



POLICY AND PROCEDURE

BLADDER AND BOWEL MANAGEMENT



Developed by:
Toronto Best Practice in LTC Initiative
December 2006

Toronto Best Practice Implementation Steering Committee

Helen Ferley, Co-Chair
Administrator
Seniors' Health Centre – North York
General Hospital

Patty Carnegie, Co-Chair
Staff Education Coordinator
Toronto Homes for the Aged

Carolyn Acton
Manager, Client Services
Toronto Community Care Access
Centre

Sue Bailey
Psychogeriatric Resource Consultant
Providence Healthcare

Janice Buchanan
Mental Health and Addiction Consultant
Ministry of Health and Long-Term Care
Toronto Regional Office

Martha Burnside
Director of Care
Yorkview Lifecare

Glenn Dudman
LTC Program Consultant
Ministry of Health and Long-Term Care
Community Health Division

Gabriella Golea
Administrative Director
Geriatric Mental Health and Dual
Diagnosis Programs
Centre for Addiction and Mental Health

Metzie Lacroxi
Director of Nursing
Lincoln Place

Becky Li
Director of Resident Care
Mon Sheong Foundation

Penelope Minor
Nurse Manager/Clinical Coach
Baycrest

Vania Sakelaris
LTC Program Consultant
Ministry of Health and Long-Term Care
Community Health Division

Josephine Santos
Regional Best Practice Coordinator,
Long-Term Care – Toronto Region
Ministry of Health and Long-Term Care
Host Agency: Seniors' Health Centre –
North York General Hospital

Nada Simic
Nurse Manager
Castleview Wychwood Tower

Anne Stephens
Clinical Nurse Specialist in Gerontology
St. Michael's Hospital

Cindy Stephens
Director of Nursing
Cummer Lodge

Clara Tsang
Geriatric Clinical Nurse Specialist/
Nurse Practitioner
Rouge Valley Health System
Geriatric Emergency Management

Acknowledgments

This policy and procedure was developed by the Toronto Bladder and Bowel Best Practice Long-Term Care Working Group:

Helen Alemany
Clinical Practice Leader, Villa Colombo

Brenda Braganca
Director of Care, Lakeside Long-Term Care Centre

Shelly Gorchynski
Education Consultant, The Wexford

Lorna Hedger
Assistant Director of Care, Lakeside Long-Term Care Centre

Yasmin Merali
Extendicare LTC Consultant

Susee Nadlarajah
Assistant Director of Care, Hellenic Home

Frances Nelson
Staff Registered Nurse, West Park Long Term-Care Centre

Josephine Santos
Regional Best Practice Coordinator, Long-Term Care – Toronto Region
Ministry of Health and Long-Term Care
Host Agency: Seniors' Health Centre – North York General Hospital

The Toronto Best Practice Implementation Steering Committee has reviewed this policy and procedure and would also like to thank all the stakeholders who participated in the review process.

The Best Practice in Long-Term Care Initiative is funded by the Ontario Ministry of Health and Long-Term Care.

Table of Contents

Policy	5
Purpose	5
Preamble	5
Team Members – Roles and Responsibilities	5
Procedure	
A – Bladder and Bowel Continence Assessment	7
B – Care Planning	7
C – Interventions Based on Urinary Incontinence Types	8
D – Interventions to Promote Urinary Continence	8
E – Interventions for Residents with Intractable Incontinence	13
F – Interventions to Prevent and Manage Constipation	14
References	16
Appendix A	
Bladder and Bowel Continence Assessment	17
Appendix B	
Quarterly Continence Assessment	21
Appendix C	
Voiding/Fluid Record	22
Appendix D	
7-Day Bowel Record	23
Appendix E	
Classification of Laxative Therapies	24
Appendix F	
Stepwise Approach to Management of Constipation	25
Appendix G	
Glossary of Terms	26

Disclaimer: This policy and procedure has been developed by a group of LTC Homes and the Regional Best Practice Coordinator in Toronto. It is based on the 2005 Ministry of Health and Long-Term Care Standards on Continence Care and the RNAO Best Practice Guidelines on Promoting Continence Using Prompted Voiding and Prevention of Constipation in the Older Adult Population, and other best practice sources on the same topics. It has been reviewed by stakeholders from various LTC Homes and representatives of the Toronto Best Practice Implementation Steering Committee.

This policy and procedure is to be used as a guideline at the discretion of the LTC Homes.

**POLICY AND PROCEDURE
BLADDER AND BOWEL MANAGEMENT**

POLICY:

Each resident must be assessed for bladder and bowel functioning within 7 days of admission, quarterly and any change in condition that affects continence.

PURPOSE:

The purpose of the bladder and bowel management program is to:

1. Address resident's individual needs with respect to continence of the bladder and bowel.
2. Initiate appropriate strategies and interventions.
3. Provide learning opportunities.
4. Monitor and evaluate resident outcome

PREAMBLE:

The interdisciplinary team plays a significant role in bladder and bowel management, promotes open communication and monitors the outcome of the program. A continence team may be established to provide expertise with assessment for incontinence, the promotion of continence, the proper use of continence-care products, appropriate toileting routines, and to ensure the Continence program is being managed effectively for all residents.

Team Members	Roles and Responsibilities
Director of Care or Designate	<ul style="list-style-type: none"> • Facilitates the implementation of bladder and bowel management procedures for each individual resident including education. • Collects data, analyzes statistics, identifies trends, evaluates outcomes and presents quarterly statistics to an interdisciplinary committee. • Seeks advice from experts such as Nurse Continence Advisors including suppliers to support team decisions. • Coordinates education processes relating to bladder and bowel management. • Ensures equipment and supplies are adequate for resident's needs.
Nursing (RN and RPN)	<ul style="list-style-type: none"> • Completes a bladder and bowel continence assessment within 7 days of admission, quarterly and any change in condition that affects continence. • Initiates and communicates a plan of care to address the resident's bladder and bowel issues. • Makes referral to other interdisciplinary team members.

Team Members	Roles and Responsibilities
Nursing (RN and RPN)	<ul style="list-style-type: none"> • Provides education to family/resident about bladder and bowel management. • Evaluates the plan of care and updates as necessary. • Assesses Health Care Aide/Personal Support Worker skills and encourages staff development, e.g., transfer skills. • Reviews bladder and bowel record and addresses constipation with interdisciplinary team. • Responds to Health Care Aide/Personal Support Worker's assessment, re. bladder and bowel management concerns.
Health Care Aide/Personal Support Worker	<ul style="list-style-type: none"> • Offers privacy and develop rapport with resident when toileting/changing. • Encourages fluid and nutritional intake, e.g., 1500 ml of fluid daily. • Follows procedure and care plan to promote continence. • Assists residents when transferring, ambulating or walking to the toilet. • Maximizes mobility and passive exercises. • Toilets the residents prior to bathing and as per care plan. • Completes the voiding and bowel record and reports concerns or changes to the RN/RPN. • Recognizes and reports resident verbalizations and behaviours indicative of discomfort. • Reports any signs and symptoms of bladder and bowel discomfort to the RN.
Occupational Therapist (OT)/ Physiotherapist (PT)	<ul style="list-style-type: none"> • Assesses, develops a treatment plan and implements rehabilitative/restorative/maintenance balance and mobility interventions; communicates treatment plan to interdisciplinary team. • Advises staff on transferring techniques. • Assesses and recommends assistive equipment, such as wheelchairs, walkers, and canes. • Educates residents, family and staff on how to use equipment safely. • Evaluates and reassesses resident status.
OT Assistant /PT Assistant/Rehabilitation Assistant	<ul style="list-style-type: none"> • Carries out the rehabilitative/restorative/maintenance balance and mobility treatment plan. • Monitors resident responses and reports responses to OT/PT & interdisciplinary team. • Monitors/inspects assistive equipment, such as wheelchairs, walkers, and canes on a regular basis.
Registered Dietitian	<ul style="list-style-type: none"> • Completes nutritional risk assessment within 7 days. • Orders appropriate diet and supplements as described by the LTC Homes policy. A Physician co-signature is required. • Makes recommendations to Physicians. • Suggests fluid and nutritional intake to reduce possibility of constipation.
Recreation Therapist/Restorative	<ul style="list-style-type: none"> • Involves the resident in group or one to one exercise, range of motion, social programs. • Recognizes and reports resident verbalizations and behaviours indicative of discomfort. • Helps resident to toileting if needed during program. • Reports resident changes to RN.
Physician	<ul style="list-style-type: none"> • Identifies and implements medical interventions to address bladder and bowel symptoms. • Takes into consideration the recommendations of Pharmacists and Dietitians.

