NGN NCLEX 2026 · GENITOURINARY · RENAL/URINARY

Urinary *Incontinence* Types

A complete bedside reference for the six classifications of urinary incontinence — stress, urge, overflow, functional, reflex, mixed (plus transient/reversible causes) — paired with type-specific nursing care, pharmacology, patient teaching, and a full Next-Gen Clinical Judgment scenario.

SYSTEM · GENITOURINARY | BLUEPRINT · PHYSIOLOGICAL INTEGRITY | NCJMM · STEP 1–6 INCLUDED | 2026 TEST PLAN

SOURCE TRANSPARENCY

This topic was **not present in your uploaded reference notes**. Content was developed from the standard NGN NCLEX 2026 evidence base: *Saunders Comprehensive Review for the NCLEX-RN* (Silvestri), *ATI RN Adult Medical-Surgical Nursing*, *Lippincott Illustrated Reviews — Pharmacology*, and the AUA/SUFU guideline on Diagnosis and Treatment of Non-Neurogenic Overactive Bladder. The DIAPPERS mnemonic for transient incontinence originates from Resnick (1995) and remains the established framework in current geriatric nursing curricula.

1 Definition & Overview

WHY IT MATTERS

A — What it is

The **involuntary loss of urine** in sufficient quantity or frequency to be a social or hygienic problem. It is a *symptom*, not a disease — the underlying cause determines the type and treatment.

B — Why it matters on NCLEX

Incontinence threatens **skin integrity, dignity, falls risk, infection (UTI), and quality of life**. NCJMM items test whether you can match the *type* to the correct intervention — getting that wrong worsens the patient.

C — Who is affected

~50% of community-dwelling older women, ~75% of nursing home residents. **Not a normal part of aging** — always investigate. Most prevalent: *stress* in younger women, *urge* & *mixed* in older adults, *overflow* in older men with BPH.

2 Pathophysiology — The Continence Mechanism

SIMPLIFIED

Normal continence requires: bladder that *stores* at low pressure + sphincter that stays *closed* + intact *neuro control* (S2–S4 micturition center, pontine center, cortex) + ability to *reach* the toilet.

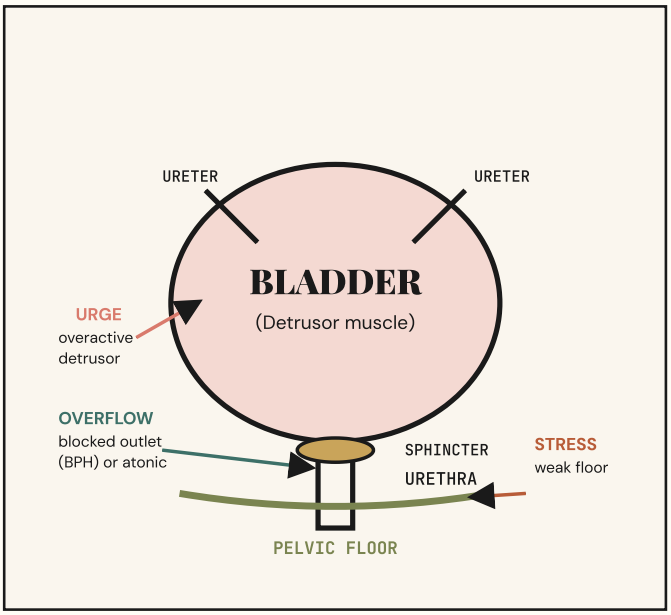
Stress → outlet/sphincter failure → ↑intra-abdominal pressure overcomes weak pelvic floor → leak.

Urge → detrusor overactivity → uncontrolled bladder contractions → sudden urge & leak.

Overflow → outlet obstruction (BPH) OR atonic detrusor (neuropathy) → bladder overfills → dribbling.

Reflex → spinal cord lesion above S2 → no cortical awareness → reflex emptying at set volume.

Functional → urinary tract intact, but mobility/cognition/access fails.



