asp?isSubmitted=res3&var=H1b&date=31](http://www.cms.gov/MDSPubQlandResRep/04_activeresreport.asp?isSubmitted=res3&var=H1b&date=31)

# Overview of Regulation

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- These articles indicate that more than 50% of the nursing home population experience some degree of urinary incontinence.

# Overview of 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 urinary incontinence and to restoring as much normal bladder function as possible.
- Various conditions or situations may aggravate the severity of urinary incontinence in nursing home residents.

# Overview of Regulation

- In addition, urinary incontinence may be associated with changes in skin integrity, skin irritation or breakdown, urinary tract infections, falls and fractures, sleep disturbances, and psychosocial complications including social withdrawal, embarrassment, loss of dignity, feelings of isolation, and interference with participation in activities.

# Overview of Regulation

- Various factors common to elderly individuals may increase the risk of infection including underlying diseases (e.g., diabetes mellitus); medications that affect immune responses to infection (e.g., steroids and chemotherapy; history of multiple antibiotic usage); conditions that cause incontinence; and indwelling urinary catheters.

# Overview of Regulation

- The urinary tract is a common source of bacteremia in nursing home residents. Urinary tract infection (UTI) is one of the most common infections occurring in nursing homes and is often related to an indwelling urinary catheter. Without a valid clinical rationale for an indwelling catheter, its use is not an acceptable approach to manage urinary incontinence.

# Overview of Regulation

- Although UTIs can result from the resident's own flora, they may also be the result of microorganisms transmitted by staff when handling the urinary catheter drainage system and/or providing incontinence care. Hand hygiene remains one of the most effective infection control tools available.

# Resources

- It is important for the facility to have in place systems/procedures to assure assessments are timely and appropriate; interventions are defined, implemented, monitored, and revised as appropriate in accordance with current standards of practice; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed.

# Resources

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- The medical director and the quality assessment and assurance committee may help the facility evaluate existing strategies for identifying and managing incontinence, catheter use, and UTIs, and ensure that facility policies and procedures are consistent with current standards of practice.

# Resources

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- Research into appropriate practices to prevent, manage, and treat urinary incontinence, urinary catheterization, and UTI continues to evolve. Many recognized clinical resources on the prevention and management of urinary incontinence, infection, and urinary catheterization exist.

# Resources

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Some of these resources include:

- The American Medical Directors Association (AMDA) at [www.amda.com](http://www.amda.com)
- The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives at [www.medqic.org](http://www.medqic.org)
- IDSA webpage at <https://academic.oup.com/cid/article/68/10/e83/5407612>

# Resources

- The CMS Sharing Innovations in Quality website at [www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp](http://www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp)
- Association for Professionals in Infection Control and Epidemiology (APIC) at
- [www.apic.org](http://www.apic.org);
- Centers for Disease Control at [www.cdc.gov](http://www.cdc.gov)
- The Annals of Long-Term Care publications at [www.mmhc.com](http://www.mmhc.com)

# Resources

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- American Foundation for Urologic Disease, Inc. at [www.afud.org](http://www.afud.org) and
- The American Geriatrics Society at [www.americangeriatrics.org](http://www.americangeriatrics.org)

# Resident Choice

- In the course of developing and implementing care plan interventions for treatment and services related to achieving the highest practicable level of urinary continence, preventing and treating urinary tract infections, and avoiding the use of indwelling catheters without medical justification, it is important to involve the resident and/or her or his surrogate in care decisions and to consider whether the resident has an advance directive in place.

# Resident Choice

- In order for a resident to exercise his or her right appropriately to make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment.

# Person Centered Considerations

- A resident who is at the end of life or in terminal stages of an illness or who has multiple organ system failures may have written directions for his or her treatment goals (or a decision has been made by the resident's surrogate or representative, in accordance with State law).

# Person Centered Considerations

- Although a facility's care must reflect a resident's wishes as expressed in the Directive, in accordance with State law, the presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advance Directive.

# Person Centered Considerations

- If the facility has implemented individualized approaches for end-of-life care in keeping with the resident's wishes, and has implemented appropriate efforts to try to stabilize the resident's condition and has provided care based on the assessed needs of the resident, then the development, continuation, or progression of urinary incontinence; the insertion and prolonged use of an indwelling urinary catheter; the development of infection or skin related complications from urine or an indwelling catheter may be consistent with regulatory requirements.

# Urinary Incontinence

# Urinary Incontinence

- 42 CFR 483.25 (d) (2) Urinary Incontinence requires that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

# Urinary Incontinence

- Urinary incontinence generally involves a number of transitory or chronic progressive factors that affect the bladder and/or the urethral sphincter. Any condition, medication, or factor that affects lower urinary tract function, bladder capacity, urination, or the ability to toilet can predispose residents to urinary incontinence and may contribute to incomplete bladder emptying.

# Urinary Incontinence

- The first steps toward assuring that a resident receives appropriate treatment and services to restore as much bladder function as possible or to treat and manage the incontinence are to identify the resident already experiencing some level of incontinence or at risk of developing urinary incontinence and to complete an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence.

# Urinary Incontinence

- This is followed by implementing appropriate, individualized interventions that address the incontinence, including the resident's capabilities and underlying factors that can be removed, modified, or stabilized, and by monitoring the effectiveness of the interventions and modifying them, as appropriate.

# Urinary Incontinence

- The practitioner, may at his or her option, refer residents to various practitioners who specialize in diagnosing and treating conditions that affect urinary function.

# Assessment

- Factors contributing to urinary incontinence sometimes may be resolved after a careful examination and review of history. In addition, for a resident who is incontinent of urine, determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.

# Assessment

- A resident should be evaluated at admission and whenever there is a change in cognition, physical ability, or urinary tract function. This evaluation is to include identification of individuals with reversible and irreversible (e.g., bladder tumors and spinal cord disease) causes of incontinence.

# Assessment

- If the resident has urinary incontinence that has already been investigated, documented, and determined to be irreversible or not significantly improvable, additional studies may be of limited value, unless there has been advancement in available treatments.
- Documentation of assessment information may be found throughout the medical record, such as in an admission assessment, hospital records, history and physical, and the RAI.
- The location of RAI assessment information is identified on the CAA Summary form.

# Section H of MDS

# Section H Assessment

Let's begin with the Assessment: MDS Chapter 3,  
Section H Bowel and Bladder at H0100: Appliances

H0100. Appliances	
↓ Check all that apply	
<input type="checkbox"/>	A. <b>Indwelling catheter</b> (including suprapubic catheter and nephrostomy tube)
<input type="checkbox"/>	B. <b>External catheter</b>
<input type="checkbox"/>	C. <b>Ostomy</b> (including urostomy, ileostomy, and colostomy)
<input type="checkbox"/>	D. <b>Intermittent catheterization</b>
<input type="checkbox"/>	Z. <b>None of the above</b>

# Section H

## MDS Chapter 3, Section H Bowel and Bladder at HO200: Urinary Toileting Program

H0300. Urinary Continence	
Enter Code <input type="checkbox"/>	<p>Urinary continence - Select the one category that best describes the resident</p> <ol style="list-style-type: none"><li>0. <b>Always continent</b></li><li>1. <b>Occasionally incontinent</b> (less than 7 episodes of incontinence)</li><li>2. <b>Frequently incontinent</b> (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)</li><li>3. <b>Always incontinent</b> (no episodes of continent voiding)</li><li>9. <b>Not rated</b>, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days</li></ol>

# Section H

## MDS Chapter 3, Section H Bowel and Bladder at HO400: Bowel Incontinence

H0400. Bowel Continence	
Enter Code <input type="checkbox"/>	<b>Bowel continence - Select the one category that best describes the resident</b> <ul style="list-style-type: none"><li>0. <b>Always continent</b></li><li>1. <b>Occasionally incontinent</b> (one episode of bowel incontinence)</li><li>2. <b>Frequently incontinent</b> (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</li><li>3. <b>Always incontinent</b> (no episodes of continent bowel movements)</li><li>9. <b>Not rated</b>, resident had an ostomy or did not have a bowel movement for the entire 7 days</li></ul>

# Section H

## MDS Chapter 3, Section H Bowel and Bladder at HO500: Bowel Toileting Program

HO500. Bowel Toileting Program	
Enter Code <input type="checkbox"/>	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

# Section H

MDS Chapter 3, Section H Bowel and Bladder at  
HO600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code	Constipation present?
<input type="checkbox"/>	0. No 1. Yes

# Section H Definitions

## **Indwelling Catheter:**

- A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

## **Suprapubic Catheter:**

- An indwelling catheter that is placed by a Urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

# Section H Definitions

## **Nephrostomy Tube:**

- A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

## **External Catheter:**

- Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majoria for females and connected to a drainage bag.