Team Members	Roles and Responsibilities
Social Work	<ul style="list-style-type: none"> • Provides support to resident's psychosocial needs. • Counsels and supports families as needed.
Pharmacist	<ul style="list-style-type: none"> • Reviews medications and supplements. • Provides consultation services. • Provides education.
Podiatrist/Chiropodist	<ul style="list-style-type: none"> • Assesses for nail care and advices for the prescription of appropriate footwear for the resident's individual needs.
Chaplain	<ul style="list-style-type: none"> • Provides support to resident's spiritual/cultural needs. • Counsels and supports families.
Maintenance/Housekeeping	<ul style="list-style-type: none"> • Supports a clean and odour-free environment. • Maintains a comfortable environmental temperature.
Family/Resident	<ul style="list-style-type: none"> • Provides information on bladder and bowel habits to staff. • Attends the multidisciplinary conference. • Works with staff and resident to support plan of care.

PROCEDURE:

A. Bladder and Bowel Continence Assessment

The interdisciplinary team will:

1. Conduct and document a bladder and bowel continence assessment,
 - Within 7 days of admission.
 - Following any change in condition that affects continence.
 - With quarterly documentation.

B. Care Planning

The interdisciplinary team will:

1. Initiate a written plan of care upon completion of the bladder and bowel continence assessment and update as necessary.
2. Promote the independence and dignity of continent residents by:
 - Providing orientation to bathroom locations.
 - Assisting as required.
3. Develop an individualized toileting routine for each individual resident.
4. Ensure that all residents, where possible, are toileted e.g., toilet incontinent residents.
5. Assess residents who require continence care products for proper product fit, using supplier guidelines. (Refer to Interventions for Residents with Intractable Incontinence).
6. Reassess and evaluate the effectiveness of the resident's continence care plan on a quarterly basis.
7. Educate staff, resident and families on continence/incontinence care.
8. Take any or all of the following actions when there is a change in health status that affects continence:
 - Use a voiding record for 3 days if the resident demonstrates a change in voiding patterns or abnormal bladder control.
 - Identify contributing factors and the type of urinary incontinence.
 - Develop a written plan of care.
 - Evaluate and document resident outcome.

- Reassess as required for any further change in resident's health status that affects continence and refer to appropriate interdisciplinary team members as necessary.

C. Interventions Based on Urinary Incontinence Types

The interdisciplinary team will:

1. Follow the table below for interventions based on urinary incontinence types.

	Stress UI	Urge UI	Overflow UI	Functional UI
Cause	Failure to store	Failure to store	Failure to empty	Failure to store
Frequency	20% of all cases	50% of all cases	10% of all cases	20% of all cases
Symptoms	<ul style="list-style-type: none"> • Small amount of urine loss frequently when residents coughs, laughs, changes position • Wet during day • Dry at night, no distention 	<ul style="list-style-type: none"> • Large amounts of urine loss frequently "can't get to bathroom in time" • Wet day and night • No distention 	<ul style="list-style-type: none"> • Small amounts of urine loss frequently • Wet day and night • Distention 	<ul style="list-style-type: none"> • Bladder and sphincter are normal • Wet day and night • No distention
Pathology	Weakness of sphincter	Result of neurological and/or urological disease	<ul style="list-style-type: none"> • Female: result of cystocele • Male: result of enlarged prostate, fecal impaction 	Other factors cause incontinence: <ul style="list-style-type: none"> • Drugs • Environment • Psychological
Prevalence	Mostly female	Both male and female	Both male and female	Both male and female
Treatments/ Interventions	<ul style="list-style-type: none"> • Medications (e.g., Premarin & Entex-LA) • Kegel exercises* • Prompted voiding* 	<ul style="list-style-type: none"> • Medications (e.g., Ditropan & antibiotics) • Surgery • Bladder retraining routines* • Toileting routines* • Prompted voiding* 	<ul style="list-style-type: none"> • Medications (e.g., Prazosin & Proscar) • Surgery • Double voiding* • Crede maneuver* • Bowel maintenance program** • Disimpaction 	<ul style="list-style-type: none"> • Medications • Surgery • Environment • Mobility • Psychological • Prompted voiding*

*See details under Section D: Interventions to Promote Continence.

**See details under Section F: Interventions to Prevent and Manage Constipation.

Note: See Appendix A for Critical Pathway for Urinary Incontinence

D. Interventions to Promote Urinary Continence

Strategies/Approaches		
Bladder Retraining Routines	Description	Bladder retraining programs are most appropriate for residents with urge urinary incontinence. It includes techniques to suppress precipitancy and the use of scheduled voiding to restore normal bladder function or to improve continence.

Strategies/Approaches		
Bladder Retraining Routines	Description	<p>Bladder retraining programs are most effective for residents who are:</p> <ul style="list-style-type: none"> • alert; • can fully understand; • can communicate with their care providers; and • able to follow instructions given to them. <p>The resident must have adequate cognitive functioning to indicate when he/she has to go to the bathroom. A 3 to 4 hour toileting schedule can generally be established within 4 to 6 weeks from the time that the program is initiated.</p>
	Interventions	<p>The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Ensure that all contributing factors (e.g., medications, disease) and functional limitations (e.g., strength for standing and transferring) have been assessed and corrected. 1. Determine, from the voiding study, the period of time that the resident usually holds his/her urine before voiding (i.e., if the resident only holds urine for a half hour, toileting should begin at quarter hour intervals). 2. Explain the program to the resident in simple language. 3. Toilet the resident at the determined interval for one week. If the resident's voiding pattern cannot be clearly identified, start the toileting interval every two hours. 4. Leave the resident on the toilet a maximum of five minutes. 5. Increase the toileting interval by 15 minutes at the end of week one. 6. Give the resident positive feedback each time the resident holds urine for the correct amount of time. If the resident cannot hold the urine, encourage him/her to try again. 7. Gradually increase the interval between voiding by 15 minutes each week until the resident can hold the urine for a 4-hour period.
Prompted Voiding	Description	<p>Prompted voiding is a behavioural intervention used to treat residents with stress, urge and functional urinary incontinence.</p> <p>Note, however, that it is the care provider's response that changes, and not that of the incontinent individual. The caregiver is expected to intervene prior to the undesired bladder voiding rather than rely on an incontinence aid or clothing.</p> <p>Prompted voiding is used most effectively for the treatment of urinary incontinence in persons with physical and/or cognitive deficits, who will respond to timely reminders from caregivers.</p> <p>The best predictor of an individual's response to prompted voiding will be his or her success to a therapeutic trial.</p>

