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ACT Program for Continence Management
Nursing Care Plans
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Educational Material

Interactive

ACT Program
For Continence Management

Assessment and Continence Training
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INTRODUCTION

As a concerned caregiver, you know the challenges incontinence can present both for your resident’s quality of life and for you as a medical professional working to improve physical and mental health. Incontinence is not a normal part of aging and is a symptom, not a disease. In many cases, it can be improved.

This program is designed to take you through a process that will help you assess the specific needs of each incontinent resident and design a care plan to meet the physical and psychosocial challenges presented. This can be done in a manner consistent with the overall goal of your healthcare facility and the F315 guidelines as outlined by the Centers for Medicare & Medicaid Services (CMS). The goal of the program is to help each incontinent resident achieve their highest level of continence.

The Assessment and Continence Training (ACT) Program is one tool to assist you in reaching the goals of your healthcare facility as well as to aid you in achieving compliance with the F315 and MDS 3.0 guidelines. Please note that this tool may be used in conjunction with other tools available to achieve those goals.

The practices described in this program are meant to be general guidelines only. Caregivers should consult with and rely on trained practitioners and their own facility’s protocols to determine proper care and treatment regimens for their patients.

How to use the ACT Program

1. Choose a facility team member to manage the program
2. Consult with a Covidien Nurse Consultant for guidance
3. Complete the Bowel and Bladder Daily Diary to determine the resident’s voiding and bowel pattern upon admission and with any significant change in status
4. Complete the Physical Assessment form to determine the type of incontinence upon admission and with any significant change in status
5. Determine appropriate plan of care for bowel/bladder retraining
6. Determine appropriate incontinence product for use based on level of incontinence
7. Write a Nursing Care Plan
8. Implement resident’s program and re-evaluate as necessary
9. Use Flow Sheets, Evaluation Forms, and Resident Logs to document resident progress or make necessary modifications to the bowel/bladder retraining program
10. Educate resident and family about program goals and progress
Urinary and Bowel Incontinence

Incontinence is defined as the inability to control the release of urine or stool.
Urinary Incontinence

What is urinary incontinence?

Urinary incontinence is defined as the inability to control the release of urine at the appropriate time or place.

Incontinent episodes can range from infrequent, involuntary discharge of large volumes of body waste to constant or intermittent dribbling of small amounts of urine.

Urinary incontinence is not considered a normal part of aging. It is a symptom of an underlying condition and may be reversible. If it is found to be irreversible, it is important to manage the incontinence to reduce potential complications.

Incontinence affects the resident at three levels:

- Physical effects of incontinence:
  - Changes in skin integrity
  - Skin irritation or breakdown
  - Urinary tract infections
  - Sleep disturbances

- Psychosocial effects of incontinence:
  - Social withdrawal
  - Embarrassment
  - Loss of dignity
  - Feelings of isolation
  - Interference with participation in activities

- Economical effects of incontinence:
  - Cost of testing to diagnose incontinence
  - Treatment cost (drugs or surgery)
  - Management cost (labor, supplies, laundry)

Most elderly residents who are incontinent do have some degree of bladder control, either consciously or unconsciously. Their chronic incontinence is mainly due to abnormalities in the function of the bladder detrusor muscle (bladder wall) and/or the sphincter muscles (outlet). For this reason, it is important to understand the function of the lower urinary tract.

Anatomy of the Urinary System

Function of the Urinary System

There are four main structures in the urinary system: the kidneys, the ureters, the bladder and the urethra. The function of the urinary system is to remove waste from the body. The urinary system also regulates the amount of water in the body. Voiding, urination and micturition are terms that refer to the process of emptying the bladder.

Actual output volume of urine depends on fluid intake, cardiac output, hormonal influences and fluid loss through the lungs, skin and the large bowel. The approximate urine output of the healthy adult is between 1000 mL and 1500 mL per day with an average void measuring between 200 mL and 400 mL. In an adult, the first sensation of bladder filling normally occurs at a volume of 90 mL to 150 mL. The sensation of fullness occurs at a volume of 300 mL to 600 mL. The amount of urine produced is also influenced by body temperature, perspiration, and the external temperature. The kidneys function more efficiently when people lie down and are at rest, causing them to make more urine. Because of this, older adults may need to use the bathroom one or more times at night. The frequency of urination also depends on personal habits, the amount of fluid consumed in a given period of time, accessibility of toilet facilities, general health and level of physical activity.

The muscles of the pelvic floor form what is known as the urogenital diaphragm. They are attached to the pubic bone and ischium; they encircle and help support the urethra, vagina and rectum.
Voluntary contraction of these muscles results in compression, lengthening and elevation of the urethra. Voiding can be interrupted by contracting the pubococcygeal muscle. The deep perineal muscles of the urogenital diaphragm are attached to the pubic arch superiorly and surround the membranous urethra as the external muscle sphincter, a structure important to continence.

The normal cycle of micturition begins when the bladder receives urine from the kidneys through the ureters. As the bladder slowly fills with urine, the pressure inside the bladder remains low. When the detrusor muscle reaches a certain threshold of distention, sensory nerve endings in the bladder-wall are stimulated to transmit the sensation of fullness to the spinal cord through the pelvic nerve. Other nerves then transmit this message to the brain. The brain then sends a message back down the spinal cord and out through the peripheral nerves to initiate voiding (at the appropriate time and place). This sequence of events is known as the micturition reflex. This is also known as the brain-bladder connection which is important for the success of a bladder retraining program.

**Identifying Incontinence**

Although urinary incontinence is not considered part of the normal aging process, age-related changes are predisposing factors and do make incontinence more likely in older people. For example, the elderly may have more uninhibited bladder contractions and urine leakage at night. The bladder size is smaller so the rate of flow is decreased. The restriction of toilet accessibility along with changes in sight, hearing, balance and ambulation also increase the vulnerability of incontinence for the frail elderly.

**Functional (Environmental) Incontinence**

Some residents may have total control over their bladder function but, due to outside influences, they cannot reach or use a toilet. This condition is referred to as functional, or environmental, incontinence. Physical inability or unwillingness to reach the toilet on time, poor vision, lack of mobility, inaccessible facilities and unfamiliar surroundings are some of the factors affecting functional incontinence.

