Incontinence Solutions

Know How.
Assessment and Care Plans.

Documents and forms provided here are available through the online Continence Management Program. Enrolled members, please log on to print forms, access tools and view additional educational courses and materials.

Incontinence Solutions

Urinary Continence

Assessment and Implementation Form

Resident: _____ Room #: _____ Date: _____

Assessed by: _____ Date of last MDS: _____

Current Product Information Size: _____ Type: _____ Frequency of Leakage: ____ times/week ☐ None

Diagnosis: _____

Medications: _____

1. Determine Type of Incontinence

Questions	Circle one	If "Yes," Then...
Resident is continent	N Y	Proceed to section 2
Does resident leak when he/she coughs, sneezes, exercises, laughs?	N Y	Stress
Does resident need to rush suddenly to the toilet?	N Y	Urge
Does resident urinate more than 7 times/day or 2 times/night?	N Y	Urge
Does resident have a weak stream of urine?	N Y	Overflow
Does resident have frequent dribbling?	N Y	Overflow
Does resident have burning or blood in urine?	N Y	Transient
Chart		
Is the incontinence related to something other than urinary tract, such as inability to undo a zipper?	N Y	Functional
Does the resident have a post-void residual greater than 200 cc?	N Y	Overflow
Does the resident take stool softeners, antipsychotics, anticholinergics, narcotic analgesics or other drugs that may affect continence?	N Y	Further evaluation may be necessary
Female		
Is there presence of pelvic prolapse or other abnormal finding?	N Y	Stress
Is the vaginal wall reddened and/or thin?	N Y	Transient
Is there abnormal discharge?	N Y	Transient
Male		
Is the foreskin abnormal (difficult to draw back, reddened)?	N Y	Transient
Is there drainage from the penis?	N Y	Transient
Is the urethral meatus obstructed?	N Y	Overflow

Check the type of incontinence that most fits the resident based on answers above:

☐ **Urge**	☐ **Stress**	☐ **Mixed**	☐ **Overflow**	☐ **Functional**	☐ **Transient**
Sudden urge, large amounts, can't get to toilet in time.	Leakage when coughing, standing up, sneezing.	Combination of urge and stress symptoms.	Weak stream, dribbling, incomplete voiding.	Unable to get to toilet without assistance (mobility).	Temporary or recent onset, variety of causes.

Continued on next page...

2. Determine Resident's Voiding Pattern

Every resident should have a completed voiding diary upon admission and with significant changes in condition.

Voiding diary scheduled (date): _____ Date completed: _____ Initials: _____

Did the resident have a pattern?: _____ (for pattern, see voiding diary)

3. Evaluate for Behavioral Program

What is the MDS coding for item B0800 (ability to understand others)?

If **0, 1**
Consider MDS coding on G0110, 1-I (self-performing toileting).

If **0, 1, 2**
Bladder rehabilitation or pelvic floor rehab.

If **2, 3**
Scheduled voiding.

Residents with the following conditions could still benefit from participating in a prompted or scheduled voiding program:

» Those who cannot feel urge to urinate.
» Agitated or disoriented patients.
» Bedridden residents or those with mobility limitations.

If **3, 4**
Prompted voiding.

Based on above, the resident may be a candidate for: _____

Resident is not a candidate for bladder program due to:

☐ Use of appliances

☐ No bowel or bladder pattern

☐ Other: _____

Continued on next page...

4. Determine Appropriate Absorbent Product

Minimum Data Set (MDS) Version 3.0—Section H 0300& 0400, Bladder and Bowel

<table>
<tr><th></th><th>Ambulatory</th><th colspan="2">Non-Ambulatory, Contracted, Chronic Diarrhea, Combative, Low Air Loss Mattress</th></tr>
<tr><td>0
Always Continent
H0300 & H0400</td><td>------</td><td colspan="2">------</td></tr>
<tr><td>1
Occasionally Incontinent
Bladder—less than 7 episodes of incontinence
Bowel—1 episode of incontinence</td><td> 
LINER
BLADDER CONTROL PAD
PROTECTIVE UNDERWEAR</td><td rowspan="2"> 
ADULT BRIEF</td><td rowspan="2"> 
ULTRASORBS OR EXTRASORBS (USE ON A LOW AIR LOSS MATTRESS)</td></tr>
<tr><td>2
Frequently Incontinent
Bladder—7+ episodes, at least 1 episode of continence
Bowel—2+ episodes, at least 1 continent bowel movement</td><td> 
LINER</td></tr>
<tr><td>3
Always Incontinent
Bladder—No episodes of continent voiding
Bowel—No episodes of continent voiding</td><td> 
HEAVY LINER</td><td> 
ADULT BRIEF
 