Strategies/Approaches		
Prompted Voiding	Description	<p>The 3 primary techniques of prompted voiding are monitoring, prompting and praising:</p> <p>Monitoring involves asking the incontinent individual if he or she needs to use the toilet at regular intervals. The interval, however, will not always be timed by the clock. The caregiver should also respond to behavioural indicators (restlessness, agitation, disrobing) that suggest the resident may need to use the toilet. In such cases, the 'regular interval' for prompting may have to coincide with the individual's personal schedule.</p> <p>Prompting a person to use the toilet at regular intervals encourages the maintenance of bladder control between prompted voiding sessions.</p> <p>Praising is positive reinforcement given by the staff for dryness and maintaining bladder control.</p>
	Interventions	<p>Before Initiating Prompted Voiding The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Determine the resident's pattern of incontinence using a 3-day voiding record before initiating prompted voiding. 1. Address constipation and fecal impaction. 2. Encourage fluid intake of 1500 ml/day. 3. Minimize caffeinated and alcoholic beverages where possible. 4. Initiate an individualized prompted voiding schedule based on the resident's toileting needs, and as indicated by the 3-day voiding record. 5. Initiate another 3-day voiding record between 3 and 8 weeks after the prompted voiding schedule begins. 6. Determine the success of the prompted voiding trial and develop the plan of care based on the results. 7. Evaluate and document resident outcome. <p>Calculation: To determine the success of the prompted voiding trial, calculate the number of times toileting was successful, and divide the total number of toileting attempts and multiply by 100.</p> <ul style="list-style-type: none"> • Residents who show a poor ability to toilet using this method (less than 49% successful attempts), and who do not express a desire to be either changed or toileted, should be treated as incontinent and cared for using appropriate incontinence products and changing schedules. • Research indicates that residents who respond well to prompted voiding can be identified with a high degree of accuracy during a 3-day trial of intervention. Residents who achieve a wet rate of 20% or less or an appropriate toileting higher than 66% should continue to undergo prompted voiding. Residents who do not meet either of these criteria should be considered for further urinary evaluation such as urodynamic tests. • Research also shows that prompted voiding is not successful during the night, especially between one am (0100) and (0400) four a.m.

Strategies/Approaches		
<p>Prompted Voiding</p>	<p>Interventions</p>	<p>Prompted Voiding Procedure The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Contact the resident every two hours during the day. 2. Focus the resident's attention on voiding by asking whether he or she is wet or dry. 3. Check resident for wetness and give feedback on whether the resident's self-report was correct or incorrect. 4. Ask the resident if he or she would like to use the toilet whether resident is wet or dry. 5. Assist resident with toileting. 6. Record the results on the voiding record. 7. Give the resident positive reinforcement by spending an extra minute or two conversing with him or her. 8. Repeat the request if the resident does not want to use the toilet and has not attempted to void in the last four hours, and assist him/her if an affirmative response is received. 9. Inform the resident that they will be back in two hours and request that the resident try to delay voiding until then. 10. Change the resident if he/she is wet and declines to use the toilet. 11. Record the results of each check and toileting attempt on the voiding record.
<p>Toileting Routines</p>	<p>Description</p>	<p>Toileting routine is most appropriate for residents with urge urinary incontinence.</p> <p>An individualized toileting routine can be established for residents who have the ability to be toileted, as determined by a continence assessment and prompted voiding trial.</p> <p>Purpose of a toileting routine:</p> <ul style="list-style-type: none"> • Restore a normal pattern of voiding • Reduce incontinent episodes • Provide for resident comfort • Hygiene • Safety • Increased self-esteem • Prevent skin breakdown
	<p>Interventions</p>	<p>The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Assist resident to transfer to toilet or commode using safe transfer techniques. 2. Position the resident to provide adequate support for feet and body as needed. 3. Provide privacy while remaining in the immediate area to ensure

Strategies/Approaches		
Toileting Routines	Interventions	<p>safety.</p> <ol style="list-style-type: none"> 4. Ensure that any resident requiring support in sitting position is not left unattended. Restraint is not to be used while resident is using a toilet or a commode chair. 5. Allow resident 5 minutes to void. 6. Provide peri-care as required. 7. Assist resident to rearrange clothing as necessary. 8. Allow resident to wash hands. 9. Wash their own hands thoroughly. 10. Assist resident to return to comfortable position. 11. Support and reassure resident to achieve success in toileting routine. 12. Toilet the resident at the following times based on the individual resident's pattern. <ul style="list-style-type: none"> • Upon awakening in the morning • After breakfast • Before or after lunch • Before or after supper • At bedtime • During the night if resident is awake 13. Assist as requested by resident.
Kegel Exercise	Description	<p>Kegel exercises are most appropriate for residents with stress urinary incontinence.</p> <p>They are designed to strengthen the muscles of the pelvic floor, which improves function of the urethral and rectal sphincter muscles.</p>
	Interventions	<p>The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Teach resident Kegel exercises to strengthen muscles of the pelvic floor: <ul style="list-style-type: none"> • Seat resident on toilet and instruct to initiate voiding. • Once flow has been initiated, have resident stop by contracting muscles. • Hold flow to count of three. • Gradually increase the number of contractions to 10-20 times per exercise.
Double Voiding	Description	<p>Double voiding is most appropriate for overflow urinary incontinence.</p> <p>It involves reinitiating the voiding reflex a minute or two after the resident has finished voiding. It offers the bladder a second opportunity to contract and expel urine.</p>
	Interventions	<p>The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Perform techniques to trigger voiding such as running water and stroking the inner thigh or base of the spine to stimulate voiding reflex.

Strategies/Approaches		
Crede Maneuver	Description	Crede maneuver is most appropriate for overflow urinary incontinence. It facilitates bladder emptying through external bladder manual bladder compression. This is done after voiding, or during voiding, to assist urine drainage.
	Interventions	The interdisciplinary team will: 1. Instruct the resident to elevate his/her feet on a footstool and lean forward slightly during voiding to increase intra-abdominal pressure and facilitate bladder emptying.

E. Interventions for Residents with Intractable Incontinence

Type of Urinary Incontinence		
Intractable Incontinence	Description	Residents identified as having intractable incontinence are those who have been assessed, have had contributing factors identified, and for whom attempts at regaining continence have not been successful.
	Interventions	The interdisciplinary team will: 1. Assess the need for a continence-care product at the time of admission and re-evaluate with documented change in continence status. <ul style="list-style-type: none"> • If a continence-care product is required, the resident should be measured to determine the appropriate size and evaluated for the most effective category of product according to their level of incontinence. • An adequate supply and usage of products, in a range of absorbencies and sizes, should be stocked. • Develop a system to monitor product usage and effectiveness. 2. Check incontinent residents frequently and change as necessary based on product manufacturer's recommendation, such as: <ul style="list-style-type: none"> • Upon awakening • After breakfast • After morning nourishment • After lunch • After afternoon nourishment before supper • After supper, at bedtime • Last rounds • Twice during the night 3. Provide peri care and skin care when changing the incontinence product. 4. Assess the perineum for redness and skin breakdown and follow the LTC Homes' own policy and procedure on skin care.

Type of Urinary Incontinence	
Intractable Incontinence	<p>Interventions</p> <ol style="list-style-type: none"> 5. Document the frequency of changes and bowel movements on the resident's daily care flow sheet. 6. Update the care plan quarterly or when there is a change in condition that affects continence.

