Guideline Summary NGC-8401

Guideline Title

Urinary incontinence.

Bibliographic Source(s)

American Medical Directors Association (AMDA). Urinary incontinence. Columbia (MD): American Medical Directors Association (AMDA); 2010. 20 p. [26 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Urinary incontinence. Columbia (MD): American Medical Directors Association (AMDA); 1996. 16 p.

Scope

Disease/Condition(s)

Urinary incontinence

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Urology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Nurses

Pharmacists

Physician Assistants

Physicians

Social Workers

Guideline Objective(s)

- To improve the quality of care delivered to patients with urinary incontinence in long-term care facilities
- To guide the diagnosis and management of urinary incontinence in older adults residing in long-term care settings

Target Population

Elderly individuals and/or residents of long-term care facilities

Interventions and Practices Considered

Diagnosis/Evaluation

1. Review of patient history of urinary incontinence
2. Documentation of signs/symptoms of urinary incontinence
3. Identification of factors (including modifiable factors) affecting continence
4. Physical examination and additional work-up, as indicated (e.g., postvoid residual testing, urinalysis, bladder stress testing, prostate specific antigen [PSA] testing)
5. Summarization of patient information

Treatment/Management

1. Development of treatment goals and individualized treatment plan
2. Addressing transient causes and modifiable risk factors for incontinence
3. Toileting program
4. Additional or alternate programs including bladder rehabilitation/retraining or pelvic floor rehabilitation
5. Pharmacologic therapy
6. Incontinence devices and products
7. Pelvic support devices
8. Electrical stimulation (considered but not recommended)
9. Surgery for incontinence
10. Catheterization (intermittent or indwelling)
11. Monitoring the course of urinary incontinence and its treatment

Major Outcomes Considered

- Continence
- Quality of life
- Side effects/complications of treatment

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Medline, PubMed, and geriatric-specific journals such as the Journal of the American Medical Directors Association (JAMDA), Annals of Long Term Care, and Journal of the American Geriatrics Society (JAGS) were searched from May 2009 through February 2011. Studies were included if they met the following criteria:

- Studies that are valid, consistent, applicable and clinically relevant
- Studies where the recommendation is supported by fair evidence (based on studies that are valid, but there are some concerns about the volume, consistency, applicability and clinical relevance of the evidence that may cause some uncertainty but are not likely to be overturned by other evidence)

Searches were specific to the guideline topic under consideration.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review

Description of the Methods Used to Analyze the Evidence

Not applicable

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Original guidelines are developed by interdisciplinary workgroups, using a process that combines evidence and consensus-based approaches. Workgroups include practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group works to make a concise, usable guideline that is tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations are based on the expert opinion of practitioners in the field. A bibliography is provided for individuals who desire more detailed information.

Guideline revisions are completed under the direction of the Clinical Practice Guideline Steering Committee. The committee incorporates information published in peer-reviewed journals after the original guidelines appeared as well as comments and recommendations not only from experts in the field addressed by the guideline but also from "hands-on" long-term care practitioners and staff.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

All American Medical Directors Association (AMDA) clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

AMDA's guidelines are supported by the following associations/organizations, who are members of its Clinical Practice Guideline Steering Committee. These associations/organizations all have representatives who participate in the external review phase and officially sign off on the guideline before publication: American Association of Homes and Services for the Aging (Now LeadingAge); American College of Health Care Administrators; American Geriatrics Society; American Health Care Association; American Society of Consultant Pharmacists; Gerontological Advanced Practice Nurses Association; Direct Care Alliance; National Association of Directors of Nursing Administration in Long-Term Care; National Association of Health Care Assistants.

Recommendations

Major Recommendations

Note from the American Medical Directors Association (AMDA) and the National Guideline Clearinghouse (NGC): The original full-text guideline provides an algorithm on "Urinary Incontinence in the Long-term Care Setting" to be used in conjunction with the written text. Refer to the "Guideline Availability" field for information on obtaining the algorithm, as well as the full text of the guideline, which provides additional details.

Recognition

Step 1

Does the patient have a history of urinary incontinence?

If the patient has a history of urinary incontinence, identify the type of incontinence to the extent possible (see Table 1 in the original guideline document). Document information about the patient's incontinence history in the medical record. Use the criteria in the Minimum Data Set (MDS) (Table 2 in the original guideline document) for guidance in identifying the degree of an individual's incontinence.

Step 2

Does the patient show signs and symptoms of urinary incontinence?

Urinary incontinence is identified by direct observation (i.e., by observing an incontinence episode or finding the patient wet). Document any signs and symptoms of urinary incontinence in the patient's medical record.

Assessment

Step 3

Identify factors affecting the patient's urinary continence.

