



Evidence-Based Clinical Assessment Toolkit

Continence Assessment Pack - Basic



LA TROBE
UNIVERSITY



MONASH
University

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| Tool | Download |
|-------------------|--|
| ACFI Urine Record | This assessment is available from the ACFI Assessment Pack @ https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-assessment-pack |
| ACFI Bowel Record | This assessment is available from the ACFI Assessment Pack @ https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-assessment-pack |

Screen Questions

| | YES | NO | DK |
|--|-----|----|----|
| Does the person have a diagnosis of urinary incontinence? State source: | | | |
| Does the person have a diagnosis of faecal incontinence? State source: | | | |
| Does the person regularly/ frequently use suppositories? State source: | | | |
| Does the person regularly/ frequently use enemas? State source: | | | |

Continence Screening Form

Document No: _____

To be completed within 48 hours of resident's admission or if there is a change in their continence status.

ID Label _____

If the resident is unable to answer these questions, please complete using your observations or by asking a family member or other staff member.

Date: ____/____/____

Bladder Health

-
1. Does the resident go to the toilet more than 6 times in the day to pass urine? Yes
 No
 Don't know
-
2. Does the resident get up more than once during the night to pass urine? Yes
 No
 Don't know
-
3. Does the resident leak urine? Yes
 No
 Don't know
-
4. Does the resident have any other bladder problems (ie. difficulties passing urine and/or pain)? Yes
 No
 Don't know

Bowel Health

-
5. Has the resident lost control of or leaked bowel motions? Yes
 No
 Don't know
-
6. Does the resident have any other bowel difficulties (ie. constipation or diarrhoea)? Yes
 No
 Don't know

Pad Usage

-
7. Does the resident wear pads? Yes
 No
 Don't know
-
8. Does the resident have to change his/her underclothes or wear protection because of bladder or bowel leakage or soiling? Yes
 No
 Don't know

If you ticked Yes or DoN'T kNow to any of these questions, please:

- Complete Bladder Chart and Bowel Chart

Three Day Bladder Chart

Document No: _____

Please complete details for each time the resident passes urine.

Complete each day for 3 complete days (*identify which day*)

ID Label

Day _____ Date _____

| Time | | Drinks (amt, type) | Continent Yes/No (ie. In toilet) | Incontinent Yes/No Degree of wetness: Pad only. Pad & underwear. Pad, underwear & outer clothing. | No. of pad and/or clothing changes | Comments (assoc. circumstances, effect on daily activity) |
|-------------------------|------|-----------------------|---|---|---------------------------------------|---|
| <i>(Example)</i> | 0800 | <i>Cup of tea</i> | <i>No</i> | <i>Yes- pad only</i> | <i>1 change of pad</i> | <i>unable to get to toilet</i> |
| Waking to morning tea | | | | | | |
| | | | | | | |
| | | | | | | |
| Morning tea to lunch | | | | | | |
| | | | | | | |
| | | | | | | |
| Lunch to afternoon tea | | | | | | |
| | | | | | | |
| | | | | | | |
| Afternoon tea to dinner | | | | | | |
| | | | | | | |
| | | | | | | |
| Dinner to bed | | | | | | |
| | | | | | | |
| | | | | | | |
| Overnight | | | | | | |
| | | | | | | |
| | | | | | | |

Seven Day Bowel Chart


Document No: _____

Please complete details for each time the resident has a bowel movement.