3 The Six Types — Side-by-Side

CORE COMPARISON

TYPE	CAUSE / MECHANISM	HALLMARK CUE	PRIORITY NURSING CARE	KEY TREATMENT
STRESS	Weak pelvic floor / sphincter incompetence — post-childbirth, menopause (low estrogen), post-prostatectomy, obesity, chronic cough	Small leak with **cough, sneeze, laugh, lift, exercise**. No urge sensation. Loss of *small* volumes.	Teach **Kegels** (pelvic floor exercises) 3×/day × 10 reps; weight loss; treat constipation; smoking cessation (chronic cough); skin barrier care.	Kegels (first-line) · Pessary (women) · Pseudoephedrine (mild) · Topical vaginal estrogen · Surgical sling / urethropexy
URGE (OAB)	Detrusor overactivity — idiopathic, UTI, bladder stones, neuro disease (stroke, MS, Parkinson's), bladder irritants	**Sudden, intense urge** followed by leak before reaching toilet. Loss of *large* volumes. Frequency & nocturia.	**Bladder training** (timed voiding q2–3 h, gradually ↑interval); urge suppression; eliminate caffeine/alcohol/citrus/artificial sweeteners; commode at bedside.	Anticholinergics: *oxybutynin, tolterodine, solifenacin* · Beta-3 agonist: *mirabegron* · Botox injection · Sacral neuromodulation
OVERFLOW	**Outlet obstruction** (BPH, stricture, tumor) OR **atonic bladder** (diabetic neuropathy, anticholinergic meds, spinal injury)	**Constant dribbling**, weak stream, sensation of incomplete emptying, hesitancy, post-void residual > 100 mL, palpable bladder.	Check post-void residual (bladder scan) · **Intermittent (clean) catheterization q4–6 h** · Credé maneuver (only if no reflux) · Double voiding · Avoid anticholinergics.	Alpha-blockers: *tamsulosin (Flomax)* · 5-alpha reductase: *finasteride* · Cholinergics: *bethanechol* for atonic bladder · TURP for BPH
FUNCTIONAL	Urinary tract is *intact* — barrier is physical (arthritis, stroke, walker), cognitive (dementia, delirium), or environmental (restraints, side rails, distance to toilet)	Patient knows they need to void but **cannot get there in time**. Common in long-term care & hospitalized older adults.	**Scheduled toileting** q2 h; bedside commode; call light in reach; clothing with elastic/Velcro; clear pathway; nightlight; assistive devices; remove restraints.	No medication treats functional incontinence — environment & mobility intervention is the cure.
REFLEX (Neurogenic)	**Spinal cord injury or lesion above S2** — loss of cerebral awareness; bladder empties reflexively at set volume. Also MS, spina bifida.	Voiding **without warning or sensation**, often at predictable volumes. Patient unaware of bladder filling.	**Intermittent self-catheterization** q4–6 h is gold standard · Monitor for **autonomic dysreflexia** (BP spike, headache, flushing — bladder distension is #1 trigger).	Anticholinergics + ISC · Botox · Indwelling catheter (last resort) · Sphincterotomy
MIXED	Combination — most commonly **stress + urge** in older women. Each component requires its own intervention.	Both pressure-related leaks *and* sudden urge leaks. Identify which component is more bothersome and treat first.	Combine strategies — Kegels + bladder training + lifestyle changes. Treat the dominant component first.	Combine: pelvic floor PT + anticholinergic/mirabegron + lifestyle modification.
TRANSIENT (Reversible)	Acute, reversible causes — see **DIAPPERS** mnemonic in section 8. Always rule out before labeling as chronic.	New-onset incontinence, especially in older adults. Often coincides with hospitalization, new med, infection, or mobility decline.	Treat the cause: UA & C&S for UTI, review meds, treat constipation/impaction, reorient for delirium, mobilize, address depression.	Cause-directed: antibiotics, stool softeners, med adjustment, vaginal estrogen, etc.