F. Interventions to Prevent and Manage Constipation

Strategies/Approaches	
Preventive Measures for Residents At Risk of Constipation	<p>Description</p> <p>Bowel management involves promoting regular, voluntary, controlled bowel evacuations of normal consistency. Normal bowel function involves passage of soft, formed stools in adequate volumes without straining.</p>
	<p>Interventions</p> <p>The interdisciplinary team will:</p> <ol style="list-style-type: none"> 1. Determine the resident's bowel using a 7-day bowel record before initiating a constipation protocol. 2. Encourage intake of a minimum of 1500 ml of fluid every 24 hours, unless it is contraindicated for a particular individual and whenever possible, minimize caffeinated and alcoholic beverages. 3. Provide an adequate amount of fiber in the resident's daily diet in consultation with a dietitian. 4. Promote a regular pattern of toileting at the same time each day, based on the resident's triggering meal. 5. Assist the resident into a squat position to facilitate the defecation process. 6. Encourage physical activity based on the resident's abilities and health condition. 7. Evaluate the resident's response to interventions through the use of a bowel record. It should document frequency, character and amount, bowel movement pattern, episodes of constipation/fecal soiling and use of oral and rectal laxative interventions. 8. Respond in a timely way to the resident's urge to defecate usually after the triggering meal. 9. Provide education regarding the promotion of bowel health to all who are involved – health care providers, residents, family or caregivers. 10. Evaluate the success of preventive measure by using a 7 day bowel record.
Routine Bowel Protocol	<p>Description</p> <p>The purpose of a routine bowel protocol is to facilitate early identification of constipation (as indicated by individual resident bowel patterns and as documented on a bowel record), and to reduce episodes of constipation.</p>

Strategies/Approaches	
Routine Bowel Protocol	<p>Description</p> <p>Contraindications:</p> <p>Do not apply a routine bowel protocol if:</p> <ul style="list-style-type: none"> • There is blood in the resident's stool. • There is a significant change in the resident's mental status. • Bowel sounds are not heard on assessment. • An abdominal mass of unknown origin is palpated.
	<p>Interventions</p> <p>The interdisciplinary will:</p> <ol style="list-style-type: none"> 1. Consider the following before implementing a routine bowel protocol: <ul style="list-style-type: none"> • Documentation on recent bowel records. • Assessment for abdominal distension, presence of bowel sounds, rectal examination. • Contributing factors and management of them. • Changes in medications, food or fluid intake, activity levels, emotional status 2. Consult the dietitian and contact a physician for implementation of a bowel protocol. 3. Avoid reoccurrence through follow-up on strategies with the physician and/or the dietitian. <ul style="list-style-type: none"> • Note: See Appendix E for the Classification of Laxative Therapies and Appendix F for a Stepwise Approach to Management of Constipation.

References:

Folden, S., Backer, J. H., Maynard, F., Stevens, K., Gilbride, J. A., Pires, M., & Jones, K. (2002). Practice guidelines for the management of constipation in adults. Rehabilitation Nursing Foundation. [On-line]. Available: <http://www.rehabnurse.org/profresources/BowelGuideforWEB.pdf>.

IC 5: Improving Continence Care in Complex Continuing Care Hospitals. [On-line]. Available: www.hospitalreport.ca/projects/QI_projects/IC5.html

Ministry of Health and Long-Term Care. (2005). *Standards: Continence Care.* Toronto, Canada: Ministry of Health and Long-Term Care.

Ontario Association of Non-Profit Homes and Services for Seniors. (2005). *A Resource Guide for Long Term Care Homes: Skin and Wound Care, Continence Care, Nutrition and Hydration.* Woodbridge, Canada: Ontario Association of Non-Profit Homes and Services for Seniors.

Ouslander, J. G., Schnelle, F. J., Uman, G., Fingold, S., Nigam, G. J., Tuico, E., & Jensen, B. B. (1995). Predictors of successful prompted voiding among incontinent nursing home residents. *Journal of the American Medical Association, 273*(17), 1366-1370.

Registered Nurses' Association of Ontario. (2005). *Orientation Program for Nurses in Long-Term Care Workbook.* Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario. (2005). *Prevention of Constipation in the Older Adult Population.* (Revised). Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: www.rnao.org/bestpractices

Registered Nurses' Association of Ontario. (2005). *Promoting Continence Using Prompted Voiding.* (Revised). Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: www.rnao.org/bestpractices

Sanburg, A., L., McGuire, T. M., & Lee, T. (1996). Stepping out of constipation: An educational campaign. *Australian Journal of Hospital Pharmacy, 26,* 350-355.

Tramonte, S. M., Brand, M. B., Mulrow, C. D., Amato, M. G., O'Keefe, M. E., & Ramirez, G. (1997). The treatment of chronic constipation in adults. A systematic review. *Journal of General Internal Medicine, 12*(1), p. 17.

University of North Carolina-Chapel Hill School of Medicine, Program on Aging & the Division of Social Services, State of North Carolina. *Bladder Management and Adult Care Home.* [On-line]. Available: <http://www.med.unc.edu/aging/documents/NursingMaterials.pdf>

APPENDIX A: Bladder & Bowel Continence Assessment

Date Assessment Initiated: _____
Information Source (please circle) – Resident (R), Family (F) _____,
 Chart (C), RN, RPN, PSW, other.

A. RELEVANT MEDICAL &/OR SURGICAL CONDITIONS

(From Resident, Family, Chart)

- | | |
|---|---|
| <input type="checkbox"/> Immobility Issues
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Other _____
<input type="checkbox"/> Neurological Conditions
<input type="checkbox"/> Stroke
<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Spinal Cord injury
<input type="checkbox"/> Other _____
<input type="checkbox"/> Medical Conditions
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Heart Problems
Weight : _____ (kg) | <input type="checkbox"/> Cognitive Problems
<input type="checkbox"/> Dementia
<input type="checkbox"/> Other _____
<input type="checkbox"/> Genito-Urinary (GU) Problems
<input type="checkbox"/> Recurrent Urinary Tract Infections
<input type="checkbox"/> Previous G/U Surgery or Injury
<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Other _____
<input type="checkbox"/> Gastro-Intestinal (GI) Problems
<input type="checkbox"/> Chronic constipation
<input type="checkbox"/> Diverticular disease
<input type="checkbox"/> Hemorrhoids/fissures
<input type="checkbox"/> Previous colon surgery
<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Other _____ |
|---|---|

B. MEDICATIONS

See over	Y	N	Comments
Antacids with aluminum			
Analgesics/NSAIDS			
Anticholinergic/ Antispasmodic/ Anti-emetics			
Antidepressants			
Antihistamines			
Anti-hypertensives			
Anti-Parkinson agents			
Anti-psychotics			
Calcium Channel Blockers			
Cholinergic			
Diuretic			
Histamine-2 blockers			
Iron supplements			
Laxatives			
Narcotic analgesic			
Sedative/hypnotic			
Other			

C. URINARY CONTINENCE HISTORY

Urinary Incontinence Pattern	Urinary Incontinence (UI) Frequency and Timing	<input type="checkbox"/> No daytime UI <input type="checkbox"/> Once a day or less <input type="checkbox"/> 1-2 times a day <input type="checkbox"/> 3 times a day or more <input type="checkbox"/> Nighttime only <input type="checkbox"/> Both day and night UI
	Urinary Incontinence (UI) Volume	<input type="checkbox"/> Entire bladder contents: large volume <input type="checkbox"/> Small volume: leaks, drips, spurts <input type="checkbox"/> Continuous bladder leakage <input type="checkbox"/> Unable to determine
Urinary Incontinence History	Onset	<input type="checkbox"/> Sudden <input type="checkbox"/> Gradual
	Duration	<input type="checkbox"/> < 6 months <input type="checkbox"/> 6 months – 1 year <input type="checkbox"/> > 1 year <input type="checkbox"/> Unknown
	Symptoms over the past 6 months	<input type="checkbox"/> Worsening <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Fluctuating <input type="checkbox"/> Unknown
Has a physician been consulted with above urinary problems? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Addressograph

D: SYMPTOMS ASSOCIATED WITH URINARY INCONTINENCE

Type of Urinary Incontinence	Symptoms	Y	N	N/A	*Total number of "yes" answers
Stress UI	Leakage with cough, sneeze, physical activity				
	UI in small amounts (drops, spurts)				
	UI during daytime only				
	Fecal incontinence may be present				
Urge UI	Strong, uncontrolled urge prior to UI				
	UI moderate/large volume (gush)				
	Frequency of urination				
	Nocturia > 2 times				
Overflow UI	Difficulty starting urine stream or straining to void				
	Weak or stop/go stream				
	Post-void dribbling				
	Prolonged voiding				
	Fullness after voiding				
	Suprapubic pressure and pain				
Functional UI	Spurt of urine with movement				
	Limited mobility				
	Requires assistance with toileting				
	Assistive aids/devices required (e.g., mechanical lift, 1-2 staff to assist, high seat, commode, support bars, hand rail, etc.)				
	Unable to get to the toilet on time/toilet too far				
	Can't hold urinal or sit on toilet				
	Can't reach/use call bell				
	Restraints or gerichair				
	Poor vision				
	Altered mental status				
Pain poorly managed					
Can't manage clothing					

*Follow interventions for the type of urinary incontinence that has the most "yes" answers. Take note that mixed incontinence (feature of both stress and urge incontinence) may be possible and interventions should focus on both types of incontinence. Refer to Physician and/or Nurse Continence Advisor for complex urinary incontinence issues.

Drugs that affect Bowel/Bladder Control

<p>The purpose of this list is to give examples of drugs that can affect incontinence. It is not a comprehensive list.</p> <p>Blood pressure/Heart Anti-hypertensives (Postural hypotension leads and functional urinary incontinence).</p> <p>ACE inhibitors</p> <ul style="list-style-type: none"> - Benazepril - Captopril - Enalapril - Fosinopril - Lisinopril - Quinapril - Ramipril <p>ACE II inhibitors (ARB's)</p> <ul style="list-style-type: none"> - Candesartan - Eprosartan - Irbesartan - Losartan - Telmisartan - Valsartan <p>Alpha Adrenergics</p> <ul style="list-style-type: none"> - Clonidine <p>Diuretics (Diuresis causes overflow incontinence)</p> <ul style="list-style-type: none"> - Acetazolamide - Amiloride - Bumetanide - Chlorthalidone - Hydrochlorothiazide - Indapamide - Metolazone - Spironolactone <p>Calcium Channel Blockers (Constipation, diarrhea)</p> <ul style="list-style-type: none"> - Amlodipine - Diltiazem - Felodipine - Nifedipine - Verapamil <p>Digestion/Excretion: Antacids with aluminum (laxative effect, can cause diarrhea or loose stools)</p> <ul style="list-style-type: none"> - Various Alumina compounds 	<ul style="list-style-type: none"> - Aluminum Hydroxide - Calcium Carbonate - Calcium Carbonate and Magnesia - Calcium Carbonate, Magnesia, and Simethicone - Calcium and Magnesium Carbonates - Magaldrate - Magaldrate and Simethicone - Magnesium Carbonate and Sodium Bicarbonate - Magnesium Hydroxide <p>Laxatives (Diarrhea, intestinal cramping, fecal incontinence)</p> <ul style="list-style-type: none"> - Polycarbophil - Psyllium; Hydrophilic Mucilloid and Senna - Lactulose - Polyethylene glycol 3350 - Magnesium Citrate - Magnesium Hydroxide (Milk of magnesia) - Magnesium Sulfate - Sodium Phosphate - Milk of Magnesia & Mineral Oil - Mineral Oil - Bisacodyl - Cascara Sagrada; and Aloe; and Bisacodyl - Castor Oil - Senna - Sennosides - Bisacodyl and Docusate - Casanthranol and Docusate - Danthron and Docusate - Sennosides and Docusate - Docusate <p>Mood/Behaviour: Antidepressant (Constipation, especially in elderly. Contributes to overflow and functional urinary incontinence. Problems with urination and loss of bladder control. Monoamine oxidase inhibitors (MAO's) can cause urinary retention.)</p> <p>Tricyclic antidepressants</p> <ul style="list-style-type: none"> - Amitriptyline - Clomipramine - Desipramine - Doxepin - Imipramine - Maprotiline (tetracyclic) - Nortriptyline 	<ul style="list-style-type: none"> - Protriptyline - Trimipramine <p>MAO Antidepressants</p> <ul style="list-style-type: none"> - Amoxapine - Bupropion - Citalopram - Fluoxetine - Fluvoxamine - Mirtazapine - Nefazadone - Paroxetine - Sertraline - Trazodone - Venlafaxine <p>Anti-psychotics (Constipation, confusion, sedation, rigidity and immobility leading to overflow and functional urinary incontinence).</p> <ul style="list-style-type: none"> - Chlorpromazine - Clozapine* - Fluphenazine - Haloperidol - Loxapine - Olanzapine* - Perphenazine - Pimozide - Quetiapine* - Risperidone* - Thioridazine - Trifluoperazine *atypicals <p>Sedative/Hypnotic/ Barbiturate (Can cause excessive sedation and decreased mobility in elderly people predisposing them to functional urinary incontinence. Not commonly used in long term care.)</p> <ul style="list-style-type: none"> - Butabarbital <p>Pain; Analgesics Narcotic Constipation and confusion leading to overflow and functional urinary incontinence.</p> <ul style="list-style-type: none"> - Codeine - Hydrocodone - Hydromorphone - Levorphanol - Meperidine - Morphine - Oxycodone - Pentazocine 	<ul style="list-style-type: none"> - Propoxyphene - Nalbuphine <p>NSAIDs -Urinary retention in elderly and or arthritic patients (on large doses) Oral</p> <ul style="list-style-type: none"> - Diclofenac - Diflunisal - Etodolac - Fenoprofen - Floctafenine - Ibuprofen - Indomethacin - Ketoprofen - Meclofenamate - Mefenamic Acid - Nabumetone - Naproxen - Oxaprozin - Piroxicam - Sulindac - Tenoxicam - Tiaprofenic Acid - Tolmetin <p>Other</p> <p>Anticholinergic/ Antispasmodic/ Anti-emetics (Constipation and urinary retention leading to overflow and functional urinary incontinence)</p> <ul style="list-style-type: none"> - Benztropine - Oxybutynin - Procyclidine - Scopolamine - Tolterodine - Trihexyphenidyl <p>1st Generation Antihistamines</p> <ul style="list-style-type: none"> - Chlorpheniramine - Diphenhydramine - Dimenhydrinate - Hydroxyxine <p>Cholinergic (Cause urge incontinence due to bladder relaxation. Not commonly used in long term care).</p> <ul style="list-style-type: none"> - Bethanechol <p>Anti-Parkinson agents (Constipation, diarrhea)</p> <ul style="list-style-type: none"> - Levodopa - Carbadopa - Pergolide
---	---	--	---