ID Label

| Date | shift | Time | Type of bowel movement (refer to Bristol Stool Form Scale) | Incontinent of stool Yes/No | Number of pad/clothing changes (identify pads or clothing or both) | Comments (associated circumstances/effects on daily activities/laxative use) |
|------|-------|------|---|--------------------------------|---|---|
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |
| | am | | | | | |
| | pm | | | | | |
| | night | | | | | |


The Bristol stool Form scale *(Use this as a guide to the stool type)*




Type 1
Separate hard lumps like nuts (hard to pass)



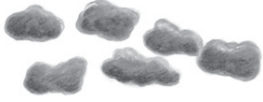
Type 2
Sausage-shaped but lumpy




Type 3
Like a sausage but with cracks on its surface




Type 4
Like a sausage or snake, smooth and soft



Type 5
Soft blobs with clear-cut edges (passed quickly)



Type 6
Fluffy pieces with ragged edges, a mushy stool



Type 7
Watery, no solid pieces
ENTIRELY LIQUID

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Continence Assessment Form and Care Plan

RESIDENT ID

Date: ____/____/____

Refer to "Education Guide" for further information on assessment cues and care options

SECTION A: Toileting ability, Cognitive skills & Mobility

Best practice recommendations

- Encourage residents to participate as much as possible in toileting activities to remain optimal mobility and independence
- Consider each residents personal preferences for continence care

| Assessment Cues <i>(tick appropriate response)</i> | Care Options <i>(tick appropriate care option)</i> |
|---|---|
| <p>1. Does the resident know when to go to the toilet?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No</p> | <p>If sometimes or no:</p> <ul style="list-style-type: none"> Identify behaviours showing that the resident may need to go to the toilet (eg restlessness) <p><i>(List possible cues)</i> _____</p> <p>_____</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to go to the toilet at</p> <p><input type="checkbox"/> fixed times <input type="checkbox"/> individualised times</p> |
| <p>2. Can the resident tell you where the toilet is?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Show/remind the resident where the toilet is</p> <p><input type="checkbox"/> Ensure toilet is easy to identify</p> <p><input type="checkbox"/> Leave the toilet light on</p> |
| <p>3. Can the resident walk to the toilet independently?</p> <p><input type="checkbox"/> Yes, independently</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No, requires supervision</p> <p><input type="checkbox"/> No, requires physical assistance</p> <p><input type="checkbox"/> No, requires lifting equipment</p> <p><input type="checkbox"/> N/A, unable to use toilet</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Place the resident close to the toilets</p> <ul style="list-style-type: none"> Place the following ambulation aids close to the resident <p><input type="checkbox"/> Wheely frame <input type="checkbox"/> Pick up frame <input type="checkbox"/> Gutter frame <input type="checkbox"/> Walking stick <input type="checkbox"/> Wheel chair</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to walk to the toilet</p> <ul style="list-style-type: none"> If physical assistance is required, provide: <p><input type="checkbox"/> 1 staff member <input type="checkbox"/> 2 staff members <input type="checkbox"/> Lifting equipment <input type="checkbox"/> Other _____</p> |
| <p>4. Can the resident get on and get off the toilet independently?</p> <p><input type="checkbox"/> Yes, independently</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No, requires supervision</p> <p><input type="checkbox"/> No, requires physical assistance</p> <p><input type="checkbox"/> No, requires lifting equipment</p> <p><input type="checkbox"/> N/A, unable to use toilet</p> | <p>If sometimes or no:</p> <ul style="list-style-type: none"> Encourage the resident to use the following assistive devices <p><input type="checkbox"/> Handrails <input type="checkbox"/> An over the toilet seat frame <input type="checkbox"/> A donut <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to get on and off toilet</p> <ul style="list-style-type: none"> If physical assistance is required, provide: <p><input type="checkbox"/> 1 staff member <input type="checkbox"/> 2 staff members <input type="checkbox"/> Lifting equipment <input type="checkbox"/> Other _____</p> |
| <p>5. Can the resident undress and dress themselves before and after toileting?</p> <p><input type="checkbox"/> Yes, independently</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No, requires supervision</p> <p><input type="checkbox"/> No, requires physical assistance</p> <p><input type="checkbox"/> No, requires lifting equipment</p> <p><input type="checkbox"/> N/A, unable to use toilet</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Ensure that the resident has clothing that is easy to manage (i.e. elastic waisted pants with no zips).</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to adjust their own clothing.</p> |

SECTION A: Toileting ability, Cognitive skills & Mobility *(continued)*

| Assessment Cues <i>(tick appropriate response)</i> | Care Options <i>(tick appropriate care option)</i> |
|---|--|
| <p>6. Can the resident use toilet paper and wipe themselves?</p> <p><input type="checkbox"/> Yes, independently</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No, requires supervision</p> <p><input type="checkbox"/> No, requires physical assistance</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to get toilet paper ready and to use it.</p> <p><input type="checkbox"/> Supervise <input type="checkbox"/> Prompt <input type="checkbox"/> Physically assist the resident to wash their hands at toilet completion.</p> |
| <p>7. Does the resident co-operate with staff when they assist with toileting or changing?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No</p> | <p>If sometimes or no:</p> <p>■ ask the RN, Continence Nurse or GP about the care required and refer to resident's behavioural management plan.</p> |
| <p>8. Does the resident experience pain that restricts their toileting ability?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Sometimes</p> <p><input type="checkbox"/> No</p> | <p>If sometimes or yes:</p> <p><input type="checkbox"/> Check that the resident is getting their pain medication as ordered</p> <p><input type="checkbox"/> Limit the resident's movement until pain subsides</p> <p><input type="checkbox"/> Offer bedpans, urinals and/or pads</p> <p>■ If the resident is unable to verbally communicate, search for cues that indicate pain. <i>(List possible cues)</i> _____</p> <p>_____</p> |

SECTION B: Bladder & Bowel pattern

Refer to 3 day bladder chart and 7 day bowel chart to complete questions

Best practice recommendations

- Aim for the resident to be continent and to void 4-6 times a day and no more than 2 times at night
- Aim for the resident to have a regular (at least 3 per week) continent, soft formed stool (i.e. Bristol Stool type 3 or 4 that is easy to pass)
- If the resident has incontinence, aim for them to feel clean and dry with changes of pads soon after each episode
- Assess residents risk for falling if they need to go to the toilet at night

| Assessment Cues <i>(tick appropriate response)</i> | Care Options <i>(tick appropriate care option)</i> |
|--|--|
| <p>9. During the day, how many times does the resident need to pass urine/go to the toilet on average (from 7am-7pm)?</p> <p><input type="checkbox"/> Less than 3 times</p> <p><input type="checkbox"/> 4 - 6 times (normal)</p> <p><input type="checkbox"/> More than 6 times</p> | <p>■ If less than 3 times, ask the RN, Continence Nurse or GP about the care required.</p> <p>■ If more than 6 times, ask the RN, Continence Nurse or GP about the care required.</p> |
| <p>10. During the night, how many times does the resident need to pass urine/go to the toilet on average (from 7pm-7am)?</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Once</p> <p><input type="checkbox"/> Two or more times</p> | <p>If once or more:</p> <p>■ Ensure call bell is within reach.</p> <p>■ Turn night light on.</p> <p>■ Ensure commode/pan/toilet is near the bed.</p> <p>■ Turn sensor/s on.</p> <p>■ If resident is awake, offer toileting assistance.</p> <p>■ If the resident passes urine two or more times during the night, ask the RN, Continence Nurse or GP about the care required.</p> |

SECTION B: Bladder & Bowel pattern (continued)

| Assessment Cues (tick appropriate response) | Care Options (tick appropriate care option) |
|--|---|
| <p>11. Does the resident experience urine leakage during the day?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often?</p> <p><input type="checkbox"/> Once every few days <input type="checkbox"/> Once a day <input type="checkbox"/> Several times a day <input type="checkbox"/> Most or every time</p> | <p>If yes to urine leakage during the day:</p> <p><input type="checkbox"/> Develop and put in place an individualised toileting program</p> <p><input type="checkbox"/> Develop and put in place a fixed time toileting program</p> <p><input type="checkbox"/> Develop and put in place a pad check and change program</p> |
| <p>12. Does the resident experience urine leakage during the night?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how often?</p> <p><input type="checkbox"/> Once every few nights <input type="checkbox"/> Once a night <input type="checkbox"/> Several times a night <input type="checkbox"/> Most or every time</p> | <p>If yes to urine leakage during the night:</p> <p><input type="checkbox"/> Develop and put in place an individualised toileting program</p> <p><input type="checkbox"/> Develop and put in place a fixed time toileting program</p> <p><input type="checkbox"/> Develop and put in place a pad check and change program</p> |
| <p>13. Does the resident have a predictable pattern of passing urine (including urine leakage) ?</p> <p>a) During the day?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) During the night?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>If yes:</p> <p><input type="checkbox"/> Refer to the 3 day bladder chart and use the grid below to mark the times for an individualised toileting program based on the resident's pattern.</p> <p>If no:</p> <p><input type="checkbox"/> Use the grid below to mark the times for a fixed time toileting program (i.e. at least every 4 - 6 hours during the day)</p> <p><input type="checkbox"/> Use the grid below to mark the times for a pad check and change program (i.e. at least every 4 - 6 hours during the day)</p> |

Toileting / pad check and change grid (please tick)

| | mid-night | 1 am | 2 am | 3 am | 4 am | 5 am | 6 am | 7 am | 8 am | 9 am | 10 am | 11 am | 12 noon | 1 pm | 2 pm | 3 pm | 4 pm | 5 pm | 6 pm | 7 pm | 8 pm | 9 pm | 10 pm | 11 pm |
|--------------------------|-----------|------|------|------|------|------|------|------|------|------|-------|-------|---------|------|------|------|------|------|------|------|------|------|-------|-------|
| Toileting times | | | | | | | | | | | | | | | | | | | | | | | | |
| Pad check & change times | | | | | | | | | | | | | | | | | | | | | | | | |

| Assessment Cues (tick appropriate response) | Care Options (tick appropriate care option) |
|---|---|
| <p>14. Does the need to pass urine or incontinence at night make it difficult for the resident to go back to sleep?</p> <p><input type="checkbox"/> N/A No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes <input type="checkbox"/></p> | <p>If sometimes or yes:</p> <p><input type="checkbox"/> Place a commode beside the resident's bed.</p> <p><input type="checkbox"/> Offer the resident a bedpan or urinal.</p> <p><input type="checkbox"/> Identify and put in place individualised strategies to help the resident to return to sleep</p> |

SECTION B: Bladder & Bowel pattern (*continued*)

