NAME _____

Impaired Urinary Elimination (Incontinence)

Date	Problem	Goal/Outcome	Interventions	Date	Evaluation	NOTES
	Related To: □ Reflex/Bladder hyperactivity □ Loss of voluntary control due to _____ □ Function/ Decrease level of Consciousness due to _____ □ Function/Inability to communicate urge to urinate □ Function/ Impaired physical mobility □ Stress/Leakage due ↑ abd pressure □ other (list) AEB: □ enuresis □ involuntary dribbling □ other (list)	1. Urinary incontinence < 3 times/week 2. Verbalize at least one technique to decrease episodes of incontinence 3. Verbalize how to use absorbent underwear as needed	**NURSING** 1. Assess pattern of fluid intake and urination (times, amount, activities, etc.) 2. Palpate abd for bladder distention _____ (freq) 3. Develop bladder training - urination plan/schedule 4. Assess need for bedside commode 5. Facilitate communication with others as needed 6. Monitor I & O 7. Other (list) **DELEGATE** 1. Offer bedpan/urinal/ bedside commode, bathroom every 2-4 hours 2. Monitor I & O daily 3. Assist with positioning as needed to facilitate bladder emptying 4. If difficulty speaking, establish effective method to		***(Address all items listed in "goal/outcome" column. If goal not met, revise plan)***	

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			communicate the need to urinate 5. Offer/encourage fluids at spaced intervals – no large amounts at one time 6. Limit fluids in the evening/night 7. Other (list)			
RN SIGNATURE:				**DATE:**		