

E — Elimination

9 statements · Recommended tool: CP-ELIM Elimination Check · Validated scales: Bristol Stool Chart, bladder scan

E1 Hard or infrequent bowel movements

Group: Elimination | Type: Actual problem

Definition: Stools are hard, dry, or rare, with straining or discomfort.

Possible causes: Low fiber and fluids; inactivity; opioids; weak muscles; ignoring the urge

Signs and symptoms: No stool for 3 days; hard dry stools; straining; belly swelling; poor appetite

Scenario. A patient on opioid pain medicine has not passed stool for four days.
S: "I haven't had a bowel movement in four days and I feel bloated."
O: No stool for 4 days; abdomen distended and firm; on morphine; fluid intake 800 ml per day; sluggish bowel sounds.
Tools: CP-ELIM, CP-PAIN, CP-FLUID · Bristol Stool Chart, bladder scan, NRS 0-10, FLACC, PAINAD, MUST, fluid chart, glucose
CarePath diagnosis: Hard or infrequent bowel movements related to opioid medicine and low fluid intake, as evidenced by no stool for 4 days and a firm, distended abdomen.
Interventions and rationale | Intervention | Rationale | |---|---| | Encourage fluids, fiber, and movement. | Fluid softens stool, fiber adds bulk and movement stimulates the gut, so stool moves along more easily. | | Offer toilet privacy. | Privacy helps him relax and respond to the urge, since ignoring the urge makes stool harder and drier. | | Give laxatives as ordered. | Laxatives soften or stimulate the bowel. Opioid constipation often needs them regularly, and they are given as ordered. | | Keep a bowel chart. | A chart shows how long since the last stool and whether the plan is working. |
Expected outcomes - Within 24-48 hours: passes a soft formed stool, abdomen soft and comfortable. - Drinks 1.5-2 liters per day unless limited. - Patient states a bowel routine.
Linking the data to the diagnosis
The patient takes morphine and has had no stool for 4 days. The abdomen is distended and firm, bowel sounds are sluggish and fluid intake is only 800 ml per day. He says he is bloated. This is an actual problem because the constipation is already present. Frequent loose stools is the opposite problem and does not apply. The plan aims for a soft formed stool and a soft, comfortable abdomen within 24-48 hours, fluid intake of 1.5-2 liters per day unless limited, and the patient stating a bowel routine.

CarePath diagnosis: Hard or infrequent bowel movements related to opioid medicine and low fluid intake, as evidenced by no stool for 4 days and a firm, distended abdomen.

Intervention	Rationale
Encourage fluids, fiber, and movement.	Fluid softens stool, fiber adds bulk and movement stimulates the gut, so stool moves along more easily.
Offer toilet privacy.	Privacy helps him relax and respond to the urge, since ignoring the urge makes stool harder and drier.
Give laxatives as ordered.	Laxatives soften or stimulate the bowel. Opioid constipation often needs them regularly, and they are given as ordered.
Keep a bowel chart.	A chart shows how long since the last stool and whether the plan is working.

Expected outcomes: Within 24-48 hours: passes a soft formed stool, abdomen soft and comfortable. · Drinks 1.5-2 liters per day unless limited. · Patient states a bowel routine.

Linking the data: The patient takes morphine and has had no stool for 4 days. The abdomen is distended and firm, bowel sounds are sluggish and fluid intake is only 800 ml per day. He says he is bloated. This is an actual problem because the constipation is already present. Frequent loose stools is the opposite problem and does not apply. The plan aims for a soft formed stool and a soft, comfortable abdomen within 24-48 hours, fluid intake of 1.5-2 liters per day unless limited, and the patient stating a bowel routine.

E2 Frequent loose stools

Group: Elimination | Type: Actual problem

Definition: Watery or frequent stools that risk fluid loss, weakness, and skin damage.

Possible causes: Stomach infection; antibiotics; medicines; food intolerance; stress

Signs and symptoms: Watery stools many times a day; cramps; urgency; sore skin

Scenario. A hospital patient on antibiotics has seven watery stools in a day.

S: "I keep running to the toilet and my bottom is sore."

O: 7 watery stools in 24 hours; skin around the anus red; temperature normal; on antibiotics.

Tools: CP-ELIM, CP-SKIN · Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Frequent loose stools related to antibiotic use, as evidenced by 7 watery stools in 24 hours and red skin around the anus. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Replace fluids. | Frequent watery stools lose a lot of water and salts, and replacing them prevents dehydration. | | Protect skin with barrier cream. | Stool irritates skin, and barrier cream protects it from breakdown and soreness. | | Use infection precautions. | The cause may be infectious, so precautions such as gloves, handwashing and a separate toilet prevent spread to others. | | Send a stool sample if ordered. | A stool test finds the cause, so the right treatment can be given. | | Record each stool. | Records show how much fluid is being lost and whether the problem is improving. | ****Expected outcomes**** - Within 48 hours: stools return to a formed pattern, skin intact and not red, hydration normal. - Patient follows hand hygiene and infection precautions. ****Linking the data to the diagnosis**** The hospital patient is on antibiotics and has had 7 watery stools in 24 hours. The skin around the anus is red and temperature is normal. He says he keeps running to the toilet and his bottom is sore. This is an actual problem because the loose stools are already happening. Dehydration could follow, but no signs of it are described, so this statement is the main one. Hard or infrequent bowel movements is the opposite problem. The plan aims for formed stools, intact and non-red skin and normal hydration within 48 hours, with the patient following hand hygiene and infection precautions.

CarePath diagnosis: Frequent loose stools related to antibiotic use, as evidenced by 7 watery stools in 24 hours and red skin around the anus.

Intervention	Rationale
Replace fluids.	Frequent watery stools lose a lot of water and salts, and replacing them prevents dehydration.
Protect skin with barrier cream.	Stool irritates skin, and barrier cream protects it from breakdown and soreness.
Use infection precautions.	The cause may be infectious, so precautions such as gloves, handwashing and a separate toilet prevent spread to others.
Send a stool sample if ordered.	A stool test finds the cause, so the right treatment can be given.
Record each stool.	Records show how much fluid is being lost and whether the problem is improving.

Expected outcomes: Within 48 hours: stools return to a formed pattern, skin intact and not red, hydration normal. · Patient follows hand hygiene and infection precautions.

Linking the data: The hospital patient is on antibiotics and has had 7 watery stools in 24 hours. The skin around the anus is red and temperature is normal. He says he keeps running to the toilet and his bottom is sore. This is an actual problem because the loose stools are already happening. Dehydration could follow, but no signs of it are described, so this statement is the main one. Hard or infrequent bowel movements is the opposite problem. The plan aims for formed stools, intact and non-red skin and normal hydration within 48 hours, with the patient following hand hygiene and infection precautions.

E3 Unable to empty the bladder

Group: Elimination | Type: Actual problem

Definition: Urine stays in the bladder, causing fullness, discomfort, or overflow leaking.

Possible causes: Enlarged prostate; nerve injury; medicines; after surgery; pain

Signs and symptoms: Little urine passed; lower belly fullness; discomfort; dribbling

Scenario. After surgery a man cannot pass urine for eight hours and feels bladder pressure.

S: "I need to pass urine but nothing comes out."

O: No urine for 8 hours after surgery; lower belly distended and tender; bladder scan 650 ml; uncomfortable.

Tools: CP-ELIM, CP-SKIN · Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Unable to empty the bladder related to the effects of surgery and anesthesia, as evidenced by no urine for 8 hours and a bladder scan of 650 mL. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check with a bladder scan or palpation as ordered. | A scan or palpation confirms how much urine is held, so action is based on facts. | | Offer privacy and a normal position. | Privacy and a normal position relax the pelvic muscles, which helps the bladder empty. | | Try running water or warm water. | The sound or warmth of water can trigger the urge to pass urine without drugs or tubes. | | Catheterize if ordered. | If other methods fail, a catheter drains the bladder, relieving pain and preventing overstretching and kidney damage. | ****Expected outcomes**** - Within 6-8 hours: passes at least 200 ml per void or catheter placed as ordered. - Leftover urine under 100 ml on scan. - Discomfort resolved. ****Linking the data to the diagnosis**** After surgery the man has passed no urine for 8 hours. The lower belly is distended and tender and a bladder scan shows 650 ml. He says he needs to pass urine but nothing comes out. This is an actual problem because the bladder is already full and not emptying. Urinary leaking or frequency statements would not fit, since little urine is passing. The plan aims for passing at least 200 ml per void or catheter placement as ordered within 6-8 hours, leftover urine under 100 ml on scan, and the discomfort resolved.

CarePath diagnosis: Unable to empty the bladder related to the effects of surgery and anesthesia, as evidenced by no urine for 8 hours and a bladder scan of 650 mL.

Intervention	Rationale
Check with a bladder scan or palpation as ordered.	A scan or palpation confirms how much urine is held, so action is based on facts.
Offer privacy and a normal position.	Privacy and a normal position relax the pelvic muscles, which helps the bladder empty.
Try running water or warm water.	The sound or warmth of water can trigger the urge to pass urine without drugs or tubes.
Catheterize if ordered.	If other methods fail, a catheter drains the bladder, relieving pain and preventing overstretching and kidney damage.

Expected outcomes: Within 6-8 hours: passes at least 200 ml per void or catheter placed as ordered. · Leftover urine under 100 ml on scan. · Discomfort resolved.

Linking the data: After surgery the man has passed no urine for 8 hours. The lower belly is distended and tender and a bladder scan shows 650 ml. He says he needs to pass urine but nothing comes out. This is an actual problem because the bladder is already full and not emptying. Urinary leaking or frequency statements would not fit, since little urine is passing. The plan aims for passing at least 200 ml per void or catheter placement as ordered within 6-8 hours, leftover urine under 100 ml on scan, and the discomfort resolved.

E4 Leaking urine

Group: Elimination | Type: Actual problem

Definition: Urine escapes without control, for example with coughing, urgency, or at other times.

Possible causes: Weak pelvic muscles; infection; nerve problems; medicines; coughing

Signs and symptoms: Leaking with cough or urgency; wet clothing; skin irritation; embarrassment

Scenario. A woman leaks a little urine each time she coughs or laughs.

S: "I leak a little when I cough or laugh and I'm embarrassed."

O: Leaks small amounts with coughing and laughing; uses 3 pads a day; no signs of infection; has had two children.

Tools: CP-ELIM, CP-INFECT · Bristol Stool Chart, bladder scan, qSOFA / sepsis screen ****CarePath diagnosis:**** Leaking urine related to weak pelvic muscles, as evidenced by leaking with cough or urgency and wet clothing. ****Interventions and rationale**** | Intervention | Rationale | ---|---| | Teach pelvic floor exercises. | Strengthening the pelvic floor muscles improves support of the bladder outlet, so less urine escapes when pressure rises with coughing or laughing. | | Set a toileting schedule. | Emptying the bladder at regular times keeps it from becoming overfull, which lowers the chance of leaks and reduces urgency. | | Use pads. | Pads absorb leaked urine, keeping clothing dry and protecting the patient's confidence and dignity while the muscles are being strengthened. | | Encourage fluids but limit caffeine. | Enough fluid keeps urine dilute and less irritating to the bladder, while caffeine irritates the bladder and acts as a diuretic, which can increase urgency and leaking. | | Protect skin. | Urine left on the skin causes irritation and breakdown, so gentle cleansing and drying, with a barrier product if needed, keeps the skin intact. | ****Expected outcomes**** - Within 4 weeks: leaking episodes reduced by half, skin dry and intact. - Patient does pelvic floor exercises correctly and states a toileting routine. ****Linking the data to the diagnosis**** The woman says she leaks a little when she coughs or laughs and that she is embarrassed. The nurse observed small leaks with coughing and laughing, three pads used each day, no signs of infection, and a history of two children. These facts point to weak pelvic muscles as the cause, and the lack of infection makes a urine infection a less likely explanation. The leaking has already happened, so this is an actual diagnosis and not a risk. The plan aims to cut leaking episodes by half within 4 weeks, keep her skin dry and intact, and help her do pelvic floor exercises correctly and state a toileting routine.

CarePath diagnosis: Leaking urine related to weak pelvic muscles, as evidenced by leaking with cough or urgency and wet clothing.

Intervention	Rationale
Teach pelvic floor exercises.	Strengthening the pelvic floor muscles improves support of the bladder outlet, so less urine escapes when pressure rises with coughing or laughing.
Set a toileting schedule.	Emptying the bladder at regular times keeps it from becoming overfull, which lowers the chance of leaks and reduces urgency.
Use pads.	Pads absorb leaked urine, keeping clothing dry and protecting the patient's confidence and dignity while the muscles are being strengthened.
Encourage fluids but limit caffeine.	Enough fluid keeps urine dilute and less irritating to the bladder, while caffeine irritates the bladder and acts as a diuretic, which can increase urgency and leaking.
Protect skin.	Urine left on the skin causes irritation and breakdown, so gentle cleansing and drying, with a barrier product if needed, keeps the skin intact.

Expected outcomes: Within 4 weeks: leaking episodes reduced by half, skin dry and intact. · Patient does pelvic floor exercises correctly and states a toileting routine.

Linking the data: The woman says she leaks a little when she coughs or laughs and that she is embarrassed. The nurse observed small leaks with coughing and laughing, three pads used each day, no signs of infection, and a history of two children. These facts point to weak pelvic muscles as the cause, and the lack of infection makes a urine infection a less likely explanation. The leaking has already happened, so this is an actual diagnosis and not a risk. The plan aims to cut leaking episodes by half within 4 weeks, keep her skin dry and intact, and help her do pelvic floor exercises correctly and state a toileting routine.

E5 Unable to reach the toilet in time

Group: Elimination | Type: Actual problem

Definition: Bladder control is present but mobility, distance, or timing leads to accidents.

Possible causes: Poor mobility; unfamiliar ward; confusion; poor sight; distance to the bathroom

Signs and symptoms: Arrives too late; calls for help late; wet floor or clothing

Scenario. An older man with a walker has accidents because the toilet is far away.

S: "By the time I get to the toilet, it's too late."

O: Walks slowly with a frame; toilet 12 meters from bed; two wet accidents in 24 hours; bladder control otherwise normal.

Tools: CP-ELIM · Bristol Stool Chart, bladder scan ****CarePath diagnosis:**** Unable to reach the toilet in time related to poor mobility, as evidenced by arrives too late and calls for help late. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Place the bed near the toilet. | A bed close to the toilet shortens the distance he must walk, so he can arrive before the bladder empties. | | Use a commode. | A commode at the bedside gives a very short, safe route to a toilet seat when walking 12 meters is too slow for him. | | Set regular toilet times. | Offering the toilet at regular times means he goes before the urge becomes urgent, so he does not have to rush or wait. | | Clear the path. | A clear path lets him move safely with the frame and more quickly, lowering the risk of tripping when he hurries. | | Answer the call bell quickly. | A fast response to the call bell gets him to the toilet before the bladder is too full, and it lowers his worry about accidents. | ****Expected outcomes**** - No accidents for 48 hours. - Commode or nearby toilet used safely. - Call bell answered within 5 minutes. - Patient feels less anxious. ****Linking the data to the diagnosis**** The older man walks slowly with a frame, the toilet is 12 meters from his bed, and he has had two wet accidents in 24 hours. He says that by the time he gets to the toilet it is too late. His bladder control is otherwise normal, so this fits unable to reach the toilet in time and not leaking urine, which would point to loss of control itself. The problem has already happened, so it is an actual diagnosis. The plan aims for no accidents for 48 hours, safe use of a commode or nearby toilet, call bell answers within 5 minutes, and a less anxious patient.