HEAVY LINER</td><td> 
ULTRASORBS OR EXTRASORBS (USE ON A LOW AIR LOSS MATTRESS)</td></tr>
</table>

Daytime selection: _____ Overnight protection: _____

Continued on next page...

5. Determine Sizing of Absorbent Product

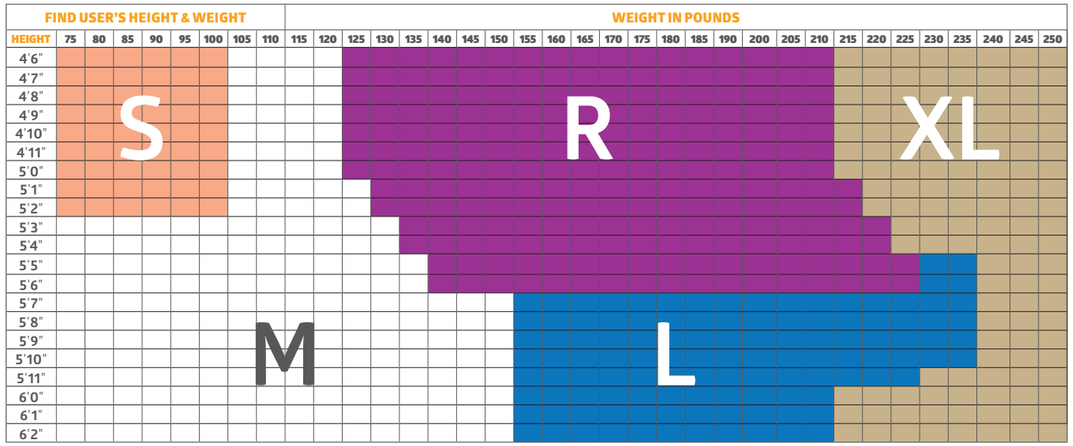
Determine and document the size by selecting the **larger** of the hip or waist measurement, or use sizing matrix reference based on gender/weight.

Gender: M F Waist measurement: _____

Weight: _____ Hip measurement: _____

Brief Size Selection

- **SMALL** = 20–32" (51–81 cm)
- **MEDIUM** = 32–42" (81–107 cm)
- **REGULAR** = 40–50" (102–127cm)
- **LARGE** = 48–58" (122–147 cm)
- **X-LARGE** = 59–66" (150–168 cm) (beige)
- **XX-LARGE** = 60–69" (152–175 cm)
- **BARIATRIC** = 69–90" (165–229 cm)



Sizing chart above is a recommendation only. ALSO AVAILABLE: BARIATRIC SIZE XXXL (For patients weighing more than 250 lbs.; waist size from 70 to 90").

6. Catheterization

Catheter Type: _____ Catheter Size: _____

Medical Justifications

☐ Urinary retention that cannot be treated medically or surgically, related to:

- » Post-void residual volume over 200 ml
- » Inability to manage retention/incontinence with intermittent catheterization
- » Persistent overflow incontinence
- » Symptomatic infections
- » Renal dysfunction

☐ Contamination of Stage III or IV pressure ulcers with urine that impeded healing.

☐ Terminal illness/severe impairments that make positioning/changing uncomfortable or associated with intractable pain.

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Functional Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Incontinence, Functional

Related to: (check all that apply)

- ☐ Impaired manual dexterity
- ☐ Access to toilet/toilet substitute
- ☐ Impaired physical mobility
- ☐ Altered cognition
- ☐ Visual difficulties
- ☐ Pain
- ☐ Poor motivation
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Inability to move purposefully within the environment
- ☐ Inability to dress self
- ☐ Limited muscle strength
- ☐ Impaired coordination
- ☐ Depression
- ☐ Other, specify: _____

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Use toilet substitute devices, such as urinal, commode when appropriate.		
	☐ Void in toilet at least 50% of the time according to individualized schedule and toileting program: (circle one) –routine scheduled toileting –habit training –prompted voiding –scheduled times: _____		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Maintain or increase strength and endurance of upper/lower extremities to assist in toileting process.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		

Continued on next page...

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Determine toileting program type and times to be toileted.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Assess for risk of pressure ulcers.
- ☐ Implement pressure ulcer prevention protocol.
- ☐ Check skin at least daily.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6–8 glasses of fluids unless medically prohibited.
- ☐ Assist to the bathroom as needed.
- ☐ Provide privacy for incontinence care.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Apply moisture barrier as needed.
- ☐ Maintain resident's dignity and privacy during continence care.
- ☐ Psych or social service referral for depression or motivational issues.
- ☐ Review Resident Education Brochure with resident and family.

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Fecal Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Bowel Incontinence

Related to: (check all that apply)

- ☐ Muscle damage (anal sphincters)
- ☐ Nerve damage due to childbirth injuries, spinal cord injury, multiple sclerosis or diabetes
- ☐ Rectal prolapse, rectocele, hemorrhoids, fissures, or fistulas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Anorectal surgery or trauma
- ☐ Idiopathic (unknown) causes
- ☐ Immobility
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Physical exam
- ☐ Involuntary leakage of stool
- ☐ Other, specify: _____

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Experience no involuntary stool loss.		
	☐ Have soft formed stool every _____ days.		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		

Continued on next page...

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review medications that affect bowel function with physician.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Assess abdomen for distention and bowel sounds upon initiation of bowel program and PRN any resident change in habit.
- ☐ Implement bowel program to promote defecation.
- ☐ Record color, odor, amount and frequency of stool.
- ☐ Report signs and symptoms requiring medical attention to physician.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6-8 glasses of fluids unless medically prohibited.
- ☐ Teach to avoid foods such as greasy or spicy foods, dairy products, cured or smoked meats, and alcohol or caffeine.
- ☐ Assist to the bathroom as needed.
- ☐ Provide privacy for incontinence care.
- ☐ Assess for type of absorbent disposable product/external collection device or internal drainage system.
- ☐ Measure for correct size of absorptive product.
- ☐ Assist with perineal care and containment device as needed.
- ☐ Check skin at least daily.
- ☐ Apply skin barrier product as needed.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Maintain resident's dignity and privacy during continence care.

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Mixed Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Incontinence, Urge, Stress

Related to: (check all that apply)

- ☐ Hyperactivity of detrusor muscle surrounding the bladder
- ☐ Poor urethral support from pelvic floor structure
- ☐ Local bladder irritation or infection
- ☐ Neuropathic detrusor instability
- ☐ Incomplete closure of urethra due to mucosal atrophy
- ☐ Medications
- ☐ Idiopathic causes
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Urinary frequency (> once every 2 hours while awake)
- ☐ Urinary frequency (> 8 times in a 24 hour period)
- ☐ Nocturia (waking up > 3 times per night to urinate)
- ☐ Urgency
- ☐ Involuntary urine loss associated with desire to urinate
- ☐ Involuntary passage of urine while asleep
- ☐ Observed loss of urine with physical exertion
- ☐ Reported loss of urine associated with physical exertion or activity
- ☐ Urine loss associated with increased abdominal pressure
- ☐ Other, specify: _____

Continued on next page...

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Experience no urine loss with physical exertion.		
	☐ Perform pelvic floor exercises according to individualized program.		
	☐ Void according to individualized schedule and bladder training program.		
	☐ Void in toilet according to individualized schedule and toileting program: (circle one) –routine scheduled toileting –habit training –scheduled times: _____ –prompted voiding		
	☐ Maintain intact skin/Experience no further skin breakdown.		
	☐ Clothing/Bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Determine toileting program type and times to be toileted.
- ☐ Complete urinalysis.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Begin pelvic floor muscle rehabilitation program.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6-8 glasses of fluids unless medically prohibited.
- ☐ Teach to avoid bladder irritants such as caffeine.
- ☐ Assist to the bathroom as needed.
- ☐ Provide privacy for incontinent care.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Check skin at least daily.
- ☐ Apply moisture barrier as needed.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Maintain resident's dignity and privacy during continence care.

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Overflow Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Incontinence, Overflow

Related to: (check all that apply)

- ☐ Outlet obstruction
- ☐ Prostate cancer
- ☐ Benign Prostatic Hyperplasia
- ☐ Urethral stricture
- ☐ Hypotonic bladder (detrusor muscle underactivity)
- ☐ Neurogenic bladder (due to diabetes, spinal cord injury, pelvic nerve damage from surgery or radiation)
- ☐ Medications
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Urine passively leaking through urinary sphincter
- ☐ Inability to void even when the urge is felt
- ☐ Weak urinary stream
- ☐ Nocturia
- ☐ Post-Void Residual > 200 cc
- ☐ Bladder Scan
- ☐ Other, specify: _____

Continued on next page...

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Experience urine loss that is adequately contained.		
	☐ Void according to individualized schedule and toileting program: (circle one) –routine scheduled toileting –habit training –prompted voiding –scheduled times: _____		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		
	☐ Maintain dignity; conceal any collection/containment devices when used.		
	☐ Perform Clean Intermittent Catheterizations every _____ (circle one) –by self –with assistance Consult physician regarding the use of indwelling catheter		

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Determine toileting program type and times to be toileted.
- ☐ Complete urinalysis.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6–8 glasses of fluids unless medically prohibited.
- ☐ Assist to the bathroom as needed.
- ☐ Assess for risk of pressure ulcers.
- ☐ Implement pressure ulcer prevention protocol.
- ☐ Check skin at least daily.
- ☐ Provide privacy for incontinence care.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Apply moisture barrier as needed.
- ☐ Maintain resident's dignity and privacy during continence care.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Monitor for signs and symptoms of upper urinary tract involvement (fever, flank pain, hematuria, chills, etc.).

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Stress Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Incontinence, Stress

Related to: (check all that apply)

- ☐ Urethral hypermobility secondary to poor anatomical pelvic support (lax pelvic floor muscles)
- ☐ Intrinsic sphincter deficiency (defect in urethra)
- ☐ Urethral sphincter incompetence s/p prostatectomy
- ☐ Urinary tract infection
- ☐ Medications
- ☐ Idiopathic causes
- ☐ Other, specify _____

As evidenced by: (check all that apply)

- ☐ Observed loss of urine with physical exertion
- ☐ Reported loss of urine associated with physical exertion or activity
- ☐ Urine loss associated with increased abdominal pressure
- ☐ Positive provocative stress test
- ☐ Other, specify _____

Continued on next page...

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Experience no urine loss with physical exertion.		
	☐ Experience no urine loss with increased abdominal pressure.		
	☐ Perform pelvic floor exercises according to individualized program.		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other _____		

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Complete urinalysis.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6-8 glasses of fluids unless medically prohibited.
- ☐ Begin pelvic floor muscle rehabilitation program.
- ☐ Teach to avoid bladder irritants such as caffeine.
- ☐ Assist to the bathroom as needed.
- ☐ Provide privacy for incontinence care.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Apply moisture barrier as needed.
- ☐ Check skin at least daily.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Maintain resident's dignity and privacy during continence care.

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Transient Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Elimination, Impaired

Related to: (check all that apply)

- ☐ Delirium, dementia, depression
- ☐ Infection (UTI)
- ☐ Atrophic vaginitis or urethritis
- ☐ Medications
- ☐ Excess urine production
- ☐ Restricted mobility
- ☐ Stool impaction
- ☐ Trauma
- ☐ Stress
- ☐ Idiopathic causes
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Physical exam
- ☐ Cognitive exam
- ☐ New onset urinary incontinence
- ☐ New onset fecal incontinence
- ☐ Other, specify: _____

Continued on next page...

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		
	☐ Transient incontinence will resolve with the identification/treatment and/or removal of reversible/causative factors.		

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Determine toileting program type and times to be toileted.
- ☐ Complete urinalysis.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6-8 glasses of fluids unless medically prohibited.
- ☐ Assist to the bathroom as needed.
- ☐ Provide privacy for incontinence care.
- ☐ Check skin at least daily.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Apply moisture barrier as needed.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Maintain resident's dignity and privacy during continence care.
- ☐ If incontinence not resolved after all possible reversible, causative factors, then treated resident should be evaluated for urge, stress, mixed, overflow (chronic urinary retention) or functional incontinence.

