NGN NCLEX 2026 · STUDY SERIES

Urinary Incontinence & Nursing Care

Types, pathophysiology, priority interventions, pharmacology & clinical judgment — mapped to the NCJMM framework.

SYSTEM · GENITOURINARY | EXAM FOCUS · HIGH-YIELD | ADULT HEALTH · GERIATRICS · PHARM

Definition & overview

01 / WHAT IT IS

DEFINITION

Urinary incontinence is the involuntary loss of urine severe enough to be a social or hygienic problem. It is a **symptom**, not a disease — always identify the underlying cause.

WHY IT MATTERS

Leads to skin breakdown (IAD), UTIs, falls, social isolation, depression, and premature nursing home placement. Strongly under-reported — patients rarely bring it up on their own.

KEY FACT

Incontinence is **NOT a normal part of aging**. It is common in older adults but always warrants assessment. Many causes are **reversible** (remember DIAPPERS).

The six types of incontinence

02 / CLASSIFICATION

STRESS

Stress Incontinence

Trigger: laughing, coughing, sneezing, exercise

URGE

Urge Incontinence

Trigger: sudden strong urge, water running, key-in-door

OVERFLOW

Overflow Incontinence

Trigger: bladder over-distension

Weak pelvic floor / urethral sphincter → increased intra-abdominal pressure forces urine out. Most common in women after childbirth & menopause.

Overactive detrusor muscle contracts involuntarily. Also called **overactive bladder (OAB)**. Patient "can't make it to the bathroom in time."

Bladder cannot empty → urine dribbles out when it exceeds capacity. Causes: **BPH**, diabetic neuropathy, spinal cord injury, anticholinergics.

FUNCTIONAL

Functional Incontinence

Trigger: cognitive or mobility barriers

Urinary system is **intact** — but patient can't reach toilet in time (arthritis, dementia, restraints, bed rails, poor lighting).

REFLEX

Reflex Incontinence

Trigger: predictable intervals (no sensation)

Involuntary voiding **without urge** from spinal cord injury above S2. Bladder empties on reflex arc alone.

MIXED / TRANSIENT

Mixed & Transient

Trigger: multiple causes or reversible factor

Mixed = stress + urge combined (common in older women). **Transient** = temporary, reversible (UTI, meds, delirium).

Pathophysiology *simplified*

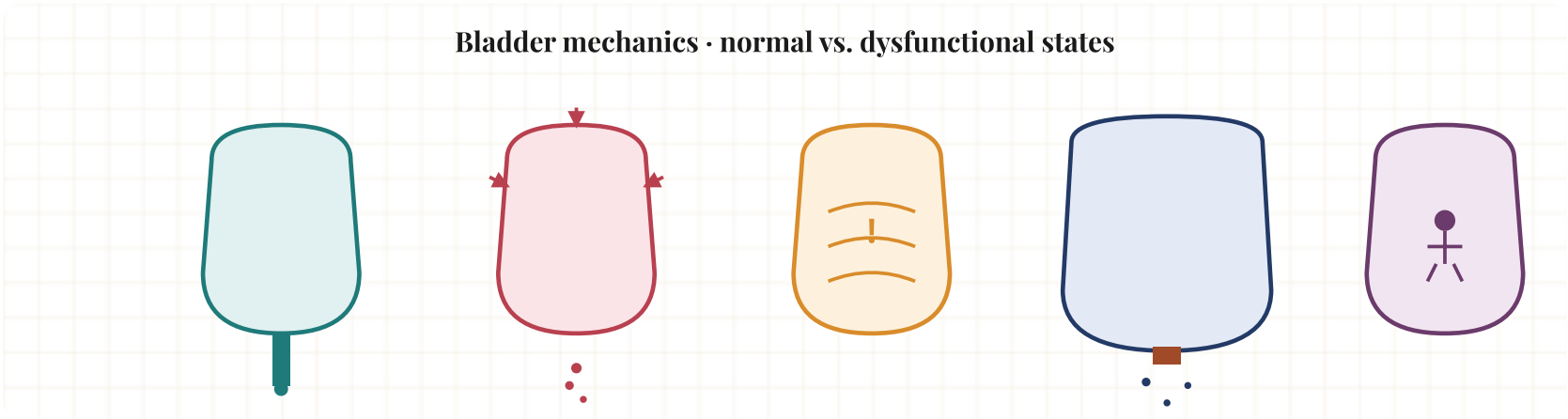
03 / MECHANISM

NORMAL CONTROL

Detrusor (bladder wall muscle) **relaxes** to fill; **urethral sphincters contract** to hold. Voiding = opposite. Requires intact brain, spinal cord (S2–S4), and pelvic floor.

