Toileting & Elimination Tutorial

Possible Undesirable Effects of Urinary Incontinence:

Skin breakdown - Urine is very irritating to the skin.

Urinary tract infections - Good pericare needs to be given after every episode of incontinence.

Falls - If a patient who needs help with toileting doesn't receive assistance to the toilet in a timely manner, she may fall and injure herself trying to go to the bathroom alone.

Sleep disturbances, Social withdrawal, Impaired activities

Loss of dignity - This is a very serious effect. All of our lives we are used to elimination being something we do in private. The smell and sight of our urine is something we don't want anyone else to be aware of.

Types of Urinary Incontinence

Urge Incontinence

The most common cause of urinary incontinence in elderly persons
Urgency, frequency, and nocturia – needing to urinate during the night
Patient can feel the need to void, but is unable to inhibit the urge long enough to reach the commode
Interventions: Bladder retraining, Kegel exercises

Stress Incontinence

Second most common type of urinary incontinence in elderly women
Loss of small amount of urine with physical activity such as coughing, sneezing, laughing, walking stairs, or lifting
Interventions: Kegel exercises, pads

Functional Incontinence

Secondary to factors other than inherently abnormal urinary tract function
May be related to: physical weakness or poor mobility/dexterity (poor eyesight, arthritis, stroke, contracture, cognitive problems, medications, or environmental factors
Intervention: Prompted voiding

Incontinence Programs

Bladder Retraining / Rehabilitation

Best for patient with urge incontinence and who is cognitively intact and fairly physically independent
Requires patient to postpone voiding, and to urinate according to a time schedule
Depending on patient's success, intervals between voiding can be increased progressively
Combines patient education and positive reinforcement

Prompted Voiding
For dependent or more cognitively impaired patients
Focuses on teaching the patient to recognize the need to void, to ask for help, or to respond when prompted to void.
Has Three Components:
- Regular monitoring with encouragement to report continence status
- Prompting to toilet on a scheduled basis
- Praise and positive feedback when the patient is continent and attempts to toilet

General Interventions for Urinary Incontinence

Check patient every two hours, and assist with toileting as needed

Provide urinal/bedpan/bedside commode

Provide pericare after each incontinent episode

Keep call light within reach, and remind patient to call for assistance

Monitor for signs and symptoms of urinary tract infection

Provide loose fitting, easy to remove clothing

Assist patient to maintain dignity, privacy, and independence

Each patient is different, so interventions will be unique to each patient.

Depending on the patient's mobility, he may use:
Toilet, bedside commode, bedpan, urinal, briefs, pads – or a combination of these.

Alert the charge nurse when you think changes in interventions may need to be considered.

The important thing is that we assist each patient to reach and maintain her dignity and highest possible level of continence.

Catheter Care and Urinary Tract Infections

We do everything we can to maintain a patient's continence. Urinary catheters are not inserted unless there is a medical reason, such as urinary retention or the need to keep a pressure ulcer dry for healing.

We try to avoid the use of urinary catheters because they can cause a lot of problems for the patient, including infection and decreased mobility.

The catheter and its tubing and bag are a closed, sterile system. A sterile, soft rubber tube is inserted through the urethra into the bladder. A small balloon on the catheter is filled with sterile water to hold the catheter in place in the bladder. The tubing and bag are attached to the catheter, and urine drains out by gravity. Urine will usually drain at a steady rate, filling the bag slowly.

The Urinary Catheter and Pericare

Do catheter and perineal care with a.m. and p.m. care, and after each bowel movement.

Always wash your hands before and after handling the catheter, tube or bag, and wear gloves, following standard precautions for infection control.

The meatus is the opening into the urethra, where the catheter is inserted. Clean the area by wiping away from the meatus, to prevent germs from being moved from the anus to the urethra. Hold the end of the catheter tube to keep it from being pulled while cleaning. Wash the catheter to remove any blood or other materials from the catheter, wiping downwards from the urethra.

