PROCEDURE

TITLE: **BLADDER TRAINING**

PURPOSE: To provide a nursing methodology for teaching bladder training.

1. To enable patient to control urination without catheter, if at all possible, thus reducing the possibility of urinary tract infection.
2. To restore the patient's dignity and self-respect, improve the morale of the patient and reduce incidence of skin irritation and breakdown.

SUPPORTIVE DATA:

1. Indications: Patients with urinary incontinence or after removal of catheter.
2. Incontinence is a predisposing factor for skin breakdown (Bryant p. 232).

LEVEL OV RESPONSIBILITY: RN's, LPN's and Nursing Assistants may perform.

EQUIPMENT LIST:

1. Graduate for measuring urine
2. Bedpan or urinal for bedridden patient
3. Bedside commode, walker or cane for poor ambulators.
4. Clamp

CONTENT:	**PROCEDURE STEPS**:	**KEY POINTS**:
A. Without Catheter	**A. WITHOUT CATHETER**	
	1. Take patient to toilet or commode every two to three hours around the clock.	Bedpan and urinal are used only if absolutely necessary.
	2. Observe and record the present voiding pattern to establish a definite schedule.	This should be done for two to three days or longer if necessary.
	3. Encourage patient to empty bladder completely at each voiding.	Instruct patient to lean forward and push down with abdominal muscles.
	4. Provide adequate fluid intake. Offer eight to ten 8 oz. glasses (2,000-2,400cc) in 24 hours.	To maintain proper hydration unless contra-indicated. Avoid increasing sodium beverages and caffeine.
	5. Evaluate program and update patient care plan every few days.	
	6. Continue program until success has been achieved.	Encourage patient and do not allow him/her to be discouraged if "accident" occurs.

DOCUMENTATION:

7. Record episodes of incontinence, voids, toileting schedule in nursing notes and update nursing care plan.
8. Document tolerance to procedure and success rate (all three shifts).

B. WITH CATHETER

B. <u>WITH CATHETER – Nurisng Assistants may perform with RN/LPN's guidance</u>

1. Explain procedure to patient and encourage patient to participate and cooperate in the program.
2. Clamp catheter off for approximately two hours, depending on patient's tolerance.
   Physician will sometimes specify exact time, up to 4 hours. This will increase bladder tone.
3. Unclamp catheter for 30 minutes and encourage patient to push down with abdominal muscles to completely empty bladder.
   To develop muscle control.
4. Continue to clamp and unclamp catheter at prescribed times until the patient is able to hold approximately 250 cc's and feels the urge to void.
   Keep accurate record of fluid intake and output. Be alert for signs of infection or unusual bleeding.
5. Remove catheter and proceed as for patient without catheter.

DOCUMENTATION:

6. Document tolerance to procedure and amounts and color of urine obtained with each unclamping when pertinent.
7. Document time and by whom catheter discontinued - important.

REFERENCE: Bryant: R.A (2000) <u>Acute and Chronic Wounds Nursing Management</u>, 2nd Edition. Philadelphia: Mosby pg. 229-232