# Section H Definitions

## **Ostomy:**

- Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

## **Urostomy:**

- A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

# Section H Definitions

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## **Ileostomy:**

- A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

## **Colostomy:**

- A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

# Section H Definitions

## **Intermittent Catheterization:**

- Sterile insertion and removal of a catheter through the urethra for bladder drainage.

## **Constipation:**

- If the resident has two 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).

# Section H Definitions

## **Fecal Impaction:**

- A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

# CARE AREA ASSESSMENT 6:

- CAA 6 begins with a review of “Modifiable Factors contributing to transitory urinary incontinence” – Areas coded on the MDS should be reflected here with explanation of reason why area was coded.
- Then the CAA goes on to review “Other factors and Laboratory Tests” – Again areas coded on the MDS should be reflected here with an explanation of reason why area was coded.

# CARE AREA ASSESSMENT 6:

- The CAA continues with a review of “Diseases and Conditions”, “Type of incontinence”, and “Medications” – Again areas coded on the MDS should be reflected here with an explanation of reason why the area was coded.
- Then the CAA goes on to review “Use of Indwelling Catheter” – Again areas coded on the MDS should be reflected here with an explanation of reason why area was coded.

# Evaluation

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

- Prior history of urinary incontinence,
- Voiding patterns
- Medication review,
- Patterns of fluid intake
- Use of urinary tract stimulants or irritants

# Evaluation

- Pelvic and rectal examination to identify physical features that may directly affect urinary incontinence,
- Functional and cognitive capabilities
- Type and frequency of physical assistance necessary to assist the resident to access the toilet
- Pertinent diagnoses

# Evaluation

- Identification of and/or potential of developing complications such as skin irritation or breakdown
- Tests or studies indicated to identify the type(s) of urinary incontinence
- Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet

# Types of Urinary Incontinence

# Types of Urinary Incontinence

- Identifying the nature of the incontinence is a key aspect of the assessment and helps identify the appropriate program/interventions to address incontinence. The different type of incontinence are; Urge, Stress, Mixed, Overflow, Functional and Transient

# Interventions

- It is important that the facility follow the care process (accurate assessment, care planning, consistent implementation and monitoring of the care plan with evaluation of the effectiveness of the interventions, and revision, as appropriate).
- Recording and evaluating specific information (such as frequency and times of incontinence and toileting and response to specific interventions) is important for determining progress, changes, or decline.

# Interventions

- A number of factors may contribute to the decline or lack of improvement in urinary continence, for example: underlying medical conditions, an inaccurate assessment of the resident's type of incontinence (or lack of knowledge about the resident's voiding patterns) may contribute to inappropriate interventions or unnecessary use of an indwelling catheter.

# Interventions

- Facility practices that may promote achieving the highest practicable level of functioning, may prevent or minimize a decline or lack of improvement in degree of continence include providing treatment and 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;

# Interventions

- Removing or 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);

# Interventions

- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and
- Implementing a fluid and/or bowel management program to meet the assessed needs.

# Interventions

- Options for managing urinary incontinence in nursing home residents include primarily behavioral programs and medication therapy. Other measures and supportive devices used in the management of urinary incontinence and/or urinary retention may include intermittent catheterization; pelvic organ support devices (pessaries); the use of incontinence products, garments and an external collection system for men and women; and environmental accommodation and/or modification.

# Programs

- Interventions involving the use of programs are among the least invasive approaches to address urinary incontinence and have no known adverse complications.
- Programs involve efforts to modify the resident's behavior and/or environment. Critical aspects of a successful program include education of the caregiver and the resident, availability of the staff and the consistent implementation of the interventions.

# Programs

Programs that require the resident's cooperation and motivation in order for learning and practice to occur include the following:

- 1. Bladder Rehabilitation/Bladder Retraining** is a behavioral technique that 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.

# Programs

- Depending upon the resident's successful ability to control the urge to void, the intervals between voiding may be increased progressively.
- Bladder training generally consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This program is difficult to implement in cognitively impaired residents and may not be successful in frail, elderly, or dependent residents.

