

TRUST CONTINENCE SERVICE

CONTINENCE ASSESSMENT ADULT

D.O.B. & CHI No:

PLEASE USE BLOCK CAPITALS

NAME:

DIAGNOSIS:

ADDRESS:

RELEVANT

HISTORY:

TEL. No:

GENERAL PRACTITIONER:

ASSESSING OFFICER:

DURATION OF PROBLEM:

DESIGNATION:

DRUG THERAPY:

BASE:

Initial & Reassessment Dates (Elaborate on any Section under 'Comment' for appropriate review date)																			
Tick As Appropriate 'Y'=Yes 'N'=No		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
TYPE OF URINARY INCONTINENCE	Stress																		
	Urge																		
	Overflow																		
	Reflex																		
FREQUENCY How Often? (Enter Number)	Day																		
	Night																		
DEGREE (Tick as appropriate) (Enter amount if possible)	Mild																		
	Moderate																		
	Severe																		
FLOW	Freeflow																		
	Dribble																		
	Hesitancy																		
DISORDER	Dysuria																		
	Haematuria																		
BOWEL HABIT	Regular																		
	Irregular																		
	Daily																		
	Often																		
	Faecal Incontinence																		
MOBILITY	Good																		
	Impaired																		
	Walks with Aid																		
	Bed (B) or Chair (C) Bound																		
DEXTERITY	Good																		
	Limited																		
	Poor																		

DATE																			
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
IS TOILET WITHIN EASY REACH																			
DOES PATIENT LIVE	Alone																		
	With Family																		
	Other (Specify)																		
DOES THE CONDITION AFFECT RELATIONSHIPS	1. Social																		
	2. Physical																		

PERCEPTION OF PROBLEM
(Mark Scale as Appropriate)

PATIENT 0 _____ 10
 CARER 0 _____ 10
 NURSE 0 _____ 10

PREVIOUS HISTORY

MEDICAL

GYNAECOLOGICAL/SURGICAL

OBSTETRIC No. of Pregnancies Normal Delivery Other (Specify)

Relevant Comments

PLAN OF ACTION																			
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
DISCUSSED WITH G.P.																			
INTERVENTION ENVISAGED	Surgical																		
	Medical																		
	Pelvic Floor Exercise																		
	Bladder Retraining																		
	Catheter & Size																		
	Self Catheterisation																		
	Urinary Sheath																		
Other (Specify)																			

INITIAL ASSESSMENT - Comments

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Urinalysis Result:

Frequency & Volume recorded: YES / NO

Product Currently Used:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature:

Date:

Official Use Only:

Date Received:

1st Review - Comments

Urinalysis Result:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature: _____

Date: _____

Official Use Only:
Date Received:

2nd Review - Comments

Urinalysis Result:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature: _____

Date: _____

Official Use Only:
Date Received:

3rd Review - Comments

Urinalysis Result:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature: _____

Date: _____

Official Use Only:
Date Received:

4th Review - Comments

Urinalysis Result:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature: _____

Date: _____

Official Use Only:
Date Received:

5th Review - Comments

Urinalysis Result:

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature: _____

Date: _____

Official Use Only:
Date Received:

6th Review - Comments

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature:

Date:

Urinalysis Result:

Official Use Only:

Date Received:

7th Review - Comments

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature:

Date:

Urinalysis Result:

Official Use Only:

Date Received:

8th Review - Comments

Product Requested:

No. per Day:

Hip Size:

Collection Point:

Signature:

Date:

Urinalysis Result:

Official Use Only:

Date Received:

OFFICIAL USE ONLY

PRODUCT ALLOCATION

Monthly Allocation

Pkts.

Date/Initial

Date/Initial

Date/Initial

1.....	.....	.....	.....	.....
2.....	.....	.....	.....	.....
3.....	.....	.....	.....	.....
4.....	.....	.....	.....	.....
5.....	.....	.....	.....	.....
6.....	.....	.....	.....	.....
7.....	.....	.....	.....	.....
8.....	.....	.....	.....	.....
9.....	.....	.....	.....	.....

Product Information and Advice available from:

WITHDRAWN:-

DATE: REASON:

ADVISORS
SIGNATURE:

Guidelines for Completion of Continence Assessment

Continence Assessment Form THB MR555 is designed to be used for an initial assessment and further reassessment of adult clients incontinence problems.

Clients should be offered a reassessment of their incontinence at 6 monthly intervals, or more frequently as required.

Continence Assessment forms should be completed by a Registered Nurse.

Forms are available from the Continence Advisory and Treatment Service (C.A.T.S.) (please see contact details at the end of this document).

Terminology

- Assessing Officer Name of Registered Nurse carrying out assessment
- Diagnosis Medical History
 e.g. Parkinson's Disease, dementia etc.
- Relevant History Any factors which influence the clients ability to be continent
 e.g. reduced mobility, frail, elderly etc.
- Duration of Problem How long has the client been incontinent
- Drug Therapy All drugs and dosage, plus over the counter medicine taken by client

1. Types of Urinary Incontinence

Stress

Small spurts of urinary leakage which occur when laughing, coughing, sneezing or on exertion.

Cause Pelvic floor weakness, incompetent urethral sphincter

Treatment Pelvic floor exercises – for specialist help refer to C.A.T.S./physiotherapy

Urge

Leakage of urine occurs involuntarily or after a sudden strong urge to pass urine.

Cause Overactive bladder – bladder contracts during filling phase e.g. due to CVA

Treatment Bladder retraining – individualised toileting programme - appropriate fluid intake -
 antimuscarinic drugs (which act to relax the bladder)

Overflow

Feeling of incomplete emptying; Hesitancy; Poor stream; Passive dribbling

Cause	Outlet obstruction e.g. enlarged prostate or urethral stricture, underactive bladder muscle
Treatment	Check for post void residual (significant >100ml)
Consider	Prostate assessment; Medication; Intermittent self catheterisation; Neurological assessment; Urological assessment

Reflex – (normal in children under 2½ year olds)

No sensation and/or awareness of bladder filling and/or emptying.

Cause	Spinal trauma/lesion, head injury, neurological disease
Treatment	Individualised toileting regime. Intermittent self-catheterisation

- 2. Frequency** Please indicate the average number of times urine is passed day and night. (Average person goes to the toilet 4-7 times in 24 hours). A frequency volume chart will assist in determining this and should be completed wherever possible.
- 3. Degree** Indicator of the severity of the incontinence. This helps confirm the diagnosis and also the choice of treatment and/or absorbency of pad required.
- 4. Flow** This also helps establish the correct diagnosis.
- 5. Disorder** It is important to rule out any underlying causes e.g. urinary tract infection.
- 6. Bowel Habit** Constipation can affect urinary incontinence e.g. impacted bowel or straining to pass stool puts pressure on the pelvic floor and can cause leakage of urine.
Faecal Incontinence This can be caused by infection, irritable bowel syndrome, tumours, constipation. It is important to look at client's lifestyle to exclude laxative abuse or faecal impaction. Check fluid intake/fibre/mobility etc. Treat the cause e.g. anti-diarrhoeal drugs/diet. For advice and current information refer to C.A.T.S.
- 7. Mobility** If mobility is impaired the incontinence may have a functional cause. Therefore would a commode or urinal help the client with poor mobility?
Please note B for bedbound and C for chairbound
- 8. Dexterity** Consider the clients ability to remove clothes. Could the client manage to wash non-disposable pants or would disposable pads be more appropriate.

- 9. Does the Patient Live Alone?** Who is there to help the client or do they stay in residential home or hospital long stay ward?
- 10. Does the Condition Affect Relationships** Consider using the Quality of Life Questionnaire to determine how adversely the persons life is affected or restricted by their incontinence.
- 11. Perception of Problem** To be graded by client, carer and assessor - a guide to how the client/carer feels the problem affects their quality of life.
- 12. Previous History** Medical – e.g. CVA
Gynaecologist/Surgical – e.g. Hysterectomy, Pelvic Floor Repair.
Obstetric - This should be completed for **all** female clients.
Relevant Comments:- e.g. triplets, forceps etc.
- 13. Plan of Action** i.e. elaborate on any proposed treatment or management system.
- 14. Initial Assessment** A thorough review of the client's condition by questioning, observation and physical examination.
- 15. Product Currently Used** State what product (if any) client is currently using eg. toilet tissue or sanitary towels etc.
- 16. Product Requested** State what product(s) are required for both day and night (please refer to the products available on the C.A.T.S. Core List).
- 17. No. Per Day** Number of product(s) required per day and per night (maximum of 5 products in 24 hours).
- 18. Hip Size** Please indicate biggest measurement of client, usually waist in men and hips in ladies (essential when requesting pants or all in ones).
- 19. Collection Point** A home delivery service is available or products can be collected from Drumhar Health Centre, Perth or Wallacetown Health Centre, Dundee. Home delivery clients will be informed by letter how to order their products. The Continence Service does not initiate product orders unless specifically asked. In Angus clients products are delivered directly to their home.
- 20. "Official Use Only"** Section to be completed by the C.A.T.S. when allocating the clients pads/pants etc.

The following are available from the C.A.T.S:-

- Bladder and Bowel monitoring charts
- Frequency Volume charts
- Bladder Retraining leaflet
- Fluid intake leaflets
- Pelvic Floor Exercise leaflets
- Guidelines for accessing continence services
- Good defaecation guide
- Healthy diet leaflet
- Company product literature

If clients fail to respond to your chosen treatment within 3 months and/or you wish to discuss the options available, please contact your local C.A.T.S.

Perth	Drumhar Health Centre, North Methven Street, Perth	Tel. 01738 564258
Angus	The Lodge, Forfar Infirmary, Forfar	Tel. 01307 468383
Dundee	Wallacetown Health Centre, Lyon Street, Dundee	Tel. 01382 462861

References and further suggested reading:-

- N.M.P.D.U. Continence – Adults with Urinary Dysfunction. Best Practice Statement 2000. (www.nhshealthquality.org/nhsqis/files/BPSContinence_adults_urinary_dysfunction)
- Management of Urinary Incontinence in Primary Care. January 2005. SIGN Guidelines (www.sign.ac.uk)
- InContact Tel. 0870 770 3246 (www.incontact.org)
- Promocon Tel. 0161 834 2001 (www.promocon2001.co.uk)
- ACA Tel. 020 8692 4680 (www.aca.uk.com)
- The Continence Foundation Tel. 0845 345 0165 (www.continence-foundation.org.uk)