Continence Assessment - Community Nurse

To be completed by Community Nurse for all adults referred with urinary incontinence

Variation in this process – If indicated by clinical condition or nursing professional judgement, this assessment does not need to be completed. Reasons should be documented in the patient's notes.

Section 1 Patient Details (use patient label if available)

Name :	
Date of birth :	
Address :	
Phone no :	
GPs Details :	
CHi :	
Date of Referral :	
Date of Assessment :	
Assessment completed by : Grade / job title :	

Be aware of red flags when completing this form (A list of red flags with advice contained in Continence Information Folder)

Haematuria	Refer to GP
Bleeding PR	Refer to GP
Abnormal bleeding/discharge	Refer to GP
Bleeding in post menopausal women	Refer to GP
Severe back pain/ Pain, numbness or weakness in one/both legs causing stumbling/trouble getting up from a chair Saddle Anaesthesia	Symptoms of Caudia Equina - seek medical advice straight away
Bladder pain/pelvic pain	Refer to GP
Chronic Urinary Retention	Consider blood test to check renal function
Unexplained weight loss	Refer to GP
Recent surgery/radiotherapy to lower pelvic region	Consider possible bladder/bowel trauma
Undiagnosed diarrhoea	Consider dehydration & electrolyte imbalance - be aware of mistaking overflow for diarrhoea
Autonomic Dysreflexia	Care with interventions/awareness of symptoms of AD

Section 2 Current History

2.1 Reasons for seeking help now?

2.2 Duration of symptoms/ trigger for onset? <3 months 3month – 1 year >5yr
(explore triggers in detail)

2.3 Is it getting better / worse / staying the same?

2.4 Any previous investigations for incontinence?

2.5 Any experience of problems with bladder or bowels in the past, including childhood? Y / N

2.6 Are you aware when you need to pass urine? Y / N

2.7 Do you have any pain, stinging or burning when you pass urine? Y / N

2.8 If male do you suffer from after dribble? Y / N

2.9 Do you have any discomfort, pain or bleeding during intercourse? Y / N

2.10 How much does this problem bother you?

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2.11 What bothers you most about this problem?

2.12 How much does this affect your life and relationships?

2.12 How do you manage with this problem?

2.14 What are your goals/expectations from this assessment/treatment?

Undertake urinalysis at this point and record in section 13.1

If Leucocytes/Nitrite or symptoms of UTI present, take MSU, refer to GP and discontinue assessment until treated.

Section 3 Social, Past Medical, Drug and Gynaecological History

3.1 **Social History :**

3.1.1 Occupation:

3.1.2 Hobbies:

3.1.3 What are your home circumstances? eg. Live alone?

3.2 **Relevant Medical History:**

3.2.1 Weight : Height : BMI :

3.2.2 Smoker Y / N

3.2.3 Do you have any allergies? Y / N

3.2.4 If so, what?

3.2 Other medical / surgical history :

Condition	Y / N	Comments	Condition	Y / N	Comments
Respiratory problem			Epilepsy		
Diabetes Type I / Type II			Malignancies		
Cardiac condition			Recurrent UTI cystitis		
Neurological problem			Low back pain/ injury/spinal cord injury		
Dementia			Osteoporosis RA/OA		
Enlarged prostate			Radiotherapy		
Current or past psychological issues			Physical or Sexual abuse		
Bowel disorders			Physical disability		

3.4 Drug History
(if medication sheet available please note here and attach to assessment form)

Medication	Reason
Please include over the counter remedies	

3.5 Gynaecological History

3.5.1 Pre / peri / post menopausal

3.5.2 On HRT? Y / N When commenced? When stopped?

3.5.3 If you have had any pregnancies, please complete the following questions, otherwise please go to section 4.

3.5.4 How many babies have you had?

3.5.5 How many of your babies weighed over 8 lbs at birth?

3.5.6 Please give details of any difficult deliveries, use of forceps episiotomies or tears.

Section 4 Assessment of Function

4.1	Do you have difficulties getting to the toilet?	Y / N
4.2	Do you require assistance to get to the toilet?	Y / N
4.3	Do you use a mobility aid?	Y / N
4.4	Have you ever fallen on the way to the toilet?	Y / N
4.5	Do you use a wheelchair?	Y / N
4.6	Do you have enough room in the toilet?	Y / N
4.7	Do you have difficulties adjusting your clothing?	Y / N
4.8	Are you confined to chair / bed?	Y / N

Section 5 Assessment of Skin and Protection

5.1	Does the skin around groin/perianal area get sore?	Y / N
5.2	If yes give details	
5.3	Do you use creams / talc?	Y / N
5.4	If so, what do you use?	
5.5	If you wear protection what type of pad do you use?	
5.6	Are your pads usually damp / wet / soaked?	
5.7	How many pads do you use during day? during night?	