| Assessment Cues (tick appropriate response) | Care Options (tick appropriate care option) |
|---|---|
| <p>15. Does the resident have a urinary catheter in place?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, is the catheter</p> <p><input type="checkbox"/> Suprapubic? <input type="checkbox"/> Urethral?</p> | <p>If yes, ask the RN, Continence Nurse or GP about the care required and refer to resident's catheter care plan.</p> <p><input type="checkbox"/> No assistance required to empty catheter bag <input type="checkbox"/> Supervise the resident to empty catheter bag <input type="checkbox"/> Physically assist the resident to empty catheter bag</p> |
| <p>16. How often does the resident normally use their bowels?</p> <p><input type="checkbox"/> Daily to second daily <input type="checkbox"/> Less than 3 times per week</p> | <p>If less than 3 times per week, or if yes to question 17: discuss the following options with RN, Continence Nurse or GP</p> <p><input type="checkbox"/> Increase fluid to _____ a day. <input type="checkbox"/> Increase fibre by _____. <input type="checkbox"/> Increase mobility (refer to mobility / activity care plan). <input type="checkbox"/> Medication (as determined by RN, Continence Nurse or GP). <input type="checkbox"/> Refer for further investigation (i.e. Abdominal X-Ray, GUT motility study). <input type="checkbox"/> Monitor bowel elimination frequency and stool consistency. <input type="checkbox"/> Prompt / supervise / assist resident to the toilet at _____ each day. <input type="checkbox"/> Encourage the resident to respond to the urge to use their bowels. <input type="checkbox"/> Supervise / prompt / assist the resident to sit on the toilet and rest their elbows on their knees with their feet flat on the floor or stool to facilitate bowel emptying.</p> |
| <p>17. In the past two weeks has the resident leaked, or had accidents or lost control with stool/bowel motion?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>If yes to any symptom, ask the RN, Continence Nurse or GP about the care required.</p> |
| <p>18. Has the resident got any of the following symptoms when they use their bowels?</p> <p><input type="checkbox"/> Pain and discomfort <input type="checkbox"/> Straining <input type="checkbox"/> Bleeding <input type="checkbox"/> Hard, dry motions <input type="checkbox"/> Very fluid bowel motions</p> | <p>If yes to any symptom, ask the RN, Continence Nurse or GP about the care required.</p> |
| <p>19. Has the resident had a urine test (dipstick) done in the past 28 days?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No (<i>this needs to be done</i>)</p> <p>pH _____ SG _____</p> <p>Blood <input type="checkbox"/> Yes <input type="checkbox"/> No Nitrites <input type="checkbox"/> Yes <input type="checkbox"/> No Leukocytes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>If the resident's urine dip-stick shows blood or nitrites or leukocytes or has a pH equal to 8 or above, ask the RN, Continence Nurse or GP about the care required.</p> |

Further comments and/or observations _____

SECTION C: Nutrition (fluid & diet)

Best practice recommendations

- Aim for the resident to have 5-10 cups of fluid per day unless otherwise indicated & limit known bladder irritants (i.e. coffee, alcohol)
- Aim for the resident to have 30gm of dietary fibre per day unless otherwise indicated

| Assessment Cues (tick appropriate response) | Care Options (tick appropriate care option) |
|--|--|
| <p>20. Does the resident drink an adequate amount of fluid to maintain hydration and healthy bladder and bowel function? (Refer to 3-day bladder chart and check colour of urine)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Encourage resident to drink _____ cups of _____ per day.</p> <p><input type="checkbox"/> Monitor and report underhydration (under 5 cups per day & dark coloured urine).</p> <p><input type="checkbox"/> Monitor and report excessive drinking (over 10 cups per day).</p> <p><input type="checkbox"/> Monitor urine colour (if concerned about dehydration).</p> |
| <p>21. Does the resident eat an adequate amount of food with fibrous content to maintain healthy bladder and bowel function? (Refer to nutritional assessment)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No</p> | <p>If sometimes or no:</p> <p><input type="checkbox"/> Refer to resident's nutritional care plan.</p> <p><input type="checkbox"/> Encourage the resident to eat cereals, vegetables and fruit regularly.</p> <p><input type="checkbox"/> Offer small snacks regularly.</p> <p><input type="checkbox"/> Refer to nutritional/swallowing assessment and care plan.</p> <p><input type="checkbox"/> Ensure dentures are in at meal times and that they fit.</p> |

SECTION D: Skin care

Best practice recommendations

- Aim for the resident's skin to remain intact and free from rashes, excoriation and pressure ulcers