WHERE IT BREAKS DOWN

- Weak pelvic floor / sphincter → ↑ Abdominal pressure → STRESS leak
- Overactive detrusor → Sudden contraction → URGE leak
- Outlet blocked (BPH) or weak detrusor → Retention & distension → OVERFLOW dribble
- Spinal cord lesion above S2 → Loss of cerebral inhibition → REFLEX voiding



Signs *& symptoms*

04 / RECOGNIZE CUES

⚠ Typical presentation

- **Stress:** small-volume leaks with cough/sneeze/laugh/lifting
- **Urge:** large-volume leaks, strong sudden urge, frequency, nocturia
- **Overflow:** constant dribbling, weak stream, hesitancy, sensation of fullness
- **Functional:** "accidents" on the way to the bathroom
- **Reflex:** scheduled leaks with no sensation of urge

🚨 Red flag findings

- **Sudden new incontinence** in an older adult → rule out **UTI / delirium**
- **Hematuria** or dysuria → rule out infection, stones, malignancy
- **Post-void residual > 100 mL** → retention / overflow
- **Saddle anesthesia, new weakness** → **cauda equina** emergency
- **IAD** (red, macerated perineal skin) → breakdown risk

🚨 **DIAPPERS** — the classic mnemonic for **transient / reversible** causes. Screen every patient before labeling incontinence as chronic:
Delirium · **I**nfection (UTI) · **A**trophic vaginitis · **P**harmaceuticals · **P**sychological (depression) · **E**xcess urine output (↑ fluids, diabetes, diuretics) · **R**estricted mobility · **S**tool impaction

Priority *nursing interventions*

05 / TAKE ACTION

ASSESSMENT FIRST (ABC + SAFETY)

- **Voiding diary** × 3 days — pattern, volume, triggers, fluid intake

BEHAVIORAL (FIRST-LINE FOR ALL TYPES)

- **Pelvic floor (Kegel) exercises** — 10 reps × 3× daily; hold 5–10 seconds. First-line for stress incontinence.

- **Post-void residual (PVR)** with bladder scanner — normal < 50 mL; >100 mL = retention
- Urinalysis & urine culture — rule out UTI before anything else
- Med review — diuretics, anticholinergics, alpha-blockers, sedatives
- Fall risk & skin integrity (IAD, pressure injuries)

- **Bladder training** — scheduled voiding Q2H, gradually lengthen intervals. Best for urge.
- **Prompted/habit toileting** — best for functional and cognitively impaired
- **Double voiding** — wait & void again for overflow
- Weight loss, smoking cessation, limit caffeine/alcohol/carbonation

SKIN & SAFETY

- Cleanse with **pH-balanced no-rinse perineal cleanser** — NOT soap & water (strips skin)
- Apply **moisture-barrier cream** (zinc oxide, dimethicone) after every incontinence episode
- Absorbent briefs/pads changed **immediately** when wet — never leave wet
- Clear path to bathroom, night-light, elevated toilet seat, call-light within reach
- **Catheters = last resort** — CAUTI risk; remove ASAP

FLUID MANAGEMENT

- **Do NOT restrict fluids** — causes concentrated urine, UTI, constipation, dehydration
- Target **1,500–2,000 mL/day** (unless medically restricted)
- Most fluids earlier in the day; limit 2–3 hrs before bedtime
- Avoid bladder irritants: caffeine, alcohol, citrus, artificial sweeteners, carbonation, spicy foods
- Treat constipation — impacted stool worsens incontinence

Pharmacology *at a glance*

06 / DRUGS BY TYPE

DRUG / CLASS	FOR WHICH TYPE	MECHANISM (SIMPLE)	SIDE EFFECTS & NURSING CONSIDERATIONS
Oxybutynin *(Ditropan)* **Tolterodine** *(Detrol)* **Anticholinergics**	**URGE** Overactive bladder	Block muscarinic receptors → relax detrusor, ↓ bladder spasms	**"Can't see, can't pee, can't spit, can't poop."** Dry mouth, blurred vision, urinary retention, constipation, confusion (esp. elderly). **Avoid in BPH, glaucoma, dementia.** Monitor PVR.
Mirabegron *(Myrbetriq)* **Beta-3 agonist**	**URGE** (alternative to anticholinergics)	Activates β3 receptors → relaxes detrusor during filling	HTN (monitor BP!), headache, UTI. Safer option for elderly & dementia patients. Avoid in uncontrolled HTN.

