Evidence-Based Clinical Assessment Toolkit (EBCAT)

Continence Workbook

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Acronyms and Glossary

ACCR	Aged Care Client Record
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
BAF	Behavioural Assessment Form
BCOPE	Best Care For Older People Everywhere
BPSD	Behavioural and Psychological Symptoms of Dementia
CAM	Confusion Assessment Method
CCF	Care Continuum Framework
CDAMS	Cognitive, Dementia and Memory Service
CDC	Consumer Directed Care
CHA	Comprehensive Health Assessment (CHA) for Older People in the Health Care System
CHAOP	Comprehensive Health Assessment of the Older Person
DBMAS	Dementia Behaviour Management Advisory Service
DOMS	Dementia Outcomes Measurement Suite
EBCAT	Evidence Based Clinical Assessment Toolkit
EBCAT Assessment Packs	Each Workbook has an assessment pack. This contains the recommended screens, assessments and Standardised Care Processes recommended within the Workbook.
EBCAT Introductory Guide	This document presents: Project methodology; Overview of products; and details of the Management role;
EBCAT Reading Pack	This document provides the background reading for all EBCAT Workbooks.
EBCAT Topics	1. Nutrition 2. Mobility 3. Self-care (Personal Hygiene, Toileting) 4. Continence 5. Cognition 6. Behavioural Expressions (Wandering, Verbal & Physical, Mood) 7. Medicines 8. Pain 9. Swallowing 10. Skin & Wounds
EBCAT Workbooks	The toolkit is presented in six 'user friendly educational Workbooks' to walk the user through the process of using evidence-based clinical assessment tools for each domain of: • ADL Workbook (Topics 1-3)

	• Continence Workbook (Topic 4) • Cognition Workbook (Topic 5) • Behavioural Expressions Workbook (Topic 6) • Medicine Workbook (Topic 7) • Complex Health Workbook (Topic 8-10)
FRAT	Falls Risk Assessment Tool
GP	General Practitioner
IPA	International Psychogeriatric Association
KICA-Cog	Kimberley Indigenous Cognitive Assessment
MP	Medical Practitioner
M-VRBPI	Modified Resident Verbal Brief Pain Inventory
NATFRAME	National Framework for Documenting Care in Residential Aged Care Services http://webarchive.nla.gov.au/gov/20140803082152/http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe01.htm
NCD	Neuro-Cognitive Disorder
NPI-NH	Neuro-Psychiatric Inventory for Nursing Homes
NRS	Numeric Pain Rating Scale
PAINAID	Pain Assessment in Advanced Dementia
PAS-CIS	Psychogeriatric Assessment Scales- Cognitive Impairment Scale
PCC	Person Centred Care
PMS	Physical Mobility Scale
PSRACS	Public Sector Residential Aged Care Services
QoC	Quality of Care
QoL	Quality of Life
RACF	Residential Aged Care Facilities
RNDC	Resident Nutrition Data Card
ROM	Range Of Movement
RUDAS	Rowland Universal Dementia Assessment Scale
SCP	Standardised Care Process
SCORE	Strengthening Care Outcomes for Residents with Evidence
VDS	Verbal Descriptor Scale

Overview of the Toolkit Products

The Evidence-Based Clinical Assessment Toolkit (EBCAT) consists of the following products:

Resource	How used
Introductory Guide	The Introductory Guide is aimed at the lead nurse and the nursing management. It presents: the project methodology; an introduction to the products; and details on the Nursing Management role.
Reading Pack	The Reading Pack, provides further reference information for the background reading section of each workbook, it is aimed at care staff. This pack contains reading material which cannot be sourced from the internet. References for supporting material that can be sourced off the internet are provided in workbook appendices. There is also a sample Quality of Life questionnaire in the Reading Pack.
Workbooks	The EBCAT workbooks are designed to be used by the lead nurse. The workbooks should be used as a training tool by the lead nurse when training the care staff on the EBCAT. There are six workbooks which cover the domains of: • Activities of Daily Living • Continence • Cognition • Behavioural Expressions • Medicine • Complex Health Each workbook contains detailed information and case studies on how to complete the recommended assessment tools as part of a nursing-based process. The Appendices provide references for the suggested resources, and a workbook exercise to practice what has been learnt.
Quick Guides	The Quick Guides are designed for use by care staff. There is one quick guide per workbook. The Quick Guide is a quick reference to the EBCAT process and tools. It is recommended it be kept handy for use on the 'floor', whenever required.
Assessment Packs	The assessment packs contains the recommended screen, assessment tools and relevant clinical risk tools. There is one assessment pack per workbook. The tools are used by the care staff when identifying the needs of the residents.

Suggested Roles for Staff Implementing the Toolkit

The toolkit requires the participation of three types of staff.

	Who and what they do in regard to the Toolkit
Nursing Management	This group would typically consist of nursing staff who do not work 'on the floor', for example the Director of Nursing or Nurse Unit Manager. They are vital to ensuring, that the toolkit is set up properly to support implementation at the site, to ensure that the process is continuously monitored and improved, and to monitor the process to ensure the documentation and ACFI claiming is accurate. The nursing management role includes: o Preparing the toolkit and auditing for readiness to implement o Selecting a lead nurse for the leadership role and to train the care staff o Implementing the toolkit and monitoring the progress The nursing management role is described in detail in the Introductory Guide.
Lead Nurse	This person will be selected by the Nursing Management group to lead the EBCAT process at the site. It is recommended they be a nurse (RN or EN). The lead nurse role includes: o Assisting the Nursing Management group to prepare the toolkit o Training the care staff on how to implement the EBCAT process and tools o Providing leadership to the care staff during the implementation of the process o Assisting the Nursing Management group to monitor the progress The lead nurse role is described in detail in the Introductory Guide.
Care Staff	This group are the nurses (RN or EN) and Personal Care Workers who deliver the daily care to the residents 'on the floor'. They receive the training and implement the EBCAT process and tools when undertaking the resident assessment process.

Introduction to the Continence Workbook

The Continence Workbook is one of six that form the Evidence Based Clinical Assessment Toolkit (EBCAT). The Continence Workbook is one of four resources relevant to the Continence Topic which comprise:

- A Reading Pack
- Continence Workbook
- Continence Quick Guide
- Continence Assessment Pack

The toolkit aims to provide a resource to assist Public Sector Residents Aged Care Services (PSRACS) staff to systematically and consistently determine and manage resident care needs. The toolkit uses evidence-based clinical assessment tools for assessing and managing residents with the goals of improving the clinical and quality of life for the residents and demonstrating accountability to government regulators for example, with the Aged Care Funding Instrument (ACFI) requirements.

During 2013, the Australian Government made changes to the Aged Care Funding Instrument (ACFI) requiring further evidence to support funding claims made by services with activities of daily living support needs. In addition, the Australian government introduced more stringent penalties for providers with inaccurate or misleading ACFI appraisals from 1 July 2013.

While the ACFI assessment pack determines that the mandatory assessments for the continence domain are the Continence Records, this workbook looks beyond ACFI and has recommended a comprehensive approach to the assessment of continence. The continence workbook will assist a service meet the continence evidence requirements using familiar and freely available Australian toolkits and resources including:

- Continence Tools for Residential Aged Care" developed by the School of Nursing at Deakin University and funded under the (Australian) National Continence Management Strategy. An Initial Nurse Assessment – e.g. the Comprehensive Health Assessment (CHA) for Older People in the Health Care System which was designed for recording assessment results based on the Comprehensive Health Assessment for the Older Person (CHAOP) resource
- Standardised Care Processes (SCP) developed as part of the Strengthening Care Outcomes for Residents with Evidence (SCORE) project
- The NATFRAME (National Framework for Documenting Care in Residential Aged Care Services)
- Best Care for Older People Everywhere (BCOPE). The toolkit.

Topic 4: Continence

The Continence Topic

This topic focuses on urinary and bowel continence.

Investigating Continence

The following four process steps should be followed when investigating continence (consistent across all EBCAT topics). The steps are:

1. **Preparation by staff** – ensuring that staff have the required qualifications or competencies and have completed background reading if required. The background reading includes:

   - Comprehensive Health Assessment of the Older Person (CHAOP) Module 4
   - Best Care for Older People Everywhere (BCOPE). The Toolkit (2012)

   The references for these resources can be found in the Continence Appendix.

