Urinary Incontinence

Non-Pharmacologic Interventions

Non-pharmacologic interventions to improve incontinence focus on the behavioral treatment component. These are the least invasive treatments with no identified complications or adverse events. Interventions outlined below will focus on resident behavior and/or environment modifications in order to achieve improved outcomes and reduced incidence of incontinence.

Intervention	Level	Method	Timeline	Appropriate Resident
Bladder Retraining	Occasional Incontinence	Resist the sense to urinate, only urinate according to the established timetable rather than when resident has the urge to void. Timetable for voiding works progressively. The interval between voiding begins small and gradually increases.	Several weeks	Fairly independent with activities of daily living (ADLs). Aware of the need to void and has established continence as a goal.
Pelvic Floor Rehabilitation	Occasional Incontinence	Aimed to strengthen voluntary peri-urethral and per-vaginal muscles that contribute to closing force of urethra and support pelvic organs. Kegel exercises to strengthen muscles.	A few weeks or months	Cognitively intact. Able and willing to participate in this intervention.
Prompted Voiding	Frequently Incontinent/ Always Incontinent	Teach the resident to recognize bladder fullness or the need to void and ask for help or respond when prompted to toilet. Regularly monitor with encouragement to report incontinence status. Use schedule and prompt resident to toilet. Provide positive feedback when resident is continent and attempts to toilet.	Several days	Dependent or cognitively impaired.

Intervention	Level	Method	Timeline	Appropriate Resident
Habit Training/ Scheduled Voiding	Always Incontinent	Scheduled: Timed voiding, usually every three to four hours while awake. Habit Training: Timed voiding based on resident's usual voiding patterns	Immediate	Cannot self-toilet.
Diet/Lifestyle	Occasional Incontinence /Frequently Incontinent	Avoid bladder irritants such as sugar, reduce amount of caffeine and/or carbonated drinks, avoid foods high in acid, spicy foods and alcoholic beverages. Consume 1.5-2 L of fluid unless contraindicated (preferably water) to maintain hydration. Limit fluids near bedtime. Limit caffeine intake. Reduce Stress: High levels of stress increase cortisol which decreases the antidiuretic hormone (ADH) and causes increased urination. Decrease episodes of fragmented sleep, which impairs the body's ability to produce and release ADH.	Varies	All residents regardless of ADL or cognitive status.

To successfully implement any of these non-pharm interventions, caregivers and residents must receive adequate education regarding the methods, timeline, and appropriate use. Workforce engagement is necessary and requires availability of staff dedicated to these interventions to promote consistency of implementation.

Resources

- Low-Risk Residents Who Lose Control of Bladder or Bowel, Mountain-Pacific Quality Health
- Nonsurgical Treatments for Urinary Incontinence in Adult Women: A Systematic Review Update, Agency for Healthcare Research and Quality (AHRQ)
- Urinary Incontinence, National Library of Medicine (NLM)
- Falls in the Elderly Second to Urinary Symptoms, NLM
- The impact of urinary incontinence on falls: A systematic review and meta-analysis, NLM
- Urinary and Fecal Incontinence in Nursing Home Residents, NLM
- Incontinence Management for Nursing Homes, hcpro

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