Do not use powder around the catheter entry site.

Check for any irritation, redness, tenderness, swelling, drainage or leaking around the catheter entry site.

Catheter Tubing and Bag

Check frequently to be sure there are no kinks or loops in the tubing and that the patient is not lying on the tubing.
Secure catheter tubing to upper leg to prevent catheter being pulled out.
Keep the bag below the level of the patient's bladder at all times.
Use a catheter bag cover to protect the patient's dignity.

Emptying the Catheter

Empty the catheter bag when it is 2/3 full. If the bag were to fill completely, urine would back up into the bladder, causing risk of infection.
Place a large plastic container on the floor beneath the bag. Remove the drain spout from its sleeve at the bottom of the catheter bag without touching its tip, open the slide valve on the spout, and let

the urine flow out of the bag into the container. Do not let the drain tube touch anything. Close the slide valve and put the drain spout into its sleeve at the bottom of the bag.

Monitoring for Problems

Measure urinary output at the end of every shift, and record in the patient's record. Notify the charge nurse if the output is low. This could mean the patient is dehydrated, has a urinary tract infection, there is a blockage preventing the urine from flowing out, or that the catheter is leaking.

Check urine for dark or unusual color, signs of blood, mucus, sediment, or foul odor. Healthy urine is clear and light yellow.

Periodically check the skin around the catheter entry site for signs of irritation, redness, tenderness, swelling, or drainage.

If the bed or patient's clothes are wet with urine, check to see if the catheter tubing is twisted or bent, or if the patient is lying on the catheter or tubing. Make sure the catheter bag is below the level of the bladder.

Urinary Tract Infections

The elderly are more prone to UTIs due to:
Decreased thirst
Decreased mobility - Concentrated urine and urine sitting in the bladder lead to infection
Weakened immunity
Incontinence
Self-care deficits
Irregular toileting
Catheters

Signs and Symptoms of a Urinary Tract Infection:
Increased confusion or sudden cognitive decline
Fever
Pain with urination, urgency, or frequency
Flank or suprapubic pain
Change in character of urine
A UTI can be very serious in an elderly person, leading to infection, confusion, falls, sepsis, and death.

Interventions to Prevent Urinary Tract Infections

Instruct patient in proper cleaning of perineal area after voiding or bowel movement

Monitor fluid intake, and make sure patient is well hydrated

Encourage frequent voiding

Advise patient that cotton underwear is less hospitable to germs than nylon underwear

Monitor for bladder distention, small, frequent voidings, patient complaint of bladder feeling full

Monitor urine appearance, amount, odor, and clarity

Assist with pericare after incidents of incontinence

Offer cranberry juice with snacks

Constipation

Constipation is the most common gastrointestinal problem in the United States.
The normal bowel pattern varies in people anywhere from three bowel movements per week to three per day.
Constipation is generally defined as less than three bowel movements per week. Straining with bowel movement and hardened stools are also signs of constipation.

The Elderly and Constipation

Elderly persons are more prone to constipation for several reasons:
Decreased exercise and mobility
Inadequate fluid intake
Poor diet, Diseases, Medications
Dependency on laxatives

Consequences of Constipation

Constipation can be fatal!
Stool sitting in the bowel can become increasingly drier, and eventually occlude the bowel, causing a fecal impaction.
Increasing pressure behind the impaction can cause the bowel to rupture, causing peritonitis and death.
Sometimes a person with an impaction will pass liquid stool, so any irregularity in pattern or consistency of bowel movements should be reported to the charge nurse.
If a patient has not had a bowel movement for two days, you should report this to the charge nurse as soon as possible. Also report:
Straining at bowel movement
Hardened stools
Abdominal swelling or pain

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Wellness comes home.

Prevention and Treatment of Constipation

Encourage fiber foods and fluid intake

Encourage activities

Assist or cue patient to toilet at the same time every day patient usually has bowel movement

Provide adequate time and privacy for elimination

Bowel program as indicated