# Programs

- The resident who may be appropriate for a bladder rehabilitation (retraining) program is usually fairly independent in activities of daily living, has occasional incontinence, is aware of the need to urinate (void), may wear incontinence products for episodic urine leakage, and has a goal to maintain his/her highest level of continence and decrease urine leakage.

# Programs

- Successful bladder retraining usually takes at least several weeks.
- Residents who are assessed with urge or mixed incontinence and are cognitively intact may be candidates for bladder retraining.

# Programs

- 2. Pelvic Floor Muscle Rehabilitation** also called Kegel and pelvic floor muscle exercise, is performed to strengthen the voluntary periurethral and perivaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs.
  - These exercises are helpful in dealing with urge and stress incontinence. Pelvic floor muscle exercises (PFME) strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment of stress urinary incontinence.

# Programs

- PFME requires residents who are able and willing to participate, and the implementation of careful instructions and monitoring provided by the facility. Poor resident adherence to the exercises may occur even with close monitoring.

# Programs

Programs that are dependent on staff involvement and assistance, as opposed to resident function, include the following:

- 3. Prompted Voiding** is a technique appropriate for use with dependent or more cognitively impaired residents.
  - Prompted voiding techniques have been shown to reduce urinary incontinence episodes up to 40% for elderly incontinent nursing home residents, regardless of their type of urinary incontinence or cognitive deficit.

# Programs

Prompted Voiding has 3 components:

- Regular monitoring with encouragement to report continence status;
- Prompting to toilet on a scheduled basis; and
- Praise and positive feedback when the resident is continent and attempts to toilet.

Residents who are assessed with urge or mixed incontinence and are cognitively impaired may be candidates for prompted voiding.

# Programs

4. **Habit Training/Scheduled Voiding** is a technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits.
  - Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges.
  - Habit training includes timed voiding with the interval based on the resident's usual voiding schedule or pattern.

# Programs

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5. **Scheduled voiding** is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.

# Medication Therapy

Medications are often used to treat specific types of incontinence

- Stress Incontinence
- Overactive Bladder
- Urge Incontinence
- Urinary Urgency
- Frequency
- Nocturia

# Pessary Use

- A Pessary is an intra-vaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs. Women whose urine retention or urinary incontinence is exacerbated by bladder or uterine prolapse may benefit from placement of a pessary.
- Female residents may be admitted to the nursing home with a pessary device.

# Pessary Use

- The assessment should note whether the resident has a pessary in place or has had a history of successful pessary use.
- If a pessary is to be used, it is important to develop a plan of care for ongoing management and for the prevention of and monitoring for complications.

# Use of Products

Absorbent Products, Toileting Devices, External Collection Devices

Absorbent Incontinence Products include:

- Perineal pads or panty liners for slight leakage;
- Undergarments and protective underwear for moderate to heavy leakage (called pull-ups);
- Guards and drip collection pouches for men; and
- Products (called adult briefs) for moderate or heavy loss.

# Use of Products

- Absorbent products can be a useful, rational way to manage incontinence; however, every absorbent product has a saturation point. Factors contributing to the selection of the type of product to be used should include the severity of incontinence, gender, fit, and ease of use.

# Use of Products

- Advantages of using absorbent products to manage urinary incontinence include the ability to contain urine (some may wick the urine away from the skin), provide protection for clothing, and preserve the resident's dignity and comfort.
- Disadvantages of absorbent products are the impact on the resident's dignity, cost, the association with skin breakdown and irritation, and the amount of time needed to check and change them.

# Skin Related Complications

- Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning.
- One key to preventing skin breakdown is to keep the perineal skin clean and dry.
- Research has shown that a soap and water regimen alone may be less effective in preventing skin breakdown compared with moisture barriers and no-rinse incontinence cleansers.

# Catheterization

- 42 CFR 483.25 (d) (1) Urinary Incontinence requires that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

# Catheterization

- Some residents are admitted to the facility with indwelling catheters that were placed elsewhere (e.g., during a recent acute hospitalization). The facility is responsible for the assessment of the resident at risk for urinary catheterization and/or the ongoing assessment for the resident who currently has a catheter. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.

# Evaluation

- A resident may be admitted to the facility with or without an indwelling urinary catheter (urethral or suprapubic) and may be continent or incontinent of urine. Regardless of the admission status, a comprehensive assessment should address those factors that predispose the resident to the development of urinary incontinence and the use of an indwelling urinary catheter.

