



Supersedes: 2/01	Reviewed by:	Date:	Approved: (Signature on File)	Effective Date: 11/16/04
	CNS Group	9/04		
	WOC Nursing Service	8/04		
	TWICE Committee	8/04		
	Pt Care Practice & Outcomes	10/04		

TITLE: * Prevention and Management for the adult patient with urinary or fecal incontinence.

PERSONNEL: RN's, LPN's/NA's under the direction of the RN, and Wound, Ostomy, Continence (WOC) Nurse.

PATIENT OUTCOME:

- * 1. Will have fewer or no episodes of incontinence.
- * 2. Will not have complications associated with urinary or fecal incontinence.
- * 3. Patient/family verbalizes appreciation for consideration of dignity, well-being.
- * 4. Patient/family verbalize factors associated with incontinence and options in management.

SUPPORTIVE DATA: * Urinary and fecal incontinence is a common problem in hospitalized patients. Early recognition and protection and/or treatment minimizes skin injury and pressure ulcer development.

- * TYPES OF INCONTINENCE:
 1. Bowel: Involuntary passage of stool.
 2. Functional: due to difficulty or inability to reach toilet in time.
 3. Overflow: Involuntary loss of urine associated with bladder overdistension.
 4. Reflex: Predictable involuntary loss of urine with no sensation of urge, voiding, or bladder fullness.
 5. Stress: Immediate involuntary loss of urine with an increase in intra-abdominal pressure.
 6. Total: Continuous, unpredictable loss of urine without distention or awareness of bladder fullness.
 7. Transient Urinary: Sudden onset of potentially reversible symptoms. Possible causes: delirium, infections, atrophic vaginitis, urethritis, pharmaceuticals, depression, restricted mobility, stool impaction or constipation.
 8. Urge: Involuntary loss of urine associated with a strong, sudden desire to void.

- * Bladder and/or Bowel Program Protocols
- * Pain Management Protocol
- * Nursing Philosophy Caring Framework, and Cultural Caring Policy and Procedure

*Indicates addition/change



AREAS OF RESPONSIBILITY
ASSESSMENT

- A. Identify at-risk patients.
- * – Neurological deficit or limited cognitive ability.
 - Limited mobility or physical disability.
 - Medical disorders resulting in inability to manage urine or feces.
 - Dementia.

- B. Bowel Incontinence.
- * 1. Contributing factors.
 - a. Lack of routine evacuation schedule.
 - b. Lack of knowledge of bowel elimination techniques.
 - c. Insufficient fluid, fiber, activity.

INTERVENTIONS

- *A. 1. Determine urinary/fecal history (pre-existing incontinence or risk factors). Focus on: time of onset, frequency, and severity.
- * 2. Review past health history, possible precipitants of urinary incontinence (e.g., coughing, acute illness), lower urinary tract symptoms (e.g., Nocturia, hematuria, hesitancy).
3. Consider alternatives before utilizing indwelling catheter
- * 4. Determine mobility needs, identify obstacles.
- * 5. Modify hospital environment to facilitate continence:
 - a. Call light within easy reach.
 - b. Commode for those with limited mobility.
 - c. Use of urinal/bedpan.
 - d. Avoid side-rails.
- * 6. Encourage voiding before leaving unit for diagnostic tests.
7. Collaborate with physician for referral to PT/OT.
8. Collaborate with physician to determine need for further diagnostic testing and evaluation for sudden onset urinary fecal incontinence.

- B. 1.
 - a. Plan a consistent appropriate time for elimination.
 - * b. Teach effective bowel elimination techniques (e.g. position functionally, pelvic floor exercises, Valsalva maneuver).
 - * c. Encourage 8-10 glasses of water daily. Diet high in bulk and fiber. Ambulate when possible. Consult nutritionist.
 - d. Obtain a fecal incontinence collector from Dispensing. Apply according to package directions. Consult WOC nurse for assistance with assessment or intervention recommendations when necessary.
 - * e. Avoid use of disposable brief until other interventions have failed.
 - * f. Bladder and/or Bowel Program Protocol.

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ASSESSMENT

- C. Urinary incontinence.
- * 1. Contributing/causative factors.
 - Impaired cognition
 - Impaired mobility
 - Fluid and electrolyte imbalances
 - Medical disorders (eg. urinary tract infections), resulting in inability to manage urine
 - Certain medications
- *D. Risk for impaired skin integrity related to chemical trauma secondary to incontinence.
1. Assess perineal skin.

