CMS requires nursing homes to develop individualized toileting programs to help residents with incontinence relieve themselves safely and hygienically. These programs implicate the entire frontline care team, including CNAs, who are often responsible for facilitating intimate personal care tasks. Quality toileting programs usually encompass a breadth of care-related activities, including:

- Identifying the presence—or potential—of incontinence and determining the specific type
- Flagging any factor(s) that predispose a resident to incontinence
- Tracking elimination habits (e.g., time of day, frequency, volume) in a bladder or bowel record
- Establishing a customized program for elimination based on a resident’s needs and personal patterns
- Regularly reviewing the contents of this program, particularly in terms of its effectiveness and need for refinement based on changes in a resident’s condition or ability to go to the bathroom

Depending on the specific circumstances surrounding a resident’s incontinence, interventions in a toileting program that a CNA would play a fundamental part in performing may include:

- Helping a resident ambulate to the toilet
- Scheduling regular bathroom trips to facilitate bowel and bladder training and to avoid accidents
- Changing bed linens in the event of an accident
- Changing incontinence pads or adult diapers
- Emptying bedpans
- Helping residents use assistive devices for improving continence
- Monitoring continence patterns, and reporting any major changes identified to facilitate timely clinical action
- Preventing and caring for complications from ineffective elimination (e.g., skin breakdown, body odor, emotional distress)

The remainder of this in-service explores the implications of incontinence in greater depth, as well as the specific roles CNAs play in related toileting activities.

Understanding urinary incontinence
UI can affect all types of individuals but is particularly common among elders. Despite its prevalence among this major nursing home population, UI is not a part of the natural aging process and can be improved or even cured through resident education and quality care.

Managing and treating UI hinges on staffs’ ability to recognize its spe-
cific causes and signs. Potential causes include urinary tract infections, confusion and forgetfulness, muscle weakness, vaginal or prostate problems, medication reactions, and problems with clothing. Patients who suffer from UI may wet the bed, leak urine, and/or require protective pads or padded briefs. If you notice a patient’s clothing or bed has urine stains or odors, he or she will most likely require your help dealing with the condition.

Types

UI can take a number of forms, and residents may experience more than one variety at a time. Although it may not be initially clear which kind(s) of UI a patient has, CNAs can often learn this information by keeping track of urinary habits in a bladder record.

Below are some of the most common types of UI:

- **Functional incontinence** refers to loss of urine in residents whose urinary tract function is normal. Affected individuals are unable to maintain continence because of external factors, such as an inability to reach the toilet in time.
- **Overactive incontinence** refers to the leakage of small amounts of urine when the bladder reaches its maximum capacity and becomes distended.
- **Stress incontinence** refers to the leakage of small amounts of urine when intra-abdominal pressure on the bladder increases from movements such as sneezing, laughing, or climbing stairs.
- **Transient incontinence** refers to temporary episodes of UI that are reversible once the cause of the episodes is identified.
- **Urge incontinence** (overactive bladder) involves a sudden, strong urge to expel moderate to large amounts of urine before the bladder is full.
- **Mixed incontinence** is the combination of stress incontinence and urge incontinence.

Specific UI treatments

Depending on the specific circumstances surrounding a resident’s UI, a care plan can be developed that will include at least one of the following service categories: behavioral treatment, medicine, or surgery.

While medicine and surgery are largely in the hands of the resident’s nurse and/or doctor, CNAs often contribute to behavioral treatments. These interventions help residents control their urine and use the toilet at the right time. There are three types of behavioral UI treatments with which a CNA can assist:

1. **Scheduled toileting**, which can help residents who are unable to get out of bed or reach the bathroom alone. Help the resident ambulate to the bathroom every three to four hours, or according to the individualized program.
2. **Prompted voiding**, which can help residents who know they have a full bladder but do not ask to go to the bathroom. Check these residents often for wetness, asking whether they want to use the toilet, and assist them on their trip to the bathroom.
3. **Habit training**, which can help residents who tend to urinate around the same time every day. Monitor an individual to determine the times he or she urinates, recording observations in the bladder record. Take the resident to the bathroom at those times every day.

In addition to service categories that target the actual act of elimination, there are certain interventions facilitated in part by CNAs that are more proactive in focus.

Dietary management

Although there is no dietary treatment for UI, some foods and drinks can irritate the bladder, such as sugar, chocolate, citrus fruits, alcohol, grape juice, and caffeinated drinks. CNAs may be asked to encourage residents with UI to try eliminating these foods and beverages from their diets and see whether their condition improves.