2. **Identifying** – gathering the resident's history by collating documents, talking with residents and their family, looking for signs and symptoms in the initial nurse assessment, and completing a comprehensive assessment approach and assessing the scope of the challenge. It is recommended that all new residents have a comprehensive assessment approach to identify the person's continence care needs. A comprehensive approach will include:

   File Notes Review:

   - Aged Care Client Record (ACCR) – Parts 4 and 5 includes diagnoses and questions on continence
   - Comprehensive Medical Assessment – which (if available) may have, for example, diagnoses of incontinence, continence status, stomas, catheters and continence aids

   Screen:

   - Initial nurse assessment e.g. the CHA is an initial nurse assessment based on the 'Comprehensive Health Assessment of the Older Person' resource), and records a set of questions on continence and provides information about other domains

   Further Assessment:

The following assessment tools and Standardised Care Processes are recommended for assessing the continence care needs of the resident (found in the Continence Assessment Pack and references are found in the Continence Appendix):

- Urinary Record (for recording frequency and pattern after a positive screen)
- Bowel Record (for recording frequency and pattern after a positive screen)
- Continence Assessment Form and Care Plan (for a comprehensive assessment approach that investigates other contributing factors)
- Standardised Care Processes: Constipation (for addressing the clinical risk of constipation) and Dehydration (for addressing the clinical risk of constipation)

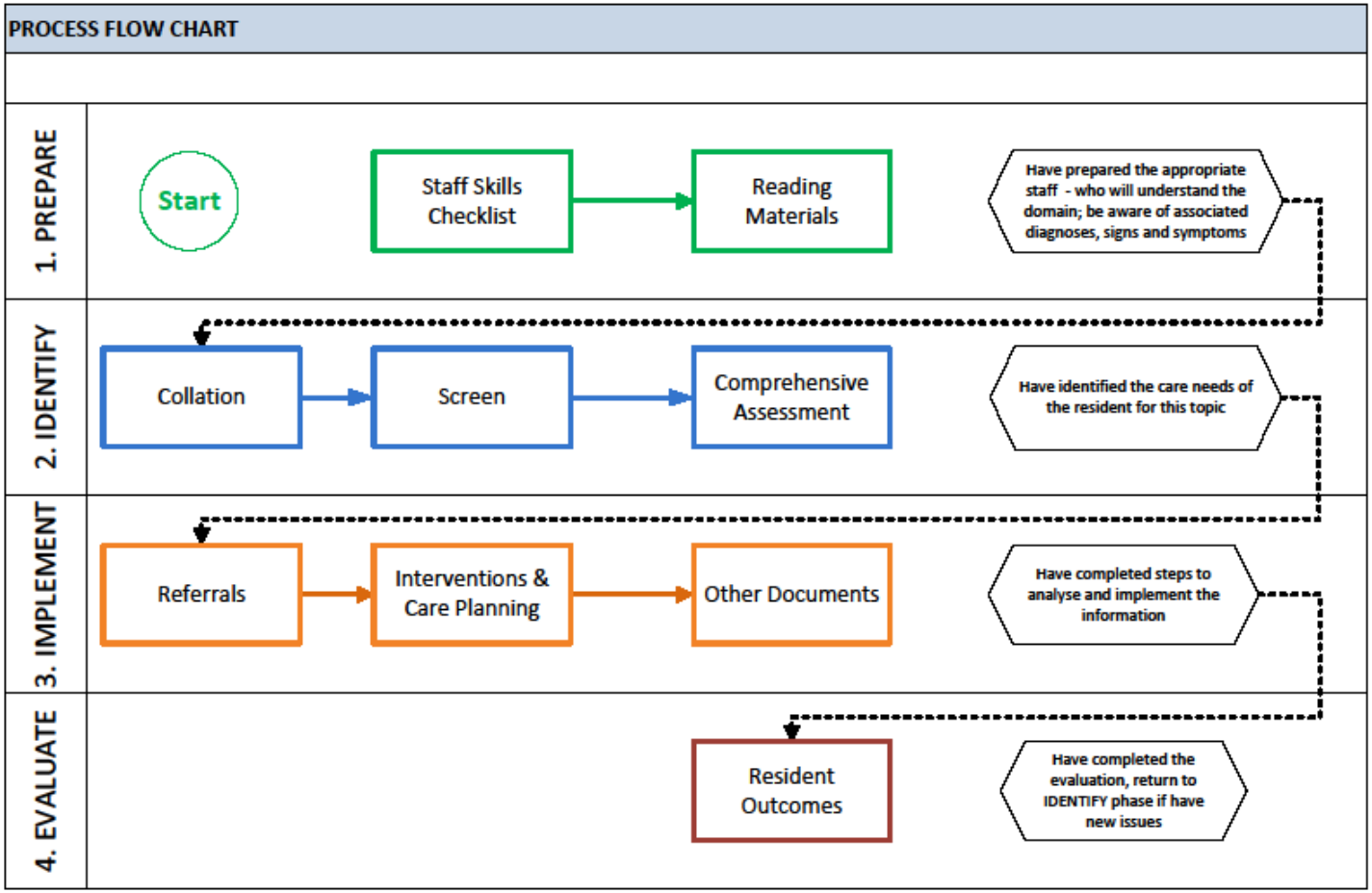
The recommended Continence Assessment Forms and Care Plan are part of the resource "Continence Tools for Residential Aged Care" developed by the School of Nursing at Deakin University and funded under the (Australian) National Continence Management Strategy. This resource consists of a Management Flow Chart, Assessment Tools, Review Form and an Education Guide which provide information about how to complete the associated documents. Further information on this resource is found in the Continence Appendix.

3. **Implementing** – based on the information from the identification phase this covers making needed referrals, selecting and trying interventions, writing a care plan, completing the ACFI and documenting the process. The steps are:
   - Undertaking referral options to complete gaps or seek specialist advice
   - Planning evidence-based care strategies to assist the person to maintain or possibly improve their participation ability
   - Listening to and setting goals with the consumer (resident and family) to hear their understanding and personalise the approach
   - Understanding the role of communicating the care needs, goals and strategies through care plans and resident file notes to provide the documentation trail
   - Completing ACFI documentation

4. **Evaluating** – monitoring and evaluating the effectiveness of the process, interventions and looking for ways to further improve the care outcomes for residents.

The overall continence process and associated activities is illustrated in Figure 1 which shows the phases (e.g. prepare, identify, implement, evaluate), the steps within each phase and the aim for each phase (e.g. have identified the care needs of the resident). Each topic of the workbooks follows the same pattern. Consistent application of this process will assist your home provide systematic, accountable care and facilitate the best possible resident care outcomes.

Figure 1: Continence Process



Getting Started with a Continence Example

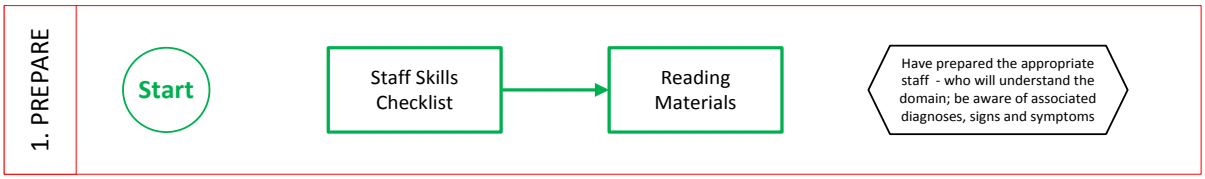
This case study will be referred to as we discuss the continence topic.

Mrs. Rose Smith is an 83- year old woman who has lived with her son David and daughter-in-law Susan for the last two years since her husband died. Rose has severe arthritis which has affected her mobility and hand dexterity, and she now has urinary incontinence and was finding it difficult to physically manage incontinence pads due to her mobility and hand impairments.

Both David and Susan work full-time. Rose was also becoming more socially isolated and withdrawn due to the mobility and incontinence issues and more vulnerable to falls. She was embarrassed by her loss of urinary control, and decided to limit her fluid intake. She then became dehydrated and subsequently developed a urinary tract infection (UTI) with an associated episode of delirium which placed her in hospital. Rose was assessed in hospital by the Aged Care Assessment Service as requiring residential care. Rose and the family decided that residential care was a better and safer alternative.

Rose arrived at the facility heavily perfumed (worried about the smell of urine), and looking quiet and withdrawn.