4 Signs & Symptoms — Cluster by Type

CUE RECOGNITION

Early / Mild Cues

- **Frequency** (> 8 voids in 24 h)
- **Nocturia** (> 2 voids per night)
- **Small dribbles** with cough/sneeze (stress)
- **Sudden urge** with hand washing or hearing water (urge cue)
- **Hesitancy** or weak stream (early overflow / BPH)
- Pad use; avoidance of social activities
- Reports of "I just can't make it in time"

Late / Severe Cues

- **Continuous leakage** (overflow or fistula)
- **Palpable, distended bladder** above symphysis (overflow — emergency)
- **Post-void residual > 100 mL** on bladder scan
- Recurrent UTIs · skin breakdown · IAD (incontinence-associated dermatitis)
- **Falls** while rushing to toilet
- Social isolation, depression, caregiver burden
- Hydronephrosis or AKI from chronic retention

Red Flags — Notify HCP / Escalate Immediately

- **Acute urinary retention** — distended bladder, no output × 8 h, suprapubic pain
- **New-onset incontinence + fever + flank pain** → pyelonephritis
- **Saddle anesthesia + new incontinence** → cauda equina syndrome (surgical emergency)
- **Autonomic dysreflexia** in SCI: BP spike + pounding headache + flushing (drain bladder NOW)
- **Hematuria with incontinence** → r/o bladder cancer, stones
- **Anuria or PVR > 500 mL** → catheterize, prevent AKI

5 Priority Nursing Interventions (ABC Framework)

ACTION VERBS

A

Assess First

- **Assess** bladder diary × 3 days (frequency, volume, triggers)
- **Palpate** for distended bladder; perform **bladder scan** for PVR
- **Inspect** perineal skin for IAD & breakdown
- **Review** medications (diuretics, anticholinergics, sedatives, opioids, alpha-1 blockers)
- **Obtain** UA & C&S to r/o UTI before labeling as chronic
- **Screen** cognition & mobility (functional vs. transient)

B

Behavioral & Bedside

- **Implement** timed voiding q2–3 h (urge & functional)
- **Teach** Kegels (stress) — 10 contractions × 3 sets/day, hold 10 sec
- **Position** commode at bedside; clear pathway; nightlight
- **Apply** barrier cream (zinc oxide, dimethicone) after every episode
- **Limit** fluids 2 h before bedtime; 1.5–2 L/day during the day (do NOT restrict)
- **Eliminate** bladder irritants: caffeine, alcohol, citrus, artificial sweeteners, spicy

C

Catheter / Clinical Escalation

- **Catheterize** intermittently q4–6 h (overflow, reflex) — preferred over indwelling
- **Avoid** indwelling Foley unless absolutely necessary (CAUTI risk)
- **Drain** bladder immediately if SCI patient develops autonomic dysreflexia
- **Administer** medications correctly matched to type (see Pharm section)
- **Refer** to pelvic floor PT, urology, or continence nurse specialist
- **Document** response to interventions in the bladder diary

6 Pharmacology — Matched to Type

TYPE-SPECIFIC

DRUG / CLASS	USED FOR	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Oxybutynin (Ditropan) **Tolterodine (Detrol)** **Solifenacin (Vesicare)** *Anticholinergic*	URGE / OAB	Blocks muscarinic receptors → relaxes detrusor → ↓ bladder contractions	**Dry mouth, constipation, blurred vision, urinary retention, tachycardia, confusion** in elderly (Beers list)	Contraindicated in **narrow-angle glaucoma, BPH/overflow, GI obstruction**. Caution in elderly (falls, delirium). Offer sugar-free gum; teach to rise slowly.
Mirabegron (Myrbetriq) *Beta-3 agonist*	URGE / OAB (alternative when anticholinergics intolerable)	Relaxes detrusor during storage phase → ↑ bladder capacity	**Hypertension**, tachycardia, headache, UTI	**Monitor BP** before and during therapy. Avoid in severe uncontrolled HTN. Better tolerated in elderly than anticholinergics.
Tamsulosin (Flomax) **Doxazosin · Terazosin** *Alpha-1 blocker*	OVERFLOW from BPH	Relaxes smooth muscle of bladder neck & prostate → ↑ urine flow	**Orthostatic hypotension, first-dose syncope**, dizziness, retrograde ejaculation	Give at **bedtime** for first dose. Teach to rise slowly. Hold for systolic < 100. **Floppy iris syndrome** — disclose before cataract surgery.
Finasteride (Proscar) **Dutasteride** *5-alpha reductase inhibitor*	OVERFLOW from BPH (long-term shrinking)	Blocks conversion of testosterone to DHT → ↓ prostate size	↓ libido, ED, gynecomastia, ↓ PSA (mask cancer)	**Teratogenic** — pregnant or potentially pregnant women must not handle crushed/broken tablets. Effects take 3–6 months.
Bethanechol (Urecholine) *Cholinergic*	OVERFLOW from atonic/neurogenic bladder	Stimulates muscarinic receptors → contracts detrusor → empties bladder	**SLUDGE**: Salivation, Lacrimation, Urination, Defecation, GI upset, Emesis; bradycardia, bronchospasm	Give on **empty stomach**. Have **atropine** available as antidote. Contraindicated in asthma, peptic ulcer, bradycardia, obstruction.
Topical vaginal estrogen (cream, ring, tablet)	Postmenopausal atrophic urethritis contributing to stress & urge	Restores urogenital mucosal integrity	Local irritation; minimal systemic absorption with vaginal route	Different risk profile than systemic HRT. Teach correct application; reassess in 8–12 weeks.
Pseudoephedrine *Alpha-1 agonist*	Mild STRESS incontinence	↑ urethral sphincter tone	**HTN, insomnia, tachycardia, anxiety**	Caution / avoid in HTN, cardiac disease, hyperthyroidism, glaucoma. Not first-line — Kegels preferred.
OnabotulinumtoxinA (Botox) *Detrusor injection*	Refractory URGE; neurogenic detrusor overactivity	Blocks ACh release at neuromuscular junction → ↓ detrusor activity	**Urinary retention** (may need ISC), UTI, hematuria	Teach patient may need to **self-catheterize**. Effect lasts ~6 months; repeat injections required.

7 NCLEX Test Traps — Wrong vs. Right

PRIORITY THINKING

⚠ WRONG	✓ RIGHT
"Restrict fluids to prevent leakage." Cutting daily intake concentrates urine, irritates the bladder, worsens urgency, and risks UTI & dehydration.	Maintain **1.5–2 L/day** spread through daytime hours and **limit only the 2 hours before bedtime**. Eliminate *bladder irritants* (caffeine, alcohol, citrus), not water.
⚠ WRONG	✓ RIGHT
"Give oxybutynin to the older man with BPH and dribbling." Anticholinergics worsen *overflow* — they relax the detrusor and ↑ retention.	Use **alpha-blockers** (tamsulosin) for BPH-related overflow. Save anticholinergics for *urge* incontinence with a normal post-void residual.
⚠ WRONG	✓ RIGHT
"Insert an indwelling Foley for the patient with frequent incontinence to keep skin dry."	**Avoid indwelling Foley** for incontinence alone (CAUTI risk). Use **scheduled toileting + barrier cream + absorbent products + ISC** for retention. Foley is a last resort.
⚠ WRONG	✓ RIGHT
"Teach Kegels as first-line for urge incontinence in a patient with sudden, overwhelming need to void."	Kegels are best for **STRESS**. For urge, the first-line is **bladder training** + urge suppression techniques + eliminate irritants. Anticholinergics or mirabegron if behavioral fails.
⚠ WRONG	✓ RIGHT
"New incontinence in an 82-year-old confused patient is expected age-related decline — provide briefs."	Incontinence is **NOT normal aging**. New-onset = work up **DIAPPERS** reversible causes (UTI, delirium, impaction, meds). Skipping the workup is a fail.
⚠ WRONG	✓ RIGHT
"SCI patient with sudden BP 200/110, pounding headache, and flushing — give the antihypertensive."	This is **autonomic dysreflexia**. The #1 trigger is a **distended bladder**. *First action*: sit patient upright, **check & drain the bladder/catheter**, then check for fecal impaction. Antihypertensive only if BP remains elevated after removing the trigger.
⚠ WRONG	✓ RIGHT
"Push fluids and give bethanechol to the patient with a palpable, distended bladder and no urine output."	**Catheterize first** to relieve acute retention. Then investigate cause. Bethanechol is for *chronic atonic* bladders *without* obstruction — never as the first intervention for acute retention.

8 Patient & Family Education — By Type

TEACH BACK

Strengthen & Support

STRESS

- ✓ **Kegels**: tighten muscles as if stopping urine flow, hold 10 sec, relax 10 sec, ×10 reps, 3×/day
- ✓ Continue Kegels for life — results in 6–12 weeks
- ✓ Lose weight (each 5–10% weight loss ↓ episodes)
- ✓ Treat chronic cough; quit smoking
- ✓ Manage constipation (straining weakens floor)
- ✓ Cross legs & tighten pelvic floor *before* coughing/sneezing ("the Knack")

Retrain the Bladder

URGE

- ✓ Void on a **schedule** (start q2 h, ↑by 15 min weekly until q3–4 h)
- ✓ Urge suppression: **stop, sit/stand still, deep breathe, do 5 quick Kegels**, then walk slowly to toilet
- ✓ Eliminate caffeine, alcohol, citrus, artificial sweeteners, carbonated & spicy foods
- ✓ Keep a bladder diary × 3 days
- ✓ Anticholinergic teaching: dry mouth (gum/water), constipation (fiber/fluids), no driving if drowsy

Empty Completely

OVERFLOW

- ✓ **Double voiding**: void, wait 1–2 min, void again
- ✓ Sit fully on toilet; lean forward; do not strain
- ✓ If self-cathing: clean (not sterile) technique at home, wash hands, lubricate, insert q4–6 h
- ✓ Avoid OTC anticholinergics (cold meds with diphenhydramine) — worsen retention
- ✓ Report fever, flank pain, hematuria (UTI/pyelo)
- ✓ Take alpha-blocker at **bedtime** to ↓ orthostatic falls

Remove the Barriers

FUNCTIONAL

- ✓ Place commode/urinal within arm's reach overnight
- ✓ Wear elastic-waist or Velcro clothing — no buttons/zippers
- ✓ Keep pathway clear, well-lit, with nightlights
- ✓ Use grab bars, raised toilet seat, mobility aids
- ✓ Caregiver offers toileting **q2 h** (prompted voiding), not just on request
- ✓ Remove restraints whenever possible

Self-Cath & Watch BP

REFLEX / SCI

- ✓ Master **intermittent self-catheterization** q4–6 h (sterile in hospital, clean at home)
- ✓ Know signs of **autonomic dysreflexia**: sudden severe headache, BP spike, sweating above lesion, flushing — sit up, check catheter/bowels, call HCP
- ✓ Drink adequate fluids; monitor for cloudy/foul urine (UTI)
- ✓ Keep emergency cath supplies at hand

Universal Teaching

SKIN & SAFETY

- ✓ Cleanse perineum gently with pH-balanced cleanser after every episode
- ✓ Apply **barrier cream** (zinc oxide, dimethicone) — protects against IAD
- ✓ Change pads/briefs promptly; do not let skin sit wet
- ✓ Fall prevention: clear path, lighting, footwear, no rushing
- ✓ Incontinence is a **symptom, not a normal part of aging** — always evaluable
- ✓ Bring bladder diary to follow-up visit

9 Memory Boosters & Mnemonics

RECALL TRIGGERS

DIAPPERS — Transient Incontinence

D	**Delirium** — reorient, treat cause
I	**Infection** (UTI) — UA, C&S, antibiotics
A	**Atrophic urethritis/vaginitis** — topical estrogen
P	**Pharmaceuticals** — diuretics, sedatives, anticholinergics, alpha-blockers
P	**Psychological** — depression, anxiety
E	**Excessive urine output** — uncontrolled DM, HF, hypercalcemia, fluid overload
R	**Restricted mobility** — get patients up, mobilize
S	**Stool impaction** — disimpact, treat constipation

Quick Pattern Recognition

- `STRESS = SNEEZE` — small leaks with pressure (cough, sneeze, laugh, lift). Fix the floor with Kegels.
- `URGE = URGENT` — gotta go NOW and can't make it. Retrain & relax the detrusor.
- `OVERFLOW = OBSTRUCTED OUTLET` — dribble & distended bladder. Open the outlet or empty by cath.
- `FUNCTIONAL = FURNITURE` — bathroom too far, clothes too tight, restraints in the way. Fix the environment.
- `REFLEX = ROAD CLOSED` (spinal cord interrupted) — no warning, ISC q4–6 h.
- `"Dop" hurts kidneys, "doBUT" helps the U-rine` — also applies to thinking about drug categories: alpha agonists tighten outlet, alpha blockers open it.
- `"Bethanechol BLASTS bladder"` — contracts atonic detrusor; SLUDGE side effects; atropine is antidote.
- `"Flomax for the flow"` — tamsulosin opens BPH-obstructed outlet → flow returns.
- `Distended bladder + SCI + BP spike = autonomic dysreflexia` → drain the bladder FIRST.