Incontinence Solutions

Urge Incontinence Care Plan

Resident Name: _____ Unit: _____ Room Number: _____

Start Date: _____ Notification of Physician: _____ Notification of Direct Care Staff: _____

Nurse's Signature: _____

Nursing Diagnosis: Urinary Elimination, Impaired

Related to: (check all that apply)

- ☐ Neurological disorders (stroke, diabetes, Parkinson disease and multiple sclerosis)
- ☐ Detrusor instability or detrusor hyperreflexia (detrusor contractions)
- ☐ Bladder stones or bladder cancer
- ☐ Acute or chronic urinary tract infection
- ☐ Utero-vaginal prolapse and tumors
- ☐ Idiopathic causes
- ☐ Medications
- ☐ Other, specify: _____

As evidenced by: (check all that apply)

- ☐ Urinary frequency (> once every 2 hours while awake)
- ☐ Urinary frequency (> 8 times in a 24 hour period)
- ☐ Nocturia (waking > 3 times per night to urinate)
- ☐ Urgency
- ☐ Involuntary urine loss associated with desire to urinate
- ☐ Involuntary passage of urine while asleep
- ☐ Other, specify: _____

Continued on next page...

Date and Sign	Plan and Outcome (check all that apply) This Resident Will:	Target Date	Date Achieved
	☐ Decrease incontinent episodes by _____ within _____ days.		
	☐ Void according to individualized schedule and bladder re-training program.		
	☐ Void according to individualized schedule and toileting program: (circle one) –routine scheduled toileting –prompted voiding –habit training –scheduled times: _____		
	☐ Perform pelvic floor exercises according to individualized program.		
	☐ Maintain intact skin/experience no further skin breakdown.		
	☐ Clothing/bedding remains dry during the day and night using: (circle one) –liner –pad –brief –other: _____		

Nursing Interventions: (check all that apply)

- ☐ Call bell within reach, answer promptly.
- ☐ Review meds for those that affect bladder function with physician for possible changes.
- ☐ WOC Nurse referral if available.
- ☐ Complete history, physical assessment, voiding and bowel elimination diary.
- ☐ Determine toileting program type and times to be toileted.
- ☐ Complete urinalysis.
- ☐ Assess resident for functional limitations consult therapy as needed.
- ☐ Begin pelvic floor muscle rehabilitation program.
- ☐ Provide well lit, clear path to bathroom or commode and easy access to devices such as urinal or bed pan.
- ☐ Encourage at least 6-8 glasses of fluids unless medically prohibited.
- ☐ Teach to avoid bladder irritants such as caffeine.
- ☐ Assist to the bathrooms needed.
- ☐ Provide privacy for incontinence care.
- ☐ Assess for type of absorbent disposable product and measure for correct size.
- ☐ Assist with perineal care and disposable absorbent product as needed.
- ☐ Check skin at least daily.
- ☐ Apply moisture barrier as needed.
- ☐ Review Resident Education Brochure with resident and family.
- ☐ Maintain resident's dignity and privacy during continence care.

Incontinence Solutions

Completing and Interpreting a Voiding and Bowel Elimination Diary

Objective

To objectively document patterns of elimination and leakage and the effects of the environment, fluids and/or dietary intake on elimination/incontinence. Use the information obtained to determine individualized interventions to regulate elimination and prevent complications of incontinence.

Candidates

Incontinent residents after transient (acute) causes of incontinence have been evaluated and treated (UTI, medications, vaginitis, fecal impaction, etc.). The diary is an important component of an initial assessment and also may help monitor progress while on a toileting program.

Procedure

1. Identify resident in need of voiding and bowel elimination diary.
2. Identify type of assessment (bladder, bowel, both) and time frame (minimum is three days for a voiding diary, one week for a bowel diary).
3. Communicate to staff the resident being assessed, what is being assessed (e.g., bowel and/or bladder eliminations, continent episodes, leakages, fluid and dietary intake, awareness of need to eliminate) and number of days the assessment will occur.
4. Provide documentation forms. Suggest including on the 24-hour report documentation to note resident on Voiding and Elimination Diary day 1 of 3, 2 of 3, or 3 of 3, etc.
5. Bladder scan the resident post-void at least twice per day to assess if there is post-void residual.
6. Assign staff members responsible for resident documentation (each shift) and review expectation. The expectation of the diary is documentation of the status of the resident every one to two hours, not the reduplication of any of the previous shift's documentation.
7. Utilize information obtained to determine management of bladder and bowel incontinence.

