

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION D: PSYCHOLOGICAL ADAPTATION CHAPTER 17: PHYSIOLOGICAL NURSING CARE</p> <p>POLICY AND PROCEDURE 17.5.3 Managing Urinary Incontinence</p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Registered Nurses and Licensed Practical Nurses</p>

Standard of Practice:

The Nurse will ensure that the patient is assessed for urinary incontinence. The Nurse will ensure that appropriate Nursing interventions are instituted to prevent or manage incontinence.

Standard of Care:

The patient can expect the Nurse to provide care that will help the patient maintain continence and effective hygienic care thereby increasing comfort and preventing skin breakdown and infection.

Policy:

It is the policy of Connecticut Valley Hospital that all patients are assessed for urinary incontinence and are provided with care that can prevent or minimize incontinence. Nursing interventions shall be based on the types of incontinence assessed and the patient's specific need for assistance. Identified problems and planned interventions regarding urinary incontinence shall be addressed in the Nursing Plan of Care. Patients who have the cognitive ability and desire to participate shall be provided with continence training. Patients who are not candidates for continence training shall require alternative methods based on their physical limitations such as absorbent undergarments, use of a commode, urinal, or bed pan.

Procedure:

Assess for type (s) of urinary incontinence and plan the Nursing approach based on the type(s) as follows:

- a. Stress Incontinence – Loss of small amounts of urine when intra abdominal pressure rises, i.e., coughing, sneezing, lifting, laughing or rising from a chair or bed.

Nursing Approach:

- Teach patient pelvic floor muscle strengthening exercises such as kegel exercises
- Encourage or assist the patient with weight loss strategies regarding diet,

exercise (be specific)

- b. Urge Incontinence – Need to void perceived frequently, voiding commences when there is a delay in accessing a restroom.

Nursing Approach:

- Maintain fluid intake of at least 2000 mL/day
- Omit bladder irritant such as caffeine
- Administer diuretics in the morning

- c. Reflex Incontinence – Spontaneous loss of urine when bladder is stretched with urine but without prior perception of a need to void. This is found in patients who have paralysis.

Nursing Approach:

- Take the patient to the bathroom every 2 hours
- Use cutaneous triggering which is lightly massaging or tapping the skin above the pubic area. This initiates urination in patients who have retained a voiding reflex (spontaneous relaxation of the urinary sphincter in response to physical stimulation)
- Straight intermittent catheterization

- d. Functional Incontinence – Control over urination lost because of inaccessibility of a toilet or a compromised ability to use one, i.e., restrictive clothing, overcoming barriers, getting assistance.

Nursing Approach:

- Modify clothing
- Facilitate access to toilet, commode, or urinal
- Assist to toilet according to a preplanned schedule
- Wash the patient promptly with soap & water following incontinence to prevent skin breakdown

- e. Total Incontinence – Loss of urine without any identifiable pattern or warning, no ability or effort to control.

Nursing Approach:

- Use absorbent undergarments; check for wetness every 2 hours and wash and change the patient as needed. Use only one absorbent undergarment at a time, or the patient will be at increased risk of skin breakdown or infection.
- Use external catheter; check and empty bag as needed, wash the patient following changes to prevent skin breakdowns

- f. Over Flow Incontinence – Urine leakage because the bladder is not completely empty; bladder is distended with retained urine. Overstretched bladder or weakened muscle tone secondary to an enlarged prostate, distended bowel or post operative bladder spasm.

Nursing Approach:

- Ensure adequate hydration (bespecific)
- Ensure adequate bowelelimination
- Perform Crede's Maneuver (bending over and applying hand pressure over the bladder)

Provide Continence Training using the following guidelines as applicable to each patient.

- Compile a log of the patient's elimination patterns in order to analyze the patient's type of incontinence and plan the rehabilitation program.
- Set specific, realistic, short-term goals to promote success
- Discourage strict limitations of fluid intake in order to ensure an adequate volume of urine
- Plan a trial schedule for voiding that coordinates with the times that the patient is usually incontinent or expresses bladder distention. This may reduce the potential for accidental voiding or sustained urinary retention.
- In the absence of any identifiable pattern, plan to assist the patient with voiding every 2 hours during the day and every 4 hours at night.
- Communicate the plan with nursing staff, the patient, and the family for continuity of care.
- Assist the patient to a toilet or commode, position the patient on a bedpan or place a urinal just before the scheduled time for voiding.
- Simulate the sound of urination by running water from the faucet. This stimulates relaxation of the sphincter muscles.
- Suggest performing Crede's Maneuver (the act of bending forward and applying hand pressure over the bladder). This increases abdominal pressure to overcome the resistance of the internal sphincter muscle.
- Instruct patients with paralysis to identify any sensation that precedes voiding, such as a chill, a muscular spasm, restlessness, or a spontaneous erection, thus providing a cue for anticipatingurination
- Use cutaneous triggering (lightly massaging or tapping the skin above the pubic area) for patients with paralysis who have reflex incontinence. This may initiate urination in patients who have retained a voiding reflex (spontaneous relaxation of the urinary sphincter in response to physical stimulation).
- Teach patients with stress incontinence to perform kegel exercises, which tighten the internal muscles used to prevent urination or interrupt urination once it has begun.
 - Once tightened, keep the muscles contracted for at least 10 seconds.
 - Relax the muscles for 2seconds
 - Repeat the pattern of contraction and relaxation 10-25 times.
 - Perform the exercise 3-4 times a day for 2 weeks to 1 month.
- Assist patients with urge incontinence to walk slowly and concentrate on holding their urine when nearing thetoilet.
- To maintain the patient's dignity, do not use or refer to absorbent undergarments as diapers.