| Assessment Cues (tick appropriate response) | Care Options (tick appropriate care option) | | | | | | | | | | | | | | | |
|---|--|---------------------------------------|-----|-------|---|---------------------------------------|---------------------------------------|--|---------------------------------------|---------------------------------------|----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <p>22. Does the resident's skin around their buttocks, groin and perineal area appear to:</p> <p><input type="checkbox"/> Be very thin or fragile <input type="checkbox"/> Be reddened <input type="checkbox"/> Be unusually pale <input type="checkbox"/> Have a discharge <input type="checkbox"/> Have a foul or bad smell <input type="checkbox"/> Be broken, have a rash or have lumps and blotches <input type="checkbox"/> Other (specify) _____</p> | <p>If yes to any skin abnormalities, consider the general care options below and ask the RN, Continence Nurse and/or GP about the care required.</p> <p><input type="checkbox"/> Change wet pads, linen and clothing soon after incontinent episodes.</p> <p><input type="checkbox"/> Use the wetness indicators on disposable continence pads as a guide to know when to change the pad.</p> <p><input type="checkbox"/> Use a non-irritating, pH neutral product for washing the skin after each incontinent episode.</p> <p><input type="checkbox"/> Use a soft toilet paper or 'wet ones' for wiping if skin is very sensitive.</p> <p><input type="checkbox"/> Apply a barrier cream for protection against exposure to urine and/or faeces</p> | | | | | | | | | | | | | | | |
| <p>23. Is the resident currently using a continence product to contain their incontinence?</p> <p><input type="checkbox"/> Yes – during day and night <input type="checkbox"/> Yes – during day only <input type="checkbox"/> Yes – during night only <input type="checkbox"/> No</p> | <p>If yes, select a product that is able to absorb the volume of urine loss and/or contain the faecal matter and is comfortable for the resident.</p> <p>Select from the following options:</p> <table> <thead> <tr> <th></th> <th>Day</th> <th>Night</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Disposable pad</td> <td><input type="checkbox"/> (type) _____</td> <td><input type="checkbox"/> (type) _____</td> </tr> <tr> <td><input type="checkbox"/> Washable pad/pant</td> <td><input type="checkbox"/> (type) _____</td> <td><input type="checkbox"/> (type) _____</td> </tr> <tr> <td><input type="checkbox"/> Commode</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Condom drainage</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> | | Day | Night | <input type="checkbox"/> Disposable pad | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> Washable pad/pant | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> Commode | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Condom drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| | Day | Night | | | | | | | | | | | | | | |
| <input type="checkbox"/> Disposable pad | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> (type) _____ | | | | | | | | | | | | | | |
| <input type="checkbox"/> Washable pad/pant | <input type="checkbox"/> (type) _____ | <input type="checkbox"/> (type) _____ | | | | | | | | | | | | | | |
| <input type="checkbox"/> Commode | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | |
| <input type="checkbox"/> Condom drainage | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | |

SECTION E: Medical

(This section may need to be completed by an RN, Continence Nurse or GP)

24. Please indicate whether or not the resident has any of the following potentially reversible causes of incontinence

- | | | | | |
|---|--|---------------------------------------|---|--|
| <input type="checkbox"/> Delirium | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Constipation | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Atrophic vaginitis | <input type="checkbox"/> Unstable diabetes | <input type="checkbox"/> Depression | <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Restraint use |

25. If yes to any of the conditions, could this condition be causing the residents incontinence?

- No
- Yes (please list) _____

26. Is there any potential to treat or improve the residents' condition with any of the following options

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Bladder training | <input type="checkbox"/> Electrical stimulation | <input type="checkbox"/> Pelvic floor muscle training program |
| <input type="checkbox"/> Referral to: <input type="checkbox"/> GP | <input type="checkbox"/> Continence Nurse | <input type="checkbox"/> Urologist | <input type="checkbox"/> Geriatrician |
| | <input type="checkbox"/> Gynaecologist | <input type="checkbox"/> Physiotherapist | |

SECTION F: Resident Perspectives

(This section should be completed in conjunction with residents and/or their family members)

Best practice recommendations

- Ensure residents and families are given information about healthy bladder and bowel habits
- If the resident has a low affect and/or is bothered by their symptoms discuss this with an RN or the GP
- If a continence product is used, ensure that it fits the resident, absorbs any incontinence, and protects the resident's underwear and outer clothing

| Bladder Function | Bowel Function |
|---|--|
| <p>27. If you are experiencing a bladder problem, what kind of assistance would you prefer? (may tick more than one)</p> <p><input type="checkbox"/> No assistance</p> <p><input type="checkbox"/> To be assisted to go to the toilet at _____</p> <p><input type="checkbox"/> To wear pads during the day</p> <p><input type="checkbox"/> To wear pads during the night</p> <p><input type="checkbox"/> To be seen by a specialist for further investigation</p> <p><input type="checkbox"/> Other _____</p> | <p>28. If you are experiencing a bowel problem, what kind of assistance would you prefer? (may tick more than one)</p> <p><input type="checkbox"/> No assistance</p> <p><input type="checkbox"/> To be assisted to go to the toilet at _____</p> <p><input type="checkbox"/> To wear pads during the day</p> <p><input type="checkbox"/> To wear pads during the night</p> <p><input type="checkbox"/> To have a laxative</p> <p><input type="checkbox"/> To be seen by a specialist for further investigation</p> <p><input type="checkbox"/> Other _____</p> |
| <p>29. If you are experiencing a bladder problem, how much of a problem is this for you?</p> <p><input type="checkbox"/> No problem <input type="checkbox"/> A bit of a problem</p> <p><input type="checkbox"/> Quite a problem <input type="checkbox"/> Severe problem</p> | <p>30. If you are experiencing a bowel problem, how much of a problem is this for you?</p> <p><input type="checkbox"/> No problem <input type="checkbox"/> A bit of a problem</p> <p><input type="checkbox"/> Quite a problem <input type="checkbox"/> Severe problem</p> |
| <p>31. If you are wearing a continence product, does it keep you dry and comfortable? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, would you like to consider other options? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | |

Further comments and/or observations _____

| Staff member completing assessment | Staff member endorsing this assessment | Care plan discussed with and agreed to by family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
|------------------------------------|--|--|
| Name _____ | Name _____ | Family/Other-Name _____ |
| Signature _____ | Signature _____ | Signature _____ |
| Designation _____ Date _____ | Designation _____ Date _____ | Relationship _____ Date _____ |

Continence Care Summary

1. Is the resident:

Incontinent of urine Yes No

Incontinent of faeces Yes No

3. Behaviours that indicate need to toilet

Restless Wandering

Pulls at clothes Other

2. What level of assistance is required to support toileting

N/A, unable to use toilet

No assistance required (is independent)

Requires supervision (i.e. prompting, reminding and directional support)

Requires physical assistance One person assist Two person assist

Lifting equipment Other

4. Resident's day time toileting / pad check & change program

| | 7am | 8am | 9am | 10am | 11am | noon | 1pm | 2pm | 3pm | 4pm | 5pm | 6pm | 7pm |
|--------------------------|-----|-----|-----|------|------|------|-----|-----|-----|-----|-----|-----|-----|
| Toileting times | | | | | | | | | | | | | |
| Pad check & change times | | | | | | | | | | | | | |

5. Resident's night time toileting / pad check & change program

| | 7pm | 8pm | 9pm | 10pm | 11pm | midnight | 1am | 2am | 3am | 4am | 5am | 6am | 7am |
|--------------------------|-----|-----|-----|------|------|----------|-----|-----|-----|-----|-----|-----|-----|
| Toileting times | | | | | | | | | | | | | |
| Pad check & change times | | | | | | | | | | | | | |

6. Resident's preferences for continence care (if resident is able to indicate)

a) During the day

No assistance

Assistance to go to the toilet at _____ (specify times)

To wear pads (specify type) _____

Other _____

b) During the night

No assistance

Assistance to go to the toilet at _____ (specify times)

To wear pads (specify type) _____

Other _____

7. Individual requirements for regular bowel elimination

No additional requirements

Encourage resident to sit on toilet for bowel action after breakfast each day

Encourage additional dietary fibre (specify type)

Encourage additional fluid (specify amount & type)

Ensure laxative administration (specify) _____

8. Individual requirements for skin care

No additional requirements

Apply _____ cream after each pad change

9. Other _____