Preparation



There are two specific aspects to **preparing** staff for the management of resident continence care needs. They are:

1) Ensuring that staff have the required qualifications or competencies; and

2) Completing the pre-reading if required

Recommended Staffing Skill Set

Table 1 below provides a structure for management to identify which staff have the skills required to complete activities within the continence process. The process includes:

- Identifying the required activities (examples provided in Table 1)
- Assessing staff competency to complete the activities
- Addressing identified gaps

This will assist nursing management to select and determine the roles of staff to ensure the process can be completed effectively. For example, if there is a gap found in the continence assessment and management activity, the facility could consider further training of current staff, or securing a nurse with the required clinical knowledge (i.e. Continence Consultant) who could complete the assessment.

The introductory guide also provides further instructions for nursing management in preparation for implementing this toolkit.

Table 1: Staff Activities for the Continence Process

Activity	Responsible for sign off	Does the activity
Collating Documents		
Identifying Needs from gathering documents		
Screening: • Initial Nurse Assessment: e.g. CHA • Continence Toolkit Screen • Extra screen questions		

Activity	Responsible for sign off	Does the activity
Charting • 3 day Bladder Record • 7 day Bowel Record		
Comprehensive Assessment : Continence Assessment Form and Care Plan		
Standardised Care Processes: Constipation & Dehydration		
Documenting into file notes		
Determine and action Referrals		
Develop Interventions and Strategies		
Write up the Care Plan		
Complete ACFI associated documents		
Complete Standards or audit documents		
Review the Care Plan		
Evaluate Resident Care outcomes		

Background Reading

Staff should complete the background reading or be able to demonstrate that they have adequate experience and knowledge of nutrition issues in older people. It is expected that staff will have:

- A comprehensive understanding of the domain and how it is impacted by other health areas
- An awareness of associated diagnoses, signs and symptoms
- Knowledge about and training on how to use the assessment tools
- Knowledge about evidence informed practices associated with continence- to assist with the development and implementation of evidence informed care plans

The background reading relevant to the continence topic is:

- CHAOP (Module 4) covers Nutrition, Metabolism and Assessment and offers an overview of physical examinations and assessments (by nurses) associated with continence and the elimination system. The abdominal assessment, bladder assessment, assessments for UTI and constipation, and urinalysis are most relevant

to this topic, This module is also relevant to all of the ADL domains and some of the Complex Health sections

- The BCOPE resource (Best Care for Older People Everywhere). BCOPE provides some useful pre-reading which outlines keys facts about continence, what normal bladder/bowel function should look like, common symptoms of incontinence and the care management principles to adopt.

Further information on these resources is found in the Continence Appendix. A copy of Module4 of CHAOP is found in the Reading Pack. The BCOPE resource is summarised below.

Some Basics

Continence is defined as 'the capacity to pass urine or faeces in socially and hygienically acceptable circumstances'[1] (BCOPE p186).

Incontinence is 'the accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence)'[2].

People with poor bowel control or **faecal incontinence** have difficulty controlling their bowels. This may mean they pass faeces or stools at the wrong time or in the wrong place. It is more common with advancing age and many people with poor bowel control also have poor bladder control[3].

The normal frequency for passing of urine is every 3-4 hours (BCOPE p.186) and usually not less than 3 times per day (Continence Tools for Residential Aged Care User Guide p.24).

Bowel frequency varies between individuals, however they are usually not less than 3 times per week (Continence Tools for Residential Aged Care User Guide p.24).

The Bristol Stool Form Scale is recommended by the 'Continence Tools for Residential Aged Care User Guide' (referenced in the Continence Appendix) to determine normal stools, constipated stools or diarrhoea. Healthy bowel elimination should be regular, brown in colour, soft and formed, easy to pass, and the person should be able to recognise the urge, and be able to hold on until reaching the toilet (p. 15).

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[1] (Clinical Epidemiology and Health Service Evaluation Unit: Melbourne Health 2004, *Best practice approaches to minimise functional decline in the older person across the acute, sub-acute, and residential aged care settings*, Victorian Government Department of Human Services on behalf of the Australian Health Ministers' Advisory Council, Melbourne.)

[2] *(Continence Foundation of Australia, http://www.continence.org.au/pages/what-is-incontinence.html, accessed 20/06/14*

[3] *(Continence Foundation of Australia, http://www.continence.org.au/pages/what-is-incontinence.html, accessed 20/06/14*

There are different types of incontinence, offset by different factors which have different causes. Older people can have more than one type or symptom of incontinence. The Australian Continence Foundation[4] states there are four common types of incontinence:

- **Stress incontinence:** an involuntary loss of urine as a result of intra-abdominal pressures. This type of incontinence can occur during laughing, coughing, sneezing, lifting, and exercise.
- **Urge incontinence:** is a sudden need to urinate followed by a bladder contraction. The outcomes of urge incontinence are increased frequency of urination and leakage. Urge incontinence creates a high fall risk in older women and has been identified as a major contributing factor for hip fractures. Therefore, a care plan that incorporates the functional limitations and health care needs across other care domains is vital for effective care planning.
- **Overflow incontinence:** when urine leaks from a full bladder that cannot empty properly.
- **Functional incontinence:** incontinence associated with functional mobility issues, such as making it in time to use the toilet and being able to undress as needed.

Some other signs and symptoms and types of incontinence which include (BCOPE, 2012, p.190):

- **Incomplete emptying:** refers to urine or faeces remaining in the bladder/bowel.
- **Nocturia:** increased need to pass urine during the night.
- **Dysuria:** pain during urination.
- **Haematuria:** evidence of blood in the person's urine.

There are **medical conditions that can impact on bladder symptoms** (Continence Tools for Residential Aged Care User Guide p. 14-15).

- **Congestive Cardiac failure**
- **Urinary tract infection (UTI):** Bladder infections are reversible and therefore important to identify. The CHAOP manual provides further information about how to assess for a UTI (and is summarised below).
- **Constipation and feacal impact:** Reduced mobility, reduced food and fluid intake can lead to constipation. Symptoms include pain and discomfort, straining, bleeding, hard and dry motions, or very fluid motions.
- **Medications** such as diurectics, laxatives and many more (refer to Continence Tools for Residential Aged Care User Guide p. 27-28).

[4] *(Continence Foundation of Australia, http://www.continence.org.au/pages/what-is-incontinence.html, accessed 20/06/14*

- **Prostate enlargement and cancer in men:** The prevalence of urge incontinence, which is strongly associated with prostate disease, is 30% for those aged 70-84 and 50% for those 85 years and over (Australian Institute of Health and Welfare, 2006).
- **Neurological problems:** can interfere with nerve signals affecting bladder control.

CHAOP Module 4 (pages 12- 18) provides an overview of how to undertake:

- An inspection, percussion and palpation of the abdomen
- Bladder assessment
- Constipation assessment
- Urinalysis
- Assessment for constipation; and
- Assessment for Urinary Tract Infection (UTI)

A person with dementia may not be able to tell you what is wrong, it may however be seen in their behavior or in urine and blood testing.

The signs and symptoms of Urinary Tract Infection (CHAOP Module 4 p. 18) can be:

- Dysuria (pain when urinating)
- Burning sensation when urinating
- Frequency and small amounts
- Urgency
- Haematuria (blood in the urine)
- Assess vital signs –temperature, chills
- Nausea and vomiting
- Malaise
- Inspect urine for colour and clarity (urine that is cloudy suggests infection)
- Test for protein, nitrates, blood, leucocytes
- Blood tests for white blood cell counts

It is important to consider incontinence in the care planning approach because (BCOPE, 2012, p.186)

- Promoting and encouraging continence can have a positive impact on an individual's dignity, self-esteem and wellbeing.
- Continence screening, assessment and documentation are required to identify, manage and prevent continence problems.
- Reduced mobility is the single most predictive factor of incontinence

- Urge incontinence has been identified as a major factor in hip fractures and falls in older women
- Incontinence is not an expected outcome of older age

How Continence Interacts with Other Domains

Medical conditions, cognitive impairment, limited mobility, and sensory loss can all impact on continence.

Due to the impact from other impairments on continence, and the impact of incontinence on other health and social aspects, there is a need for a broad assessment approach that encompasses other care domains. Not only do functional issues impact on incontinence, incontinence frequently has negative effects on skin integrity, personal wellbeing and mood, self-esteem, and engagement in social activities (BCOPE p190).

