Evidence-Based Clinical Assessment Toolkit

Continence Assessment Pack

AACS
APPLIED AGED
CARE SOLUTIONS

DISCLAIMER

Applied Aged Care Solutions Pty Ltd (**AACS**) and its authors are not responsible for the results of any action taken on the basis of any information in this publication or for any error in or omission from this publication. This publication contains information of a general nature that may not be suitable to your own circumstances. It is your responsibility to satisfy yourself as to its suitability for your circumstances.

The publication has been compiled from information provided by third parties and other sources. There may be technical inaccuracies, typographical errors or unsuitable material for you. If you have any concerns about such third party content, you should refer to those sources for more specialist information and advice. Attribution to such sources appears in the text of this publication.

To the fullest extent permitted by law, AACS and its authors will be under no liability to any person in respect of any loss or damage (including consequential loss or damage) which may be suffered or incurred or which may arise directly or indirectly from or in connection with any use of this publication or the information contained in it.

To the fullest extent permitted by law, all express or implied warranties are hereby excluded. Warranties or guarantees implied by statute which cannot be excluded will apply, however the liability of AACS and its authors for a breach of such implied terms will be limited, at the option of AACS, to any one or more of the following:

- replacement of the product supplied or supply of an equivalent product;
- payment of the cost of replacing the product or of acquiring an equivalent product;
- payment of the cost of having the product rectified;
- and in no circumstances extends to consequential, indirect or special loss or damage.

Contents

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.

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

ID LabeL

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**

Developed by Deakin University and funded under the National Continence Management Strategy

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)
(Example)	*0800*	*Cup of tea*	*No*	*Yes- pad only*	*1 change of pad*	*unable to get to toilet*
Waking to morning tea						
Morning tea to lunch						
Lunch to afternoon tea						
Afternoon tea to dinner						
Dinner to bed						
Overnight						

Developed by Deakin University and funded under the National Continence Management Strategy

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					

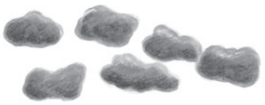
The Bristol stool Form scale *(Use this as a guide to the stool type)*

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

Type 2
Sausage-shaped but lumpy

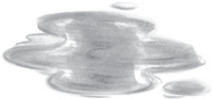
Type 3
Like a sausage but with cracks on its surface

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

Developed by Deakin University and funded under the National Continence Management Strategy

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 *(tick appropriate response)*	**Care Options** *(tick appropriate care option)*
1. Does the resident know when to go to the toilet? ☐ Yes ☐ Sometimes ☐ No	**If sometimes or no:** ■ *Identify behaviours showing that the resident may need to go to the toilet (eg restlessness)* *(List possible cues)* _____ ☐ Supervise ☐ Prompt ☐ Physically assist the resident to go to the toilet at ☐ fixed times ☐ individualised times
2. Can the resident tell you where the toilet is? ☐ Yes ☐ Sometimes ☐ No	**If sometimes or no:** ☐ Show/remind the resident where the toilet is ☐ Ensure toilet is easy to identify ☐ Leave the toilet light on
3. Can the resident walk to the toilet independently? ☐ Yes, independently ☐ Sometimes ☐ No, requires supervision ☐ No, requires physical assistance ☐ No, requires lifting equipment ☐ N/A, unable to use toilet	**If sometimes or no:** ☐ Place the resident close to the toilets ■ *Place the following ambulation aids close to the resident* ☐ Wheely frame ☐ Pick up frame ☐ Gutter frame ☐ Walking stick ☐ Wheel chair ☐ Other _____ ☐ Supervise ☐ Prompt ☐ Physically assist the resident to walk to the toilet ■ *If physical assistance is required, provide:* ☐ 1 staff member ☐ 2 staff members ☐ Lifting equipment ☐ Other _____
4. Can the resident get on and get off the toilet independently? ☐ Yes, independently ☐ Sometimes ☐ No, requires supervision ☐ No, requires physical assistance ☐ No, requires lifting equipment ☐ N/A, unable to use toilet	**If sometimes or no:** ■ *Encourage the resident to use the following assistive devices* ☐ Handrails ☐ An over the toilet seat frame ☐ A donut ☐ Other _____ ☐ Supervise ☐ Prompt ☐ Physically assist the resident to get on and off toilet ■ *If physical assistance is required, provide:* ☐ 1 staff member ☐ 2 staff members ☐ Lifting equipment ☐ Other _____
5. Can the resident undress and dress themselves before and after toileting? ☐ Yes, independently ☐ Sometimes ☐ No, requires supervision ☐ No, requires physical assistance ☐ No, requires lifting equipment ☐ N/A, unable to use toilet	**If sometimes or no:** ☐ Ensure that the resident has clothing that is easy to manage (i.e. elastic waisted pants with no zips). ☐ Supervise ☐ Prompt ☐ Physically assist the resident to adjust their own clothing.

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

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

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

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

Assessment Cues *(tick appropriate response)*	**Care Options** *(tick appropriate care option)*
11. Does the resident experience urine leakage during the day? ☐ Yes ☐ No If yes, how often? ☐ Once every few days ☐ Once a day ☐ Several times a day ☐ Most or every time	**If yes to urine leakage during the day:** ☐ *Develop and put in place* ***an individualised toileting program*** ☐ *Develop and put in place* ***a fixed time toileting program*** ☐ *Develop and put in place* ***a pad check and change program***
12. Does the resident experience urine leakage during the night? ☐ Yes ☐ No If yes, how often? ☐ Once every few nights ☐ Once a night ☐ Several times a night ☐ Most or every time	**If yes to urine leakage during the night:** ☐ *Develop and put in place* ***an individualised toileting program*** ☐ *Develop and put in place* ***a fixed time toileting program*** ☐ *Develop and put in place* ***a pad check and change program***
13. Does the resident have a predictable pattern of passing urine (including urine leakage) ? **a)** During the day? ☐ Yes ☐ No **b)** During the night? ☐ Yes ☐ No	**If yes:** ☐ 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. **If no:** ☐ 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)* ☐ 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)*

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)*
14. Does the need to pass urine or incontinence at night make it difficult for the resident to go back to sleep? ☐ N/A No ☐ Sometimes ☐ Yes ☐	**If sometimes or yes:** ☐ Place a commode beside the resident's bed. ☐ Offer the resident a bedpan or urinal. ☐ Identify and put in place individualised strategies to help the resident to return to sleep

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

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

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)*
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)* ☐ Yes ☐ Sometimes ☐ No	**If sometimes or no:** ☐ Encourage resident to drink _____ cups of _____ per day. ☐ Monitor and report underhydration (under 5 cups per day & dark coloured urine). ☐ Monitor and report excessive drinking (over 10 cups per day). ☐ Monitor urine colour (if concerned about dehydration).
21. Does the resident eat an adequate amount of food with fibrous content to maintain healthy bladder and bowel function? *(Refer to nutritional assessment)* ☐ Yes ☐ Sometimes ☐ No	**If sometimes or no:** ☐ Refer to resident's nutritional care plan. ☐ Encourage the resident to eat cereals, vegetables and fruit regularly. ☐ Offer small snacks regularly. ☐ Refer to nutritional/swallowing assessment and care plan. ☐ Ensure dentures are in at meal times and that they fit.

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)*
22. Does the resident's skin around their buttocks, groin and perineal area appear to: ☐ Be very thin or fragile ☐ Be reddened ☐ Be unusually pale ☐ Have a discharge ☐ Have a foul or bad smell ☐ Be broken, have a rash or have lumps and blotches ☐ Other (specify) _____	**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.*** ☐ Change wet pads, linen and clothing soon after incontinent episodes. ☐ Use the wetness indicators on disposable continence pads as a guide to know when to change the pad. ☐ Use a non- irritating, pH neutral product for washing the skin after each incontinent episode. ☐ Use a soft toilet paper or 'wet ones' for wiping if skin is very sensitive. ☐ Apply a barrier cream for protection against exposure to urine and/or faeces
23. Is the resident currently using a continence product to contain their incontinence? ☐ Yes – during day and night ☐ Yes – during day only ☐ Yes – during night only ☐ No	**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.** **Select from the following options:** Day / Night ☐ Disposable pad ☐ *(type)* _____ ☐ *(type)* _____ ☐ Washable pad/pant ☐ *(type)* _____ ☐ *(type)* _____ ☐ Commode ☐ ☐ ☐ Condom drainage ☐ ☐

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

☐ Delirium ☐ Bladder infection ☐ Constipation ☐ Irritable bowel syndrome ☐ Medication
☐ Atrophic vaginitis ☐ Unstable diabetes ☐ Depression ☐ Enlarged prostate ☐ 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

☐ Medication ☐ Bladder training ☐ Electrical stimulation ☐ Pelvic floor muscle training program
☐ Referral to: ☐ GP ☐ Continence Nurse ☐ Urologist ☐ Geriatrician ☐ Gynaecologist ☐ 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

27. If you are experiencing a bladder problem, what kind of assistance would you prefer? *(may tick more than one)*

☐ No assistance
☐ To be assisted to go to the toilet at _____
☐ To wear pads during the day
☐ To wear pads during the night
☐ To be seen by a specialist for further investigation
☐ Other _____

29. If you are experiencing a bladder problem, how much of a problem is this for you?

☐ No problem ☐ A bit of a problem
☐ Quite a problem ☐ Severe problem

Bowel Function

28. If you are experiencing a bowel problem, what kind of assistance would you prefer? *(may tick more than one)*

☐ No assistance
☐ To be assisted to go to the toilet at _____
☐ To wear pads during the day
☐ To wear pads during the night
☐ To have a laxative
☐ To be seen by a specialist for further investigation
☐ Other _____

30. If you are experiencing a bowel problem, how much of a problem is this for you?

☐ No problem ☐ A bit of a problem
☐ Quite a problem ☐ Severe problem

31. If you are wearing a continence product, does it keep you dry and comfortable? ☐ N/A ☐ Yes ☐ No

If no, would you like to consider other options? ☐ Yes ☐ No

Further comments and/or observations _____

Staff member completing assessment	**Staff member endorsing this assessment**	**Care plan discussed with and agreed to by family** ☐ Yes ☐ No ☐ 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

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

3. Behaviours that indicate need to toilet

☐ Restless ☐ Wandering

☐ Pulls at clothes ☐ 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 _____

_____

_____