Assess for potentially modifiable causes of incontinence and risk factors that may affect the patient's continence (see Table 3 in the original guideline document) so that interventions may be targeted to those potentially modifiable factors.

Step 4

Perform a physical examination and an additional work-up as indicated.

Consider whether additional diagnostic testing might help to define the category, severity, or causes of incontinence.

See original guideline document for details of:

- Postvoid residual testing
- Urinalysis
- Bladder stress testing
- Prostate specific antigen (PSA) testing

Step 5

Summarize relevant information about the patient's incontinence.

Treatment

Step 6

Identify treatment goals and develop an individualized care plan.

Table: Treatment Options for Managing Urinary Incontinence

- Environmental interventions (e.g., leaving bed side-rails down so patient can get out of bed to go to the bathroom, enhancing bathroom lighting, making toilet easily accessible, elevating toilet seats if necessary)
- Toileting program
- Bladder retraining or pelvic muscle exercises
- Absorbent pads and external collection devices
- Pharmacologic therapy
- Surgery
- Pelvic support devices (pessaries)
- Intermittent catheterization
- Chronic indwelling catheter

Step 7

Address transient causes of, and modifiable risk factors for, incontinence.

As appropriate, treat transient causes of urinary incontinence and address modifiable risk factors—both those related to urinary tract function and those that affect urinary function by impairing an individual's overall function, mobility, level of consciousness, and so on. For example, manage delirium, treat atrophic vaginitis or urethritis, provide an easily accessible toilet, and offer frequent reminders to toilet and assistance with toileting if necessary.

Provide appropriate treatment for patients with symptoms of a urinary tract infection (UTI) or urosepsis (bacteria in the bloodstream, probably from a urinary source, with signs of sepsis).

Step 8

Provide a toileting program as appropriate.

If the patient remains incontinent after transient causes of incontinence have been treated, consider initiating a toileting program for appropriate patients—that is, a plan whereby staff members at scheduled times each day either take the patient to the toilet, give the patient a urinal, or remind the patient to go to the toilet.

Step 9

Consider additional or alternate interventions as appropriate.

Patients who remain incontinent after a toileting intervention should be considered for other interventions. Patients may have preferences concerning the type of treatment they wish to receive for urinary incontinence. When appropriate, they should be asked about such preferences.

See original guideline document for details of:

- Bladder rehabilitation or bladder retraining
- Pelvic floor muscle rehabilitation

Step 10

Evaluate the effectiveness of interventions thus far, and implement additional approaches as indicated.

If the measures described in Steps 7 through 9 are not appropriate or do not adequately resolve the patient's incontinence, consider other possible interventions, including pharmacologic therapy (see Table 6 in the original guideline document for list of medications used to treat specific types of incontinence).

Although they do not address underlying causes, incontinence devices and products may play a limited role in the management of urinary incontinence or a more significant role if the underlying risks or causes of incontinence cannot be treated.

Some women whose urine retention or urinary incontinence is associated with bladder or uterine prolapse may benefit from the placement of a pessary (an intravaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs).

Although some data suggest that electrical stimulation may have some efficacy in treating urinary incontinence, this

intervention has not been studied in the long-term care setting.

Surgery for stress incontinence in women or urinary obstruction in men may be effective in selected cases; for example, transurethral prostate resection or dilation of a urethral stricture may be beneficial in selected cases.

Step 11

Consider catheterization.

If other interventions are not feasible or have not adequately addressed the patient's incontinence, consider bladder catheterization. Catheterization may be intermittent or indwelling.

Position, secure, and manage an indwelling catheter properly to minimize urethral damage and other complications (see Table 9 in the original guideline document for management guidelines). Use a sterile catheter technique for the initial insertion. Monitor for and manage complications such as pain, bleeding, urosepsis, and catheter blockage.

Monitoring

Step 12

Monitor the course and consequences of urinary incontinence and its treatment.

Specifically, monitor patients for:

- Effectiveness of interventions, using an objective measure of the severity of urinary incontinence such as systematic recordings or a bladder diary
- Response to any medications initiated to try to control continence
- The appropriateness of changing to a less obtrusive or lower-risk intervention
- Patient satisfaction with treatment
- Side effects or complications of treatment

Clinical Algorithm(s)

An algorithm is provided in the original guideline document for recognition, assessment, treatment, and monitoring of urinary incontinence in the long-term care setting.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary work group using a process that combined evidence- and consensus-based approaches. Because scientific research in the long-term care population is limited, many recommendations are based on the expert opinion of practitioners in the field.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Better identification of individuals who have a reversible urinary incontinence problem
- More individualized approaches to urinary incontinence management
- More effective targeting of staff resources to urinary incontinence management
- Minimization of inappropriate use of diapers and catheters
- Reduction in significant complications of urinary incontinence and urinary catheters