**Stress Incontinence**

Stress incontinence occurs when the sphincter is insufficient. When the resident coughs, sneezes, lifts, stands from a sitting position, climbs stairs, laughs, etc., the urethral pressure is not high enough to keep urine in the bladder. As a result, small leakage of urine occurs. Stress incontinence may be due to deterioration in muscle tone caused by aging, multiple childbirths or surgery that weakens the muscles of the pelvic floor.

**Urge Incontinence**

Urge incontinence involves involuntary voiding preceded by a warning time of only a few seconds to a few minutes. The resident is unable to delay voiding long enough to reach the toilet after the urge to void is perceived. Urge incontinence is the most common type found in the elderly population. Causes may include:

- Hyper excitability of the detrusor nerves (detrusor instability) caused by infection in the bladder, tumors or kidney stones
- Defect in the central nervous system’s (CNS) regulation of urination resulting from Alzheimer’s disease or CNS disease
- Deconditioned reflexes caused when a person repeatedly starts to urinate when there is only a small amount of urine in the bladder; thus, the bladder muscle gets weaker

**Transient Incontinence**

Residents who have temporary episodes of urinary incontinence that is reversible once the underlying cause of the incontinent episode (e.g. urinary tract infection) is identified and treated.

**Overflow Incontinence**

Overflow incontinence occurs when the bladder is unable to empty normally and distends with large amounts of urine. Since bursting of the bladder would be fatal, some leakage results. The resident has little control over when this leakage occurs. This problem can result from a bladder neck obstruction, malfunction of the detrusor muscle or impaired sensation. Overflow incontinence is a serious condition because urine can flow backward up into the kidneys and destroy kidney tissue.

**Mixed Incontinence**

Mixed Incontinence is the combination of two or more types of incontinence. In older adults this is most often a mix of urge incontinence and stress incontinence.

The following table will help you identify the types of urinary incontinence, the underlying physical problems and the possible causes of incontinence for your resident. Be aware that a resident may be experiencing more than one type of incontinence at a time.

continues on following page
# Summary of the Types and Causes of Urinary Incontinence

<table>
<thead>
<tr>
<th>TYPES OF URINARY INCONTINENCE</th>
<th>PROBLEM</th>
<th>POSSIBLE CAUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>Urine leakage due to environmental barriers and/or psychological unwillingness</td>
<td>Functional Disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical disabilities or mechanical barriers which prevent full independent mobility</td>
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<td></td>
<td></td>
<td>• Visual disturbances (may impair ability to see toilet)</td>
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<tr>
<td></td>
<td></td>
<td>• Inadequate or inaccessible facilities</td>
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<tr>
<td></td>
<td></td>
<td>• Unfamiliar environment</td>
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<tr>
<td></td>
<td></td>
<td>• Confusion or disorientation (medications may be implicated, such as sedatives or hypnotics)</td>
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<tr>
<td></td>
<td></td>
<td>• Pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of security or privacy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inaccessible clothing</td>
</tr>
<tr>
<td>Stress</td>
<td>Urethral sphincter failure when coughing, sneezing, lifting, standing from a sitting position, climbing stairs, laughing, etc.</td>
<td>Urethral Closure: Under activity</td>
</tr>
<tr>
<td>Females:</td>
<td></td>
<td>• Decreased pelvic muscle tone (secondary to multiple pregnancies or gynecologic surgery)</td>
</tr>
<tr>
<td>Males:</td>
<td></td>
<td>• Atrophic vaginitis/urethritis (from postmenopausal estrogen deficiency)</td>
</tr>
<tr>
<td>Both:</td>
<td></td>
<td>• Urethral or vaginal fistula</td>
</tr>
<tr>
<td>Urge</td>
<td>Involuntary loss of urine associated with strong sensation of urgency</td>
<td>Bladder Detrusor: Overactivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bladder tumor or kidney stone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limited functional bladder capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinary tract infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Concentrated urine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inflammation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• High volume voids (secondary to diuretics or excessive intake)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Atrophic vaginitis/urethritis (from postmenopausal estrogen deficiency)</td>
</tr>
<tr>
<td>Transient</td>
<td>Temporary episodes of incontinence that is reversible</td>
<td>Underlying medical condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urinary tract infection (UTI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alcohol and drug use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Heart failure</td>
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<td></td>
<td></td>
<td>• Venous insufficiency</td>
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<td></td>
<td></td>
<td>• Impacted stool</td>
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<tr>
<td></td>
<td></td>
<td>• Inflammation of the urethra or vagina</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Excessive intake of fluids</td>
</tr>
<tr>
<td>Overflow</td>
<td>Bladder overdistention with leakage</td>
<td>Bladder Detrusor: Under activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Atonic/flaccid bladder (secondary to neurologic disease, surgery, pharmaco-therapy, or chronic overdistention)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Urethral obstruction (from stool, stricture or enlarged prostate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased sphincteric resistance secondary to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– medications (over-the-counter cold preparation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– atrophic vaginitis/urethritis (from postmenopausal estrogen deficiency)</td>
</tr>
</tbody>
</table>
Bowel Incontinence

What is bowel incontinence?

Bowel, or fecal, incontinence is defined as the inability to control the passage of liquid and/or solid stool. Bowel incontinence can range from a small amount of stool to loss of a complete bowel movement.

What causes it?

- Diarrhea – the most common cause of bowel incontinence, can be caused by drugs, dietary supplements, some foods, or an imbalance of microbes found in the digestive tract
- Uncontrolled urgency to defecate
- Constipation – a mass of hard stool in the rectum blunts sensitivity for perceiving the movement of new stool, also dilates the internal anal sphincter allowing liquid stool to seep out
- Irritable bowel syndrome – nearly half of all patients with IBS experience bowel incontinence
- Inflammatory bowel disease – ulcerative colitis and Crohn’s disease are associated with diarrhea, which can cause bowel incontinence
- Hemorrhoids – especially after surgical treatment, patients can experience new onset bowel incontinence

Risk factors for developing bowel incontinence:

- Patient Characteristics
  - Increasing age
  - Dementia/cognitive impairment
  - Nursing home residence
  - Obesity
  - Poor general health
  - Physical limitations/impaired mobility
  - Urinary incontinence

- Patient Characteristics
  - Increasing age
  - Dementia/cognitive impairment
  - Nursing home residence
  - Obesity
  - Poor general health
  - Physical limitations/impaired mobility
  - Urinary incontinence
Anatomy of the Digestive System

- Esophagus
- Liver
- Gallbladder
- Duodenum
  - Ascending Colon
- Cecum
- Ileum
- Stomach
- Pancreas
- Transverse Colon
- Jejunum
- Descending Colon
- Sigmoid Colon
- Rectum
- Anus
Function of the Digestive System

The main function of the digestive system is to break down and absorb food that is consumed into energy for the body. It also creates solid waste that is then removed from the body. The digestive tract is a series of structures that begin at the mouth and end at the anus.