CarePath diagnosis: Unable to reach the toilet in time related to poor mobility, as evidenced by arrives too late and calls for help late.

Intervention	Rationale
Place the bed near the toilet.	A bed close to the toilet shortens the distance he must walk, so he can arrive before the bladder empties.
Use a commode.	A commode at the bedside gives a very short, safe route to a toilet seat when walking 12 meters is too slow for him.
Set regular toilet times.	Offering the toilet at regular times means he goes before the urge becomes urgent, so he does not have to rush or wait.
Clear the path.	A clear path lets him move safely with the frame and more quickly, lowering the risk of tripping when he hurries.
Answer the call bell quickly.	A fast response to the call bell gets him to the toilet before the bladder is too full, and it lowers his worry about accidents.

Expected outcomes: No accidents for 48 hours. · Commode or nearby toilet used safely. · Call bell answered within 5 minutes. · Patient feels less anxious.

Linking the data: The older man walks slowly with a frame, the toilet is 12 meters from his bed, and he has had two wet accidents in 24 hours. He says that by the time he gets to the toilet it is too late. His bladder control is otherwise normal, so this fits unable to reach the toilet in time and not leaking urine, which would point to loss of control itself. The problem has already happened, so it is an actual diagnosis. The plan aims for no accidents for 48 hours, safe use of a commode or nearby toilet, call bell answers within 5 minutes, and a less anxious patient.

E6 Bowel leakage

Group: Elimination | Type: Actual problem

Definition: Stool passes without control, risking skin damage and embarrassment.

Possible causes: Weak anal muscles; diarrhea; nerve damage; confusion; long labor

Signs and symptoms: Soiled clothing; skin breakdown; avoids social contact

Scenario. A woman after childbirth leaks stool when she passes gas.

S: "I leak stool when I pass gas and I'm ashamed."

O: Soiled underwear twice daily; skin around the anus red; recent vaginal delivery with a tear.

Tools: CP-ELIM, CP-SKIN · Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart **CarePath** diagnosis:**Bowel leakage related to weak anal muscles, as evidenced by soiled clothing and skin breakdown.** **Interventions and rationale** | Intervention | Rationale | |---|---| | Set a bowel routine. | A regular bowel routine, such as sitting on the toilet at set times after meals, helps the bowel empty at predictable times and reduces unplanned leakage. | | Clean skin gently and use barrier cream. | Stool irritates skin, so gentle cleaning without rubbing and a barrier cream protect the reddened skin around the anus from further breakdown. | | Use pads. | Pads absorb leakage and protect clothing, helping her go about daily life with less fear of being soiled. | | Protect dignity. | Privacy, discreet disposal and a respectful manner reduce shame, which helps her talk openly about the problem and take part in her care. | | Refer for pelvic floor help. | A pelvic floor specialist can assess damage after the delivery tear and teach exercises that rebuild anal muscle strength for lasting control. | **Expected outcomes** - Within 4 weeks: fewer leakage episodes, skin intact. - Patient practices pelvic floor exercises correctly and says she feels more confident. **Linking the data to the diagnosis** After a recent vaginal delivery with a tear, the woman says she leaks stool when she passes gas and that she is ashamed. The nurse found soiled underwear twice daily and red skin around the anus. These facts show the leakage has already happened and the skin is affected, so this is an actual diagnosis, with weak anal muscles as the likely cause. It is not a general bowel pattern problem because the main issue is stool passing without control. The plan aims for fewer leakage episodes and intact skin within 4 weeks, correct pelvic floor exercises, and greater confidence.

CarePath diagnosis: Bowel leakage related to weak anal muscles, as evidenced by soiled clothing and skin breakdown.

Intervention	Rationale
Set a bowel routine.	A regular bowel routine, such as sitting on the toilet at set times after meals, helps the bowel empty at predictable times and reduces unplanned leakage.
Clean skin gently and use barrier cream.	Stool irritates skin, so gentle cleaning without rubbing and a barrier cream protect the reddened skin around the anus from further breakdown.
Use pads.	Pads absorb leakage and protect clothing, helping her go about daily life with less fear of being soiled.
Protect dignity.	Privacy, discreet disposal and a respectful manner reduce shame, which helps her talk openly about the problem and take part in her care.
Refer for pelvic floor help.	A pelvic floor specialist can assess damage after the delivery tear and teach exercises that rebuild anal muscle strength for lasting control.

Expected outcomes: Within 4 weeks: fewer leakage episodes, skin intact. · Patient practices pelvic floor exercises correctly and says she feels more confident.

Linking the data: After a recent vaginal delivery with a tear, the woman says she leaks stool when she passes gas and that she is ashamed. The nurse found soiled underwear twice daily and red skin around the anus. These facts show the leakage has already happened and the skin is affected, so this is an actual diagnosis, with weak anal muscles as the likely cause. It is not a general bowel pattern problem because the main issue is stool passing without control. The plan aims for fewer leakage episodes and intact skin within 4 weeks, correct pelvic floor exercises, and greater confidence.

E7 Burning or pain passing urine

Group: Elimination | Type: Actual problem

Definition: Urinating hurts or burns, which may signal infection or irritation.

Possible causes: Urine infection; stones; catheter; irritation; sexually transmitted infection

Signs and symptoms: Burning; frequent small amounts; cloudy or smelly urine; lower belly pain

Scenario. A woman has burning when urinating and passes small amounts every hour.

S: "It burns when I pass urine and I need to go all the time."

O: Urine cloudy and strong smelling; small amounts hourly; temperature 37.8 C; dipstick positive for leukocytes and nitrites.

Tools: CP-ELIM · Bristol Stool Chart, bladder scan ****CarePath diagnosis:**** Burning or pain passing urine related to urine infection, as evidenced by burning and frequent small amounts. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Encourage fluids. | Extra fluid dilutes the urine and increases flushing of the bladder, which helps wash germs out and eases burning. | | Give antibiotics as ordered. | Antibiotics kill or stop the growth of the bacteria causing the infection, so symptoms settle and the infection does not spread. | | Send a urine sample. | A urine sample can be cultured to identify the germ and show which antibiotic works, so treatment can be adjusted if the first drug is not effective. | | Teach hygiene. | Wiping front to back and good hygiene reduce bacteria moving from the bowel area to the urethra, lowering the chance of repeat infection. | | Report fever or back pain. | Fever or back pain can mean the infection has reached the kidneys, which needs prompt medical review and stronger treatment. | ****Expected outcomes**** - Within 48 hours of treatment: burning stops, urine clear, temperature normal. - Drinks at least 2 liters daily. - Patient states hygiene steps. ****Linking the data to the diagnosis**** The woman says it burns when she passes urine and she needs to go all the time. The nurse found cloudy, strong-smelling urine, small amounts every hour, a temperature of 37.8 C, and a dipstick positive for leukocytes and nitrites. These findings point to a urine infection and show the problem is present, so it is an actual diagnosis and not a risk. Burning and frequency are the main complaints, which separates this from simple leaking. The plan aims to stop the burning, clear the urine and bring the temperature to normal within 48 hours of treatment, with at least 2 liters of fluid daily and hygiene steps stated.

CarePath diagnosis: Burning or pain passing urine related to urine infection, as evidenced by burning and frequent small amounts.

Intervention	Rationale
Encourage fluids.	Extra fluid dilutes the urine and increases flushing of the bladder, which helps wash germs out and eases burning.
Give antibiotics as ordered.	Antibiotics kill or stop the growth of the bacteria causing the infection, so symptoms settle and the infection does not spread.
Send a urine sample.	A urine sample can be cultured to identify the germ and show which antibiotic works, so treatment can be adjusted if the first drug is not effective.
Teach hygiene.	Wiping front to back and good hygiene reduce bacteria moving from the bowel area to the urethra, lowering the chance of repeat infection.
Report fever or back pain.	Fever or back pain can mean the infection has reached the kidneys, which needs prompt medical review and stronger treatment.

