

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
<p>F315</p>	<p>§483.25(d) Urinary Incontinence</p> <p>Based on the resident’s comprehensive assessment, the facility must ensure that—</p> <p>§483.25(d)(1)</p> <p>A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary; and</p> <p>§483.25(d)(2)</p> <p>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.</p>	<p>(Rev. 8, Issued: 06-28-05, Effective: 06-28-05, Implementation: 06-28-05)</p> <p>Intent:</p> <p>The intent of this requirement is to ensure that:</p> <ul style="list-style-type: none"> • 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; • 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. <p>DEFINITIONS</p> <p>Definitions are provided to clarify clinical terms related to evaluation and treatment of urinary incontinence and catheter use.</p> <ul style="list-style-type: none"> • “Bacteremia” is the presence of bacteria in the bloodstream. • “Bacteriuria” is defined as the presence of bacteria in the urine.

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<p>F315 cont.</p>		<ul style="list-style-type: none"> • “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: <ul style="list-style-type: none"> ◦ “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); ◦ “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; ◦ “Stress Incontinence” (outlet incompetence) is 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.; ◦ “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 ◦ “Urge Incontinence” (overactive bladder) is associated with detrusor muscle overactivity (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.

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<p>F315 cont.</p>		<ul style="list-style-type: none"> • “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 (ureteritis), 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. • “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. <p>OVERVIEW</p> <p>Urinary 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. In the younger person, urinary incontinence may result from a single cause. 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.). 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.</p> <p>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. Articles¹ 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, indicate that more than 50% of the nursing home population experience some degree of urinary incontinence. Whether the resident is incontinent of urine on admission or develops incontinence after admission, the steps of assessment, monitoring, reviewing, and</p>

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<p>F315 cont.</p>		<p>CATHETERIZATION</p> <p>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. 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.</p> <p>Assessment</p> <p>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.</p> <p>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. (See the assessment factors discussed under incontinence.) 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. The clinician's decision to use an indwelling catheter in the elderly should be based on valid clinical indicators.</p>

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F315 cont.		<p>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. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be reserved primarily for short-term decompression of acute urinary retention. 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.</p> <p>Intermittent Catheterization</p> <p>Intermittent catheterization can often manage overflow incontinence effectively. Residents who have new onset incontinence from a transient, hypotonic/atonic bladder (usually seen following indwelling catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns (e.g., up to approximately 7 days). A voiding trial and post void residual can help identify when bladder tone has returned.</p> <p>Indwelling Catheter Use</p> <p>The facility's documented assessment and staff approach to the resident should be based on evidence to support the use of an indwelling catheter. Appropriate indications for continuing use of an indwelling catheter beyond 14 days may include:⁸</p> <ul style="list-style-type: none"> • Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: <ul style="list-style-type: none"> ◦ Documented post void residual (PVR) volumes in a range over 200 milliliters (ml); ◦ Inability to manage the retention/incontinence with intermittent catheterization; and

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
<p>F315 cont.</p>		<ul style="list-style-type: none"> ◦ Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction. • Contamination of Stage III or IV pressure with urine which has impeded healing, despite appropriate personal care for the incontinence; and • Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain. <p>Catheter-Related Complications</p> <p>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. In the absence of evidence indicating blockage, catheters need not be changed routinely as long as monitoring is adequate. Based on the resident's individualized assessment, the catheter may need to be changed more or less often than every 30 days.</p> <p>Some residents with indwelling catheters experience persistent leakage around the catheter. Examples of factors that may contribute to leakage include irritation by a large balloon or by catheter materials, excessive catheter diameter, fecal impaction, and improper catheter positioning. Because leakage around the catheter is frequently caused by bladder spasm, leakage should generally not be treated by using increasingly larger catheter sizes, unless medically justified. Current standards indicate that catheterization should be accomplished with the narrowest, softest tube that will serve the purpose of draining the bladder. Additional care practices related to catheterization include:</p> <ul style="list-style-type: none"> • Educating the resident or responsible party on the risks and benefits of catheter use;

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<p>F315 cont.</p>		<ul style="list-style-type: none"> • Recognizing and assessing for complications and their causes, and maintaining a record of any catheter-related problems; • Attempts to remove the catheter as soon as possible when no indications exist for its continuing use; • Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence; • Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter; and • Securing the catheter to facilitate flow of urine. <p>Research has shown that catheterization is an important, potentially modifiable, risk factor for UTI. By the 30th day of catheterization, bacteriuria is nearly universal.⁹ The potential for complications can be reduced by:</p> <ul style="list-style-type: none"> • 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.

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<p>F315 cont.</p>		<p>URINARY TRACT INFECTIONS</p> <p>Catheter-Related Bacteriuria and UTIs/Urosepsis</p> <p>Most individuals with indwelling catheters for more than 7 days have bacteriuria. Bacteriuria alone in a catheterized individual should not be treated with antibiotics.</p> <p>A long term indwelling catheter (>2 to 4 weeks) increases the chances of having a symptomatic UTI and urosepsis. The incidence of bacteremia is 40 times greater in individuals with a long term indwelling catheter than in those without one. For suspected UTIs in a catheterized individual, the literature recommends removing the current catheter and inserting a new one and obtaining a urine sample via the newly inserted catheter.¹⁰</p> <p>Clinical Evidence That May Suggest UTI</p> <p>Clinically, an acute deterioration in stable chronic symptoms may indicate an acute infection. Multiple co-existing findings such as fever with hematuria are more likely to be from a urinary source.</p> <p>No one lab test alone proves that a UTI is present. For example, a positive urine culture will show bacteriuria but that alone is not enough to diagnose a symptomatic UTI. However, several test results in combination with clinical findings can help to identify UTIs such as the presence of pyuria (more than minimal white cells in the urine) on microscopic urinalysis, or a positive urine dipstick test for leukocyte esterase (indicating significant pyuria) or for nitrites (indicating the presence of Enterobacteriaceae). A negative leukocyte esterase or the absence of pyuria strongly suggests that a UTI is not present. A positive leukocyte esterase test alone does not prove that the individual has a UTI.¹¹</p>

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<p>F315 cont.</p>		<p>In someone with nonspecific symptoms such as a change in function or mental status, bacteriuria alone does not necessarily warrant antibiotic treatment. Additional evidence that could confirm a UTI may include hematuria, fever (which could include a variation from the individual's normal or usual temperature range), or evidence of pyuria (either by microscopic examination or by dipstick test). In the absence of fever, hematuria, pyuria, or local urinary tract symptoms, other potential causes of nonspecific general symptoms, such as fluid and electrolyte imbalance or adverse drug reactions, should be considered instead of, or in addition to, a UTI. Although sepsis, including urosepsis, can cause dizziness or falling, there is not clear evidence linking bacteriuria or a localized UTI to an increased fall risk.¹²</p> <p>Indications to Treat a UTI</p> <p>Because many residents have chronic bacteriuria, the research-based literature suggests treating only symptomatic UTIs. Symptomatic UTIs are based on the following criteria:¹³</p> <ul style="list-style-type: none"> • Residents without a catheter should have at least three of the following signs and symptoms: <ul style="list-style-type: none"> ◦ Fever (increase in temperature of >2 degrees F (1.1 degrees C) or rectal temperature >99.5 degrees F (37.5 degrees C) or single measurement of temperature >100 degrees F (37.8 degrees C));¹⁴ ◦ New or increased burning pain on urination, frequency or urgency; ◦ New flank or suprapubic pain or tenderness; ◦ Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or ◦ Worsening of mental or functional status (e.g., confusion, decreased appetite, unexplained falls, incontinence of recent onset, lethargy, decreased activity).¹⁵

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
<p>F315 cont.</p>		<ul style="list-style-type: none"> • Residents with a catheter should have at least two of the following signs and symptoms: <ul style="list-style-type: none"> ◦ Fever or chills; ◦ New flank pain or suprapubic pain or tenderness; ◦ Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or ◦ Worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present.¹⁶ <p>Follow-Up of UTIs</p> <p>The goal of treating a UTI is to alleviate systemic or local symptoms, not to eradicate all bacteria. Therefore, a post-treatment urine culture is not routinely necessary but may be useful in select situations. Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. Recurrent UTIs (2 or more in 6 months) in a noncatheterized individual may warrant additional evaluation (such as a determination of an abnormal post void residual (PVR) urine volume or a referral to a urologist) to rule out structural abnormalities such as enlarged prostate, prolapsed bladder, periurethral abscess, strictures, bladder calculi, polyps and tumors.</p> <p>Recurrent symptomatic UTIs in a catheterized or noncatheterized individual should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling in accordance with accepted practices. Recurrent UTIs in a catheterized individual should lead the facility to look for possible impairment of free urine flow through the catheter, to re-evaluate the techniques being used for perineal hygiene and catheter care, and to reconsider the relative risks and benefits of continuing the use of an indwelling catheter.</p>

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
<p>F315 cont.</p>		<p>Because the major factors (other than an indwelling catheter) that predispose individuals to bacteriuria, including physiological aging changes and chronic comorbid illnesses, cannot be modified readily, the facility should demonstrate that they:</p> <ul style="list-style-type: none"> • Employ standard infection control practices in managing catheters and associated drainage system; • Strive to keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder (e.g., cleaning fecal material away from, rather than towards, the urinary meatus); • Take measures to maintain free urine flow through any indwelling catheter; and • Assess for fluid needs and implement a fluid management program (using alternative approaches as needed) based on those assessed needs.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
F315 cont.		<p>ENDNOTES</p> <ol style="list-style-type: none"> <li data-bbox="907 272 1969 360">1 Geurrero, P. & Sinert, R. (November 18, 2004). Urinary Incontinence. Retrieved November 29, 2004 from E-Medicine. Website: www.emedicine.com/emerg/topic791.htm. <li data-bbox="907 380 1936 457">2 Delafuente, J.C. & Stewart, R.B. (Eds.). (1995). Therapeutics in the Elderly (2nd ed., pp. 471). Cincinnati, OH: Harvey Whitney Books. <li data-bbox="907 483 1982 561">3 Newman, D.K. (2002). Managing and Treating Urinary Incontinence (pp.106-107). Baltimore, MD: Health Professions Press. <li data-bbox="907 587 1705 639">4 Newman, D.K. (2002). Managing and Treating Urinary Incontinence. <li data-bbox="907 662 1957 782">5 Ouslander, J.G., Schnelle, J.F., Uman, G., Fingold, S., Nigam, J.G., Tuico, E., et al. (1995). Predictors of Successful Prompted Voiding Among Incontinent Nursing Home Residents. <i>Journal of the American Medical Association</i>, 273(17), 1366-1370. <li data-bbox="907 805 1969 906">6 Armstrong, E.P. & Ferguson, T.A. (1998). Urinary Incontinence: Healthcare Resource Consumption in Veteran Affairs Medical Centers. <i>Veteran's Health System Journal</i>, October, 37-42. <li data-bbox="907 938 1961 1036">7 Byers, P.H., Ryan, P.A., Regan, M.B., Shields, A., & Carta, S.G. (1995). Effects of Incontinence Care Cleansing Regimens on Skin Integrity. <i>Continence Care</i>, 22(4), 187-192. <li data-bbox="907 1049 1969 1159">8 Niél-Weise BS, van den Broek PJ. Urinary catheter policies for long-term bladder drainage. <i>The Cochrane Database of Systematic Reviews</i> 2005, Issue 1. Art. No.: CD004201. DOI: 10.1002/14651858.CD004201.pub2. <li data-bbox="907 1188 1885 1269">9 Maki, D.G. & Tambyah, P.A. (2001). Engineering out the Risk of Infection with Urinary Catheters. <i>Emerging Infectious Diseases</i>, 7(2), 342-347.

F-TAG #	REGULATION	GUIDANCE TO SURVEYORS
<p>F315 cont.</p>		<p>10 Grahn, D., Norman, D.C., White, M.L., Cantrell, M. & Thomas, T.T. (1985). Validity of Urinary Catheter Specimen for Diagnosis of Urinary Tract Infection in the Elderly. Archives of Internal Medicine, 145,1858.</p> <p>11 Nicolle, L.E. (1999). Urinary Tract Infections in the Elderly. In W.R.Hazzard, J.P. Blass., W.H. Ettinger, J.B. Halter & J.G. Ouslander (Eds.), Principles of Geriatric Medicine and Gerontology (4th ed., pp.823-833). New York: McGraw-Hill.</p> <p>12 Nicolle, L.E. & SHEA Long-term Care Committee. (2001). Urinary tract Infections in Long-Term Care Facilities. Infection Control Hospital Epidemiology, 22, 167-175.</p> <p>13 McGreer, A., Campbell, B., Emori, T.G., Hierholzer, W.J., Jackson, M.M., Nicolle, L.E., et al. (1991). Definitions of Infections for Surveillance in Long Term Care Facilities. American Journal of Infection Control, 19(1), 1-7.</p> <p>14 AMDA: Common Infections in the Long-term Care Setting. Clinical practice guideline Adapted from Bentley DW, Bradley S, High K, et al. Practice guideline for evaluation of fever and infection in long-term care facilities. Guidelines from the Infectious Diseases Society of America. J Am Med Dir Assoc 2001; 2(5): 246-258.</p> <p>15 Ouslander, J.G., Osterweil, D., Morley, J. (1997). Medical Care in the Nursing Home. (2nd ed., pp.303-307). New York: McGraw-Hill.</p> <p>16 Nicolle, L.E. (1997). Asymptomatic Bacteriuria in the Elderly. Infectious Disease Clinics of North America, 11, 647-62.</p>