Liver

The liver has multiple functions, but its main function within the digestive system is to process the nutrients absorbed from the small intestine. Bile from the liver secreted into the small intestine also plays an important role in digesting fat. In addition, the liver is the body's chemical “factory.” It takes the raw materials absorbed by the intestine and makes all the various chemicals the body needs to function. The liver also detoxifies potentially harmful chemicals. It breaks down and secretes many drugs.

Gallbladder

The gallbladder stores and concentrates bile, and then releases it into the duodenum to help absorb and digest fats.

Large intestine

The large intestine, also called the colon, connects the small intestine and the rectum. The five components of the colon are the cecum, ascending colon, the transverse colon, the descending colon, and the sigmoid colon. The function of the colon is to process and eliminate waste from the body.

When stool passes to the colon from the small intestine, water is removed and it takes on a solid form. Solid stool is stored in the sigmoid colon until it empties into the rectum. When the colon becomes full of solid stool, it empties into the rectum and the process of elimination from the body begins.

Rectum

The rectum connects the colon to the anus. Once in the rectum, the body recognizes the need to empty the stool from the body. With proper signals from the brain, the body is able to pass the stool by relaxing the sphincters and contracting the rectum. If it is not the appropriate time to void, the sphincter will contract and the sensation will diminish temporarily.

Anus

The digestive tract ends at the anus. Sphincters in the anus control the passage of stool. They also hold stool in the body until there is the sensation to empty the bowels. When the sensation occurs, the anal sphincters hold the stool until the toilet can be used at which point they relax to release the contents.
Assessment and Continence Training (ACT) Program

The ACT Program will help you develop and execute a complete bowel and bladder retraining program.
What Steps Should I Take?

At Covidien, we are aware of the heavy demands placed on nurses today. Residents often have more serious illnesses than in the past and require more care. There are fewer nurses to handle the increased workload and financial constraints mean less money is available for services that would free up their time. The ACT Program will help you develop and execute a complete bowel and bladder retraining program that will cover the following areas as required by F315 guidelines:

Step 1: Assessment
- Initiate a Bowel and Bladder Diary to determine pattern and frequency of continence/incontinence. A baseline of three days is adequate to determine a pattern.
- Complete the Physical Assessment and Categorizing Urinary Incontinence forms for all incontinent residents to determine:
  - Cause(s) of incontinence
  - Type(s) of incontinence
- Assessment must be completed upon admission and with any significant change in condition.

Step 2: Diagnosis
- Review the Physical Assessment and Categorizing Urinary Incontinence forms to determine the type of incontinence your resident exhibits.
- Assess resident for bowel and bladder retraining.

Step 3: Planning
- Develop the Nursing Care Plan based on your findings and individualize for each of your residents.

Step 4: Implementation
- Implement the resident’s program according to the Nursing Care Plan.
- Initiate bowel and bladder retraining where appropriate.

Step 5: Evaluation
- Follow up to be sure the program is working for your resident. Make any adjustments necessary and reassess the program regularly to maintain effectiveness.
Step 1: Assessment

Prior history of urinary incontinence may provide valuable information regarding onset, duration and characteristics, previous treatments and/or management and the occurrence of persistent or recurrent UTI's.

When completing the assessment, direct the questions to the resident if possible. If the resident is incapable of responding, then direct the questions to family members and/or caregivers.

Assessment takes the following into consideration:

- Reversible or irreversible causes of incontinence
- Incontinence history, voiding patterns, use of catheter, and catheter complications
- Medications that affect incontinence (diuretics, anticholinergics, sedatives)
- Functional and cognitive capabilities
- Type and frequency of assistance required
- Potential medical diagnosis (MS, Parkinson's, tumors, obesity, CHF, etc.)
- Environmental factors/assistive devices that facilitate or restrict resident's ability to toilet
- Candidacy to improve incontinence status

Once the Physical Assessment and Bowel and Bladder Diary are completed, you are ready to form your diagnosis.

Step 2: Diagnosis

After completing the Assessment and reviewing the daily Bowel and Bladder Diary, make your nursing diagnosis of the specific type of urinary incontinence that applies to your resident:

- Functional
- Stress
- Urge
- Transient
- Overflow
- Mixed
- Bowel

There is a Nursing Care Plan for each type of incontinence provided in the Nursing Care Plans section.

Step 3: Planning

The ACT Program includes Nursing Care Plans for bladder/bowel incontinence. These are intended to be used as a guide to remind caregivers of all possible treatment choices available. These Nursing Care Plans are in no way a substitute for good nursing judgment, but are designed as a helpful tool that nurse managers can use to individualize their resident’s Nursing Care Plan for urinary/bowel incontinence.

The following guidelines will help achieve the maximum benefit from the Nursing Care Plans.

- Once assessment has been completed, select the particular Nursing Care Plan that lists the goals, interventions and rationales which are associated with your nursing diagnosis.
- Set your treatment goals and interventions for the resident. Your long-term goals are to have the resident either reestablish some or complete voluntary control, or manage irreversible incontinence safely and discreetly.
- Be sure that your nursing interventions involve the resident, the resident’s family and all health care providers. Resident education must include an explanation of incontinence that can be easily understood.
- Choices for interventions must also be explained to the caregivers. Whenever deciding on the interventions, the least invasive technique should be used.
- Keep in mind that the Nursing Care Plan must be adjusted as the resident’s condition changes. Therefore, periodic reassessments must be performed.
Step 4: Implementation

The Nursing Care Plans can be used as a quick reference guide to help you remember all aspects of a specific resident’s problem to be addressed under the categories of:

- Issues/Needs
- Goals/Objectives
- Approaches/Interventions
- Rationales
- Evaluations

Include the completed Nursing Care Plans for incontinence in your interdisciplinary care plan. The Nursing Care Plans will lead you to the implementation phase. Determine the components of the bowel and bladder retraining program to be implemented:

- Scheduled or prompted toileting
- Pelvic muscle exercises
- Resident/family education
- Resident positive reinforcement

Step 5: Evaluation

One of the most important parts of the resident’s treatment will be an ongoing evaluation program. You will want to determine if the following changes have taken place:

- Has the resident’s quality of life improved?
- Has the wet to dry ratio improved for the resident?
- Is the resident experiencing good skin condition?
- Is the resident comfortable with the current method of treatment/containment?