Sources: AHCPR. 2006. Urinary Incontinence. <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.section.10079>; Brigham & Women's Hospital. 2004. Urinary incontinence <http://www.brighamandwomens.org/medical/HandbookArticles/Urinaryincontinence.pdf>; The Hartford Institute for Geriatric Nursing. 2001. Urinary incontinence. <http://www.hartfordign.org/publications/trythis/issue11.pdf>; IC-5 Continence Project, 2005, http://www.hospitalreport.ca/projects/QL_projects/IC5.html. Rehabilitation Nursing Foundation. 2002. Constipation. www.rehabnurse.org; RNAO. 2005. Preventing Constipation; Prompting Continence. <http://www.rnao.org/bestpractices>; Royal Women's Hospital. 2005. Urinary incontinence, http://www.rwh.org.au/rwhcpg/womenshealth.cfm?doc_id=3661; Singapore Ministry of Health. 2003, http://www.moh.gov.sg/cmaweb/attachments/publication/Nursing_Management_of_Patients_with_Urinary_Incontinence_1-2003.pdf. U.S. National Library of Medicine and U.S. National Institute of Health. 2006. Drugs, supplements. < <http://www.nlm.nih.gov/medlineplus/druginformation.html>>.

Addressograph

E. BOWEL CONTINENCE HISTORY

Bowel Pattern	Comments
<input type="checkbox"/> Normal <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fecal incontinence <input type="checkbox"/> Irritable bowel pattern <input type="checkbox"/> Impaction <input type="checkbox"/> Laxative use/ suppositories/enemas – type and frequency: <input type="checkbox"/> Other remedies used to help with bowel movement:	Frequency: Usual time of day: Triggering meal: Nature & consistency: Other factors that have caused loss of bowel control:
Has a physician been consulted with above bowel problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	

F. MISCELLANEOUS RISK FACTORS

Caffeine use (coffee/tea/colas) <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount:
	Frequency:
	Time of Day:
Alcohol use <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount:
	Frequency:
	Time of Day:
Fiber intake <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount:
	Frequency:
	Time of Day:
Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Activity:
	Frequency:
	Time of Day:

G. TOILETING PATTERN AND PRODUCT USE

	Day	Evening	Night
Toileting pattern	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode <input type="checkbox"/> Urinal <input type="checkbox"/> Bed pan	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode <input type="checkbox"/> Urinal <input type="checkbox"/> Bed pan	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode <input type="checkbox"/> Urinal <input type="checkbox"/> Bed pan
Frequency of Toileting			
Identify type of pads, briefs or other incontinent products worn including size			

H. ABILITIES

Cognitive	Y	N	Comments
Aware of urge to void and defecate			
Aware of the urge to defecate			
Socially aware of appropriate place to pass urine/stool			
Able to find the toilet			
Able to understand reminders or prompts			
Aware of when wet and/or urine is being passed			
Motivated to be continent			
Preferences about toileting			
Aware of the risk factors related to not emptying bladder and bowel completely and regularly and the importance of doing so			

I. PHYSICAL ASSESSMENT

Voided Volume	Residual Urine
Send for C & S <input type="checkbox"/> Yes <input type="checkbox"/> No	Voiding Record Initiated <input type="checkbox"/> Yes <input type="checkbox"/> No
Perineum <input type="checkbox"/> Intact <input type="checkbox"/> Redness <input type="checkbox"/> Excoriation <input type="checkbox"/> Other _____	Bowel Record Initiated <input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Urine Odour <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge Post Voiding <input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual Stool Odour <input type="checkbox"/> Yes <input type="checkbox"/> No	Discharge Post BM <input type="checkbox"/> Yes <input type="checkbox"/> No

J. FLUID & FOOD INTAKE (Obtain from initial bladder and bowel record)

Fluid/food Intake in 24 hours	Type of fluid	Quantity (1 cup=250 mls)	Type of food	Quantity
Breakfast				
Mid am				
Lunch				
Mid pm				
Supper				
Evening				
Night				
Total				

K. SUMMARY – CONTINENCE STATUS

Bladder
<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent : <input type="checkbox"/> Stress UI <input type="checkbox"/> Urge UI <input type="checkbox"/> Overflow UI <input type="checkbox"/> Functional UI <input type="checkbox"/> Care Plan Initiated/Updated <input type="checkbox"/> Voiding Record Initiated <input type="checkbox"/> Referral required: <input type="checkbox"/> Dietitian <input type="checkbox"/> Physician <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Treatment Options: <input type="checkbox"/> Prompted Voiding <input type="checkbox"/> Fluid Intake Changes <input type="checkbox"/> Caffeine Reduction <input type="checkbox"/> Intermittent Catheterization <input type="checkbox"/> Bedside Commode <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Incontinent Product <input type="checkbox"/> Other: _____
Bowel
<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Care Plan Initiated/Updated <input type="checkbox"/> Bowel Record Initiated <input type="checkbox"/> Referral required: <input type="checkbox"/> Dietitian <input type="checkbox"/> Physician <input type="checkbox"/> OT <input type="checkbox"/> PT
Contributing Factors
<input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Constipation <input type="checkbox"/> Weight <input type="checkbox"/> Cognitive – Mini Mental Status Examination (MMSE) Score: ____ <input type="checkbox"/> Fluid Intake <input type="checkbox"/> Medications <input type="checkbox"/> Environmental Factors <input type="checkbox"/> Caffeine Intake <input type="checkbox"/> Alcohol Intake <input type="checkbox"/> Mobility <input type="checkbox"/> Other

L. CONTINENCE CARE PLAN

Problems Identified	Interventions

Date of Assessment: _____

Assessor: _____

Urinary Incontinence Types and Interventions (Adapted from: RNAO, 2005. Orientation Program for Nurses in Long-Term Care Workbook. Toronto, Canada: RNAO)

	Stress UI	Urge UI	Overflow UI	Functional UI
Cause	Failure to store	Failure to store	Failure to empty	Failure to store
Frequency	20% of all cases	50% of all cases	10% of all cases	20% of all cases
Symptoms	-Small amount of urine loss frequently when residents coughs, laughs, changes position -Wet during day -Dry at night, no distention	-Large amounts of urine loss frequently "can't get to bathroom in time" -Wet day and night -No distention	-Small amounts of urine loss frequently -Wet day and night -Distention	-Bladder and sphincter are normal -Wet day and night -No distention
Pathology	Weakness of sphincter	Result of neurological and/or urological disease	-Female: result of cystocele -Male: result of enlarged prostate, fecal impaction	Other factors cause incontinence: -Drugs -Environment -Psychological
Prevalence	Mostly female	Both male and female	Both male and female	Both male and female
Treatments/ Interventions	-Medications (e.g., Premarin & Entex-LA) -Kegel exercises -Prompted voiding	-Medications (e.g., Ditropan & antibiotics) -Surgery -Bladder training routines -Toileting routines -Prompted voiding	-Medications (e.g., Prazosin & Proscar) -Surgery -Double voiding -Crede maneuver -Bowel maintenance program -Disimpaction	-Medications -Surgery -Environment -Mobility -Psychological -Prompted voiding

Critical Pathway for Urinary Incontinence (Stress, Urge, and Functional Types)

(© UNC-CH School of Medicine, Program on Aging & the Division of Social Services, State of North Carolina)