INTERVENTIONS

- C.
- * 1. Offer toileting reminders every 2 hours after meals and before bedtime.
 - 2. Establish means to communicate need to void.
 - 3. Answer call light promptly.
 - * 4. Allow for privacy while maintaining safety.
 - * 5. Allow sufficient time for task.
 - * 6. Maintain optimal hydration (2000-3000 mL/day), unless contraindicated.
 - * 7. Avoid medications that may contribute to incontinence.
 - 8. Avoid indwelling catheter whenever possible.
 - * 9. Avoid use of disposable brief until other interventions have failed.
 - 10. Bladder and/or Bowel Program Protocol.
- D.
- * 1. All skin folds must be exposed and inspected (e.g. scrotum, foreskin retraction, labia, inner aspect of thigh, and lower abdominal).
 - * 2. Institute measure to protect skin when containment is not possible. Avoid use of disposable plastic underpads next to skin. Avoid disposable briefs for newly incontinent patients. Utilize reusable underpads.
 - a. Mild incontinence without erythema:
 - * - Avoid use of products containing alcohol (i.e., Comfort Cloths).
 - Cleanse skin with Prevacare cleanser after episodes of incontinence. Apply Barrier Cream q 12 hr and after cleansing.
 - b. Incontinence with mild erythema:
 - Cleanse skin with cleanser after episodes of incontinence. Apply topical barrier:
 - Zinc-based barrier: (Prevacare ointment).
 - Occlusive barrier: (Prevacare Cream).

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ASSESSMENT

INTERVENTIONS

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| <p>* E. Risk for Acute pain related to chemical trauma secondary to incontinence.</p> | <p>c. Incontinence with severe erythema with or without ulcer development.</p> <ul style="list-style-type: none"> - Cleanse skin with cleanser after episodes of incontinence. Apply No Sting Barrier Film every 24 hours. In severe cases of incontinence, Barrier Film can be reapplied every 12 hours. <p>d. Consult WOC nurse for assistance with skin care assessment or intervention recommendation if care plan is not effective.</p> |
| <p>* F. Risk for situational low self esteem related to incontinence.</p> <ul style="list-style-type: none"> 1. Patient's dignity, self-esteem. | <p>E. 1. Premedicate for pain prior to perineal skin care, as needed.</p> <p>2. Cool application (not ice) to affected areas.</p> <p>3. Consider cool application of barrier creams/ointments, if not contraindicated.</p> <p>* 4. Avoid use of products containing alcohol (i.e., Comfort Cloths).</p> |
| <p>* G. Risk for ineffective management of therapeutic regimen.</p> <ul style="list-style-type: none"> 1. Patient/family's knowledge of incontinence, resources, and readiness to learn. | <p>F. 1. Promote dignity by providing privacy with interventions and encourage ventilation of feelings.</p> <p>* 2. Challenge patient to imagine positive futures and outcomes.</p> <p>* 3. Encourage trial of new behavior.</p> <p>* 4. Reinforce use of esteem building exercises (self affirmation, imagery, use of humor, etc.)</p> <p>* 5. Assist in identifying problem areas.</p> |
| <p>* G. Risk for ineffective management of therapeutic regimen.</p> <ul style="list-style-type: none"> 1. Patient/family's knowledge of incontinence, resources, and readiness to learn. | <p>G. 1. Instruct patient and family in contributing factors, the importance of toileting schedule, and/or bowel program.</p> <p>2. Encourage involvement of patient/family.</p> <p>3. Instruct patient/family in skin care associated with incontinence and signs and symptoms of actual or potential skin breakdown.</p> <p>4. Review discharge instructions with patient/family. Consider Micromedex (Care Notes™)</p> |

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ASSESSMENT

INTERVENTIONS

5. Provide resources for outpatient referral for further evaluation of continuing problem with incontinence

- * Further information:
National Association for Continence
P.O. Box 8310
Spartanburg, SC 29305
(800) BLADDER or (800) 252-3337
- * Simon Foundation for Continence
Box 835
Wilmette, IL 60091
(800) 23-SIMON or (800) 237-4666

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