Please use the following links to access forms:

- [Nursing Care Plans](#)
- [Physical Assessment Form](#)
- [Categorizing Urinary Incontinence Form](#)
- [Bowel and Bladder Daily Diary Form](#)
Bowel and Bladder Retraining Implementation

To restore urinary and/or bowel continence to the individual’s maximum rehabilitation potential.
Bowel and Bladder Retraining Goals

Prior to beginning a bowel and bladder retraining program, it is important that you understand the goals to be attained.

Purpose:
To restore urinary and/or bowel continence to the individual’s maximum rehabilitation potential.

Policy:
Following the F-315 Guidelines and using the information obtained from the completed MDS, Physical Assessment, and Daily Bowel and Bladder Diary to assess the incontinence and level of cognition, a decision will be made to determine if the resident is a candidate for retraining. When the criteria have been met, the daily voiding diaries will be used to determine the individualized toileting schedule and to monitor the resident’s outcome.

Objectives:
- Enable the individual to function at his/her optimum rehabilitation potential and enhance their quality of life
- Provide the individual and his/her family with explanation and education regarding the basic procedures and rationale for bladder/bowel retraining
- Improve the individual’s morale and restore self-esteem
- Promote safety and comfort for the individual while he/she is working toward regaining bowel and/or bladder control

Program:
Determine the resident’s suitability for retraining based on the type of incontinence (stress, urge, overflow, transient, functional, mixed or bowel), as well as the ability of the resident to participate appropriately.

The focus of the program is on urinary and bowel continence. The specific principles to be used are reinforcement of appropriate toileting behavior by using praise, prompting the individual to toilet at regularly scheduled intervals and to individualize these scheduled times.

The individual will develop increased pelvic muscle tone by practicing pelvic muscle exercises that will increase the sense of control over his/her toileting practices. The end result is increased dryness, self-esteem and dignity.

Because retraining is an intensive process, you need to select those residents who have the highest probability for achieving successful results. The following guide can help you identify those residents. Always consider resident history, co-morbidities and how long the resident has been incontinent.

<table>
<thead>
<tr>
<th>Type of Incontinence</th>
<th>Probability of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional</td>
<td>High</td>
</tr>
<tr>
<td>Transient</td>
<td>High</td>
</tr>
<tr>
<td>Stress</td>
<td>High</td>
</tr>
<tr>
<td>Urge</td>
<td>Moderate</td>
</tr>
<tr>
<td>Mixed</td>
<td>Moderate</td>
</tr>
<tr>
<td>Overflow</td>
<td>Low</td>
</tr>
<tr>
<td>Bowel</td>
<td>*Varies</td>
</tr>
</tbody>
</table>

*The cause of bowel incontinence will determine probability for achieving successful results.
Starting a Bowel and Bladder Retraining Program

During the course of this program, our goals will be to:

- Enable the resident to function at his/her optimum rehabilitation potential and enhance his/her quality of life.
- Improve the resident’s morale and restore his/her self-esteem and dignity.
- Educate the caregivers on the reasons for incontinence and how they may be a part of the possible solution.
- Eliminate the stigma of incontinence and promote confidence with knowledge.
- Promote safety for the resident while he/she is facing the challenge of regaining control over something that has embarrassed, confused and frustrated him/her. By imposing safety rules at the start of the program and reinforcing them during the transition, the resident will learn to live safely and at the same time regain their dignity.
- Stimulate a desire for progress and cooperation.

Residents admitted with indwelling catheters should be medically evaluated for removal of the catheter and possible bowel and bladder retraining. For various reasons, some residents are not able to achieve continence. In such cases, external catheters or incontinent absorbent products are appropriate.

At this point in the process, the resident has been assessed and determination has been made that the resident is a candidate for retraining.

1. Enlist the resident’s cooperation, explain the program and offer positive support and encouragement. A good candidate for a bowel and bladder retraining program will display the following:
   - Good transfer (at least moderate assist of one) or ambulation skills
   - Able to manage clothing with at least moderate assist of one
   - Recent onset of incontinence
   - Short term post-catheter placement
   - Desire to be in the Bowel and Bladder Program

Any of the following may exclude candidate from the Bowel and Bladder Program. However highly motivated residents, family and caregivers can overcome many common obstacles to bladder retraining.

- Totally dependent in mobility ADLs (activities of daily living)
- Severe cognitive impairment
- Long term or chronic incontinency
- Refuses or is unable to cooperate with the program
- Acutely or terminally ill
- Unable to communicate the need (verbally and non verbally)
- Combative (do not exclude patients due to agitation)

- Significant urinary retention due to renal dysfunction or symptomatic chronic infections
- Cannot be positioned safely on toilet or bedside commode with or without supervision

2. Determine the individual’s voiding patterns (continent and incontinent). Include frequency, amount and timing (i.e. days, night only, particular days or events). A baseline of several days will be necessary before a bowel and bladder retraining program is initiated. Use the Bowel and Bladder Diary (completed during the assessment phase) to determine daily elimination habits.

3. Determine an individualized toileting schedule based on your individual resident’s pattern shown in the Bowel and Bladder Diaries and record on the Retraining Flow Sheet. A typical schedule might be:
   a. Upon awakening
   b. Every 2 hours during the day and evening
   c. Before bed
   d. Every 2 hours during the night

You will need to individualize this according to the resident’s pattern. For example:

- Mrs. Y is never incontinent during the day. Eliminate 2 hour toileting during the day.
  Or…
- Mrs. Y is never incontinent between 1 and 5 a.m. Toilet at midnight and 5a.m., not every 2 hrs.
  Or…
- Mrs. Y voids incontinently every 3 hours at night. Keep scheduled at every 2 hours.