Tamsulosin *(Flomax)* **Doxazosin** **Alpha-1 blockers**	**OVERFLOW** from BPH in men	Relax smooth muscle of prostate & bladder neck → improves flow	**Orthostatic hypotension** — take at bedtime, rise slowly. First-dose syncope. Retrograde ejaculation. Dizziness.
Bethanechol *(Urecholine)* **Cholinergic**	**OVERFLOW** / urinary retention (non-obstructive)	Stimulates cholinergic receptors → contracts detrusor to empty bladder	**SLUDGE** effects: Salivation, Lacrimation, Urination, Defecation, GI upset, Emesis. Give on empty stomach. **Contraindicated in obstruction, asthma.**
Topical estrogen *(vaginal cream/ring)*	**STRESS / URGE** in postmenopausal women	Reverses atrophic vaginitis → improves urethral tone	Local route minimizes systemic effects. Report vaginal bleeding. Not for history of estrogen-sensitive cancers.
Duloxetine *(Cymbalta)* **SNRI**	**STRESS** incontinence	↑ serotonin & norepinephrine → strengthens urethral sphincter tone	Nausea, dry mouth, insomnia, suicide risk warning. Do NOT stop abruptly (withdrawal). Monitor BP.

NCLEX *test traps*

07 / DON'T GET CAUGHT

❌ TRAP
"Restrict fluids so the patient has fewer accidents."

✅ CORRECT
Maintain **1,500–2,000 mL/day**. Fluid restriction → concentrated urine (bladder irritant), UTI, constipation, and dehydration.

❌ TRAP
"Insert an indwelling Foley to manage the incontinence."

✅ CORRECT
Catheters are a **last resort** — high CAUTI risk. Use behavioral strategies, scheduled toileting, and external catheters (condom/PureWick) first.

❌ TRAP
"Give oxybutynin to the 82-year-old with dementia and BPH for her urge symptoms."

✅ CORRECT
Anticholinergics **worsen confusion** and can cause urinary retention in BPH. Mirabegron is safer — or behavioral therapy first.

❌ TRAP
"A new onset of incontinence in a 78-year-old just means she's aging."

✅ CORRECT
Incontinence is **NEVER normal aging**. **Sudden new-onset incontinence** in an older adult = **UTI until proven otherwise** (often the only symptom).

❌ TRAP
"Clean the incontinent patient's skin with soap and hot water to get it really clean."

✅ CORRECT
Use **pH-balanced no-rinse cleanser** + moisture-barrier cream. Soap strips the acid mantle and worsens IAD.

❌ TRAP
"The patient with overflow incontinence needs a diuretic to 'flush it out.'"

✅ CORRECT
Overflow = bladder can't empty. Treat the **cause** (relieve obstruction, alpha-blocker for BPH, intermittent cath, bethanechol). Diuretics worsen the problem.

Patient *education*

08 / TEACH BACK

- **Kegel exercises:** "Squeeze the muscles you'd use to stop urinating mid-stream. Hold 5–10 seconds, relax 10 seconds. 10 reps, 3× per day. Don't hold your breath or contract abdominal/thigh muscles."
- **Bladder diary:** Track every void, leak, fluid intake, and trigger for 3 days before your follow-up appointment.
- **Scheduled voiding:** Go to the bathroom every 2 hours whether you feel the urge or not. Gradually extend the interval.
- **Bladder irritants to avoid:** caffeine, alcohol, citrus, tomato, artificial sweeteners, carbonated drinks, spicy food.
- **Fluids:** Drink 1.5–2 L/day. Finish most fluids earlier in the day; stop 2–3 hours before bed to reduce nocturia.
- **Skin care:** Change wet pads immediately. Use pH-balanced cleanser and barrier cream. Report redness, rash, or broken skin.
- **Medication teaching:** Rise slowly on alpha-blockers. Report urinary retention or severe dry mouth on anticholinergics. Don't stop duloxetine abruptly.
- **When to call:** Fever, back/flank pain, blood in urine, new confusion, inability to urinate, or saddle numbness/new leg weakness.
- **Prevent constipation:** A full rectum presses on the bladder. Fiber + adequate fluids + regular activity.
- **Dignity & privacy:** Incontinence is treatable — it is NOT a reason for isolation. Many options exist; bring the diary and med list to every visit.