Potential Harms

Pharmacologic Therapy

- Consider significant risks and anticipated benefits before prescribing medication for incontinence. Other medications in the patient's regimen may counteract the beneficial effects or exacerbate the side effects of agents prescribed for urinary incontinence. For example, medications with anticholinergic properties may impair continence or cause urinary retention in patients with benign prostate hyperplasia. The concomitant use of cholinesterase inhibitors with anticholinergic medications may reduce the efficacy of both agents and cause significant side effects.
- Although older medications for incontinence have been studied in the long-term care population, some newer agents have to date not been studied in this setting. No data as yet suggest that newer agents are more effective overall, but these agents may cause less frequent or less severe side effects (e.g., dry mouth, blurred vision, confusion, agitation).
- All medications used to treat urinary incontinence can have significant side effects in susceptible patients, including changes in behavior, level of consciousness, and function. This is particularly true of hyoscyamine-based (e.g., Anaspaz, Cystospaz, Levbid, NuLev) and atropine-like (e.g., flavoxate, methenamine combination) medications that are sometimes used but are generally not appropriate choices in frail, cognitively impaired elderly patients.
- Side effects of medications used to treat incontinence are listed in Table 6 of the original guideline document.

Pelvic Support Devices

Pelvic support devices need to be monitoring for infectious and bleeding complications.

Indwelling Catheters

Complications of indwelling catheters include symptomatic urinary tract infection and catheter-related erosion or discomfort.

Qualifying Statements

Qualifying Statements

- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association (AMDA), its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of AMDA's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinicians' ability to practice.
- Long-term care facilities care for a variety of individuals, including younger patients with chronic diseases and disabilities, short-stay patients needing postacute care, and very old and frail individuals suffering from multiple comorbidities. When a workup or treatment is suggested, it is crucial to consider if such a step is appropriate for a specific individual. A workup may not be indicated if the patient has a terminal or end-stage condition, if it would not change the management course, if the burden of the workup is greater than the potential benefit, or if the patient or his or her proxy would refuse treatment. It is important to carefully document in the patient's medical record the reasons for decisions not to treat or perform a workup or for choosing one treatment approach over another.

Implementation of the Guideline

Description of Implementation Strategy

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. **Recognition**

- Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG

II. **Assessment**

- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes

III. **Implementation**

- Identify and document how each step of the CPG will be carried out and develop an implementation timetable
- Identify individual responsible for each step of the CPG
- Identify support systems that impact the direct care
- Educate and train appropriate individuals in specific CPG implementation and then implement the CPG

IV. **Monitoring**

- Evaluate performance based on relevant indicators and identify areas for improvement
- Evaluate the predefined performance measures and obtain and provide feedback

Implementation Tools

Clinical Algorithm

Tool Kits

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

American Medical Directors Association (AMDA). Urinary incontinence. Columbia (MD): American Medical Directors Association (AMDA); 2010. 20 p. [26 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1996 (revised 2010)

Guideline Developer(s)

American Medical Directors Association - Professional Association

Guideline Developer Comment

Organizational participants included:

- American Association of Homes and Services for the Aging
- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- National Association of Directors of Nursing Administration in Long-Term Care
- National Association of Geriatric Nursing Assistants
- National Conference of Gerontological Nurse Practitioners

Source(s) of Funding

Aventis Pharmaceuticals Inc., Boehringer Ingelheim Pharmaceuticals, Inc., Bristol-Myers Squibb Company, Eli Lilly and Company, GlaxoSmithKline, J & J Long-Term Care Group, Merck and Co., Inc., Novartis, Organon, Inc., Paperpak, Pfizer Inc., Reckitt Benckiser Inc., and Watson Pharmaceuticals were corporate supporters of this guideline.

Guideline Committee

Clinical Practice Guideline Steering Committee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

All contributors must submit an Accreditation Council for Continuing Medical Education (ACCME) approved disclosure form prior to being accepted as a volunteer member of the guideline workgroup. This disclosure form is reviewed by the chair of the American Medical Directors Association (AMDA) Clinical Practice Committee. If any conflicts are perceived, that person is not accepted to be part of the workgroup.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Medical Directors Association (AMDA). Urinary incontinence. Columbia (MD): American Medical Directors Association (AMDA); 1996. 16 p.

Guideline Availability

Electronic copies: Not available at this time.

Print: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

Availability of Companion Documents

A tool kit for implementation of the clinical practice guideline (CPG) on urinary incontinence is available for purchase from the American Medical Directors Association Web site.

Patient Resources

None available

NGC Status

This summary was completed by ECRI on July 12, 1999. The information was verified by the American Medical Directors Association as of August 8, 1999. This NGC summary was updated by ECRI Institute on October 4, 2011. The updated information was verified by the guideline developer on November 29, 2011.

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