4. Do not delay in responding to the resident if toileting assistance is requested. Consistent, documented implementation is essential to success.

5. As the individual progresses and has longer intervals between incontinent episodes, adjust times accordingly.

6. Base alterations in program on weekly, monthly or quarterly evaluations based on your facility policy.

7. It may be necessary to decrease intervals if the individual’s pattern changes or reverts to a previous level.

NOTE: Adequate hydration, determined by the resident’s medical condition, offered primarily during waking hours and at night if congruent with the resident’s lifestyle and usual request, is essential. Hydration and fluid administration should be promoted and encouraged, never forced.
INTRODUCTION

Continence can be regained in many circumstances, though training will require the combined efforts and dedication of the nursing team, the resident and his or her family. By helping the individual regain continence, you, the caregiver will:

- Help the individual to regain dignity.
- Help to restore his or her independence.
- Help your resident regain interaction with others.
- Prevent skin issues.
- Reduce odor in the facility.
- Lessen your work with fewer clothing and linen changes.
- Have more time to care for your residents.
- Care for an individual with dignity resulting in improved quality of life!

This program is not for everyone but, for those who can participate, it will mean that they can once again be involved in the activities of daily life without restrictions or embarrassment. Covidien’s clinical nurse consultant will help guide your staff, the individual and their family down the path to continence. We believe in the worth and dignity of every individual and, with you as a partner, we will succeed in making this a reality for your residents.

The components of a bowel and bladder retraining program include:

- Behavioral modification
- Education
- Prompted voiding
- Scheduled voiding/habit training
- Pelvic muscle exercises
- Positive reinforcement
Bladder Retraining Techniques

1. PROMPTED VOIDING

Definition:
Prompted voiding, or reminding someone to void, is a consistent schedule of toileting with the use of prompting techniques. The resident may be able to recognize some degree of bladder fullness/need to void or can respond when prompted to void. Resident may not have sufficient cognitive ability (brain/bladder connection) to participate in a Bowel and Bladder Retraining Training Program.

Purpose:
- To promote resident dignity.
- A prompting to void process to assist in reducing incontinent episodes.

Components:
- Regular monitoring by staff
- Prompting to void on a scheduled basis
- Praise when resident is continent

Procedure:
1. Determine and document Nursing Care Plan based on assessment.
2. Determine and document times for prompted voiding based on assessment.
3. Communicate positive reinforcement for success.
4. Strictly adhere to toileting schedule.
5. Review and update Nursing Care Plan according to facility policy.

2. SCHEDULED VOIDING

Definition:
Scheduled voiding is also referred to as habit training. If the resident goes to the bathroom at the same time every day, habit training can be used. The plan is to take the resident to the bathroom prior to the need to void. This will happen at regular, timed, intervals. It may be every two hours, every three hours or every four hours based on the resident’s needs.

Purpose:
- To promote resident dignity.
- Habit Training will assist in reducing incontinent episodes by bringing the resident to the bathroom prior to the need to void.

Procedure:
1. Determine and document Nursing Care Plan based on assessment.
2. Determine and document times for bathroom visits based on assessment.
3. Praise the resident for being dry and using the toilet.
4. Strictly adhere to the bathroom schedule.
5. Review and update Nursing Care Plan according to facility policy.
3. PELVIC MUSCLE EXERCISES

**Definition**
Pelvic floor muscle exercises, also called Kegel exercises, are performed to strengthen the muscular components of urethral supports. They are commonly used as a noninvasive treatment for stress and urge urinary incontinence.

**Purpose**
Kegel exercises increase muscle tone and improve the control of urine.

**Procedure:**
1. Instruct the resident to draw in or lift up the pelvic floor muscles as if to control urination or defecation with minimal contraction of abdominal, buttock, or inner thigh muscles.
2. Residents should be instructed to squeeze their pelvic floor muscles by stopping the flow of urine during urination, or by squeezing the anal sphincter as if to prevent passing gas.

For beginners, the resident should perform the squeezing exercise five times, holding each contraction for a count of five. Five contractions equal one set. Residents should do one set every hour while awake. After they become proficient, the resident should increase the contraction to 10 seconds. These exercises should be performed daily for three to four months to be effective.

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**Bowel Retraining Techniques**

**1. Scheduled Toileting**
It is important to attempt to establish a regular, predictable pattern of bowel evacuation through patient teaching and adherence to a routine. Because peristaltic contractions of the colon increase in frequency upon awakening and following meals, the period after breakfast is the best time for scheduled defecation. Facilitate toileting at usual defecation time and allow ample time for a bowel movement.

**2. Diet Education and Modification**
Certain dietary components such as lactose, sorbitol, fructose, caffeine, and alcohol may cause loose stools that can potentially aggravate bowel incontinence. Fiber supplements, and a higher-fiber diet, appear to benefit diarrhea-associated bowel incontinence, but not constipation-associated incontinence.

**3. Exercise and Mobility Program**
Mobility is important for normal bowel elimination. Involve the resident in a scheduled exercise program whenever possible and encourage participation in facility activities. Assist in walking and toileting if necessary. If the resident is not able to actively participate in mobility, give passive range of motion exercises. A PT, OT or Activity Director referral may be appropriate.

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Please use the following links to access forms:

- Retraining Flow Sheet
- Bowel and Bladder Weekly Evaluation
- Bowel and Bladder Monthly Evaluation
- Bowel and Bladder Quarterly Evaluation
- Bowel and Bladder Retraining Log
F315 and MDS 3.0 Compliance
F315 and MDS 3.0 Compliance

Covidien supports the Five RIGHTS of Continence Management as outlined in the F315 guidelines for those residents who are determined, after the initial assessment, to be in need of an incontinence product.

■ The RIGHT Choice of Absorbent Product
Choose the product best suited for the unique needs of your incontinent resident.

■ The RIGHT Sized Product
Choosing the correctly sized brief will reduce skin breakdown, increase resident comfort and enhance patient dignity. Choosing the correct sized underpad reduces linen changes and may reduce the number of underpads used on a daily basis.