NCJMM *clinical judgment framework*

09 / THINK LIKE A NURSE

STEP 1 **Recognize cues**	Patient reports leaking with cough; constant dribbling; sudden strong urges; scheduled leaks without urge. Post-void residual, voiding diary, U/A, med list, cognition & mobility, skin status, fluid pattern. New onset in older adult → **screen for UTI & delirium (DIAPPERS)**.

STEP 2 **Analyze cues**	Match pattern to **type**: triggered by pressure = stress · sudden urge = urge · overflow with retention = overflow · intact bladder but barrier = functional. Rule out **reversible causes first**. Identify high-risk side effects from meds (anticholinergics, alpha-blockers, diuretics).
STEP 3 **Prioritize hypotheses**	**Safety first:** UTI/sepsis, urinary retention with distension, fall risk, cauda equina (saddle anesthesia + new weakness = EMERGENCY). **Then:** skin integrity (IAD), psychosocial impact, medication-related, functional limitations.
STEP 4 **Generate solutions**	Treat reversible causes → behavioral therapy (Kegels, bladder training, scheduled toileting) → environmental fixes (clear path, call light, elevated seat) → pharmacology matched to type → surgery (sling, TURP) last. Avoid catheters; use moisture barrier.
STEP 5 **Take action**	Obtain PVR & U/A; initiate voiding diary; teach & supervise Kegels; establish Q2H toileting schedule; administer prescribed agent; provide pH-balanced skin care; remove environmental barriers; hold anticholinergics if retention present; notify HCP of red flags.
STEP 6 **Evaluate outcomes**	↓ Leak episodes on diary; PVR < 50 mL; intact skin (no IAD); no UTI; patient verbalizes Kegel technique and trigger foods to avoid; BP stable on alpha-blocker; no confusion on anticholinergic; patient reports improved QOL.

Memory *boosters*

10 / MAKE IT STICK

DIAPPERS

Reversible causes of incontinence — always rule these out first:

- **D**elirium
- **I**nfection (UTI) — #1 cause of sudden incontinence in elders
- **A**trophic vaginitis / urethritis
- **P**harmaceuticals (diuretics, sedatives, anticholinergics)
- **P**sychological (depression)
- **E**xcess urine output (hyperglycemia, CHF, hypercalcemia)
- **R**estricted mobility
- **S**tool impaction

SUOF — The 4 types

- **S**tress → **S**neeze/cough leaks · weak pelvic floor → Kegels
- **U**rge → **U**nexpected urgency · overactive detrusor → bladder training + anticholinergic / mirabegron
- **O**verflow → **O**bstruction (BPH) or weak detrusor → alpha-blocker, intermittent cath
- **F**unctional → **F**unctioning bladder but can't get there → environment + prompted toileting

"Can't see, pee, spit, or poop"

SLUDGE

Cholinergic side effects (Bethanechol) — opposite of anticholinergics:

Classic **anticholinergic** side effects (Oxybutynin, Detrol): **blurred vision · urinary retention · dry mouth · constipation**. Add **confusion** in the elderly — these are Beers-list drugs. Always check PVR and mental status.

- **S**alivation
- **L**acrimation
- **U**rination
- **D**efecation
- **G**I upset
- **E**mesis

Flomax → Fall down

Alpha-1 blockers (**Tamsulosin/Flomax, Doxazosin**) relax smooth muscle — including blood vessels. **Orthostatic hypotension & first-dose syncope** are #1 risks. Give at **bedtime**, teach patient to rise slowly, hold the bedrail.

"New confusion? Check the urine."

In older adults, **new-onset incontinence + confusion = UTI until proven otherwise**. Classic dysuria and fever are often absent. Always obtain a U/A before attributing symptoms to dementia or "just aging."