Assistive devices

Bedbound residents who are experiencing UI may need to use a bedpan, urinal, or bedside commode. If this is the case, CNAs can ensure these articles are always accessible. In addition, always keep the path to the bathroom—and the room itself—clear and well-lit.
TOILETING PROGRAMS

Understanding bowel incontinence
Like UI, treatment and care for BI depends on the specific cause. Some of the most common instigators include incorrect diet or fluid intake, confusion and forgetfulness, injury or weakness of the anal muscles, nerve injury, medication reactions or laxative abuse, diarrhea, paralysis, constipation, and fecal impaction.

Constipation is characterized by the feeling of bloating or intestinal fullness; decreased amounts of stool; the need to strain to have a bowel movement; or the requirement of laxatives, suppositories, or enemas to maintain regular bowel movements.

Many factors can cause constipation, but the most common culprits include inadequate fiber or fluid intake, inactivity or a sedentary lifestyle, change in routine, abnormal growths or diseases, damaged or injured muscles, medication side effects, and laxative abuse.

A fecal impaction is 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.

Specific BI treatments
Much like treatments for UI, those for BI include medicine, surgery, dietary management, and bowel management and retraining. Of these interventions, CNAs often contribute to dietary management and bowel retraining—two activities that can also relieve constipation.

Dietary management
Most people can successfully treat their bowel irregularities by adding high-fiber foods to their diet, while at the same time increasing their fluid intake. Despite the positive effects such mindful dietary alterations can have, CNAs should help ensure residents increase fiber consumption slowly to give the bowels time to adjust.

Bowel retraining
Bowel retraining is executed by designating a specific time each day for a resident’s bowel movement. CNAs can maintain a record of a resident’s bowel habits and schedule a daily movement by any identified patterns.

General toileting interventions
In addition to the interventions specific to UI and BI, there are several general toileting strategies CNAs can apply when caring for residents with elimination issues.

Vigilant monitoring and diligent reporting
The CNA’s first responsibility upon discovering new onset of incontinence is to report the occurrence to the appropriate supervisor, a move that can help the resident’s nurse or doctor determine the cause of incontinence and develop a tailored care plan.

Compassionate communication
Many elders don’t report incidences of incontinence due to embarrassment and the misconception that the condition is an unavoidable component of aging. Thus, CNAs should take a proactive approach to ensure all their residents understand that incontinence is treatable and encourage them to report incidences, thereby speeding the delivery of effective care.

When facilitating treatments for incontinence, draw on these specific communication strategies:
• Be patient. Interventions—and elimination activities—often take time.
• Emphasize your respect for a resident’s privacy, dignity, and confidentiality by closing the bathroom door, even if you must stay in the room.
• Never yell at a resident for being wet.
• Offer compliments when a resident is dry.

Safe transfer techniques
During toileting for individuals who are able to ambulate to the bathroom with assistance, special transfer equipment can promote safety. Raised toilet seats and risers decrease the distance and amount of effort it takes for a resident to lower him- or herself to the toilet. Grab bars allow the resident to sit and rise at his or her own pace. CNAs should ensure that a transfer aid is able to support the resident’s weight before each use.
1. Which of the following statements about toileting is accurate?
   a. Promotes incontinence in residents
   b. Is restricted to helping residents ambulate to the bathroom
   c. Involves helping residents fulfill urinary and/or bowel elimination needs
   d. Consists of a single set of standardized interventions

2. Incontinence is a regular part of the aging process.
   a. True
   b. False

3. Which of the following care activities would a quality toileting program likely incorporate?
   a. Identifying the presence or potential of incontinence in a resident
   b. Tracking elimination habits in a bladder and/or bowel record
   c. Establishing a customized program of elimination based on a resident’s needs and personal patterns
   d. All of the above

4. Which of the following would NOT constitute a potential intervention in a toileting program?
   a. Scheduling regular bathroom trips to facilitate bowel and/or bladder training
   b. Scolding a resident for being wet
   c. Monitoring continence patterns
   d. Caring for complications stemming from ineffective elimination

5. Which of the following is NOT a potential cause of urinary incontinence?
   a. Urinary tract infection
   b. Confusion and forgetfulness
   c. Prostate problems
   d. Fever

6. ________ incontinence is characterized by the leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended.
   a. Functional
   b. Overflow
   c. Stress
   d. Transient

7. ________ works best for residents who tend to urinate around the same time every day.
   a. Surgery
   b. Scheduled toileting
   c. Habit training
   d. Prompted voiding

8. ________ is described as the inability to control when or where one passes gas or stool.
   a. Urinary incontinence
   b. Bowel incontinence
   c. Constipation
   d. Fecal impaction

9. A common cause of constipation is __________.
   a. side effects from medication
   b. an active lifestyle
   c. consistency in routine
   d. sufficient fiber and fluid intake

10. How do raised toilet seats promote toilet safety for residents who are able to ambulate to the bathroom with assistance?
    a. They decrease the distance to the toilet
    b. They decrease the amount of effort it takes to lower onto the toilet
    c. They increase the concentration it requires to go to the bathroom
    d. Both a and b