

<b>Number:</b> PROT0106	<b>Issuing Department:</b> PATIENT CARE SERVICES	<b>Supersedes:</b> 11/04, 10/07	
<b>Submitted by:</b> WOC	<b>Approved By:</b> (Signature on File)	<b>Date:</b> 08/2010	
<b>Reviewed by:</b> WOC Nursing Service	<b>Date:</b> 7/27/10	<b>Patient Care Practice &amp;</b> <b>Outcomes</b>	<b>8/10</b>
<b>Med Surg CPT</b>	<b>8/10</b>		

**PERSONNEL:** RN, LPN/NA 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.

\*Indicates addition/change

ASSESSMENT

1. Identify at-risk patients.
  - a. Neurological deficit or limited cognitive ability.
  - b. Limited mobility or physical disability.
  - c. Medical disorders resulting in inability to manage urine or feces.
  - d. Dementia.
  
2. Bowel Incontinence.
  - a. Contributing factors.
    - 1) Lack of routine evacuation schedule.
    - 2) Lack of knowledge of bowel elimination techniques.
    - 3) Insufficient fluid, fiber, activity.

INTERVENTIONS

1.
  - a. Determine urinary/fecal history (pre-existing incontinence or risk factors). Focus on: time of onset, frequency, and severity.
  - b. Review past health history, possible precipitants of urinary incontinence (e.g., coughing, acute illness), lower urinary tract symptoms (e.g., Nocturia, hematuria, hesitancy).
  - c. Consider alternatives before utilizing indwelling catheter.
  - d. Determine mobility needs, identify obstacles.
  - e. Modify hospital environment to facilitate continence:
    - 1) Call light within easy reach.
    - 2) Commode for those with limited mobility.
    - 3) Use of urinal/bedpan.
    - 4) Avoid side-rails.
  - f. Encourage voiding before leaving unit for diagnostic tests.
  - g. Collaborate with physician for referral to PT/OT.
  - h. Collaborate with physician to determine need for further diagnostic testing and evaluation for sudden onset urinary fecal incontinence.
  
2.
  - a.
    - 1) Plan a consistent appropriate time for elimination.
    - 2) Teach effective bowel elimination techniques (e.g., position functionally, pelvic floor exercises, Valsalva maneuver).
    - 3) Encourage 8-10 glasses of water daily. Diet high in bulk and fiber. Ambulate when possible. Consult nutritionist.

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ASSESSMENT

3. Urinary incontinence.
  - a. Contributing/causative factors.
    - 1) Impaired cognition
    - 2) Impaired mobility
    - 3) Fluid and electrolyte imbalances
    - 4) Medical disorders (e.g., urinary tract infections), resulting in inability to manage urine
    - 5) Certain medications
  
4. Risk for impaired skin integrity related to chemical trauma secondary to incontinence.
  - a. Assess perineal skin.

INTERVENTIONS

- 4) Obtain a fecal incontinence collector from Dispensing. Apply according to package directions. Consult WOC nurse for assistance with assessment or intervention recommendations when necessary.
  - 5) Avoid use of disposable brief until other interventions have failed.
  - 6) Bladder and/or Bowel Program Protocol.
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3.
    - a. Offer toileting reminders every 2 hours after meals and before bedtime.
    - b. Establish means to communicate need to void.
    - c. Answer call light promptly.
    - d. Allow for privacy while maintaining safety.
    - e. Allow sufficient time for task.
    - f. Maintain optimal hydration (2000-3000 mL/day), unless contraindicated.
    - g. Avoid medications that may contribute to incontinence.
    - h. Avoid indwelling catheter whenever possible.
    - i. Avoid use of disposable brief until other interventions have failed.
    - j. Bladder and/or Bowel Program Protocol.
  
  4.
    - a. All skin folds must be exposed and inspected (e.g., scrotum, foreskin retraction, labia, inner aspect of thigh, and lower abdominal).
    - b. 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.

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ASSESSMENT

5. Risk for Acute pain related to chemical trauma secondary to incontinence.

INTERVENTIONS

- 1) Mild incontinence without erythema:
    - a) Avoid use of products containing alcohol.
    - b) Cleanse skin with perineal cleanser after episodes of incontinence. Apply Add Moisture Barrier Cream every 12 hours and after cleansing.
  - 2) Incontinence with mild erythema:
    - a) Cleanse skin with perineal cleanser after episodes of incontinence. Apply topical barrier:
      - i) Zinc-based barrier protective paste
      - ii) Occlusive barrier: (Moisture Barrier Ointment).
  - 3) Incontinence with severe erythema with or without ulcer development.
    - a) Cleanse skin with perineal 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.
  - 4) Consult WOC nurse for assistance with skin care assessment or intervention recommendation if care plan is not effective.
5. a. Premedicate for pain prior to perineal skin care, as needed.  
 b. Cool application (not ice) to affected areas.  
 c. Consider cool application of barrier creams/ointments, if not contraindicated.  
 d. Avoid use of products containing alcohol.

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ASSESSMENT

6. Risk for situational low self esteem related to incontinence.
  - a. Patient's dignity, self-esteem.
  
7. Risk for ineffective management of therapeutic regimen.
  - a. Patient/family's knowledge of incontinence, resources, and readiness to learn.

INTERVENTIONS

6.
  - a. Promote dignity by providing privacy with interventions and encourage ventilation of feelings.
  - b. Challenge patient to imagine positive futures and outcomes.
  - c. Encourage trial of new behavior.
  - d. Reinforce use of esteem building exercises (self affirmation, imagery, use of humor, etc.)
  - e. Assist in identifying problem areas.
  
7.
  - a. Instruct patient and family in contributing factors, the importance of toileting schedule, and/or bowel program.
  - b. Encourage involvement of patient/family.
  - c. Instruct patient/family in skin care associated with incontinence and signs and symptoms of actual or potential skin breakdown.
  - d. Review discharge instructions with patient/family. Consider Micromedex (Care Notes™).
  - d. 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  
<http://www.nafc.org>

Simon Foundation for Continence  
Box 835  
Wilmette, IL 60091  
(800) 23-SIMON or (800) 237-4666  
<http://www.simonfoundation.org>

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