Nursing Diagnosis	Assessment	Goals	Intervention
Alteration in urinary elimination: urinary incontinence, -Stress -Urge -Functional	-History and physical exam to determine causes, contributing factors to UI. -Record voiding and incontinence pattern 3-day bladder diary. -Assess bladder symptoms. -Assess urine character, odour, colour. -Rule out urinary retention – Post Void Residual (PVR).	-Reduction or resolution of UI episodes. -Incontinence well managed to promote independence, comfort, quality of life. -Prevention of adverse sequela of UI.	Teach resident: -Toileting schedules. -Pelvic muscle exercises. -Urge control. -Appropriate selection and use of absorbent products. -Toileting devices. -Clothing adaptations. -Bowel management.
Alteration in urinary elimination: urinary retention	-Assess and document urinary retention. -Assess resident's skill in self-management of voiding and catheter use if indicated. -Monitor bladder diary to assess progress with self-care interventions for bladder emptying.	-Schedule of regular bladder emptying and fluid intake. -Utilization of voiding maneuvers and catheterization, as indicated. -Prevention and early recognition of UTI.	Teach resident: -Voiding maneuvers: Crede and double voiding. -Intermittent catheterization. -UTI prevention. -Sign/Symptom of UTI.
Alteration in fluid volume: fluid volume deficit	-Assess fluid intake from bladder diary recorded for 3 days. -Calculate fluid intake goals based on body weight and activity. -Develop fluid hydration protocol.	-Fluid intake adequate for urine dilution, bladder and bowel function, metabolic needs. -Treatment plan is acceptable to resident.	-Teach resident to implement fluid management protocol to meet individual fluid goals.
Alteration in nutritional intake: bladder irritants	-Assess consumption of bladder irritants: caffeine, artificial sweeteners, carbonated drinks, alcohol, spicy foods, milk, acidic juices. -Assess preferences for substitutions for irritants.	-Elimination or titration of bladder irritants. -Substitution of non-irritating beverages of choice.	-Instruct resident on rationale for avoidance of bladder irritants. -Teach resident ways to reduce and eliminate bladder irritants. -Monitor for effect of elimination.
Alteration in bowel elimination: constipation or fecal impaction	-Assess bowel elimination pattern, fibre and fluid intake, activity, and bowel aides.	-Establish regular bowel schedule. -Establish adequate fluid and fibre intake. -Minimize, avoid use of laxatives or enemas. -Reinforce good hygiene-wiping front to back, change after UI.	-Teach resident bowel program with dietary and fluid adjustments and fibre supplementation. -Develop exercise program within capacity of resident. -Augment toileting with knee-chest position using footstool.
Knowledge deficit related to self-care strategies for bladder health promotion	-Assess baseline knowledge of UI and self-care strategies. -Teach self-care strategies to improve or restore continence and bowel function. -Teach early recognition of UI-related problems: UTI, dermatitis, fecal impaction, urinary retention. -Teach self-monitoring of medication for UI, therapeutic, side and adverse effects.	-Resident describes causes and contributing factors to UI and bowel dysfunction. -Resident demonstrates effective self-care behaviours for urinary and bowel function.	-Instruct resident about UI status and rationale for interventions. -Modify interventions to allow for resident to implement gradually. -Set short term goals. -Reinforce resident behaviours that are health-promoting.
Self-care deficit	-Assess need for skill training to promote independence in toileting, e.g., exercises or physical therapy. -Assess need for equipment to promote independence in toileting, e.g., bedside commode, urinal, external devices. -PT/OT consults to assess need for muscle strengthening/ADL skill training for ambulation, transfer, or use of devices.	-Adaptive equipment and devices are acceptable, feasible, and appropriate for resident's needs. -Resident achieves highest level of physical function with exercise and rehabilitation therapies. -Resident assisted to achieve maximum independence in toileting skills.	-Select and instruct resident in use of adaptive equipment or devices. -Counsel resident about personal goal-setting related to toileting and continence.
Alteration in skin integrity: urine contact dermatitis	-Assess skin integrity for inflammation, maceration, infection, abrasion, and breakdown. -Assess resident's usual hygiene pattern. -Assess absorbent product usage for adequacy and appropriateness.	-Skin remains intact. -Absorbent product usage is appropriate for amount and frequency of urine loss. -Absorbent product is acceptable to the resident.	-Individualize skin care. -Monitor for sign/symptom of yeast, urine dermatitis. -Barrier ointment for fecal incontinence.
Alteration in urinary elimination: urinary tract infection	-Assess for signs/symptoms of UTI. -Assess fluid intake and voiding pattern. -Assess intake and output. -Assess bowel pattern for impaction, constipation, fecal incontinence.	-Resident is free of UTI. -Early recognition of signs/symptoms of UTI and urosepsis. -Prompt treatment of UTI.	-Reinforce good hygiene. -Increase fluid intake to 2000 – 4000 a day. -Change pad after each UI episode. -Bowel management. -Vitamin C BID per MD order. -Cranberry juice 8-12 oz. daily. -Re-culture as indicated.

APPENDIX B: Quarterly Continence Assessment

1.	Resident's Level of Continence (over all shifts in last 90 days)				
	0. Continent – Completely or usually continent. Bladder and/or bladder incontinent once a week or less.				
	1. Potential to be Continent – Sudden increase in incontinence or occasionally incontinent - bladder incontinent 2 or more times per week but not daily. Bowel incontinent less than once per week.				
	2. Incontinent – Bladder incontinent on a daily basis. Bowel incontinent all or almost all of the time.				
2.	Bowel Elimination Pattern	Regular – at least one BM every 3 days		Fecal Impaction	
		Constipation		Diarrhea	
3.	Bowel Continence Plan	Adequate fluids & fibre		Suppositories	
		Toileting routine		Laxative	
4.	Changes in Bowel Continence (BC)	Resident's BC has changed as compared to status 90 days ago or since last assessment	No change		
			Improved		
			Deteriorated		
5.	Bladder Control Pattern	Continent		Urinary tract infection	
		Leaks/dribbles/			
6.	Bladder Continence Plan	Toilet/commode/urinal		Pads/briefs	
		Scheduled toileting		Catheter	
		Bladder retraining		Ostomy	
7.	Changes in Urinary Continence (UC)	Resident's UC has changed as compared to status 90 days ago or since last assessment	No change		
			Improved		
			Deteriorated		

(adapted from Centers for Medicare and Medicaid Minimum Data Set (MDS) 2002
<http://new.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20MPAF.pdf>.)

Date of Assessment _____ Assessor _____

APPENDIX C: Voiding/Fluid Record

VOID = Amount measured **Intake: type of fluid and amount**
D = Dry **Juice glass = 120 ml**
WS = Wet small **Water glass = 180 ml**
WM = Wet medium **Tea cup = 180 ml**
WL = Wet large **Soup bowl = 125 ml**

Addressograph

TIME	DAY 1			DAY 2			DAY 3					
	Date	VOID	WET	FLUIDS	Date	VOID	WET	FLUIDS	Date	VOID	WET	FLUIDS
6:00 AM												
7:00 AM												
8:00 AM												
9:00 AM												
10:00 AM												
11:00 AM												
12:00 PM												
1:00 PM												
2:00 PM												
3:00 PM												
4:00 PM												
5:00 PM												
6:00 PM												
7:00 PM												
8:00 PM												
9:00 PM												
10:00 PM												
11:00 PM												
12:00 AM												
1:00 AM												
2:00 AM												
3:00 AM												
4:00 AM												
5:00 AM												
TOTAL												

*Please check resident q2h

APPENDIX D: 7-Day Bowel Record

IDENTIFICATION

Resident	
Start Date	
End Date	

Date	Time of BM	Description of BM	Toilet or Commode used (✓)	Incontinent (✓)	Bowel Protocol Items Given (Natural Stimulant, Laxative, Suppository, Enema)