10 NCJMM Clinical Judgment Scenario

SIX-STEP MODEL

CASE: Mrs. R, a 78-year-old woman, is admitted to a med-surg unit for IV antibiotics for cellulitis. On hospital day 2, the unlicensed assistive personnel reports she has had three episodes of "wetting the bed" overnight and seems "more confused than yesterday." She lives alone, ambulates with a walker, and was continent at home. Home meds: lisinopril, metformin, simvastatin. New in-hospital orders: diphenhydramine PRN for sleep, furosemide 40 mg IV BID, oxybutynin 5 mg PO TID.

STEP 1 · RECOGNIZE CUES

What information is clinically relevant?

→ New-onset incontinence (continent at home)

→ New-onset confusion (change from baseline)

→ Age 78, female, baseline ambulatory with walker

→ Three new medications started in-hospital: **diphenhydramine, furosemide, oxybutynin**

→ Active infection (cellulitis on antibiotics)

→ Hospitalization itself = restricted mobility & unfamiliar environment

STEP 2 · ANALYZE CUES

What do these cues mean — together?

→ Multiple **DIAPPERS** triggers stacking: *D*elirium (new confusion), *I*nfection (cellulitis), *P*harmaceuticals (diphenhydramine + oxybutynin both anticholinergic, furosemide drives volume), *R*estricted mobility (hospitalization, IV pole)

→ Diphenhydramine + oxybutynin are on the **Beers list** — both anticholinergic, both worsen confusion and urinary retention in elderly

→ Oxybutynin is also paradoxically wrong if she actually has *overflow* — would worsen retention

→ This is most likely **transient functional + medication-induced incontinence + possible delirium**, NOT a new chronic OAB

STEP 3 · PRIORITIZE HYPOTHESES

Which problems get attention first?

→ **#1 Acute confusion / delirium** — safety risk (falls, harm)

→ **#2 Medication-induced incontinence & possible retention** — check PVR; review & discontinue offending meds

→ **#3 Functional barriers** — IV pole, walker, unfamiliar bathroom, side rails

→ **#4 Skin integrity** — incontinence-associated dermatitis risk

→ Less urgent: chronic UI workup (do *after* reversible causes are corrected)

STEP 4 · GENERATE SOLUTIONS

What interventions address each priority?

→ Notify HCP — request to **discontinue diphenhydramine and oxybutynin**; review need for furosemide BID

→ Perform **bladder scan** to check post-void residual

→ Obtain UA & C&S to rule out new UTI; check chemistry (Na, glucose, BUN/Cr)

→ Initiate **q2 h prompted toileting** with bedside commode; clear pathway; nightlight

→ Re-orient frequently; family photos at bedside; pull window blinds for day-night cues

→ Apply barrier cream after every episode; pH-balanced perineal cleanser

→ Fall precautions: bed in low position, call light in reach, non-slip footwear

→ Schedule diuretic doses early in day; avoid evening doses

STEP 5 · TAKE ACTION

What does the nurse do — in this order?

→ 1. **Assess** Mrs. R now — vital signs, mental status, palpate bladder, perform bladder scan

→ 2. **Implement** immediate safety: bed low, fall precautions, commode at bedside, call light, frequent rounding

→ 3. **Call** HCP — recommend discontinuing diphenhydramine and oxybutynin; request UA, C&S, BMP

→ 4. **Begin** q2 h prompted toileting; eliminate any caffeine on tray

→ 5. **Apply** barrier cream; change linens; cleanse skin

→ 6. **Document** baseline bladder diary; communicate plan to oncoming shift & UAP

→ 7. **Educate** patient and family — explain this is likely temporary and tied to meds + hospitalization

STEP 6 · EVALUATE OUTCOMES

How will the nurse know it worked?

→ Mental status returns to baseline within 24–72 h of stopping anticholinergics

→ Continent episodes return with q2 h toileting (success = < 1 incontinent episode/shift)

→ Post-void residual < 100 mL on follow-up bladder scan

→ No new skin breakdown; perineum intact

→ UA negative or UTI treated; chemistry within limits

→ No falls; patient ambulates safely to bathroom with assistance

→ Patient/family verbalize understanding that incontinence was reversible, not "old age"