Section 6 Assessment of Stress Urinary Incontinence

6.1	Do you leak if you cough, laugh or sneeze?	Y / N
6.2	Do you leak when exercising?	Y / N
6.3	Do you leak urine when you move?	Y / N
6.4	Do you leak urine during intercourse?	Y / N

Section 7 Assessment of Over Active Bladder / Urge urinary Incontinence

7.1	Do you restrict the amount that you drink?	Y / N
7.2	Do you have to pass urine urgently?	Y / N
7.3	How long can you hold on after you feel you want to pass urine?	
	Not at all Up to 5 minutes More than 5 minutes	
7.4	Would you be wet if you did not pass urine immediately?	Y / N
7.5	Do you want to pass urine when you put your hands in water or when you put the key in the door?	Y / N

7.6	Do you go to the toilet more than 7 times per day?	Y / N
7.7	Do you leak urine at night?	Y / N
7.8	Do you get up to the toilet more than once a night?	Y / N
7.9	If yes, how often?	
7.10	If yes, is this because you are awakened with urge to pass urine or are you up anyway?	Y / N

Section 8 Assessment of Mixed Urinary Incontinence

This is a combination of both Stress Urinary Incontinence (section 6) and Urge Urinary Incontinence (section 7).

Section 9 Assessment of Overflow Incontinence

9.1	Do you have problems starting to pass urine?	Y / N
9.2	Do you have a poor flow of urine?	Y / N
9.3	Do you dribble after passing urine?	Y / N
9.4	Do you dribble with occasional gushes?	Y / N
9.5	Do you feel that you empty your bladder completely?	Y / N
9.6	Do you ever get discomfort /a dragging sensation around your abdomen?	Y / N
9.7	Are you wet all the time?	Y /N

Section 10 Bowel Habits

10.1	How often do you empty your bowels?	
10.2	Do you suffer with constipation (passing 3 or less stools per week or stools which are hard or lumpy)?	Y / N
10.3	Do you feel you have to rush to the toilet urgently to have your bowels open?	Y / N
10.4	Do you spend time straining to have your bowels open?	Y / N
10.5	If yes, please specify how long?	
10.6	Do you have a feeling of still wanting to go after emptying your bowels?	Y / N
10.7	Does your back passage get sore?	Y / N
10.8	Do you leak mucus from your back passage?	Y / N
10.9	Do you leak blood from your back passage?	Y / N
10.10	Do you have problems controlling wind?	Y / N
10.11	Is there a problem with soiling after bowel emptying?	Y / N
10.12	Do you have difficulty wiping after emptying your bowel?	Y / N
10.13	Do you lose any stool when you don't mean to?	Y / N
10.14	Is the loss of stool associated with an activity/excessive stress or food?	Y / N
10.15	Do you wear any protection for a bowel problem?	Y / N

10.16 If so, what do you use?

10.17 Are there any foods that you find affect your bowels? Y / N

10.18 If so which ones?

10.19 Please describe what you eat on an average day and how much
For breakfast :
For lunch :
For dinner :

Section 11 Objective Examination

11.1 Visual Assessment

Skin condition	
Prolapse	
Vaginal discharge	
Atrophic Vaginitis	
Leakage/decent of perineum on coughing	

11.2 Visual Assessment of Anal Area

Skin tags	
Anal fissure	
External haemorrhoids	
Perianal excoriation	
Soiling	

11.3 Pelvic Floor Assessment

Consent given	
Chaperone offered	
Visual assessment	
Digital pelvic floor assesment completed	
Oxford Scale (1-5) :	
Endurance (length of time contraction can be held)	
Repetitions (how many times can this be repeated)	
Fast contractions (how many contractions can be done in quick succession)	

11.4 Post Void Residual Volume (Bladder Scan)

Consent given	
Chaperone offered	
Pre void result :	mls
Post void result :	mls

Section 12 Test and Observation Outcomes

12.1 Urinalysis

Please enter results from the patient's urinalysis

Glucose		Ph	
Ketones		Protein	
S. Gravity		Nitrite	
Blood		Leucocytes	

12.2 Bladder Record (urinary / voiding diary)

Please enter results fromt he patient's bladder/bowel record

Total fluid intake over 24 hours :	
Total fluid output over 24 hours :	
Amount of voids over 24 hours :	
Largest single void :	
Nocturnal enuresis	
Nocturia	

12.3 Bristol Stool Chart

Please enter results fromt he patien'ts bladder/bowel record

How often are bowels emptied?	
Bristol stool chart no :	

Section 13 Conclusion / Diagnosis

Type of incontinence	
Underlying cause/s	
Treatment or management by community nurse	
Referral to other health professional	

Section 14 Care Plan

Please complete standard nursing care plan.

Discussion with patient / consent gained to share information in this assessment with other healthcare professionals if applicable : Y / N

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