CARE PLAN

Client Name _____ **D.O.B.** _____ **Address** _____

Date	Assessment of limitation/need	Goal (Expected Outcome)	Actions to be taken to reach goal	Resources/referral/report required	Comments/Changes required
5/2/15	*Urinary Incontinence*	• *Promote continence* • *Maintain Skin integrity* • *Promote client dignity*	1. *Encourage client to drink adequate amount of fluids* 2. *Help client to toilet every 2-3 hours* 3. *Wash affected skin gently with warm water & Dry carefully. Apply barrier cream if necessary.* 4. *Use incontinence-underwear if appropriate*	*Report to community nurse/agency supervisor if client notes frequency, urgency or burning with urination* *Report to community nurse/agency supervisor if skin breakdown occurs*	

Date	Assessment of limitation/need	Goal (Expected Outcome)	Actions to be taken to reach goal	Resources/referral/report required	Comments/Changes required

Review Date: _____

Signature of Client: _____