# Evaluation

- An admission evaluation of the resident's medical history and a physical examination helps identify the resident at risk for requiring the use of an indwelling urinary catheter.
- This evaluation is to include detection of reversible causes of incontinence and identification of individuals with incontinence caused by conditions that may not be reversible, such as bladder tumors and spinal cord diseases.

# Evaluation

- The assessment of continence/incontinence is based upon an interdisciplinary review. The comprehensive assessment should include underlying factors supporting the medical justification for the initiation and continuing need for catheter use, determination of which factors can be modified or reversed (or rationale for why those factors should not be modified), and the development of a plan for removal.

# Evaluation

- For the resident with an indwelling catheter, the facility's documented assessment and staff knowledge of the resident should include information to support the use of an indwelling catheter.

# Evaluation

- The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort and bleeding.

# Intermittent Catheterization

- Intermittent catheterization can often manage overflow incontinence effectively. Residents who have new onset incontinence from a transient, hypotonic/atonic bladder (usually seen following catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns, usually up to approximately 7 days. A voiding trial and post void residual can help identify when bladder tone has returned.

# Indwelling Catheter Use

The facility's documented assessment and staff approach to the resident should be based on evidence to support the use of an indwelling catheter.

Examples of Appropriate Indications for Indwelling Urethral Catheter Use:

1. Resident has acute urinary retention or bladder outlet obstruction;
2. Need for accurate measurements of urinary output;

# Indwelling Catheter Use

3. To assist in healing of open sacral or perineal wounds in incontinent residents;
4. Resident requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures);and
5. To improve comfort for end-of-life care, if needed.

# Catheter Complications

An indwelling catheter may be associated with significant complications, including:

- Bacteremia, febrile episodes, bladder stones, fistula formation, erosion of the urethra, epididymitis, chronic renal inflammation and pyelonephritis.
- In addition, indwelling catheters are prone to blockage. Risk factors for catheter blockage include alkaline urine, poor urine flow, proteinuria, and preexisting bladder stones.

# Catheter Complications

\*\*\*In the absence of evidence indicating blockage, catheters need not be changed routinely as long as monitoring is adequate. (Per regulation as set by CDC recommendations)

Based on the resident's individualized assessment, the catheter may need to be changed more or less often than every 30 days.

# Catheter Complications

- Research has shown that catheterization is an important, potentially modifiable, risk factor for UTI.
- By the 30th day of catheterization, bacteriuria is nearly universal.

# Reducing Catheter Complications

- Identifying specific clinical indications for the use of an indwelling catheter;
- Assessing whether other treatments and services would appropriately address those conditions; and
- Assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustation, urethral erosion, bladder spasms, hematuria, and leakage around the catheter.

# Physician Orders

Physician Orders should include at a minimum the ff:

- Size of catheter tubing and bulb size
- Diagnosis
- Catheter Care every shift
- Irrigation as needed for occlusion
- Frequency/When to change\*\*\*

\*\*\***Note:** CDC guidelines related to Indwelling Catheters suggests that catheters not be routinely changed. (i.e., monthly) see the following link for more information

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3362394>

# Bowel Bladder Program

- Review Policy and Procedures
- Review Forms
- Review Competency
- Provide Demonstration
- Conduct Return Demonstration Competencies

# Summary

# Summary

- It is important to assess/evaluate the resident's ability to control bodily functions upon admission, with a significant change in patterns, and on a quarterly basis.
- Identification of the type of incontinence is vital to planning of an appropriate program for the resident and assist the resident to possibly gain better control or decrease incontinence.
- Catheter use has to be based on the appropriateness related to conditions identified and evaluated on a regular basis.
- Utilize programs for specific residents as deemed appropriate.

# References

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- IDSA webpage at <https://academic.oup.com/cid/article/68/10/e83/5407612>
- Medicare and Medicaid Program Reforms of Requirements for Long Term Care Facilities; Nov. 19, 2019. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations>.
- State Operations Manual. Appendix PP-Guidance to Surveyors for Long Term Care Facilities; Nov. 22, 2017.

# Q & A

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Questions???



## *Thank you for your participation*



To learn more about this topic please contact Robin A. Bleier, President with regards to this or other services at [robin@rbhealthpartners.com](mailto:robin@rbhealthpartners.com) or call her at 727.786.3032.

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