

# Urinary Incontinence

## Types of Urinary Incontinence

**Source:** [State Operations Manual, Appendix PP](#)

Identifying the nature of the incontinence is a key aspect of the assessment and helps identify the appropriate program/interventions to address incontinence. 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:

### Urge Incontinence

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). It is characterized by abrupt urgency, frequency and nocturia (part of the overactive bladder diagnosis). It may be age-related or have neurological causes (e.g., stroke, diabetes mellitus, Parkinson's disease, multiple sclerosis) or other causes such as bladder infection, urethral irritation, etc. The resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons.

### Stress Incontinence (Outlet Incompetence)

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. Urine 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. It is the second most common type of urinary incontinence in older women.

### Mixed Incontinence

The combination of urge incontinence and stress incontinence. Many elderly persons (especially women) will experience symptoms of both urge and stress.

### Overflow Incontinence

Associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended from urine retention. Symptoms of overflow incontinence may include weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Urine retention may result from outlet obstruction (e.g., benign prostatic hypertrophy [BPH], prostate cancer and urethral stricture), hypotonic bladder (detrusor under activity) or both. Hypotonic bladder may be caused by outlet obstruction, impaired or absent contractility of the bladder (neurogenic bladder) or other causes. Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury or pelvic nerve damage from surgery or radiation therapy. In overflow incontinence, post void residual (PVR) volume (the amount of urine remaining in the bladder within five to 10 minutes following urination) exceeds 200 milliliters (ml). Normal PVR is usually 50 ml. or less. A PVR of 150 to 200 may suggest a need for retesting to determine if this finding is clinically significant. Overflow incontinence may mimic urge or stress incontinence but is less common than either of those.

## Functional Incontinence

The loss of urine that occurs in a resident whose urinary tract function is sufficiently intact that he/she should be able to maintain continence, but who cannot remain continent because of external factors other than inherently abnormal urinary tract function. Examples may include the failure of staff to respond to a request for assistance to the toilet, or the inability to utilize the toilet facilities in time. It may also be related to:

- Physical weakness or poor mobility/dexterity (e.g., due to poor eyesight, arthritis, deconditioning, stroke, contracture),
- Cognitive problems (e.g., confusion, dementia, unwillingness to toilet),
- Medications (e.g., anti-cholinergics, diuretics), or
- Environmental impediments including excessive distance from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access. Refer to §483.10(e) (3), F558, Accommodation of Needs for issues regarding unmet environmental needs (e.g., handicap toilet, lighting, assistive devices).

Note: Treating the physiological causes of incontinence, without attending to functional components that may have an impact on the resident's continence, may fail to solve the incontinence problem.

## Transient Incontinence

Temporary or occasional incontinence that may be related to a variety of causes, for example: delirium, infection, atrophic urethritis or vaginitis, some pharmaceuticals (such as sedatives/hypnotics, diuretics, anticholinergic agents), increased urine production, restricted mobility or fecal impaction. The incontinence is transient because it is related to a potentially improvable or reversible cause.

## Interventions

Source: [Stream Program Manual](#)

The following interventions and strategies should be considered during assessment and observation for all types and causes of urinary incontinence:

- Diet – Consume dietary intake of fiber. Avoid foods that trigger loose stools.
  - Avoid bladder irritants such as sugar, reduce amount of caffeine and/or carbonated drinks, avoid foods high in acid, spicy foods and alcoholic beverages.
- Fluids – Consume 1.5-2 L of fluid unless contraindicated (preferably water) to maintain hydration. Limit fluids near bedtime. Limit caffeine intake.
- Skin – Ensure perineal cares are completed, which helps decrease skin breakdown, irritation, fungal infections and urinary tract infections (UTIs).
- Medication alignment – Help eliminate unnecessary medications that may increase incontinence symptoms.
- Reduce stress – High levels of stress increase cortisol which decreases the antidiuretic hormone (ADH) and causes increased urination.
- Equipment – Ensure supplies and equipment are provided as indicated to aide elimination (such as urinal, commode, bedpan).
- Sleep – Decrease episodes of fragmented sleep, which impairs the body's ability to produce and release antidiuretic hormone.