Completion of Voiding Diary

1. CNA or designated staff member to assess the resident every one to two hours.
2. Document the time, type and nature of continent or incontinent episodes.
3. For each event, ask the resident whether he or she felt the urge to void or defecate.
4. If resident does not have urge to void, bladder scan to assess bladder volume.
5. Identify activity during incontinent episodes.
6. Bladder scan the resident post-void at least twice per day to assess if there is post-void residual.
7. Document volume of fluid intake and output (if able to).
8. Document type and amount of food intake.
9. Document applicable information such as burning sensation, pain or cognitive status.
10. Complete for a minimum of three days for a voiding diary, one week for a bowel diary.

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Completion of Voiding Diary (Continued)

11. Unit Managers/Licensed nurse to monitor for compliance in completion.

12. Input all gathered information in the resident master data screen to determine manufacturer recommended product and size for each resident.

13. Communicate recommended product for each resident in the patient charts and to the nursing staff.

Interpretation of Diary

1. Determine resident's usual sleep/wake pattern.

2. Determine daytime (diurnal) voiding and bowel movement frequency.

i. Average voiding interval of less than two hours, or more than eight episodes every twenty-four hours indicates daytime urinary frequency.

ii. Note frequencies of bowel movements and type of stool (formed, soft, liquid).

3. Determine night-time voiding and bowel movement frequency (episodes when **awakened** by the urge to void or move bowels).

4. Determine leakage or incontinent episodes of urine and/or stool.

5. Review fluids and diet for consumption of irritants and relationship to any episodes of eliminations.

6. Evaluate for any patterns:

i. **Urge Incontinence**—loss of large amounts of urine during day or night associated with a precipitating urge to void.

ii. **Stress Incontinence**—leakage of small amounts during waking hours associated with an activity.

iii. **Functional Incontinence**—loss of urine associated with cognitive or environmental barriers to toileting.

iv. **Overflow Incontinence**—loss of urine not associated with physical exertion, urge to urinate, cognitive or environmental factors. No pattern.

v. **Mixed Incontinence**—combination of above (usually Urge, Stress and Functional).

vi. **Diarrhea**—any increase in stools: frequency, liquidity or amount.

vii. **Constipation**—difficulties with defecation including: straining, use of manual maneuvers, feeling of incomplete evacuation, infrequent or hard bowel movements.

7. Evaluate for bowel and/or bladder program.

8. Begin trial program.

9. Evaluate progress (decreases in incontinent episodes or leakage) in intervals and the need to continue or discontinue toileting program attempts.

10. Document actions and responses in medical record.

NOTE: The more information and detail included in the diary, the more valuable the diary will be.

Incontinence Solutions

24-Hour Voiding Diary

Check the resident every 1-2 hours. Using key below (for those areas), document if the resident has been incontinent (urine, stool or both) or needs to be toileted. If toileted, document appropriate elimination(s).

Key: Incontinent Urine D = Damp W = Wet S = Saturated **Stool/BM** S = Soft formed H = Hard formed Lq = Liquid

Elimination Diary for Day: ____ of 3 Date: _____ Recorded by: _____

	Incontinent		Toilet/ Commode/ Bedpan		Aware Of Urge To Eliminate?		Bladder Scan		Fluids		Foods			
Time	Urine	Stool	Dry	Void Y / N	BM	Yes	No	Pre-Void	Post-Void	What kind?	Intake (cc)	What kind?	Initials	**Notes:** (e.g., c/o incomplete bladder emptying, straining w/ elimination, malodorous urine, leakage w/ activity)
12 am														
1 am														
2 am														
3 am														
4 am														
5 am														
6 am														
7 am														
8 am														
9 am														
10 am														
11 am														