The ability to *maintain* continence can be affected by the person's:

- Medical conditions
- Mobility level (this is the single most predictive factor for incontinence[5]);
- Self-care ability (impacts on level of independence with continence activities)
- Cognitive impairments (for example delirium, depression, dementia can impact on the ability to manage and control continence)
- Nutrition (hydration levels and fibre intake can impact on constipation)
- Medication can impact on urinary output

There are some simple **prevention tips** from the Continence Foundation of Australia that highlight how older people can be assisted to maintain continence. They recommend:

Drink well:

- 6-8 cups (1.5 - 2 litres) of fluid per day, unless otherwise advised by your doctor
- Reduce alcohol, fizzy drinks and drinks that have caffeine in them as they irritate the bladder.
- Don't reduce your fluid intake with a bladder control problem, as this will concentrate the urine and make the problem worse.

Eat a healthy diet:

- Plenty of fibre improves bowel function by absorbing water and adding bulk which keep things moving through the bowel to avoid constipation.

[5] *Deakin University/Eastern Health 2008, A continence resource guide for acute and subacute care settings, Deakin University/Eastern Health, Melbourne*

- A high fibre diet means plenty of fluids need to be consumed as the fibre requires water in order to bulk up the bowel motions.

Lead a positive lifestyle:

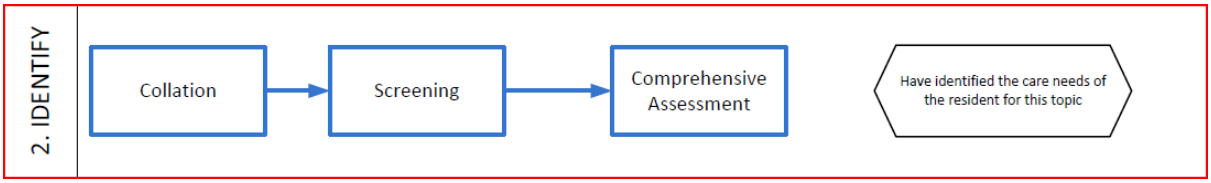
- Maintain an ideal body weight as excess body fat strains the pelvic floor and can lead to bladder and bowel control problems.
- Stop smoking. Chronic (long-term) coughing associated with smoking can weaken the muscles of your pelvic floor and lead to bladder and bowel control problems.

Key Statistics (Continence Foundation of Australia):

- Faecal incontinence is one of the three major causes (along with decreased mobility and dementia) for admittance to a residential aged care facility (Norton et al 2002).

- Around 77% of nursing home residents in Australia are affected by incontinence (Steel & Fonda 1995).

Identification Process



The steps in the process of **identifying** are:

- Gathering of current documentation and information directly from carer, family and the consumer if possible;
- Identifying a need (e.g. initial nurse assessment, screen form); and
- Completing a comprehensive assessment of the continence needs

Back to Mrs. Smith

- *Rose has been diagnosed with both stress incontinence and functional incontinence. Her stress incontinence means she has an involuntary loss of urine when she coughs, sneezes, or laughs. The functional incontinence indicates she cannot always make it to the toilet in time, in her case because she has severe arthritis in her wrists and knee joints. She doesn't move quickly, is slow to rise from a chair, and by the time she gets there her need is urgent and she has trouble removing her clothing. The arthritis makes it difficult for her to complete her toileting activities.*
- *She has a long habit of getting up more than twice every night to urinate. This increases the risk of falling, fortunately once she returns from the bathroom, she will go back to sleep if there are no more disturbances. More recently however she needs her night attire to be occasionally changed and this has impacted on her ability to get back to sleep.*

Gathering the History

What documents (before you start assessing) do you have which provide information on the resident you are focusing on? You will be able to build a picture of the person's relevant history through current documentation (i.e. ACCR, medical notes) and their personal history through discussions with their family members and carers.

It is recommended that all new residents have a comprehensive assessment of their continence and toileting abilities and preferences completed.

Documentation

The current documentation should be reviewed, checking for relevant diagnoses, information on signs and symptoms and previous assessments. Below is an example of the types of documents to be collated and reviewed and the information that is being sought for continence.

Document	Looking for
ACCR	Diagnoses, continence status, needs, aids and assistance
Medical Notes/CMA	Diagnoses, continence status, needs, aids and assistance
AHP notes/assessment (Continence nurse, Physiotherapist)	Diagnoses, continence status, needs, aids and assistance

Here are a few examples of how the collated diagnoses and issues may be indicators of care needs:

Diagnoses/status/needs	Examples of care needs
Diagnosis or evidence of incontinence of urine or faeces	The need for a comprehensive assessment approach including an individualised toileting program.
Scheduled toileting	Refer to the ACFI User Guide p4 for a definition of scheduled toileting. “Scheduled toileting for the purpose of questions 5 (Continence) is: staff accompanying a resident to the toilet (or commode) or providing a urinal or bedpan or other materials for planned voiding/evacuation according to a daily schedule designed to reduce incontinence.”
The use of scheduled toileting codes in the Continence Records e.g. code 4 (Urinary Chart) or code 7 (Bowel Chart).	ACFI User Guide p22“If claiming for scheduled toileting, you must provide documentary evidence of incontinence prior to the implementation of scheduled toileting e.g. ACCR or a flowchart completed prior to scheduled toileting being implemented.”
Specific type of urinary incontinence	Different types of incontinence may be managed differently e.g. stress/urge/functional overflow incontinence
Dehydration	A person may limit fluid intake to avoid incontinence issues, this increases the risk of dehydration. There is a Standardised Care Process to address this issue.
Constipation	Enemas, suppositories and osmotic aperients may

Diagnoses/status/needs	Examples of care needs
	be used to treat constipation (a medical referral may be appropriate). Diet, fluid intake and exercise are also important considerations in constipation (a referral to dietitian may be appropriate). There is a Standardised Care Process to address this issue.
Stoma	The care and management of an ostomy is part of the continence management, it is also covered in ACFI 12 Complex Health Care for funding purposes.
Enemas, suppositories, stool softeners and osmotic aperients	These aspects of the continence management are covered in Medication and ACFI 12 Complex Health Care for funding purposes.
Catheter or condom drainage	Catheter care and condom drainage are aspects of continence management. The care and management of an indwelling catheter is covered in ACFI 12 Complex Health Care for funding purposes. The management of drainage bags is covered in ACFI 4 Toileting for funding purposes.
Mobility impairment	If the person cannot get to the toilet in a timely manner, they may have outcomes such as leakage.
Physical functioning (dexterity, grip, arms, sitting upright)	Physical ability can affect the person's self care ability e.g. to place self on the toilet, or completing toileting hygiene or removing and dressing self for toileting purposes. Lack of self care ability can lead to functional incontinence.
Cognition (moderate to severe cognitive impairment)	Moderate or higher impairment usually requires supervision with toileting, the person may not be able to find their way to the toilet, or maybe cannot understand how to start or complete the activity of toileting. Cognitive impairment can interfere with the ability to manage continence aids and to maintain continence.
Sensory Loss (e.g. sight)	May require supervision or physical assistance related to continence/toileting activity due to sensory loss.
Communication issues of understanding others and/or communicating to others	May require supervision/assistance to initiate or undertake continence/toileting activities.

Resident and Family

It is important to include and seek input from the resident and his or her family members. Rose was embarrassed by her incontinence and this impacted on her social participation. Maintaining dignity and social interaction is important for the resident's well-being.

Screening

The recommended screening approach (consists of:

- CHA continence items
- Continence Tools for Residential Aged Care – 'Continence Screening Form'
- Additional screen questions

Screening should be completed at admission and when a possible change in a continence issue is identified or flagged. Copies of the screening tools are found in the Continence Assessment Pack and references to the tools are found in the Continence Appendix.

Initial Nurse Assessment

All residents should have an initial nurse assessment such as the Comprehensive Health Assessment (CHA) for Older People in the Health Care System. The CHA covers most domains and topics likely to impact on the health care needs of a person. Based on evidence informed practice, nurses (RN's and EN's) who have received training on a resource such as the Comprehensive Health Assessment of the Older Person (CHAOP) have the competencies to undertake a comprehensive health assessment.

The recommended CHA items to inform on the continence screen are:

CONTINENCE

Urinalysis (full ward test).....

Is the person urinary continent? Yes ☐ No ☐

If 'no' type of incontinence: Describe i.e. urge, stress, functional.....

Use of continence aids Yes ☐ No ☐

Are they able to take themselves to the toilet? .....

Does the person have a stoma? Yes ☐ No ☐

Does the person have a urinary or suprapubic catheter/condom drainage? etc

.....

Continence Topic

Is the person faecally continent? Yes ☐ No ☐

Usual bowel habits?.....

Use of aperients? ……(document in medication section)

Does the person have a stoma? Yes ☐ No ☐

Identified issues:……

The Continence Screening Form items cover:

Bladder Health

Does the resident go to toilet more than 6 times in the day to pass urine?

Does the resident get up more than once during the night to pass urine?

Does the resident leak urine?

Does the resident have any other bladder problems (i.e. difficulties passing urine and/or pain)?

Is the person urinary continent? Yes ☐ No ☐

Bowel Health

Has the resident lost control of or leaked bowel motions?

Does the resident have any other bowel difficulties (i.e. constipation or diarrhoea?)

Pad Usage

Does the resident wear pads?

Does the resident have to change his/her underclothes or wear protection because of bladder or bowel leakage or soiling?

The additional recommended questions for the continence screen are:

Is there a diagnosis of urinary incontinence by a Medical Practitioner or stated in ACCR?

Is there a diagnosis of faecal incontinence by a Medical Practitioner or stated in ACCR?

Is there an order for the use of suppositories?

Is there an order for the use of enemas?

Comprehensive Assessment

For the continence domain, it is recommended that all new residents have a comprehensive assessment. The recommended full assessment approach involves:

- CHA continence items
- Continence Tools for Residential Aged Care – 'Continence Screening Form'
- Additional screen questions

- 3 day Bladder Chart
- 7 day Bowel Chart
- Continence Assessment Form and Care Plan

Copies of the 3 day Bladder Chart, 7 day Bowel Chart and the Continence Assessment Form and Care Plan are found in the Continence Assessment Pack and references to the tools are found in the Continence Appendix.

If a resident is incontinent of urine or has bladder difficulties (as identified in the screen), it is recommended that a 3 day Bladder Chart be completed.

The Bladder Chart from the Continence Tools for Residential Aged Care covers frequency and collects other relevant information about fluid intake and impact of incontinence on underwear/clothing. This chart is recommended and can later be used to transcribe the frequency data into the ACFI 3 day Urine Chart for funding purposes.

If a resident is incontinent of faeces or has bowel difficulties, it is recommended that a 7 day Bowel Chart be completed.

The Bowel Chart from the Continence Tools for Residential Aged Care covers frequency and collects other relevant information about the type of stool and impact of incontinence on underwear/clothing. This chart is recommended and can later be used to transcribe the frequency data into the ACFI 7 day Bowel Chart for funding purposes.

It is recommended that (a) all new residents regardless of the screen result and (b) reviewed residents who screen positive for bladder or bowel issues have the 'Continence Tools for Residential Aged Care - Continence Assessment and Care Plan' completed. This will ensure that a comprehensive continence assessment has been undertaken following an evidence-informed best practices approach.

The Continence Assessment and Care Plan tool collects information across the broader domains and links the outcomes to care planning actions. The tool is part of the resource 'Continence Tools for Residential Aged Care' (reference found in the Continence Appendix) which provides a:

- Continence management flow chart
- Continence screening form (8 questions)
- Three day bladder chart and Seven day bowel chart
- Monthly bowel chart
- Continence assessment form and care plan
- Continence care summary (review form)
- Continence Tools for Residential Aged Care: An Education Guide',

The 'Continence Tools for Residential Aged Care' was developed to assist RNs, ENs, PCW's and Nursing Assistants to use the Continence Tools in Residential Aged Care. It provides information on how to conduct a continence assessment, develop a continence care plan and evaluate the effectiveness of care. However, the continence care summary does not cover goal setting for clinical or resident quality of life issues and is not measurement based, this is further discussed in the evaluation phase.

The resource (Continence Tools for Residential Aged Care) is suggested because it is based on a comprehensive approach to continence management, was developed and trialled in 18 Australian Residential Aged Care facilities, is a free resource, is referenced and provides an education guide to support the implementation of the tools (it is suggested that facilities download the full set of tools and guide).

Clinical Risks

To complete the approach, there are two developed and relevant Standardised Care Processes. The Standardised Care Process Constipation is recommended for:

(a) New residents – a bowel assessment to be completed on admission as part of a prevention approach, and
(b) Implementing interventions to lessen the likelihood of constipation or for treating symptoms of constipation.

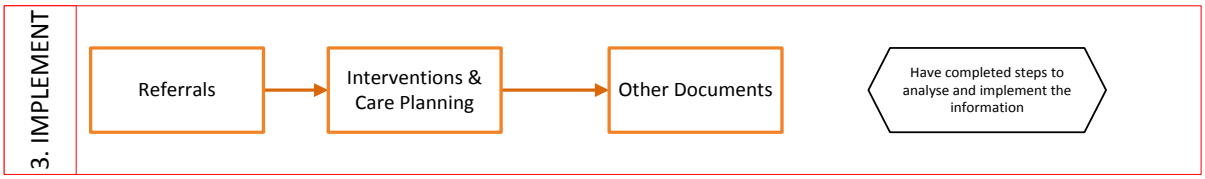
The Standardised Care Process Dehydration is recommended for:

(a) New residents – the first step of recognition to be screened for; and
(b) When the resident's condition or symptoms flag a possible dehydration issue.

Bringing the information together

The staff collated the current information and collected new assessment information in collaboration with Rose and the family. They set out actions and goals based on the information to specifically meet Rose's needs and wishes. As Rose's story progresses, her needs and goals will probably change and staff will need to gather further information and be flexible to meet her changing needs.

Implementation Process



This phase of the toolkit demonstrates how to use the information gained from the identification phase to implement interventions and care planning.

The implementation process has three main aspects. These are:

- Undertaking **referrals as identified** to gather further needed information
- Designing **interventions** and developing **care plans that provide a coherent picture of what is to be done and why**;
- Completing **other documents** that support the care process and the accountability systems, such as for the ACFI funding claims and quality of care aspects for accreditation

Back to Mrs. Smith

Rose has been admitted into a residential aged care facility which sits within a retirement village that caters for a broad range of needs from independent living units to the nursing home. While stress and functional incontinence diagnoses are very common, they are rarely openly discussed, because incontinence is viewed by those who have it as deeply embarrassing.

The manager of the home has become aware that across the village there is an increase in urinary tract infections. This identified a need for a village wide education program, to inform on tips for maintaining continence and avoiding urinary tract infections. The local Continence Foundation site was contacted and they provided Information Sheets, multi-media resources and also offered to provide a guest speaker for a nursing staff education session with an information booth that would be centrally placed so that it would be available to both the village and nursing home residents, family members and staff.

As the village already provided weekly exercises led by a physiotherapist, pelvic floor exercises were added to both the women's and men's group. These exercises strengthen pelvic floor muscles that support and hold up the bladder, helping both men and women, and they can be done anywhere.

The aim was to update carers knowledge of bladder-related issues and person centred care- have them focus on how the residents wanted to be treated, and to provide access to information for the whole community.

For Rose's individual needs:

The continence and toileting aspects of the care plan needed to address her arthritis pain and mobility, regular analgesia was commenced, and the staff were trained in simple joint exercises as recommended by the physiotherapist and agreed to by Rose.

To address her functional incontinence, Rose and her team agreed on several actions. First, Rose had expressed a desire to avoid using adult pull up continence pads. She knew when she needed to use the toilet, or when she had some stress incontinence; she wanted to get better control of those issues.

She was willing to use a pad in her underwear for small leaks that she was able to manage. Staff would remind her when to do her pelvic floor exercises.

The recording of Rose's continence habits helped to identify how often Rose needed to go to the toilet to avoid accidents. At night, based on her feedback, she was to be awakened two hours after going to bed and again five hours late. The staff handed Rose her mobility aid, supervised her mobility to and from the toilet, and assisted her onto/off the toilet. They wanted to make sure she could safely mobilise the short distance to her toilet at night. After a week, they would evaluate whether this was adequate for preventing episodes of incontinence at night and whether she could safely mobilise the short distance at night. The goal was to get her body used to a routine.

A dietitian reviewed Rose's diet as they wanted to avoid another dehydration episode and were aware that some of her fluids might need some slight changes. Rose was used to drinking several cups of both coffee and tea daily and had orange juice for breakfast and sometimes with her evening meal. As both caffeine and the citric acid can be irritating to the bladder, it was agreed with Rose that she would have one cup of coffee in the morning, and water and herbal teas throughout the day, and would switch from orange juice to cranberry juice.

Referrals

If there is an identified dietary need, then a referral to a dietitian should be considered, as was done with Rose.

If there is an identified functional impairment that may be improved with exercise, then a referral to a physiotherapist should be considered, again as was done with Rose.

If there is an identified need for medication or further investigations, then the matter should be directed to a Medical Practitioner (i.e. GP), who can implement treatments, or make referrals to medical specialists (i.e. geriatrician, urologist).

We recommend that for the continence program your nurse management group develops referral lists based on what your health service can provide, what is available in your local area and a list of important website contacts to find a practitioner or advice (Table 2).

Specialist advice can be more difficult to arrange in rural and remote areas and therefore the contact will not always be face to face, but might be by teleconferencing.

Table 2: Referrals for Continence

Health Professional	Source	Contact
Continence Nurse/Specialist	Health Service X	Name, contact details
Physiotherapist	Health Service X	Name, contact details
Dietitian	Health Service X	Name, contact details
Medical Practitioner	Health Service X	Name, contact details
Australian Physiotherapists Association	website	http://www.physiotherapy.asn.au/
Australian Dietitian's Association	website	http://daa.asn.au/
Australian Continence Foundation	website	http://www.continence.org.au/

Interventions

In the identification phase, information about the resident's healthcare and personal needs were identified. The intervention program will address these issues, by developing strategies to improve or maintain the resident's health status and quality of life.

The intervention program targeting continence should involve evidence informed strategies (refer below) that address these needs, and importantly the strategies should be specifically tailored for each individual to be most effective. The approach and actions you use to support one resident may be very different from those implemented for another resident.

When designing interventions consider the resident history and personal preferences, the assessment outcomes, the context the strategy will operate in (i.e. the physical environment, the social environment), the knowledge and attitudes of staff, residents and family, and the types of resources required and their availability. Interventions are likely to be medical, psychosocial, educational or nursing in nature.

It is also important that all staff follow a systematic process when implementing an intervention 'program'. This will increase the likelihood of your intervention's success. Having a systematic process which you can describe will also enable other staff to repeat your interventions if they prove successful.

Continence management is an important element in maintaining the resident's dignity and ability to socially interact.

The recommended Continence Assessment and Care Plan (refer to the Continence Workbook Appendix and a copy is also found in the Continence Assessment Pack), provides a direct linkage from the assessment questions to care options. The "Continence Tools for Residential Aged Care – An Education Guide" also provides further guidance on how to complete all parts of the form. The Continence Assessment and Care Plan provides strategies for all question outcomes related to toileting ability, bladder and bowel patterns, nutrition, skin care and medical needs. For example it directs staff to:

- Identify what behaviours indicate a need to go to the toilet for that resident
- Work out how to assist the resident to find the toilet (such as lighting at night)
- Document aids and assistance required to get to the toilet
- Document if supervision or assistance is required to complete toileting activities
- Consider if pain plays a role in toileting
- Understand when to refer and who to refer to
- Consider night-time strategies
- Consider leakage strategies
- Develop scheduled toileting plans
- Know how to manage catheters
- Identify symptoms that need to be reported (pain, straining, bleeding etc)
- Know how to interpret urinalysis dip sticks
- Understand nutritional and skin care strategies

BCOPE (p.189 and p.190) focuses on the management of continence issues using a person-centred approach and effective documentation. Respecting the dignity of the person and their right to be involved in their care is paramount. Effective communication of the care plan strategy with the person, their family and among staff is essential.

Once continence issues have been identified, several steps can be taken to manage incontinence as part of care planning. BCOPE (p.189) describes some of the strategies that can be put in place:

- Encourage the person to walk to the toilet where possible or, if not, get out of bed to use the commode.
- Discourage the use of bedpans and urinals where possible and if appropriate (i.e. unless this is part of the management strategy)
- Continuously monitor skin integrity and in particular around high risk areas such as the perineum, inner thigh and buttocks.

- Review the person's nutrition status to ensure they are adequately hydrated and consuming sufficient fibre, as this supports optimum bladder and bowel functioning
- Respect the person's right to choose the most appropriate treatment option. Continence can be a highly sensitive issue, therefore active listening without judgment is vital
- Implement an individualized management plan such as scheduled toileting
- Encourage the person to completely empty their bladder or bowel
- Provide education about bladder and bowel function to the person, their family and to staff to support ongoing management
- According to the supports offered at your facility and as part of your health service, you may be able to offer the person and their family referral to a continence specialist for more advice on continence aids, behavioural therapy, medication or surgery options.

Care Planning

A comprehensive care plan will be more than a summary of care needs, it will be individualised for each resident and reflect an understanding of their story, history, preferences and care needs. Facilities may have their own care plan or the Continence Care Summary found in the Continence Tools for Residential Aged Care – Continence Assessment and Care Plan could be considered.

Goal Setting

Moving beyond compliance, the care planning should also address setting goals based on clinical outcomes and the resident's perspective on their care needs and what is important to maintain their quality of life. It is recommended that a **Quality Of Life** (QoL) questionnaire be used to ascertain the resident's view of their quality of life. This could be implemented during the resident/family meeting to sign off on the Care Plan. The goals developed with the resident/family should cover **resident QoL**, **clinical outcomes** and **quality care outcomes** to address a wide range of documentation needs (i.e. consumer satisfaction and clinical expectations).

SMART Goals are an example of a standardised approach to goal setting with measurable outcomes. The SMART acronym (www.projectsmart.co.uk) stands for goals that are:

- **Specific**, that is, they provide clarity, focus and direction.
- **Measurable -** Objective measures can demonstrate the effectiveness of the goals.
- **Action-oriented**, that is, they provide a strategy for achieving them.
- **Realistic** – they meet the resident's preferences, they are practical for staff to implement and they consider the efficient use of resources, because if they're not, we're just setting up for almost certain failure

- **Time-based**, meaning for a specific duration. That enhances their ability to be measured and re-evaluated on an ongoing basis

Role of Documentation

Documentation of care is essential because members of the care staff are accountable to each resident for their actions and decisions. Accountability is also a vital function of professional, legal, accreditation and funding mechanisms and processes.

Documentation is also a communication tool about what has been investigated and the information collected, what interventions have been tried for a particular problem with a particular resident and to identify what is and isn't working. It's a communication tool that can help all staff give the best possible care.

Good documentation supports the nursing process which drives the care. It should incorporate evidence informed practices, assessments and interventions, utilise staff skills, and drive a quality care approach.

The documentation process should leave a trail that provides robust and accountable information, leaving your facility audit ready. The documentation is the basis of an evidence profile which provides objective and transparent information for the reason that assistance is or is not required. This supports the ACFI claim which is an outcome of the process, not a driver.

The process for documenting care is as follows:

- Summarise the relevant points from the collated background information and personal history
- Record the assessment and referral outcomes
- Record the identified capabilities and need for assistance following an analysis of the background information and assessment outcomes. This forms the basis of an evidence profile which provides objective and transparent information about the reason that assistance is or is not required
- Prepare the care plan with details on the care to be provided, why, and the residents goals and desired outcomes (in consultation with the family if appropriate)
- Record the evaluation of the care provided including the resident's response to the care and quality of life outcomes
- Continue to document new activities or identified issues (e.g. developed strategies and changes to care planning) in the progress notes and in the care plan, as this assists the information and communication flow and allows the process to be tracked for quality purposes

- Incident forms should be completed recording nutrition and swallowing issues. This would be documented in the resident's goals and care plan.

Linking the Evidence

This is about showing the link between the evidence from the background and assessment information (what has been collected in the identification phase) and the care that has been provided to address the identified care needs (in the implementation phase).

The links are:

- Begin by looking at and noting any underlying issues (e.g. diagnosis) or symptoms (e.g. incontinence related to functional mobility, arthritis in wrists), connect the link to the body structures and/or functions that are impacted (e.g. mobility impaired, UTI risk). The evidence is recorded in the medical notes, ACCR, family interview and admission functional and continence assessments.
- Describe the associated activity limitations (e.g. reduced social interaction, hydration risk). It's important to look at remaining strengths (e.g. cognitive awareness of when needs to void). This is recorded in the comprehensive continence assessment.
- Describe the intervention program and how it addresses the limitations to assist the resident to improve or maintain his or her status and ensure continued participation in a quality life (e.g. type of continence products). This is recorded in the care plan and allied health notes.
- Finally, define the care goals (a toileting program that reduces incontinence) and resident goals (improved social interaction) that will be evaluated. Goals give purpose to the care and provide a measurement basis for evaluating the outcomes. This is recorded in the care plan.

For Rose the strategies and goals were:

- Staff, resident and family education to improve UTI knowledge
- Commencing pain medication to reduce pain during the major activity times.
- Selecting incontinence products that assist the independence of the resident
- Trialling a toileting schedule to reduce stress incontinence
- Referral to a dietitian to modify the fluid intake as a prevention approach for dehydration and urinary tract infections.

These strategies were then turned into a number of goals such as:

- Specific e.g. to reduce improve the resident's self management of incontinence products and reduce occurrences of Urinary Tract Infection's (UTI) within one month
- Measurable e.g. record and monitor the recommended fluid intake, record adverse events (e.g. UTI's)
- Actions e.g. use of small continence pads, referral to a dietitian
- Realistic e.g. you have access to a dietitian and the products, the resident has agreed to the strategy, it is affordable
- Time based e.g. you set the evaluation date at one month after the commencement of the dietitian's recommendations by reviewing the progress notes, handover notes, fluid charts, adverse events, pad usage and interviewing the resident.

Completing the ACFI documentation

The data collected can now be used to complete the **ACFI 5 checklists** as described in Table 3**.** The Continence Assessment Form and Care Plan can also inform on many other aspects of the resident's care needs and for completing the ACFI; for example:

- Questions 4 and 6 can help to answer some of the ACFI 4 Checklist items (positioning and completing toileting activities);
- Question 14 may assist with ACFI 10 questions regarding sleep disturbance at night;
- Question 22 may assist with skin integrity.

The ACFI documentation requirements will be provided from a comprehensive management approach. It is important that the nursing assessment process drives your practices not the ACFI and the ACFI should flow out from the comprehensive assessment approach.

Table 3: ACFI Question 5 Checklists

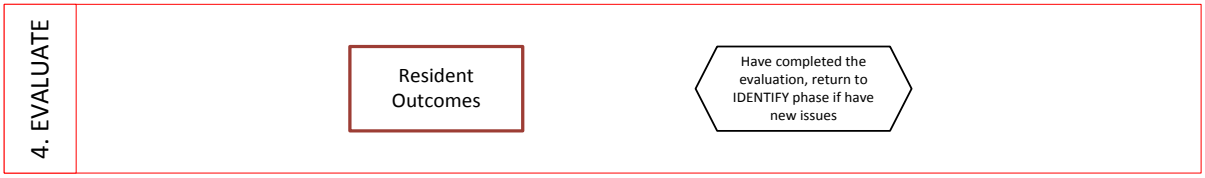
ACFI 5 Checklist Urinary continence	**Where to find the information**
No episodes of urinary incontinence or self-manages continence devices	ACCR or Medical Practitioner notes CHA Continence questions
Incontinent of urine less than or equal to once per day	3 day Bladder Chart transcribed to the ACFI Urine Record
2 to 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	3 day Bladder Chart transcribed to the ACFI Urine Record
More than 3 episodes daily of urinary incontinence or passing of urine during scheduled toileting	3 day Bladder Chart transcribed to the ACFI Urine Record

ACFI 5 Checklist Faecal continence	**Where to find the information**
No episodes of faecal incontinence or self-manages continence devices	ACCR or Medical Practitioner notes CHA Continence questions
Incontinent of faeces once or twice per week	7 day Bowel Chart transcribed to the ACFI Bowel Record
3 to 4 episodes weekly of faecal incontinence or passing faeces during scheduled toileting	7 day Bowel Chart transcribed to the ACFI Bowel Record
More than 4 episodes per week of faecal incontinence or passing faeces during scheduled toileting	7 day Bowel Chart transcribed to the ACFI Bowel Record

If using scheduled toileting, it is important to ensure ACFI documentation requirements are met:

Definition of Scheduled toileting Ref: ACFI User Guide p.4	"Scheduled toileting for the purpose of question 5 (Continence) is: staff accompanying a resident to the toilet (or commode) or providing a urinal or bedpan or other materials for planned voiding/evacuation according to a daily schedule designed to reduce incontinence."
The use of scheduled toileting codes in the Continence Records e.g. code 4 (Urinary Chart) or code 7 (Bowel Chart). Ref: ACFI User Guide p22	"If claiming for scheduled toileting, you must provide documentary evidence of incontinence prior to the implementation of scheduled toileting e.g. ACCR or a flowchart completed prior to scheduled toileting being implemented."

Evaluation Process



Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided. The evaluation process considers:

- Resident Quality of Life outcomes

  Assess if the resident's life is better? In what ways (e.g. happier, healthier)? What might have produced this outcome? This could be determined by revisiting the Quality of Life questionnaire or by interviewing the resident and family.

- Resident Care Outcomes

  With regard to continence, for example, has the intervention reduced stress incontinence episodes? This could be determined by recording a three day bladder chart and coding for stress incontinence pre and post the intervention.

- Further improvements

  What needs re-assessing, what could be implemented in a slightly different way?

Evaluation involves a systematic determination of the intervention outcomes, to ensure quality care is being provided. The goal setting stage provides criteria or measures to determine success or otherwise of the intervention. The criteria can be quantitative or qualitative. The primary purpose of evaluation is to identify the effectiveness of the intervention, to guide further improvements to the interventions to achieve the desired outcomes, and to identify emerging new issues. The finding of new issues would trigger a return to the identification phase.

Evaluation forms the basis of the iterative process that leads to a cycle of continuously improving the quality of the care provided.

Outcomes

An evaluation of Mrs. Smith's care has shown:

- *Rose can have difficulty raising herself onto and out of chairs (due to her arthritis in the wrists). Staff will need to physically assist Rose into/out of chairs and the toilet seat.*

- *There has been no need for Rose to change her clothing (due to leakage) with her toileting program and pelvic floor exercises in place, and Rose is satisfied with the day program and is managing the pad changing independently.*
- *She has found the night-time schedule is disrupting her sleep. She is now wearing thicker continence pads to bed, and only requires to get up once during the night with these pads. She would prefer to wake up naturally, and staff have recommended a sensor mat next to her bed so that they are aware when she stirs at night.*
- *She has had less debilitating pain in her wrists and knees and this has been recorded in a pain intensity chart over the month.*
- *She is satisfied with the small changes to her fluid intake*
- *Rose enjoyed the interaction with the village residents during the information talks and is interested in joining in their exercise programs*

Evaluation will show care staff what is or is not working and provide the basis for reviewing the interventions being used to achieve the goals. The evaluation provided the proof that what they had put in place had worked and improved her quality of life. New actions will also come out of the evaluation review, along with new goals.

Summary: Steps and Information Flow

Figure 2 below shows the continence topic phases and steps in the process. It involves:

The Identification phase which comprises:

- Collation of history from documentation and resident/family interviews
- Initial Nurse Assessment and Continence Screen;
- Completing the Comprehensive Assessment (Bladder and Bowel charts, Continence Assessment Form and Care Plan, and completing Standardised Care Processes to address any clinical risks)

The implementation phase which comprises:

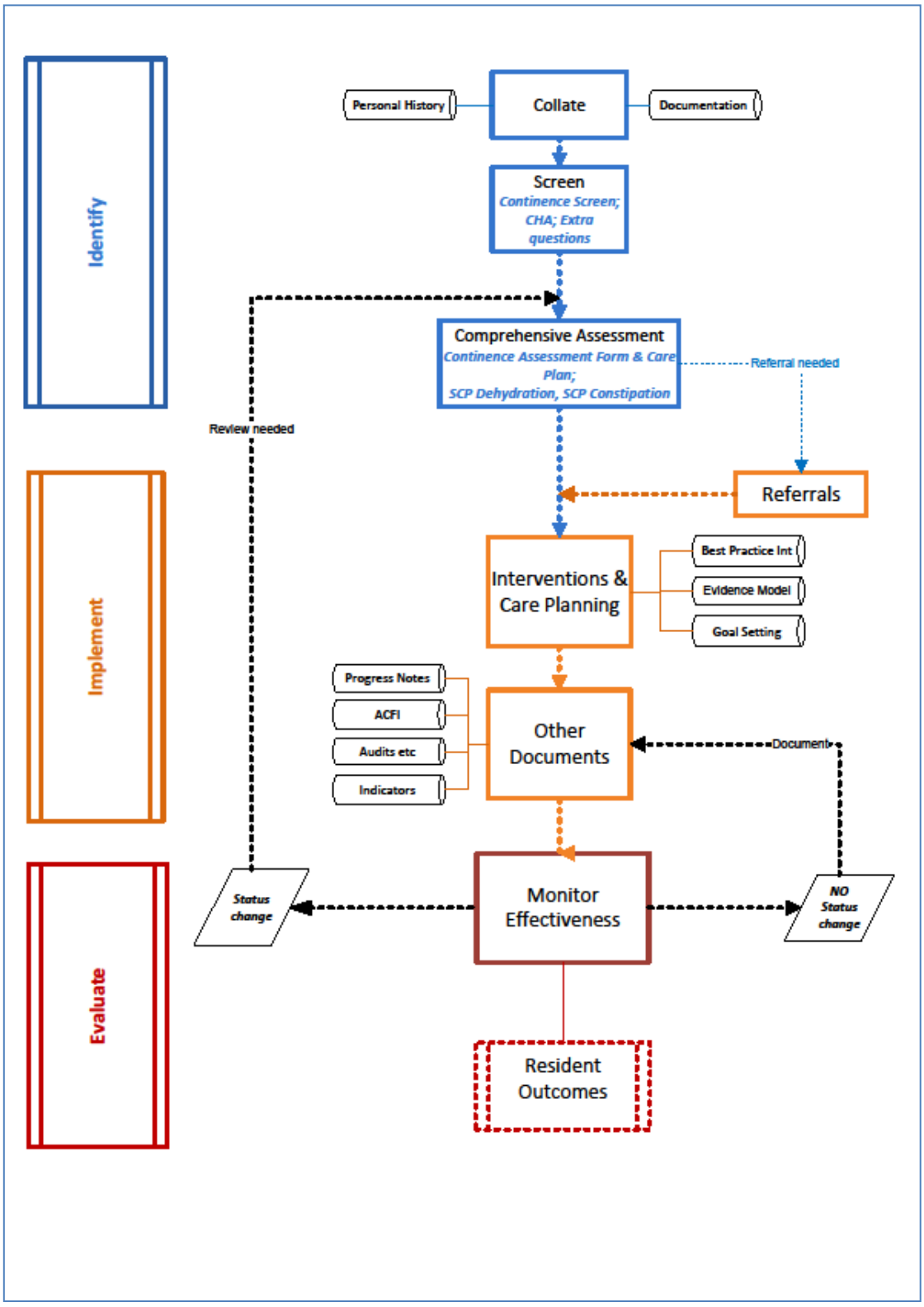
- Completing referrals as required to fill in assessment gaps or for specialist advice
- Analysing the information to develop strategies based on evidence informed practice
- Setting goals with the resident and family and completing the care plan
- Documenting the evidence steps and completing the ACFI

The evaluation phase which comprises:

- A review of the effectiveness of the interventions on resident outcomes
  Monitoring the progress and effectiveness of the interventions will inform if any changes should be considered
- If a review is required, then at this point the process returns to the identification phase and the associated steps

The Evidence Based Clinical Assessment Toolkit (EBCAT) is so named because evidence gives a reason to follow a particular plan toward improved health.

Figure 2: Continence Information Flow



Continence Resources

The recommended resources are listed below and information on where they are found in the toolkit (Table 4).

Table 4: Continence Workbook Resources

Resource Type	Details	Document
Background Reading	CHAOP Module 4	Reading Pack
Background Reading	BCOPE pp. 185-190	Download if required – refer to the Reading Pack
Screen (part 1)	Initial Nurse Assessment (e.g. CHA)	Continence Assessment Pack
Screen (part 2)	Continence Screening Form	Continence Assessment Pack
Screen (part 3)	Diagnosis of urinary incontinence Diagnosis of faecal incontinence Use of suppositories Use of enemas	Continence Assessment Pack
Mandated Assessment	3 day Bladder Record	Continence Assessment Pack
Mandated Assessment	7 day Bowel Record	Continence Assessment Pack
Comprehensive Assessment	Continence Assessment Form and Care Plan	Continence Assessment Pack
Standardised Care Processes (SCP)	Constipation Dehydration	Continence Assessment Pack
Goal setting example	Quality Of Life Questionnaire	Reading Pack
Workbook Exercises	Practice using a Case Study	Continence Workbook Appendix

Continence References

The recommended resources are listed below and references are provided (Table 5).

Table 5: References for the Continence Workbook

Document name	Reference
3 day Bladder Record	Continence Tools for Residential Aged Care Sourced @ http://www.bladderbowel.gov.au/ncp/ncms/ctrac.htm ACFI Assessment Pack Sourced@ 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
7 day Bowel Record	Continence Tools for Residential Aged Care Sourced @ http://www.bladderbowel.gov.au/ncp/ncms/ctrac.htm ACFI Assessment Pack Sourced@ 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
Best care for older people everywhere - (BCOPE)	Department of Health Victoria (2012) Best care for older people everywhere. The toolkit. http://www.health.vic.gov.au/older/toolkit/index.htm
Comprehensive Health Assessment (CHA) for Older People in the Health Care System	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria The CHA is an example of an initial nurse assessment, it is based on the CHAOP resource.
Comprehensive Health Assessment of the Older Person (CHAOP)	Authors: La Trobe University ACEBAC Sourced from the Department of Health Victoria Resource developed for comprehensive health assessment training for PSRACS (2013).
Continence Tools for Residential Aged Care	Authors: Deakin University, 2011 Sourced at: http://www.bladderbowel.gov.au/ncp/ncms/ctrac.htm
NATFRAME Care profile	Section 11 of the National Framework for Documenting Care in Residential Aged Care Services. Australian Government resource https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/suggested-assessment-tools-for-aged-care-funding-instrument-acfi
Standardised Care Processes (SCP) Constipation Dehydration	Published by the Ageing and Aged Care Branch, Victorian Government, Department of Health, Melbourne, Victoria (2012). Authors: La Trobe University ACEBAC Sourced @ http://www.health.vic.gov.au/agedcare/downloads/score/constipation_scp.pdf

Document name	Reference
	http://www.health.vic.gov.au/agedcare/downloads/score/dehydration_scp.pdf

Continence Workbook Exercises

Now that you have worked through the workbook, you are ready to complete a small case study. You may choose to do this by yourself or as a group discussion.

Facility to insert a case study relevant to ACFI 5

What clinical history about self-care is relevant?

What personal history about self-care is relevant?

Start to link the evidence together from the case study

Diagnoses

……

Body structure/function that is affected

……

What activities have been restricted

……

Would you recommend a referral? If yes,

What advice or assessment is missing

……

Who would the referral be sent to

……

What information would you prepare for the Health Professional?

……

What information would you expect from the Health Professional?

……

Develop two goals with the following aspects:

- A single issue focus
- Measurable
- Action orientated strategy
- Realistic and achievable
- Can be evaluated

Resident QoL goal

……..

Clinical Care goal

……..

What documents do you have, and where are they stored (i.e. documentation trail)

Document Name (insert name)	**Location**	**Date Completed**
Resident /family Interview		
ACCR		
CMA/ other medical notes		
Screen/ Initial Assessment		
Comprehensive Assessment Tool		
Urine Record		
Bowel Record		
Resident Goals		
Other		

Complete the following ACFI 5 Checklists and note the evidence for that claim.

	ACFI 4 Toileting Checklists	**Describe the evidence and note the documents that support the claim**
	Use of Toilet	
☐	Independent (0)	
☐	Supervision (1) o Setting up toilet aids, or handing the resident the bedpan or urinal, or placing ostomy articles in reach; OR o standing by to provide assistance with setting up activities (verbal or physical)	
☐	Physical assistance (2) o One-to-one physical assistance is required for positioning resident for use of toilet or commodes or bedpan or urinal	
	Toilet Completion	
☐	Independent (0)	
☐	Supervision (1) o standing by while the resident toilets to provide assistance (verbal or physical) with adjusting clothing or peri-anal hygiene; OR o emptying drainage bags, urinals, bed pans or commode bowls	
☐	Physical assistance (2) o One-to-one physical assistance is required for adjusting clothing AND o Wiping the peri-anal area	