■ The RIGHT Application of Product
Proper application of incontinent products from briefs and undergarments to underpads ensures the resident will be comfortable, avoid unnecessary skin breakdown or skin tears, maintain dignity and that the product will perform as it is intended.

■ The RIGHT Checks and Changes
By developing standards of care related to changing products as they become wet and soiled and a timed approach to turning your resident, you can minimize skin breakdown and maximize product effectiveness.

■ The RIGHT Skin Care to Prevent Breakdown
The proper skin care regimen is critical to avoiding skin breakdown and the associated complications.
Review and analyze your performance to determine your compliance with F315.

There are three aspects to the urinary incontinence requirements of the F315 guideline as stated by the Center for Medicaid and State Operations/Survey and Certification Group.

1. The first aspect requires that a resident’s clinical condition demonstrates the necessity for the insertion of an indwelling catheter if the resident does not already have one.

2. The second aspect requires that the facility work to prevent urinary tract infections by providing the necessary treatment and services.

3. The third aspect requires the facility to work with the patient to restore continence by providing assistance to restore as much normal bladder function as possible.

The goals of F315 are to ensure:

- If an indwelling catheter is used, there is valid medical justification for an indwelling catheter.
- An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted.
- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter.
- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

The facility has met the F315 compliance criteria if the following conditions are met:

For a resident with an indwelling catheter:

- The facility has recognized and assessed factors affecting the resident’s urinary function and has determined that there is sufficient medical justification for the use of an indwelling catheter.
- The appropriate precautions have been taken to minimize complications or infections from an indwelling catheter.
- An appropriate care plan has been defined and reviewed to allow for the removal of an indwelling catheter if clinically indicated, consistent with resident conditions, goals and recognized standards of practice.
- The resident’s response to the care plan has been monitored and evaluated and necessary revisions to the care plan have been identified and addressed as appropriate.

For a resident who is incontinent of urine:

- The resident has been assessed to identify the risk of symptomatic urinary tract infections and impaired urinary function.
- Underlying causes of urinary incontinence have been defined and interventions implemented to address correctable causes of urinary incontinence.
- Interventions to minimize the occurrence of symptomatic urinary tract infections have been implemented in accordance with resident needs, goals and recognized standards of practice.
- An appropriate care plan has been defined and reviewed to evaluate the resident’s response to preventive measures and treatments to minimize the occurrence of symptomatic urinary tract infections.
- The resident’s response to the care plan has been monitored and evaluated and appropriate revisions to the care plan have been implemented as necessary.

For a resident who currently has or has had a symptomatic urinary tract infection:

- Underlying causes of urinary incontinence have been defined and interventions implemented to address correctable causes of urinary incontinence.
- The resident has been assessed to identify the risk of symptomatic urinary tract infections and impaired urinary function.
- Interventions to address correctable underlying causes and minimize the occurrence of symptomatic urinary tract infections have been implemented in accordance with resident needs, goals and recognized standards of practice.
- An appropriate care plan has been defined and reviewed to evaluate the resident’s response to preventive measures and treatments to minimize the occurrence of symptomatic urinary tract infections.
- The resident’s response to the care plan has been monitored and evaluated and appropriate revisions to the care plan have been implemented as necessary.
The facility is in compliance with F315 if:

- Care and treatment to prevent incontinence and/or improve urinary continence has been provided to restore as much normal bladder function as possible.
- There is medical justification for the use of a catheter, if in use.
- If a catheter is in use appropriate services have been provided to the resident.
- Appropriate steps have been taken to assess, prevent and treat a symptomatic urinary tract infection.
- A resident’s continence status was assessed on admission and consistently thereafter in accordance with the care plan.
- Risk factors for the development of urinary incontinence have been identified and assessed.
- Interventions to improve, maintain or prevent the decline of urinary incontinence have been implemented consistent with the resident’s assessed need and current standards of practice.
- Clinical justification has been provided for the development of urinary incontinence or the failure to improve existing urinary incontinence.
- Symptomatic urinary tract infections were identified and managed or there is adequate explanation why the facility could or should not do so.
- If an indwelling catheter is used, appropriate steps were implemented to manage the use of the catheter including infection control procedures.
- The facility identifies and applies policies and procedures to manage urinary incontinence, catheters and/or urinary tract infections.
- The resident’s physician or representative has been notified of changes in the resident’s continence status, condition, catheter usage or development of symptoms of a symptomatic urinary tract infection.
- Continence care and/or catheter care has been provided to the resident in a manner that respects the resident’s dignity and strives to minimize feelings of embarrassment, humiliation and/or isolation.
- Continence and/or catheter care has been provided to the resident in a timely manner.
- The facility monitors and provides help to a resident who cannot request assistance.
- The staff has assessed and recognized those residents who are candidates for a toileting program.
MDS 3.0 AND INCONTINENCE

MDS 3.0 places greater focus on restorative nursing. Since regulations drive reimbursement, it is imperative that long term care facilities have a well managed restorative program. The forms and information in the ACT Program are designed to assist you with your restorative nursing program related to incontinence.

Two of the 21 quality improvement measures relating to continence are:

- Percentage of low-risk residents who lose control of bowel or bladder
- Percentage of long term residents who have a catheter inserted and left in the bladder

MDS 3.0 focuses on bowel and bladder toileting programs and counts toileting programs as restorative nursing services. It is the responsibility of facilities to provide care to residents that support their needs, physical, social and mental. Facilities are required to prevent and delay any decline in resident function. The goal of restorative nursing programs is to allow the resident to remain as independent as possible. The RAI Manual states: Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.

When looking at incontinence, we need to evaluate residents for restorative care if the resident has:

- Indwelling catheter
- Incontinence but is not on a toileting program

It is very important that your facility staff work with your MDS Coordinator and/or Restorative Nurse to understand MDS rules for restorative nursing. The rules are very specific about amount of time per day and number of days per week that restorative care must be given.

Documentation of restorative care is required and necessary. Nurse’s notes, care plans, flow sheets and other facility forms must be utilized. Consult your state surveyors for guidance on forms.

All restorative programs must be patient centered and this applies to bowel/bladder restorative care also. Each resident’s program should meet their individual needs. Many residents do not need to be toileted every 2 hours. Toilet the resident based on assessment and need, whether that is 2 hours or 4 hours.
Skin Care

In residents experiencing incontinence, skin care should be of paramount importance.

In the incontinent perineal environment, several variables can influence skin condition:

- Overhydration – the skin surface can become overly wet
- Contact with skin irritants – urine, feces, enzymes, bile salts
- Mechanical friction – skin to diaper, skin to skin
- Increased skin pH
- Diet – fecal composition
- Age – urinary frequency
- Use of antibiotic therapy
- Occurrence of diarrhea
- Underlying medical condition

For older patients, incontinence-related skin breakdown can include irritant dermatitis, skin tears, pressure ulcers and infection. Dermatitis can increase the risk of developing pressure ulcers. Prevention is a major focus of quality improvement efforts because of the substantial complications associated with pressure ulcer development.  

Incontinent Skin Management Basics

- Monitor skin condition
  - Examine at every brief change or incontinent event
- Assess resident for risk factors, including:
  - Frequent stooling
  - Loose stools or diarrhea
  - Diets or condition where digestive enzymes are not absorbed and are present in stool
  - Conditions where bile salts are excreted
  - Medications that change stool frequency or composition, including antibiotic therapy

- Begin treatment at the first sign of slight erythema, dryness, rash or abnormal skin anywhere in the perineal area
  - Examine skin for evidence of yeast or bacterial infection
- Reduce skin hydration
  - Select and use absorbent products to wick away moisture from the skin surface
  - Avoid incontinence products with plastic or nonbreathable outer sheets
  - Minimize contact with water (urine and watery stools)
  - Change frequently to minimize contact with irritants
  - Insure that product fits properly (too tight increases skin occlusion, too loose minimizes absorption of fluids)
  - Dry the skin surface after cleansing

- Use gentle skin cleansing methods
  - Soft implements
  - Avoid products with known irritants – fragrance and alcohol
  - Minimize rubbing
  - If topical creams are in place, remove only the soiled portion to minimize rubbing

- Apply topical treatments to provide skin barrier recovery and prevent further damage
  - Treat with antifungal agent if yeast present
  - Provide a semipermeable film/layer, such as a moisture barrier cream, over damaged skin
  - Provide a physical shield between skin and irritants such as urine, feces and microorganism
  - Select a product that stays in place and allows for ease of cleansing

- Monitor skin condition by noting areas of involvement (% covered) and severity of compromise (faint erythema, definite redness, intense redness, rash & bleeding)

Re-evaluate and modify plan if condition worsens or does not show improvement.
Resident Teaching Instructions

Bladder Irritants

Foods To Avoid If You Have Incontinence:

- **Alcohol**: Liquor, wine, beer, wine coolers.
- **Caffeine**: Coffee, tea, colas, herb teas (including decaffeinated), chocolate, cough medicines and over the counter medications (check labels). Substitute with low salt broth and white chocolate.
- **Acid Fruits or Fruit Juices**: Citrus, orange, grapefruit, lemon, lime, mango and pineapple. Substitute with grapes, apples, pears and papayas.
- **Spicy Foods**: Mexican, Thai, Indian, Cajun, Southwest cooking and Korean.
- **Milk Products**: Milk, cheeses, cottage cheese, yogurt, ice cream.
- **Sugar**: Corn sweeteners, honey, fructose, sucrose and lactose.

### Counting Caffeine

Caffeine consumption is not limited to coffee but may include soft drinks and tea as well. Soft drink sales have risen dramatically within the past twenty years; and while caffeine-free choices are available, they represent only a fraction of sales.

Caffeine is also found in chocolate and some over-the-counter medications. It is also used as a flavoring agent in many baked good and processed foods (although you won’t find it listed on the labels).

The amount of caffeine contained in a cup of coffee or tea can vary depending on the type of coffee/tea and the method of brewing. Because of this, it is difficult to identify the exact amount of caffeine consumed by an individual within a day. The following are the most common caffeine sources found in the American diet.

<table>
<thead>
<tr>
<th>Source</th>
<th>Serving Size</th>
<th>Milligrams of Caffeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee: Brewed</td>
<td>8 oz.</td>
<td>65 – 120</td>
</tr>
<tr>
<td>Instant</td>
<td>8 oz.</td>
<td>60 – 85</td>
</tr>
<tr>
<td>Decaffeinated</td>
<td>8 oz.</td>
<td>2 – 4</td>
</tr>
<tr>
<td>Tea</td>
<td>8 oz.</td>
<td>30 – 50</td>
</tr>
<tr>
<td>Iced Tea</td>
<td>8 oz.</td>
<td>9 – 50</td>
</tr>
<tr>
<td>Chocolate Milk</td>
<td>8 oz.</td>
<td>2 – 7</td>
</tr>
<tr>
<td>Hot Chocolate</td>
<td>8 oz.</td>
<td>3 – 32</td>
</tr>
<tr>
<td>Some Soft Drinks</td>
<td>8 oz.</td>
<td>20 – 60</td>
</tr>
</tbody>
</table>
Pharmaceutical Management of Incontinence

NOTE: Pharmaceutical management in geriatric medicine is constantly being revised and updated as new drug information becomes available to the medical profession. It becomes very complex to ensure that the information found in this teaching program is current and up to date. Therefore, it is recommended that you review this portion of the Bladder and Bowel Training Program with your Medical Director and/or your Pharmacy Consultant to revise and update the information found herein based on the Standards and Formulary established within your facility. This information was last updated as of December, 2011.

There are few drugs that are specific for incontinence. Once the underlying cause has been identified, treatment can be instituted to restore bladder and bowel control. Although drugs may be used to treat incontinence, the undesirable side effects must first be considered, especially in the elderly. Many drugs are contraindicated in persons with moderate to severe cardiac disease, hyperthyroidism, asthma and peptic ulcers to name a few. Compatibility of the drugs must also be considered. While one drug may eliminate one form of incontinence, another form may develop as a side effect of the drug. Diuretics, e.g., Lasix, are necessary in some life threatening conditions, but can also lead to urgency and incontinence as they also increase the urine output. Alpha Blockers reduce muscle tone in the bladder neck but also increase the chance of stress incontinence. One should be aware that hypnotics and sedatives decrease a person’s awareness level of the urge to void, especially at night, resulting in incontinence.

Alpha Blocker – Decreases muscle tone in the bladder neck but also increases the risk of stress incontinence. Prazosin Hydrochloride (minipress) is being tried.

Anticholinergics – Although this will inhibit bladder contractions, which may control urgency, urinary retention and overflow incontinence may result.

Antispasmodics – Help to relax smooth muscles without the anticholinergic effect.

Calcium Channel Blockers – For urge incontinence, have not been approved. These drugs, e.g., Calan (Verapamil Hydrochloride) can increase urination.

Cholinergics – Used to increase tone and motility in overflow incontinence, e.g., Urecholine.

Estrogen Therapy – Often used in stress incontinence, works by improving sphincter tone.

Tricyclic Antidepressants – Decreases bladder contractions and increases outlet resistance. Also useful to treat stress incontinence. However, one must be aware of the sedative effects, e.g., dizziness, drowsiness and confusion which are more prominent in the elderly. This drug classification also has anticholinergic effects which might worsen conditions in a person with glaucoma or urinary retention.

Although over the counter drugs, e.g., antihistamines (Benadryl) can be used to treat stress incontinence, a complete assessment must be accomplished prior to using the drugs.

Drugs Affecting Incontinence

This list is not provided as a guide to recommend any particular treatment regimen. Please consult a qualified professional within your facility to determine best treatment options.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Classification</th>
<th>Side Effects &amp; Adverse Reactions (Urinary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine (Benadryl™)</td>
<td>Antihistamine</td>
<td>Dysuria, urinary retention</td>
</tr>
<tr>
<td>Captopril (Capoten™)</td>
<td>ACE inhibitor</td>
<td>Polyuria, oliguria, frequency</td>
</tr>
<tr>
<td>Chlorpheniramine (Chlor-Trimeton™)</td>
<td>Antihistamine</td>
<td>Urinary frequency, dysuria, urinary retention</td>
</tr>
<tr>
<td>Diazepam (Valium™)</td>
<td>Antianxiety</td>
<td>Urinary retention, incontinence</td>
</tr>
<tr>
<td>Nifedipine (Procardia™)</td>
<td>Calcium channel blocker</td>
<td>Urinary retention, frequency dysuria</td>
</tr>
<tr>
<td>Dimenhydrinate (Dramamine™)</td>
<td>Antihistamine</td>
<td>Urinary frequency, difficult urination, urinary retention</td>
</tr>
<tr>
<td>Furosemide (Lasix™)</td>
<td>Diuretic</td>
<td>Urgency, fluid and electrolyte imbalance, hyponatremia, hypokalemia</td>
</tr>
<tr>
<td>Haloperidol (Haldol™)</td>
<td>Antipsychotic</td>
<td>Urinary retention, urinary frequency</td>
</tr>
<tr>
<td>Levodopa (Larodopa™)</td>
<td>Antiparkinson drug</td>
<td>Stress incontinence, frequency</td>
</tr>
<tr>
<td>Oxycodynin</td>
<td>Anticholinergic</td>
<td>Urge incontinence, dysuria</td>
</tr>
<tr>
<td>Prazosin (Minipress™)</td>
<td>Alpha-adrenergic blocker</td>
<td>Frequency, stress incontinence,</td>
</tr>
<tr>
<td>Fluoxetine (Prozac™)</td>
<td>Antidepressant</td>
<td>Urinary retention, dysuria, frequency</td>
</tr>
<tr>
<td>Oxycodeone (Percocet™)</td>
<td>Narcotic</td>
<td>Urinary retention, dysuria, frequency</td>
</tr>
<tr>
<td>Pseudoephedrine (Sudafed™)</td>
<td>Alpha stimulant</td>
<td>Urinary retention</td>
</tr>
<tr>
<td>Nyquil™, Theraflu™</td>
<td>Cold remedies</td>
<td>Urinary retention, dysuria, frequency, stress incontinence</td>
</tr>
</tbody>
</table>

™* is the trademark of its respective owner.
Additional Resources

Where Do I Go For Help?
By beginning the ACT Program you are well on your way to the successful management of incontinence in your facility and meeting the F315 Guidelines as outlined by the Centers for Medicare & Medicaid Services (CMS). The program covers:
- Education
- Assessment
- Development of Individualized Nursing Care Plan
- Bladder/Bowel Training
- Documentation

Covidien also offers educational in-service videos that go through application of the complete line of incontinence care products in great detail.

However, should you have additional questions, Covidien maintains a staff of clinical nurse consultants who will be happy to work with individual facilities to be sure the program is tailored to meet all of your needs.

In addition, you may wish to contact some of the many outside agencies with supplemental information on incontinence care:
- Agency for Health Care Research and Quality
  [www.ahrq.gov](http://www.ahrq.gov)  301-427-1104
- National Association for Continence
  [www.nafc.org](http://www.nafc.org)  1-800-BLADDER
- Alliance for Aging Research
  [www.agingresearch.org](http://www.agingresearch.org)  202-293-2856
- International Continence Society (London)
  [www.icsoffice.org](http://www.icsoffice.org)  44-117-9444881

We hope the ACT Program has helped you better meet the needs of your incontinent residents. For more information, please do not hesitate to contact your local Covidien sales representative or clinical nurse consultant.

References
ACT Program
For Continence Management
Forms and Nursing Plans

All the forms and plans included with the ACT Program for Continence Management can be opened and printed for manual use or used interactively.

Included are:

Assessment Forms
- Physical Assessment
- Categorizing Urinary Incontinence
- Bowel and Bladder Daily Diary

Nursing Care Plans
- Urinary Incontinence
- Environmental/Functional Incontinence
- Urge Incontinence
- Stress Incontinence
- Overflow Incontinence
- Transient Incontinence
- Fecal (Bowel) Incontinence: Nonreversible
- Fecal (Bowel) Incontinence: Constipation
- Fecal (Bowel) Incontinence: Diarrhea
- Fecal (Bowel) Incontinence: Fecal Impaction
- Fecal (Bowel) Incontinence

Retraining Forms
- Retraining Flow Sheet
- Bowel and Bladder Evaluation
  - Bowel and Bladder Weekly Evaluation
  - Bowel and Bladder Monthly Evaluation
  - Bowel and Bladder Quarterly Evaluation
- Bowel and Bladder Retraining Log

Light blue indicates interactive fields. To retain work, please use “Save As” function to avoid overwriting original form.

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