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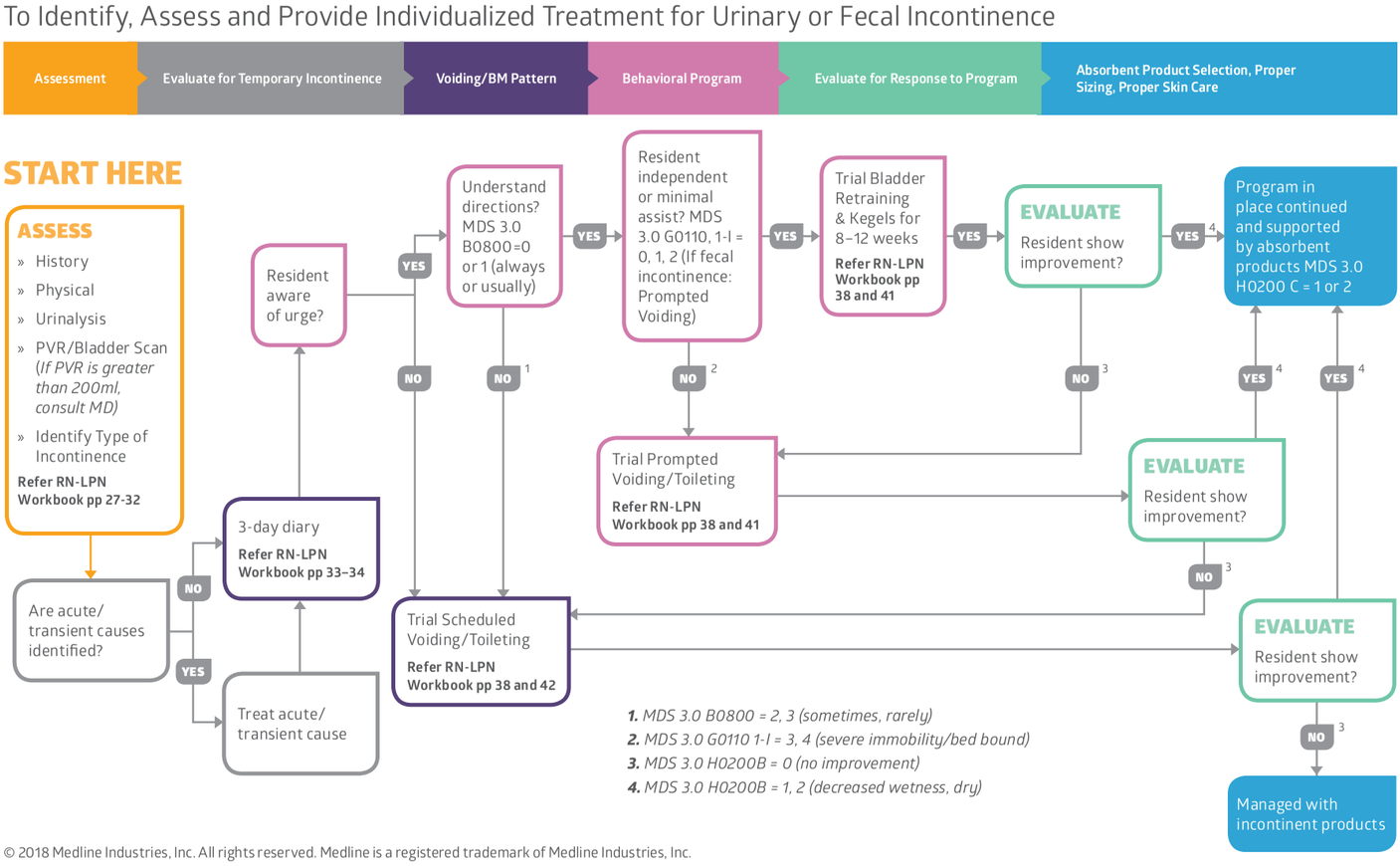
Key: Incontinent Urine D = Damp W = Wet S = Saturated
Stool/BM S = Soft formed H = Hard formed Lq = Liquid

	Incontinent			Toilet/ Commode/ Bedpan		Aware Of Urge To Eliminate?		Bladder Scan		Fluids		Foods		Notes: (e.g., c/o incomplete bladder emptying, straining w/ elimination, malodorous urine, leakage w/ activity)
Time	Urine	Stool	Dry	Void Y / N	BM	Yes	No	Pre-Void	Post-Void	What kind?	Intake (cc)	What kind?	Initials	
12 pm														
1 pm														
2 pm														
3 pm														
4 pm														
5 pm														
6 pm														
7 pm														
8 pm														
9 pm														
10 pm														
11 pm														

