Skill #50 Inserting an Indwelling Urinary Catheter in a Female

Use this scenario for ICP - INCONTINENCE, FUNCTIONAL

You get report that Mrs. Bell is confused and a fall risk whom needs assistance with all transfers. She needs to be checked frequently for incontinence because she does not always use the call light effectively. Mrs. Bell also has a diagnosis of CHF and takes 40mg of Lasix BID. Your nursing aide tells you that Mrs. Bell typically calls for the bedpan after she has already voided. Mrs. Bell tells you that she can't always tell when she needs to go especially at night, "it just happens".

NURSING DIAGNOSIS **INCONTINENCE, FUNCTIONAL**	Patient's Medical Diagnosis:
DEFINITION:	The state in which an individual experiences an involuntary, unpredictable passage of urine.
DEFINING CHARACTERISTICS:	The urge to void or bladder contractions sufficiently strong to result in loss of urine before reaching an appropriate receptacle; voiding in large amounts.
RELATED FACTORS:	Altered environment (e.g., poor lighting or inability to locate bathroom): sensory, cognitive (e.g., inattentiveness to urge to void, use of sedation) or mobility deficits (including difficulty in removing clothes): increased urine production; reluctance to use call light or bedpan.
STUDENT INSTRUCTIONS:	In the space below enter the subjective and objective data gathered during your patient assessment.

ASSESSMENT		
	Subjective Data Entry	***Objective Data Entry***
	TIME OUT!	**Student Instructions:** To be sure your patient diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your patient data matches. Do you have an accurate match or is additional data required or does another nursing diagnosis need to be investigated?
DIAGNOSIS	**PATIENT DIAGNOSTIC STATEMENT:**	**Nursing Diagnosis:** _____ **Related to:** _____ **AEB:** _____

PLANNING

Desired Outcome And Patient Criteria: The Patient Will:

TIME OUT! The desired outcome must meet criteria to be accurate. The outcome must be specific, realistic, measurable, and include a time frame for completion. Does the action verb describe the patient's behavior to be evaluated? Can the outcome be used in the evaluation step of the nursing process to measure the patient's response to the nursing interventions listed below?

Interventions	Rationale For Selected Intervention and References

EVALUATION

TIME OUT! Do your interventions assist in achieving the desired outcome? Do your interventions address further monitoring of the patient's response to your interventions and to the achievement of the desired outcome? Are qualifiers: **when, how, amount, time,** and **frequency** used? Is the focus of the action's verb on the nurse's actions and not on the patient? Do your rationales provide sufficient reason and directions?

What was your patient's response to the interventions?

Was the desired outcome achieved? If no, what revisions to either the desired outcome or interventions would you make?

Yes No

DOCUMENTATION

Documentation Focus: Now that you have completed the evaluation, the next step is to document your care and the patient's response. Use the areas below to enter your progress note information.**(Past Tense).**

INSTRUCTOR'S COMMENTS: