

 <p>Connecticut Valley Hospital Nursing Policy and Procedure</p>	<p>SECTION C: PSYCHOLOGICAL ADAPTATION CHAPTER 18: PROMOTING ELIMINATION</p> <p>POLICY AND PROCEDURE 18.2.3 Managing Fecal 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 initially and periodically assessed for fecal 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 bowel elimination and fecal incontinence and are provided with care that can prevent or minimize incontinence. Nursing interventions shall be based on the causes of fecal incontinence and the patient's specific need for assistance.

Identified problems and planned interventions regarding fecal incontinence shall be addressed in the Master Treatment Plan. In many cases of incontinence, bowel function is normal, but the incontinence results from neurologic changes that impair muscle activity or sensation. Even a fecal impaction may be an underlying cause of incontinence. Incontinence may also occur when a person can not reach a toilet in time to eliminate, such as after taking a harsh laxative.

Procedure:

In order to prevent or manage fecal incontinence the following guidelines for bowel retraining by reflex conditioning are offered:

- a. Ensure that the patient eats regularly and nutritiously, a diet rich in fiber such as raw, leafy vegetables, fruit such as prunes, rye bread and cereals.
- b. Monitor the pattern of incontinence to determine whether it occurs at a similar time each day.
- c. Have the patient sit on the toilet or bedside commode before the time(s) elimination tends to occur.

- d. Consult with the Physician about inserting a suppository or administering an enema to establish a pattern for bowel elimination.
- e. Administer medication as ordered (eg. stool softener or mild laxatives).
- f. Encourage adequate fluid intake.
- g. Encourage exercises that develop and tone the abdominal muscles.
- h. Help prevent and identify signs which may indicate a full bowel.
- i. Use moisture proof absorbent undergarments to protect clothing and bed linen.
- j. Check and change undergarments frequently to maintain effective hygienic care and to increase the patient's comfort and prevent skin breakdown and infection
- k. Write the selected interventions on the patient's Master Treatment Plan and communicate the content to assigned nursing staff to ensure continuity.
- l. To maintain the patient's dignity, do not use or refer to absorbent undergarments as diapers.