Expected outcomes: Within 48 hours of treatment: burning stops, urine clear, temperature normal. · Drinks at least 2 liters daily. · Patient states hygiene steps.

Linking the data: The woman says it burns when she passes urine and she needs to go all the time. The nurse found cloudy, strong-smelling urine, small amounts every hour, a temperature of 37.8 C, and a dipstick positive for leukocytes and nitrites. These findings point to a urine infection and show the problem is present, so it is an actual diagnosis and not a risk. Burning and frequency are the main complaints, which separates this from simple leaking. The plan aims to stop the burning, clear the urine and bring the temperature to normal within 48 hours of treatment, with at least 2 liters of fluid daily and hygiene steps stated.

E8 Likely to get urine infection from a catheter

Group: Elimination | Type: Risk problem

Definition: A urinary catheter gives germs a path into the bladder.

Risk factors: Urinary catheter; poor hygiene; long catheter use; bowel contamination

Warning signs: Fever; cloudy urine; new confusion; pain at the catheter site

Scenario. An older man has had a urinary catheter for two weeks after surgery.

S: "The catheter is uncomfortable."

O: Catheter in place 14 days; urine clear and yellow; temperature 36.8 C; stool soiling seen near the catheter site.

Tools: CP-ELIM · Bristol Stool Chart, bladder scan ****CarePath diagnosis:**** Likely to get urine infection from a catheter related to long catheter use and poor hygiene (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use clean technique. | Clean technique stops germs on hands and equipment from entering the closed drainage system and reaching the bladder. | | Keep the bag below the bladder. | Keeping the bag below bladder level lets urine drain downward and prevents contaminated urine from flowing back into the bladder. | | Give catheter care. | Cleaning around the catheter removes germs and stool from the site, which matters here because stool soiling was seen near it. | | Remove the catheter as soon as possible. | The longer a catheter stays in, the higher the infection risk, so removing it as soon as it is not needed is the best prevention. | | Check urine. | Checking urine color, clarity and smell helps catch early signs of infection, such as cloudiness, so treatment can start sooner. ****Expected outcomes**** - No fever or confusion. - Urine clear. - Catheter removed as soon as clinically possible. - Catheter care done correctly each shift. ****Linking the data to the diagnosis**** The older man has had a urinary catheter for 14 days after surgery, and stool soiling was seen near the catheter site. His urine is clear and yellow, his temperature is 36.8 C, and he only says the catheter is uncomfortable. Because there is no fever, cloudy urine or confusion, infection has not occurred, so a risk diagnosis is correct and an actual urine infection diagnosis would be wrong. The risk rests on long catheter use and poor hygiene. The plan aims to keep him free of fever and confusion with clear urine, correct catheter care each shift, and removal of the catheter as soon as clinically possible.

CarePath diagnosis: Likely to get urine infection from a catheter related to long catheter use and poor hygiene (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use clean technique.	Clean technique stops germs on hands and equipment from entering the closed drainage system and reaching the bladder.
Keep the bag below the bladder.	Keeping the bag below bladder level lets urine drain downward and prevents contaminated urine from flowing back into the bladder.
Give catheter care.	Cleaning around the catheter removes germs and stool from the site, which matters here because stool soiling was seen near it.
Remove the catheter as soon as possible.	The longer a catheter stays in, the higher the infection risk, so removing it as soon as it is not needed is the best prevention.
Check urine.	Checking urine color, clarity and smell helps catch early signs of infection, such as cloudiness, so treatment can start sooner.

Expected outcomes: No fever or confusion. · Urine clear. · Catheter removed as soon as clinically possible. · Catheter care done correctly each shift.