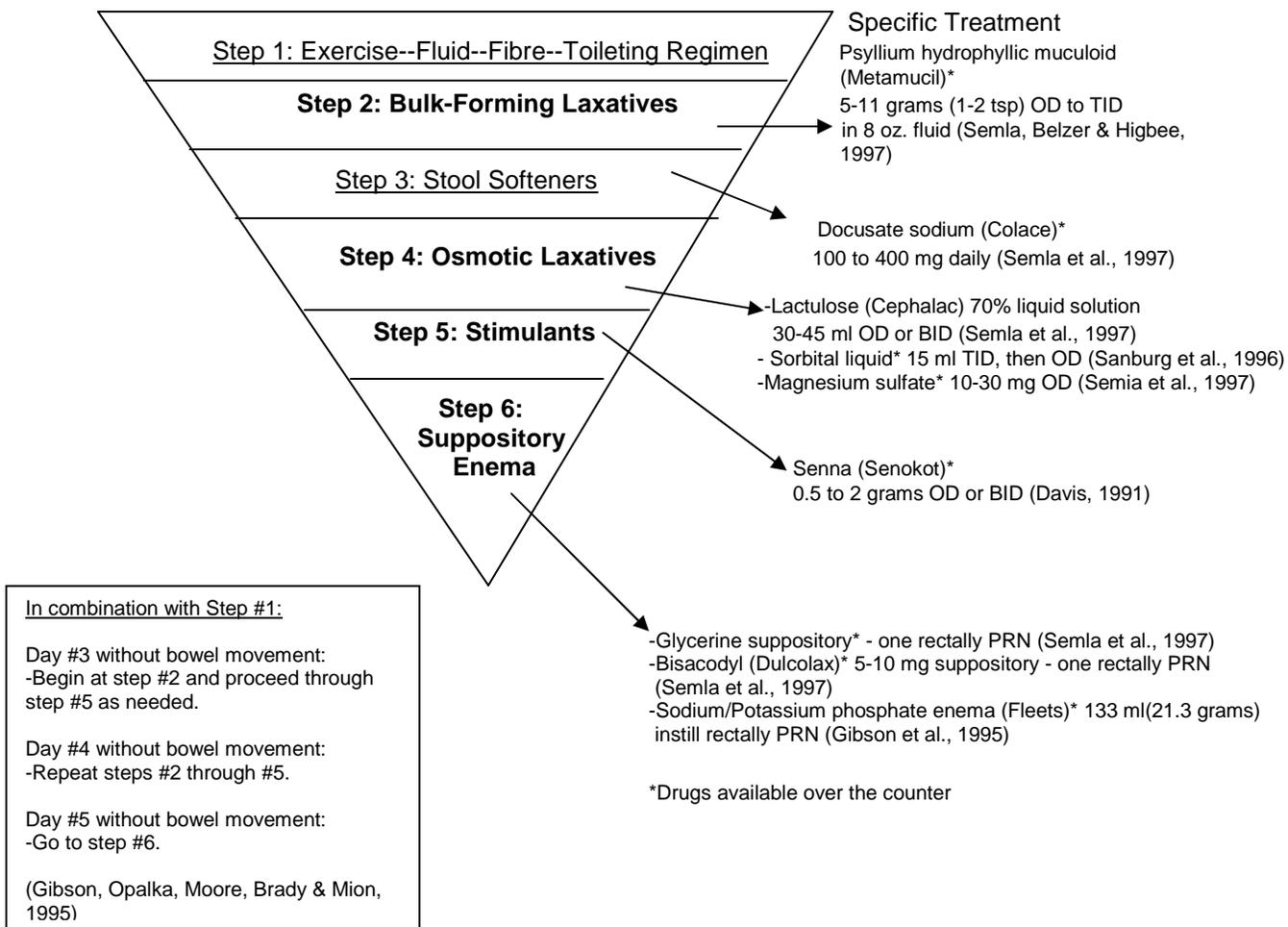
Adapted from: Ontario Association of Non-Profit Homes and Services for Seniors. (2005). *A Resource Guide for Long Term Care Homes: Skin and Wound Care, Continence Care, Nutrition and Hydration*. Woodbridge, Canada: Ontario Association of Non-Profit Homes and Services for Seniors.

APPENDIX E: Classification of Laxative Therapies

Class	Examples	Site of Action	Mechanism of Action
Osmotic	<ul style="list-style-type: none"> • Magnesium hydroxide (saline osmotic) • Lactulose • Sorbitol 	Small and large intestine	Attract/retain water in intestinal lumen increasing intraluminal pressure
Irritant or peristaltic stimulant	<ul style="list-style-type: none"> • Senna • Bisacodyl • Danthron • Cascara 	Colon	Has a direct action on mucosa, stimulates myenteric plexus, and alters water and electrolyte secretion
Bulk or hydrophilic	<ul style="list-style-type: none"> • Plantain derivatives • Methylcellulose • Psyllium • Ispaghula • Dietary bran • Celandrin • Alovera 	Small and large intestine	Holds water in stool and mechanical distention
Surfactant or softener or wetting agents	<ul style="list-style-type: none"> • Docusate • Poloxalkol 	Small and large intestine	Softens stool by facilitating admixture of fat and water to soften stool.

Tramonte, Brand, Mulrow, Amato, O'Keefe & Ramirez (as cited in Folden, Backer, Maynard, Stevens, Gilbride, Pires & Jones, 2002)

APPENDIX F: Stepwise Approach to Management of Constipation



Sanburg, McGuire & Lee (as cited in Folden et al., 2002)

APPENDIX G: Glossary of Terms

Constipation (Primary or idiopathic): Associated with immobility or decreased levels of physical activity, inadequate intake of fluids and dietary fibre, failure to respond to the urge to defecate, chronic use of stimulant laxatives, and increased serum progesterone levels in women.

Normal Bowel Elimination: Equal to or less than 3 bowel movements per day to one bowel movement daily or at least every other day; soft, brown, formed stool, equal to or greater than 250 ml to 500 ml, with use of laxatives restricted to stool softeners and/or bulk-forming agents.

Prompted Voiding: A behavioural technique using verbal and physical cues to assist the individual to use the toilet or appropriate receptacle. Prompted voiding is a first-line intervention for some types of urinary incontinence (urge, stress, mixed and functional).

Toileting: The process of encouraging the resident to use some type of containment device in which to void or defecate. The containment device may be the toilet, commode, urinal, bedpan, or some other type of receptacle but does not include briefs. Toileting is for the purpose of voiding and not for just changing briefs.

Urinary Incontinence: Involuntary loss of urine that is sufficient to be a problem, and may present as any of the following types:

Transient incontinence is the urine loss resulting from causes outside of or affecting the urinary system such as acute confusion, infection, atrophic urethritis or vaginitis, medications, psychological conditions, restricted mobility or stool impaction.

Urge incontinence is the involuntary passage of urine occurring soon after a strong sense of urgency to void.

Stress incontinence is a loss of urine with coughing and or sneezing resulting in increased abdominal pressure.

Mixed incontinence is urine loss having features of both stress and urge.

Functional incontinence is urinary leakage associated with inability to access the toilet because of impairment of cognitive and/or physical functioning or an environmental barrier.

Overflow incontinence is the involuntary loss of urine associated with bladder over-distention. Total incontinence is a continuous and unpredictable loss of urine.

Total incontinence is a continuous and predictable loss of urine.