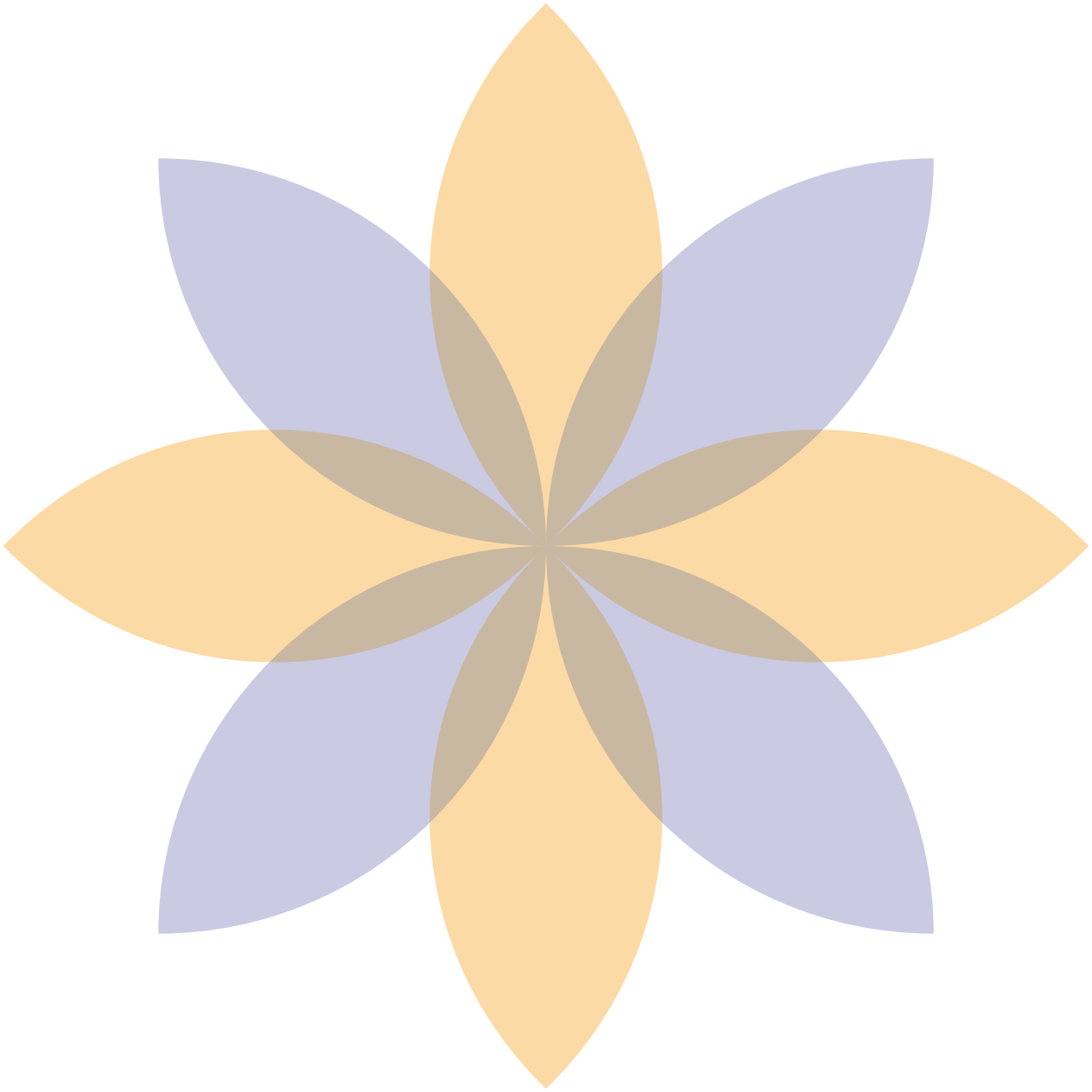
Incontinence Solutions

Flowchart

To Identify, Assess and Provide Individualized Treatment for Urinary or Fecal Incontinence



Notes:



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