Linking the data: The older man has had a urinary catheter for 14 days after surgery, and stool soiling was seen near the catheter site. His urine is clear and yellow, his temperature is 36.8 C, and he only says the catheter is uncomfortable. Because there is no fever, cloudy urine or confusion, infection has not occurred, so a risk diagnosis is correct and an actual urine infection diagnosis would be wrong. The risk rests on long catheter use and poor hygiene. The plan aims to keep him free of fever and confusion with clear urine, correct catheter care each shift, and removal of the catheter as soon as clinically possible.

E9 Very little urine being made URGENT

Group: Elimination | Type: Actual problem

Definition: Urine output is lower than expected, which may signal dehydration or kidney trouble.

Possible causes: Dehydration; kidney failure; blocked catheter; low blood pressure; heart problems

Signs and symptoms: Less urine than expected each hour; dark urine; swelling; weight gain

Scenario. A patient after surgery makes only 100 ml of urine in 6 hours.

S: "I haven't passed much urine today."

O: Urine output 100 ml in 6 hours; blood pressure 98/60; dry mouth; post-operative day 1.

Tools: CP-ELIM, CP-SKIN, CP-BREATH · Bristol Stool Chart, bladder scan, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG ****CarePath diagnosis:**** Very little urine being made related to dehydration, as evidenced by less urine than expected each hour and dark urine. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Measure output accurately. | Accurate measurement shows whether the kidneys are making enough urine, which is a key sign of fluid balance and blood flow to the organs. | | Check the catheter for kinks. | A kinked or blocked catheter can stop urine draining, so checking it separates a drainage problem from truly low urine production. | | Encourage fluids if allowed. | Extra fluid can restore blood volume when dehydration is the cause, but it is given only if allowed because some patients must limit fluids. | | Report low output. | Low output may signal dehydration, low blood pressure or kidney trouble, so the doctor needs to know early to find and treat the cause. | | Check blood pressure. | Low blood pressure means the kidneys may not receive enough blood flow, so checking it shows whether urine output is likely to improve. | ****Expected outcomes**** - Within 6 hours: urine output at least about 30 ml per hour, blood pressure and pulse within normal range. - Patient drinks as allowed. ****Linking the data to the diagnosis**** On post-operative day 1 the patient made only 100 ml of urine in 6 hours and says not much urine has been passed today. The nurse also found a blood pressure of 98/60 and a dry mouth. These findings show the problem is present, so it is an actual diagnosis, with dehydration as the likely cause. Output and blood pressure are linked, which is why both are watched, and any catheter is checked so a drainage problem is not missed. The plan aims within 6 hours for urine output of at least about 30 ml per hour, blood pressure and pulse in the normal range, and the patient drinking as allowed.

CarePath diagnosis: Very little urine being made related to dehydration, as evidenced by less urine than expected each hour and dark urine.

Intervention	Rationale
Measure output accurately.	Accurate measurement shows whether the kidneys are making enough urine, which is a key sign of fluid balance and blood flow to the organs.
Check the catheter for kinks.	A kinked or blocked catheter can stop urine draining, so checking it separates a drainage problem from truly low urine production.
Encourage fluids if allowed.	Extra fluid can restore blood volume when dehydration is the cause, but it is given only if allowed because some patients must limit fluids.
Report low output.	Low output may signal dehydration, low blood pressure or kidney trouble, so the doctor needs to know early to find and treat the cause.
Check blood pressure.	Low blood pressure means the kidneys may not receive enough blood flow, so checking it shows whether urine output is likely to improve.

Expected outcomes: Within 6 hours: urine output at least about 30 ml per hour, blood pressure and pulse within normal range. · Patient drinks as allowed.

Linking the data: On post-operative day 1 the patient made only 100 ml of urine in 6 hours and says not much urine has been passed today. The nurse also found a blood pressure of 98/60 and a dry mouth. These findings show the problem is present, so it is an actual diagnosis, with dehydration as the likely cause. Output and blood pressure are linked, which is why both are watched, and any catheter is checked so a drainage problem is not missed. The plan aims within 6 hours for urine output of at least about 30 ml per hour, blood pressure and pulse in the normal range, and the patient drinking as allowed.