Blue Ridge HealthCare System
Interdisciplinary
Patient Safety

Incontinence Skin Care: Fecal and Urinary

**Origination Date:** 03/2006
**Review/Revised Date:** 11/05/2015

**APPLICABILITY:**
Carolinas HealthCare System Blue Ridge

**POLICY:**
The nursing staff will implement treatment plans for patients incontinent of urine or stool to prevent skin damage. Techniques to address incontinence include the use of absorbent and air permeable materials, stool collection devices and Foley catheters. The goal of incontinence management is to provide the least invasive, most efficient, and cost-effective care to prevent skin damage.

**PURPOSE:**
To reduce the incidence of pressure ulcers and incontinence related to dermatitis by identification of risk factors related to incontinence and implementation of prevention and containment strategies.

**NOTE:**

A. The patient will be assessed every shift for perineal skin breakdown.
B. Perineal skin care will be promptly performed after each incontinent episode.
C. Staff will communicate with the primary care provider to rule out reversible causes of incontinence, including:
   a. Clostridium Difficile
   b. Urinary Tract Infection
   c. Fecal Impaction
   d. Urinary Retention
   e. Constipation
   f. Diarrhea
   g. Medication Side Effects
D. For patients whose incontinence and subsequent skin damage does not respond / resolve within 3 days, obtain consult for WOC Nurse (or designated staff member).
PROCESS:

A. Perform hand hygiene and use appropriate Personal Protective Equipment (PPE), set-up supplies.
B. Provide for patient privacy.
C. Cleanse perineal area after each incontinent episode with perineal cleanser. Pat dry.
D. Apply thin layer of moisture barrier.
E. Use absorbent and air-permeable products as needed to wick moisture away from patient’s skin.
   a. Use minimal layers of padding and linens beneath patient, such as one underpad and one drawsheet.
   b. Minimize use of briefs unless patient is ambulating, getting up to the chair, or going to another department for study or treatment.
   c. Check patient at least every two hours for further incontinence.
F. If signs / symptoms of monilia rash are observed, notify primary care provider to obtain order for topical antifungal agent.
G. A Foley catheter may be used based on specific criteria and with a provider order.
H. Consider Stool Management System, obtain order from primary care provider.

Condom Catheter (Male Patients)

A. Equipment: Condom Catheter
B. Interventions:
   a. If necessary, trim pubic hair.
   b. Clean and dry penile area.
   c. To open the package, tear from one end to the other.
   d. Hold on to the applicator ring with 2 fingers, to help with positioning. Place the sheath over the glans, but keep a 1cm gap between the glans and the outlet tube. Use your other hand to pull the tab slowly towards you, unrolling the sheath smoothly and evenly.
   e. Discard the applicator ring.
   f. Gently squeeze the sheath around the shaft of the penis to ensure adhesion. No additional adhesive is necessary.
   g. Connect sheath to urine collection bag.
   h. Change sheath every 24 hours / daily.
   i. To remove: detach the sheath from the urine collection bag and carefully roll off.

DOCUMENTATION:

A. Document assessment on the Patient Care Record.
B. Document goals and interventions on the Interdisciplinary Plan of Care.
C. Note patient and family education and response on the Educational Teaching Record.
REFERENCES:


